Board of Directors (In Public)

Schedule	Friday 6 November 2020, 9:15 AM — 11:30 AM GMT
Venue	Via video conferencing
Description	A meeting of the Board of Directors will take place on Friday, 6 November 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 2020 11 06 Nov.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

4. Questions from the public relating to matters on the agenda
   To RECEIVE questions from members of the public of information or clarification

relating only to matters on the agenda
Presented by Sheila Childerhouse

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

6. Minutes of the previous meeting
   To APPROVE the minutes of the meeting held on 2 October 2020
   For Approval - Presented by Sheila Childerhouse
   - Item 6 - Open Board Minutes 2020 10 02 Oct Draft.docx

7. Matters arising action sheet
   To ACCEPT updates on actions not covered elsewhere on the agenda
   For Report - Presented by Sheila Childerhouse
   - Item 7 - Action sheet report.doc
   - Item 7 Annex - Elective care communication plan.docx

8. Patient/staff story
   To RECEIVE the story
   For Report - Presented by Jeremy Over

9. Chief Executive's report
   To RECEIVE an introduction on current issues
   For Report - Presented by Stephen Dunn
   - Item 9 - Chief Exec Report Nov '20.doc

9:50 DELIVER FOR TODAY

10. Operational report
    To APPROVE the report
    For Report - Presented by Helen Beck
    - Item 10 - Board report - Operational update update 6.11.20.doc

11. Integrated quality and performance report

To APPROVE a report
For Approval - Presented by Helen Beck and Susan Wilkinson

Item 11 - Integrated quality and performance report - 6 Nov 20.pdf

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

Item 12 - Board report Cover sheet - M06.docx

Item 12 - Finance Report- September 2020 FINAL.docx

10:30 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

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13. People and organisational development (OD) highlight report
To APPROVE a report
For Approval - Presented by Jeremy Over

Item 13 - People OD highlight report.docx.doc

Item 13A - WSFT people plan.pptx.ppt

Item 13B - F2SU report.docx.doc

Item 13B2 - F2SU policy.docx.doc

Item 13C - HWB report.docx.doc

Item 13D - safe staffing.docx

Item 13E - Appraisal and Mandatory Training Board October 2020.doc

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14. Quality, safety and improvement reports
To APPROVE the reports
Presented by Susan Wilkinson

14.1. Maternity quality & safety performance report
For Approval

Item 14.1 - Maternity quality and performance report Oct 2020.pdf

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14.2. Infection prevention and control assurance framework
For Approval

Item 14.2 - COVID IPC assurance framework - Nov 2020.pdf

14.3. Improvement programme board report
For Approval

- Item 14.3 - Improvement programme board report Oct 2020.docx
- Item 14.3 Annex A - 201015 Status Summary Action Plans IPB Out.xlsx

14.4. Nursing staffing report
For Approval

- Item 14.4 - Nursing staffing report - 6 Nov 2020.docx

11:10 BUILD A JOINED-UP FUTURE

15. Integration report – Q2
To APPROVE the report
For Approval - Presented by Kate Vaughton and Helen Beck

- Item 15 - Integration report WSFT Board Paper_Nov 2020.doc

11:20 GOVERNANCE

16. Governance report
To APPROVE the report, including subcommittee activities
For Approval - Presented by Richard Jones

- Item 16 - Governance report.doc
- Item 16 Annex B - Risk Appetite Statement-2020-21.docx

11:25 ITEMS FOR INFORMATION

17. 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

18. Date of next meeting
To NOTE that the next meeting will be held on Friday, 4 December 2020 at 9:15am in West Suffolk Hospital

For Reference - Presented by Sheila Childerhouse

18.1. Future Board meeting dates
For Approval - Presented by Sheila Childerhouse

Item 18.1 - Board Dates 2021-22.doc

RESOLUTION TO MOVE TO CLOSED SESSION

19. 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, 6 November 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.	Sheila Childerhouse
6.	**Minutes of the previous meeting (attached)** To approve the minutes of the meeting held on 2 October 2020	Sheila Childerhouse
7.	**Matters arising action sheet (attached)** To accept updates on actions not covered elsewhere on the agenda	Sheila Childerhouse
8.	**Patient/staff story** (verbal) To receive the story	Jeremy Over
9.	**CEO report (attached)** To receive an introduction on current issues	Steve Dunn
9:50 DELIVER FOR TODAY		
10.	**Operational report (attached)** To approve the report	Helen Beck
11.	**Integrated quality and performance report (attached)** To approve a report	Sue Wilkinson / Helen Beck
12.	**Finance and workforce report (attached)** To approve report	Craig Black
10:30 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP		
13.	**People and OD highlight report (attached)** To approve report	Jeremy Over / Amanda Bennett

14.	**Quality, safety and improvement report** To approve reports: 14.1 Maternity services quality and performance report 14.2 Infection prevention and control assurance framework 14.3 Quality improvement programme board report 14.4 Nurse staffing report	Sue Wilkinson / Nick Jenkins Karen Newbury
11:10 BUILD A JOINED-UP FUTURE		
15.	**Integration report – Q2 (attached)** To approve report	Kate Vaughton / Helen Beck
11:20 GOVERNANCE		
16.	**Governance report (attached)** To approve report, including subcommittee activities	Richard Jones
11:25 ITEMS FOR INFORMATION		
17.	**Any other business** To consider any matters which, in the opinion of the Chair, should be considered as a matter of urgency	Sheila Childerhouse
18.	**Date of next meeting** To note that the next meeting will be held on Friday, 4 December 2020 at 9:15 am in West Suffolk Hospital 18.1 Future Board meeting dates (**attached**)	Sheila Childerhouse
RESOLUTION TO MOVE TO CLOSED SESSION		
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To AGREE any alterations to the timing of the agenda.

For Reference

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6. Minutes of the previous meeting

To APPROVE the minutes of the meeting held on 2 October 2020

For Approval

Presented by Sheila Childerhouse

DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 2 OCTOBER 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	•	
Rosemary Mason	Associate Non Executive Director	•	
Jeremy Over	Executive Director of Workforce and Communications	•	
Louisa Pepper	Non Executive Director	•	
Alan Rose	Non Executive Director	•	
David Wilkes	Non Executive Director	•	
Sue Wilkinson	Interim Executive Chief Nurse	•	
In attendance			
Claire Sorenson	Deputy director of workforce(HR & People Services)		
Daniel Spooner	Deputy Chief Nurse		
John Troup	Interim Head of Communications		
Kate Vaughton	Director of Integration and Partnerships		
Governors in attendance (observation only)			
Peter Alder, Florence Bevan, Judy Cory, Jayne Gilbert, Gordon McKay, Adrian Osborne, Joe Pajak, Liz Steele, Martin Wood			

Action

GENERAL BUSINESS

20/183 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."

ACTION: Consider options for the public and media to join open board meetings. **R Jones**

20/184 APOLOGIES FOR ABSENCE

Apologies were noted as above.

- The Chair welcomed everyone to the meeting and introduced a short poem and video had been written and put together by a member of the communications team and had been featured as part of national poetry week.

20/185 DECLARATION OF INTERESTS FOR ITEMS ON THE AGENDA

No declarations of interest were received.

20/186 QUESTIONS FROM THE PUBLIC RELATING TO MATTERS ON THE AGENDA

Q Could information be provided on the co-production leads for the new healthcare facility?

A This information would be provided at the governor and board briefing on 20 October.

Q Could governors be informed before announcements were made to the public on significant new items?

A The Chief Executive apologised and would ensure that governors were communicated with first. A major national announcement was anticipated in the next few days on the acceleration of the building of the new healthcare facility.

20/187 REVIEW OF AGENDA

The agenda was reviewed and there were no issues.

20/188 MINUTES OF MEETING HELD ON 31 JULY 2020

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

20/189 MATTERS ARISING ACTION SHEET

The ongoing actions were reviewed and the following update provided:

Item 1823; Sepsis – assess impact of establishing super-RAT (rapid assessment and treatment) within ED. WSFT had received funding towards creating a new RAT area and this was moving at pace. This would assist in managing Covid through the winter.

Item 1875; Outcome of nursing staff establishment review to be presented to the board when available in December. It was anticipated that this would be available before January.

The completed actions were reviewed and the following comment made:

Item 1751; As part of the next phase of IQPR development review the SPC metrics which are indicators of future performance. Several comments had been received at the governors meeting last night about the IQPR; these would be forwarded to Helen Beck. It was explained that the format and content of the IQPR was an ongoing process; it was hoped to return to the SPC format as soon as possible.

20/190 CHIEF EXECUTIVE'S REPORT

- The annual members meeting had taken place on 22 September via Microsoft Teams and had been well attended by board members and governors. Helena Jopling and Thomas Pulimood had given an excellent presentation on Covid.
- A recent 5 o'clock club virtual presentation had been given on Merseycare which had been attended by over 80 people, including board members and governors.
- Amanda Bennett and James Barrett had been appointed as the new Freedom to Speak Up (FTSU) Guardians.

- The executive team was working on changing the way that the organisation was led with a more engaging and empowering approach to supporting staff. This would be reflected in future sessions on the Trust's strategy/planning.
- The Trust launched its flu vaccine campaign yesterday. It was hoping to achieve or improve on the 80% off staff vaccinated last year.

Q How could the Trust actually make Mersey care happen and move forward at pace?

A A follow up meeting had taken place to look at this in greater detail and it was planned to send a cohort of staff on a training session on Merseycare. There was a need to promote the supportive and crucial role that line managers played. As part of this the Trust was investing in a team of HR business partners; to date four had been appointed and would be joining WSFT over the coming months.

ACTION: proposal for the introduction of Mersey care as part of the Trust's people plan to be presented to board meeting in November. **J Over**

DELIVER FOR TODAY

20/191 OPERATIONAL UPDATE INCLUDING: PHASE 3 RECOVERY, WINTER AND COVID PLANNING, NHS111 FIRST, BREXIT AND COMMUNITY ENGAGEMENT

- Detailed plans were being worked through for phase 3 recovery, however these were very constrained due to the structural repair work that was being undertaken.
- The Trust had written to the 20,000 plus patients who were on the waiting list to assure them that they were still on the list. It was also developing a GP microsite which would provide up to date information on waiting times and changes to clinical services due to Covid. Relevant parts of this information would also be available on the public website in the future.
- WSFT had transferred its Covid testing to ESNEFT which had resulted in much better turnaround times. Additional resource had also been approved so that the Trust's in-house point of care testing (Samba) machines could be operational 24/7.
- Very low levels of Covid activity were currently being seen in the hospital and this would continue to be carefully monitored.

Q Was there a capacity issue with the Samba machines as they required someone operate them all the time?

A This was the case because each test took 90 minutes to run.

Q Reflecting on empowerment and engagement of staff, to what extent were front line staff involved in developing these plans?

A **What** the Trust was expected to deliver in terms of high level plans came down from the national team. However, below these were very detailed action plans and the relevant services and staff had been very engaged and involved in the development of these to inform **how** we deliver

Q Was NHS 111 First still an option or was it mandatory; if so how would this be communicated.

A This was part of a national programme being led by the system and would eventually be in place across all organisations. Communications would come from the CCG and NHS 111. Cambridge was a pilot and slightly further ahead which meant that WSFT could learn from this.

Q A lot of effort was being put into all this planning. Did the Trust have the capacity to continue to manage Brexit, winter pressures and Covid? Was there any further support needed from the board?

A This was a concern of the executive team, both the physical and mental capacity of the teams as the Trust moved into winter. Nationally Brexit was being managed by Keith Willett who was also managing Covid and was looking at using the same systems for both.

Conversations were taking place with WSFT and the region around reverting to 24/7 cover as it moved into winter and Brexit. However, this time it had been made clear that Trusts should not step down elective activity unless absolutely necessary. This would require more capacity as senior leaders would need to focus on this. This would be looked at in the next couple of weeks and a workshop was also taking place. It was very important to continue to focus on leaders as well as front line staff.

Q Were there sufficient plans in place or was further support required for the community health teams?

A Three senior leaders from the CCG, social care and WSFT were working together to provider greater management support for the community teams. They were talking to the middle management of the teams and also to front line staff to find out what else they needed to deliver care to patients. They were also working with Home-Link to look at bringing in additional staff support to relieve some of the pressure.

ACTION: provide a briefing on this at a future board meeting. **H Beck**

The board approved the format and content of this report.

20/192 INTEGRATED QUALITY AND PERFORMANCE REPORT

- The number of 52 week waits had increased; this was a national issue. However, during the last two months the Trust had not been able to use the elective surgery wards, but elective activity had increased from the beginning of this week.
- 104 days waits were reducing rapidly. A significant number of patients waiting over 104 days were due to patient choice and anxiety about coming into hospital or needing to self-isolate. The Trust was committed to returning 104 day waits to pre-Covid levels by the end of October.

Q Do we communicate with GPs about this?

A GPs received a copies of letters and the Trust informed GPs if patients were unwilling to attend hospital.

Q Pre Covid the number of patients waiting over 52 weeks was in single figures whereas now nearly 5% of patients were waiting over 52 weeks which was very concerning. How realistic was the planned activity in terms of reducing this quickly, taking into account winter pressures, second Covid wave etc?

A The Trust was looking at a trajectory up to 2 years to achieve this. The 52 weeks wait position would improve but not very quickly due to theatre capacity etc; it could be two years before it returned to where it should be.

Q It was important to communicate honestly and manage the expectations of the Trust's service users and the public; how was this being done?

A It was very important to manage public expectations. A GP microsite was being developed which would show wait to first appointment times and if patients needed to be admitted, average waiting times for procedures/treatment. It was then planned to put the relevant content on the public website, eg waiting time information. There would also need to be a communication to make people aware of how to access this information.

Specialties were writing separately to patients as to what they could do to help manage their condition/situation or if they should go back to their GP. Communication with the public around increased waiting times and what to expect would be critical as the Trust moved into winter. It had been clear in the board papers and at the AMM about the situation and this had been picked up by the local media. Other communication had also been undertaken around this both on the radio and in the local press.

Q When the Trust first moved into Covid it produced a forward projection which was very helpful. Was it possible to do something similar to this in order to manage patients' expectations?

A The team would consider how it could do this, eg shape of waiting list curve. However, the referrals situation was unknown. It was important to understand that ambitious activity plans required the Trust to return to 90% of pre-Covid activity. In addition, the backlog needed to be cleared which was a major challenge.

ACTION: consider how to communicate current and future activity and waiting times to the public. **J Over / H Beck**

- Duty of candour was an ongoing focus. Verbal duty of candour was being delivered in a timely fashion and work continued on improving delivery of written duty of candour.
- Patient falls had increased per 1000 bed days; however, the organisation had seen an increase in cognitively impaired patients. A falls review had been undertaken and there was no correlation between the visiting rules and number of patient falls. This would continue to be focussed on.
- Pressure ulcers had reduced again and work continued with the quality process on how to manage pressure ulcers, particularly in the community. During the Covid outbreak patients had been reluctant to let people, eg community staff, into their home, therefore there was a need to work on concordance.
- Complaints had increased as expected which was a reflection on the increase in activity in the organisation. Work would continue to on identifying themes and putting action plans in place. Closure of complaints within the required time frame should be back on track next month.
- The clinical helpline had ceased due to the staff who were operating this returning to their clinical roles in the organisation. However, Cassia Nice and her team were putting together a robust business case to reinstate this moving forward. This would be a joined up service with Keeping in Touch.

Q Could this be reinstated quickly if there was another Covid outbreak.

A This would depend on resources to operate this, which would only be available if there was a shielding situation again.

The board were requested to feedback comments on the format of this report.

MATERNITY SERVICES QUALITY AND PERFORMANCE REPORT

Karen Newbury, head of maternity joined the meeting to present this report

- The maternity dashboard detailed the 85 indicators that were being monitored. Every month each of these indicators were categorised as red, amber or green.
- It was explained that with the exception of the number of births/babies this rating was based on 2016/17 data. Since then there had been a lot of changes in guidance and the situation was similar nationally due to the saving babies' lives bundle and preventing still births.
- Shoulder dystocia was showing red for August but this was a number, not a percentage. This was not a concern but would be monitored over the next couple of months.
- Supernumerary labour suite co-ordinator statistics were a concern and had been highlighted by the CQC. The main issue was how the data was captured which was currently not effective. This was being addressed through the purchase of the labour suite supernumerary tool, which would provide more meaningful data.
- The CNST maternity incentive scheme was halted during Covid but was now active again and the Board declaration form was required to be signed and submitted to NHS Resolutions by midday on 20 May 2010.
- The ten steps to safety were detailed in this report. Number two, MSDS; the need for Euroking to update the software package had been escalated to NHS digital. Number four, medical workforce, was close to turning back to amber and an action plan was awaited in response to the GMC's survey for medical students. Number eight, multi-professional training, was still a concern. 90% of every staff group needed to attend training and was being undertaken with the anaesthetics team to try and increase their input.
- There were no serious incidents in July but in August one lady miscarried at 32 weeks. A review had been undertaken which had concluded that there were no care issues.
- A shared learning event had taken place with the learning from deaths group.
- Work was being undertaken on continuity of carer and more information would be provided in a future report.
- A CCG/NHSEI assurance visit had taken place last Friday. Initial feedback had been positive although there were still areas that could be improved upon.

Q Was the prediction that the number of women delivering at WSFT would decrease consistent with the reduction in the number of women of child bearing age in the catchment area, or were they choosing to go elsewhere?

A This was a reflection on the normal demographic and not that women were choosing to go elsewhere. However, the number of births was likely to increase due to the recent lockdown situation.

- It was noted that there were a number of positive comments from the recent inspection. These included the assurance provided by the leadership and dedication of Karen Newbury and also the close working relationship of the obstetricians and midwives for the benefit of women in the Trust's care, which was not the case in all organisations.

Q The NEDs were conscious of the criticism that the department had come under over the last two year. Was the morale of the team beginning to recover and was the team developing well?

A The team were developing well but there was still a lot of work to be done. However, due to Covid people's resilience was very low which meant that anything negative had a big impact on morale.

The board acknowledged this, and noted that this was the case across the organisation.

Q How could board members help and support the team?

A Continue with their kindness and make people feel appreciated, ie walkabouts, free tea and coffee. Communication was very important together with being kind and caring to staff as well as patients.

Q The dashboard approach was very useful. Was it possible to provide information about the detailed action plans behind this and timeframes attached to these?

A There were some things that the Trust could not do a lot about. Home births and use of the birthing unit were a matter of choice and it was hoped to increase these. However, the number of women who were having to be induced meant that the birthing unit was not being used as much as planned for. Any indicators that were red were looked at in greater detail and what the rationale behind this was, ie if there was a service issue.

There was a robust action plan for the WHO checklist which had to be completed every time a patient went into theatre. The Trust had tried several ways of improving compliance, including more staff attending training from all areas and this helped in a more disciplined approach in caring for women.

Q There was some concern that the team might at times feel like they were existing just because of a dashboard. Was it possible to share the ambitions of the team in the next report?

A **ACTION: This would be included in the next report.** **S Wilkinson**

Q One of the issues that came out of What Matters to You from the maternity team was that they did not feel that they were listened to. Was this changing as a result of the work that was being undertaken?

A Hopefully they now felt listened to and there were a number of ways of showing this. A department meeting was now taking place which every member of the team was invited to and each individual was asked if they were okay and if there was anything that could be done to support them. The approach to safety champions was also working and Nick Jenkins did regular walkabouts in the unit which gave staff the opportunity to raise issues.

20/194 INFECTION PREVENTION AND CONTROL ASSURANCE FRAMEWORK

- Some elements of this were currently being revised in the light of new guidance, mainly around Covid. This would continue to be looked at as it came through.
- The CQC had reviewed and approved the BAF report.
- The test and trace app had also been reviewed in relation to clinical areas and Time Out.

Q Was there anything that could be done in specific areas that were currently not being utilised to enable more space for clinical staff to take breaks?

A The space utilisation group was very aware of this issue but the Trust was very constrained in finding workspace as well as rest space. It had been agreed that the group would meet for 30 minutes every week to try to move forward some of these issues and it was looking at making better use of all of the accommodation available. A booking system for office accommodation had been introduced so that staff could be moved into different workspace in order to create more rest areas. This was an ongoing challenge and everything possible was being done to address this. Borrowing space from the hospice for admin staff was currently being considered. There was more work that could be done to stagger clinical staff breaks so that the available rest space was not overcrowded.

- The board received and noted the content of the annual report. The Trust was still trying to recruit a lead infection control nurse but this was a challenge and the role had been advertised three times.

20/195 FINANCE AND WORKFORCE REPORT

- The Trust continued to break even and was expected to continue to do so until the end of the year.
- However, there was a significant amount of uncertainty around funding streams that would be available to the organisation over the next six months, eg winter pressures, Covid, staffing pressures, as well as the uncertainty generated by the challenge of the main hospital accommodation. This was being worked through with colleagues in the ICS and it was hoped that more information would be available for the next board meeting.
- The cash position remained very good.
- The reduction in spend on temporary staff, particularly nursing, was a reflection on the work undertaken recently on this.
- The main focus of the finance team and organisation was around the CIP for next year.
- The underlying financial position was as good as it had been for a number of years, therefore this was being used to strengthen the balance sheet as the organisation moved into next year.

Q The balance sheet showed planned borrowing for the year of £50m. How did this work in terms of NHS finance?

A This was part of the reason why the bank balance had significantly improved in the month. The move between long and short term borrowing changed considerably in September and this would be shown in next month's report.

Q As the Trust moved into winter the use of temporary staff increased to cope with demand. Would this happen this year and was this allowed for in the budget?

A This had been the experience in the past and it was expected that it would be the case this year. However, the Trust was looking at recruiting to a flexible nursing team that could be deployed to fill gaps as they arose which would reduce the need for temporary nurse staffing. There was a lot of uncertainty around winter and Covid and the availability of temporary staff and the budget had been phased accordingly.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

20/196 PEOPLE AND ORGANISATIONAL DEVELOPMENT (OD) HIGHLIGHT REPORT

The board were asked to feedback any comments on the content of this report.

- Two new Freedom to Speak Up (FTSU) guardians, Amanda Bennett and James Barret had been appointed.
- Over 2000 staff had provided feedback as part of What Matters to You, either through a survey or attending workshops. As a result, five key themes had been identified and the actions being taken had been fed back to staff.
- The NHS as a whole now had a people plan and WSFT be taking this plan forward, including learning from Merseycare. Details of this would be communicated to staff as in the core brief and at the Trust Executive Group (TEG) on Monday (5 October).
- WSFT would be developing a People and Organisational Development (OD) plan, which would incorporate feedback, ideas and plans from all of the initiatives outlined in this report.
- The Trust's flu vaccination campaign was launched yesterday (1 October) and a comprehensive plan had been developed to emphasise the importance of this encourage and enable all staff across the organisation to be vaccinated.

Q What plans were in place to continue to actively listen and get feedback from the organisation moving forward?

A This was not just about what was being done, but how this was being done. There had been a very good response to the 60 workshops that had taken place for staff and the style of these was very well received. The executive team were committed to finding the right way to continue to do this and make it part of business as usual. As well as continuing to actively listen to people it was also important to communicate how the Trust was responding to feedback.

ACTION: WSFT's draft people plan to be presented to the board in November, including how to measure progress and change within the organisation. **J Over**

20/197 EDUCATION REPORT, INCLUDING UNDER GRADUATE TRAINING

- This report showed the fact that WSFT was also a place of education and development as well as providing services and care for patients**.**
- The Trust had recently hosted Health Education England (HEE) for a virtual review and had spoken to trainers and trainees. An action plan in response to the report from this review had been developed and submitted.
- The delayed launch (due to Covid) of WSFT's Health and Care academy took place in September. This would focus on developing partnerships, including education providers, across the ICS.

20/198 EQUALITY, DIVERSITY AND INCLUSION REPORT

- This report was presented to the board on an annual basis and brought together all the work that was being undertaken in response to the Trust's inclusion strategy and objectives.
- Ayush Sinha, chair of WSFT's BAME group, had been unable to attend this meeting due work commitments. He would be invited to attend a future meeting.

ACTION: invite Ayush Sinha to attend a future board meeting. **J Over**

- Over the last six months there had been a focus on high risk issues such as the Covid risk to BAME staff
- The report also demonstrated the work that had been undertaken in relation to Workforce Race Equality Standards (WRES), including recruitment and the involvement on BAME staff in disciplinary processes. There were some concerns about the involvement of Filipino staff in HR cases and a review was being undertaken and a process to address this developed.
- Details on the gender pay gap were also provided in this report.

Q Considering the Covid risks to BAME staff what additional measures had the Trust taken in the event of cases increasing again?

A At the start of the pandemic all staff were asked to complete a risk assessment. This was later updated taking into account the demographic features associated with Covid, including the BAME community. A decision was then taken as to whether staff should shield or be moved to an area in the organisation with a lower risk. Nearly all staff had completed a risk assessment and new staff continued to complete these.

A system health event had taken place on Tuesday to talk to members of the broader community from different minority groups. There was a need to look at how this could be moved forward internally and also linking with external communities who were under represented.

Q There were some perceived ageism issues around certain age groups not being able return to the Trust until later in the year, eg volunteers. When would they be able to return?

A It was regrettable that volunteers had to stop coming into the Trust due to Covid as their contribution was greatly valued and they were missed. However, the Trust cared about their safety and this was a priority. When they were able to return would be followed up.

ACTION: follow up when people who were older were able to return to the Trust, including volunteers. **J Over**

20/199 NURSE STAFFING REPORT

- This report included information for July and August.
- Fill rates for nurses and health care assistants were over 100% in the majority of areas during July. Work was being undertaken to ensure that this data was as accurate as possible.
- Following cleansing of roster data, nursing shift fill rates had reduced from >100% to between 90-100% which was more realistic.
- Sickness rates had fallen during this period, however there continued to be staffing challenges due to self-isolation. Although this had reduced since April it was likely to increase as schools returned.
- There were challenges around reporting vacancies as an organisation due to ways in which Covid cases were reported. Work was being undertaken with the finance team to ensure that this was more accurate.

- Work was also being undertaken with wards and divisions to look at vacancy rates. The only area of concern was maternity; however, a number of midwives were joining the Trust between now and November.
- Overseas recruitment had recommenced and more nurses had joined the Trust over the last couple of weeks.
- A significant amount of work had been undertaken on resource management over the last two months, including an establishment review. The outcome of this would be reported to the board in November/December.
- Meetings would commence next week to look at nursing resources and check and challenge to ensure that these were being managed appropriately and to identify any gaps or risks with staffing as the organisation moved into next month.
- The board noted the recommendations and further actions as set out in the report.

Q Were staff from WSFT likely to be called upon to staff Nightingale wards?

A Royal Papworth hospital was our registered surge centre. They had requested support and Daniel Spooner was scoping what support the Trust was able to offer.

20/200 QUALITY AND LEARNING REPORT – Q1

- WSFT was as early adopter of the patient safety incident response framework (PSIRF). The steering group had met to start to pull together themes and the current priorities and risks were detailed in the report
- The Board on behalf of WSFT expressed a commitment to take part as an early adopter and to:

  Test the introductory Patient Safety Incident Response Framework (PSIRF) and associated documents; Engage with their lead commissioner and regional and local stakeholders throughout the process of implementation; Share patient safety incident response plans, insights, challenges, successes, relevant data and other material to benefit other early adopters and the wider roll out of the PSIRF; Take part in the evaluation of the pilot phase.
- It was confirmed that the vascular review issue which had been a major concern last year had not caused any harm to patients, although it was acknowledged that this could have been the case. The coroner had confirmed that the death of two patients was not due to loss to follow up. Work was still ongoing to ensure that surveillance pathways were as robust as possible.

Q The information on staff raising concerns showed that 21 of the 33 concerns were raised directly with the Chief Executive. Was it good that people were talking directly to him or was this a reflection on the lack knowledge of staff of the way in which concerns should be raised in the organisation?

A This reflected the Chief Executive's accessibility and availability but there was a need to ensure that staff were fully aware that there were multiple ways in which they could raise concerns. More information on this would be made available in the green sheet over the next few weeks. Anonymous ways of reporting also needed to continue to be encouraged.

20/201 IMPROVEMENT PROGRAMME BOARD REPORT

- Maternity services had been the pilot for a deep dive; the initial report was positive and it was hoped to bring the final report to the next board meeting. A date for another visit needed to be agreed to ensure that the actions were embedded

- The team was working with the quality lead from the CCG to undertake a similar process to review medication safety. The board would receive feedback on this when the review had been completed.
- Regular monthly update meetings took place with the CQC inspector. This week the CQC had confirmed that they were assured by the process being made which meant that they would revert to regular engagement meetings. This was a positive step but it was important to ensure that pace and progress was maintained.

Q A couple of actions had extensions to the timeframe; did the CQC consider these extensions to be reasonable?

A The time frames to achieve and review actions had been set by WSFT. Robust discussions had taken place at the improvement board about the need to extend time frames and representatives from the CQC and CCG had been at these meetings. The CQC understood that some of these actions might need to be extended, particularly when they were being done through co-production.

20/202 CONSULTANT APPOINTMENT REPORT

The board noted the following appointment:

Mr Alexander Millington; Consultant Otolaryngologist – ENT Department.

20/203 PUTTING YOU FIRST AWARD

Jeremy Over read out the citation for Claire Scott, housekeeping manager, who received a Putting You First Awards this month:

Since taking over as housekeeping manager, Claire has constantly put the welfare of her staff to the front, regularly going over and above the line of duty on many an occasion in supporting her staff, especially in difficult times. Examples of these selfless acts of care she has given to her staff are:

- Taking welfare packs in her own time to staff currently off on long-term sick leave so as to maintain contact and make them feel important and part of the team, even when off work.
- Texting all staff every week to check on their wellbeing and to talk through any concerns they may have - in her own time.
- Walking around Hardwick Heath with worried or concerned staff to talk through concerns or anxiety.
- Ensuring that staff are fully updated on issues within the trust, preparing safe methods of work to cope with issues and offering 1:1s with staff to explain and listen to any concerns they may have.
- Coming in on nights and weekends to check on staff wellbeing – again, usually in her own time.
- Sourcing the correct advice for financial and health issues.
- Letting her staff know that she is available 24 hours a day for them to call her if they need help.
- At no time being judgemental, only supporting in difficult times.

Claire's selfless actions in going that extra mile for her staff have gone a long way to maintaining staff morale and commitment to the service. This award would be recognition of all the hard work she puts in to making her staff feel important and valued, and would be fully deserved.

The board considered this award to be well deserved and congratulated Claire who was an outstanding example of a line manager.

BUILD A JOINED-UP FUTURE

20/204 PATHOLOGY SERVICES REPORT

- This report had been produced by the people leading this service and co-ordinated by Fiona Berry, Pathology Services Transformation Lead, to provide the board with assurance that from 1 November the team would transition back to WSFT and would be fully supported and enable to deliver as good a pathology service as they could for WSFT.

Q It would be good to achieve accreditation really well not just scrape through. How did the service rate re readiness for accreditation?

A The service was not yet ready for accreditation but the team was working towards this. However, accreditation had been applied for as there was a delay and the service should be ready by the time the accreditation visit took place. WSFT would be the first laboratory and others would take longer to be ready.

Q Was this service moving to mix and match structure with a series of relationships with several other organisations together with its own activity so that it no longer had a contract but a series of arrangements?

A This was the case, but there would still be contracts with all the providers and these contracts should be clearer and more concise. Previously it had been difficult being a provider and a contractor. WSFT would also be leading on some areas, eg procurement.

Q Was Helena Jopling working closely with the team in terms of what resources needed to look like in the new healthcare system?

A This was one of the work streams for the new facility and there was a need to understand which parts of this service should be on site. This work was being led from the bottom up, facilitated by Helena Jopling.

Q Were pathology staff now feeling that they were being communicated with, as this had been a key issue in the past?

A Communication had improved and Nick Jenkins talked to the laboratory staff each week. Fiona Berry was working very hard to communicate with everyone and had the confidence of the team who were assured that she fed back any comments to the relevant members of the executive team.

Q The Trust was going to have to invest in order to realise its ambitions for this service. Could these ambitions be aligned to what was available from a capital perspective?

A It was always known that the Trust was not paying enough for pathology but it needed to understand what the money was being spent on. It was estimated that there would be a £228k cost pressure, which was significantly less than expected due to the overheads that ESNEFT had been charging NEESPS and would be a saving to WSFT.

Some capital assets were transferring to the organisation but the ongoing costs would then be the responsibility of WSFT. An allowance would be made in future capital budgets to make significant improvements to the assets of pathology.

Q What if any investment would need to be made in capital equipment going forward and was it known what this would be?

A Some of the investment required was known but the Trust still needed to fully understand what equipment was being transferred from ESNEFT. However, the investment required was less than was originally expected.

Q What was the risk associated with the potential of not continuing with the community contract and what would be the implications for the pathology service?

A The community contract was a risk but it was unlikely that the CCG would want WSFT to lose this work and ESNEFT would not want to take this work on. If the Trust did lose this contract it would make other tests much more expensive.

- It was noted that the new structure for pathology services had taken a while to get to where it needed to be as it was coming from the bottom up which took longer than if the top layer decided what should happen and instructed people to make this happen. The board needed to understand that as the Trust continued to try to work in this way things may take longer to develop and evolve.
- The board welcomed and approved the strategy.

20/205 WSFT DIGITAL BOARD REPORT

- The IT team had been focussing on supporting the organisation but were still progressing with the plan.
- The Health Information Exchange (HIE) with Essex County Council went live yesterday which was a great achievement.
- The team continued to work in the community to separate WSFT's service and NEL CSU which would take effect at the end of October. However, it had been agreed that the Trust could continue to have access to some of their resources for a couple of months from the cessation date to ensure that there was no impact on clinical services.
- A great deal of progress had been made and there had been a huge amount of learning during Covid. The team was looking to learn and build on these lessons.
- From an operational and clinical point of it should not be under estimated how key the flexibility of the IT team had been to enable the organisation to function at all as a result of Covid.

Q As the Trust moved away from NEL CSU could the board be assured that community IT would continue to be a focus of the executive team as there had been issues this week with the IT system in paediatrics?

A This was why the Trust had reached this agreement with NEL CSU. However, as the Trust moved away from this service there may be short terms issues with systems. The executive would continue to focus on community IT as one of the priorities.

GOVERNANCE

20/206 TRUST EXECUTIVE GROUP REPORT

- The future of committees was a co-production and the proposal was a result of feedback received from working groups and members of the teams.

- The development of the proposal was influenced by national strategy and patient safety as well as the involvement of patients, public and staff.
- The emphasis of the work was shared learning and avoidance of silos and enabling issues to be fed back, both on what had gone well and also on concerns.
- The new structure would replace a number of existing structures and would evolve as this worked through from the bottom up.

Q It was important that a bottom up piece of work was undertaken, but was the board considering a bottom down piece of work to ensure that these aligned?

A It was agreed that this would be a good idea and it was proposed that this should be the focus of a board workshop.

ACTION: Arrange engagement sessions for Board and senior leaders to support implementation of the new committee structure. **R Jones**

- The aim was to change the focus of TEG to be more strategic with more co-production. The comments from the board would be fed back to TEG.
- The board approved in principle the proposed committee structure to allow the detailed work to be undertaken on terms of reference for the committees and enabling structures.

20/207 AUDIT COMMITTEE REPORT

- The Council of Governors had approved the audit committee's recommendation that BDO should remain in appointment as the Trust's External Auditors for an additional year.

20/208 COUNCIL OF GOVERNORS REPORT

- The board received and noted the content of this report.

20/209 REVIEW OF COVID GOVERNANCE ARRANGEMENTS

- This was an update on the arrangements that had previously been reviewed by the board.
- On the whole the Trust had returned to business as usual as far as possible, with the use of Teams for most meetings, committees etc.
- A couple of areas were still being impacted on as a result of Covid, eg quality walkabouts, clinical audits.
- The board approved that the fact that a small number of outstanding areas were subject to further review and an update would be provided to the board on 4 December 2020.

ACTION: Schedule a review of COVID governance arrangements for December. **R Jones**

20/210 USE OF TRUST'S SEAL

- The board noted the use of the Trust seal.

20/211 AGENDA ITEMS FOR NEXT MEETING

The board received and noted the content of this report.

ITEMS FOR INFORMATION

20/212 ANY OTHER BUSINESS

There was no further business.

20/213 DATE OF NEXT MEETING

Friday 6 November 2020, 9.15am

RESOLUTION TO MOVE TO CLOSED SESSION

20/214 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 – 6 November 2020

Agenda item:	7			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	30 October 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

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1875	Open	31/7/20	20/170	Outcome of nursing staff establishment review (including community) to be presented to the board when available in December	2/10/20 - confirmed that this information will be available before January	SW	29/01/21	Green
1880	Open	2/10/20	Item 1	Consider options to open access to the virtual board meeting to the public and press	Testing ability to extend the MS Live events model used for annual members meeting - plan to pilot at meeting on 4/12.	RJ	04/12/20	Green
1886	Open	2/10/20	Item 14	Consider approach and support regarding people who are older returning to work, including volunteers	This is being revisited in light of the recent Government announcement	JO	06/11/20	Green
1888	Open	2/10/20	Item 27	Schedule review of COVID governance arrangements for December		RJ	29/01/21	Green

Closed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1881	Open	2/10/20	Item 8	Receive the proposal for the introduction of Mersey care as part of Trust's people plan	**AGENDA ITEM**	JO	06/11/20	Complete
1882	Open	2/10/20	Item 9	Provide update on work with acute, community and social care leads to bolster support for community teams	**AGENDA ITEM**	HB	06/11/20	Complete
1883	Open	2/10/20	Item 10	Consider further how we communicate to patients, GPs and the public the complex activity plans and what access will look like now and going forward	Elective care communication plan provided as annex to this report.	JO / HB	06/11/20	Complete
1884	Open	2/10/20	Item 14	Receive the Trust's draft people plan at the Oct meeting and consider how to reflect progress on the journey of change within the organisation	**AGENDA ITEM**	JO	06/11/20	Complete
1885	Open	2/10/20	Item 14	Invite Ayush Sinha, chair of Trust's BAME group to talk to the Board	**AGENDA ITEM**	JO	06/11/20	Complete
1887	Open	2/10/20	Item 24	Schedule engagement sessions for Board and senior leaders regarding next steps	Proposal that the Scrutiny Committee provides forum for engagement and oversight of implementation of the new committee structure - to include additional senior leaders	RJ	06/11/20	Complete

Annex

ELECTIVE CARE COMMUNICATIONS PLAN

CONTEXT

- Due to the coronavirus pandemic, the way we provide our services has had to change significantly
- This plan outlines how the Communications Team will support the recovery of elective and diagnostic services across WSFT
- The activities within this plan are aligned with the Suffolk and North East Essex (SNEE) Integrated Care System's recovery and winter communications plans
- WSFT faces specific challenges that may hinder elective recovery, most notably the remedial works taking place around the RAAC plank issue
- The trust's communication team is working as part of a wider communications community across SNEE

DESIRED OUTCOMES

- To increase understanding and provide reassurance about how the trust is attempting to return to pre-Covid19 levels of elective activity and restart services paused due to the pandemic
- To communicate with staff about plans to restart services and consider the feedback they have given regarding their experiences of remote and virtual working (eg via our 'What Matters to You?' survey)
- To keep our local population safe and to ensure our local communities bare kept informed about how to get the care they need when they need it

CORE MESSAGES

- We are very sorry that patients have had to wait longer than we would ever have liked for their treatment and care because of Covid-19
- We are completely committed to providing the care our patients need
- We will be prioritising the treatment of those patients with the greatest clinical need, followed by those who have been on the waiting list the longest
- If your condition remains the same and you wish to continue with your treatment or procedure, you do not need to do anything - we will contact you directly in due course
- If your condition has improved and you no longer feel you require your planned treatment or procedure - please contact the department involved with your care to let them know

- If your condition has worsened and you need some additional support whilst you wait - please contact the department involved with your care

HOW WE WILL COMMUNICATE/HAVE COMMUNICATED

- The trust is in the process of sending individual letters to the 21,000 people on its waiting lists to reassure them they have not forgotten about and that we will be contacting them with details of when their treatment will take place as soon as we are able to
- Social media messages – these will be centred on encouraging patients who are awaiting treatment not to be frightened of coming to hospital because everything has been done to ensure the site is as safe and Covid-19 secure as possible
- Senior executives from the trust will take every opportunity to reinforce the core messages through radio and television interviews – Steve Dunn recently did this when appearing on BBC Suffolk to give an update on the trust's structural challenges, and Nick Jenkins together with Thomas Pulimood did the same when they recently appeared on the same station to talk about how they and colleagues had coped with the pandemic and were preparing for the second wave
- Senior executives from the trust will take every opportunity to reinforce the core messages through newspaper/online interviews – eg Steve Dunn's regular blog in the Bury Free Press (syndicated to other county titles)
- Updates on elective waiting times for primary care colleagues will be posted on the new microsite for GPs that has been developed by Chris Lockwood from the Communications Team in conjunction with James Heathcote
- Internal messaging to trust colleagues regarding the above will be achieved via Staff Briefing and Green Sheet

PLANNED FUTURE ACTIVITY

- Updates on elective waiting times will be posted on the trust's website, with appropriate signposting for patients via social media
- The Communications Team will continue using case studies (where available) to encourage people to attend appointments
- A number of surgical specialties are developing condition specific advice letters to send to patients on waiting lists

8. Patient/staff story

To RECEIVE the story

For Report

Presented by Jeremy Over

9. Chief Executive’s report

To RECEIVE an introduction on current issues

For Report

Presented by Stephen Dunn

Board of Directors – 6 November 2020

Agenda item:	9			
Presented by:	Steve Dunn, Chief Executive Officer			
Prepared by:	Steve Dunn, Chief Executive Officer			
Date prepared:	2 November 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

I am sure like most I watched with a heavy heart the Government announcement at the weekend that with **rapidly rising COVID case numbers across the whole of the UK** we will once again enter a national lockdown. It is clear that COVID-19 has not gone away, that numbers of infections are increasing and that we must do all we can to help avoid a really bad second wave. The operational report on the agenda of the Board describes the huge amount of work we are doing to plan and prepare for winter, COVID-19 and recovery. And of course we are better prepared than for the first wave, with more reliable supplies of personal protective equipment (PPE), better treatment options and increased testing available. But it will be no doubt be a tough winter for our staff, our community and our economy. I want to emphasise my sincere **thanks to all our staff** for all they do and have done. We do appreciate your continued dedication and commitment during challenging times.

We have been able to add extra **Newmarket beds to provide flexibility in fight against Covid-19**. Fourteen new beds, new nursing staff, and a new portering team have joined existing hospital and community services at the Newmarket hub. The 14 news beds have been gradually coming on stream since building work at the Exning Road site was completed in mid-May, with more than 15 new nurses and healthcare assistants recruited to care for patients. A new portering team has also introduced to help medical staff focus on patient care. It brings the total number of beds on the hospital's Rosemary Ward to 33. The beds will be used flexibly for a range of patients who do not need the more intensive levels of care available at West Suffolk Hospital.

But we also want to be **transparent with our public** around some of the challenges we face and the difficult decisions that are being made. We are committed to talking about the realities of where we are with recovery and what this means for our patients, for example, such as the increase in waiting lists and waiting times. Our elective care communication plan is shared in the Board pack and sets out a range of measures we are taking to ensure we communicate effectively with our patients and public. But while we will do everything we can to step up as much routine activity as we can, a challenging second wave might mean that once again we might need to redeploy staff to respond to the challenges we will face impacting on our waiting lists and times.

This is why it is so important that our public helps. I know we keep repeating how important it is that we all **wash our hands, cover our face, and stay two metres apart** but it does work and it will help. I also know that it can sometimes feel like an effort to stick with this guidance – but it will keep you safe and helps to prevent the transmission of Covid-19. And if you are eligible protect yourself with the flu vaccine.

We also know it has been a difficult period for our pathology laboratory with many changes and many different owners, as well as COVID-19 to deal with. On behalf of the board and our Governors I would like to personally and **warmly welcome back** to West Suffolk NHS Foundation Trust and the West Suffolk family **over 100 pathology services staff** from both ESNEFT and Public Health England (PHE). Going forward we really do want to make changes for the better and improve the lab environment and ways of working. The key focus for the transformation of WSFT pathology services will be working towards full accreditation, recruitment, updating equipment and designing solutions to the ensure sustainability in line with the future system programme. There are also lots exciting projects which are being worked through including digital pathology, mobile phlebotomy and a full review of send-away tests. Nick and Claire Sorenson (Jeremy's Deputy), and I walked around the lab on Monday and it's clear that the morale of staff is high. We talked about our commitment to engage and support our pathology team. And I want to thank Fiona Berry, Karl Love and Linda Johnstone and the path lab and HR teams for successfully guiding us through this home coming.

In addition to the items already highlighted key areas of focus of the Trust's senior leadership team are reflected on this month's Board agenda. Key items on the Board agenda include the updated

and evolving **integrated quality and performance report (IQPR)** and a report from the most recent improvement programme board, including a copy of the **Trust improvement plan**.

The board papers also include the important work to support and develop our staff as outlined in our **people plan**, including the work of the Guardian of Safe Working, Freedom to Speak Up Guardians and BAME network. Last Wednesday I did a walkabout with Amanda Bennett our new Freedom to Speak Up Guardian, and we discussed with staff right across the trust what speaking up means to them and some of those thoughts were summarised in Green Sheet. But at its core many staff talked about feeling safe in raising concerns. I'd also like thank radiologist Dr James Barratt who also starts this month as a Freedom to Speak Up Guardian.

Last month I described our 5 O'clock Club virtual session on creating a Just Culture with Amanda Oates, the Director of Workforce at **Mersey Care**. As I said last month, to me it was inspiring and gave us lots of pointers and lessons on how we can move towards a just and restorative and more open culture where staff feel able and empowered to speak up. I hope you have read my blog on this, but I want to convey that I am personally committed and curious to learn and adopt the Mersey Care philosophy, and have been reading the book by Sidney Dekker on Just Culture and doing a lot of thinking about this.

What is this likely to mean, though, practically? It means going forward that we are going to seek to **pursue a restorative approach**, to hear people's stories and try to listen and hear all sides when things have gone wrong and own up to mistakes. This is about a change in culture across our organisation and I want to lead by example on this. So, I will be part of a group of ten of us who will benefit from some training with Mersey Care and Northumbria University this month. We also want to make sure any current HR processes at West Suffolk are on the right track. So, we are temporarily pausing all current conduct, grievance and bullying and harassment investigations to check that all restorative options have been explored.

The next 5 O'clock Club meeting on Thursday 19th November, which all staff, board members and governors are welcome to attend, also continues this theme. Our next speaker will be Dr Chris Turner who leads the **Civility Saves Lives** (CSL) movement. CSL are raising the impact that respect, professional courtesy and valuing each other has in healthcare. They are seeking to raise awareness of the negative impact that rudeness (incivility) can have in healthcare, so that we can all understand the impact of our behaviours. This is all part of our journey to positively change and enhance our culture following on from our CQC report earlier in the year.

Talking of incivility some of you may have seen the distressing coverage in the media over the weekend about a doctor in our emergency department who was subjected to racial abuse. You may have seen my comments on social media and that I was deeply upset by this. We have such a diverse workforce that goes the extra mile for local people and they should be thanked and supported not victimised and abused. **Racism must not be tolerated** and has no place in our society or our Trust. I also want to thank our brilliant Suffolk Constabulary who supported our hardworking staff and acted quickly to arrest the woman, making it clear their zero tolerance for racism. We have a great working and supportive relationship with our local police force and we really appreciate that.

Compare this with the heart-warming story from Roxie Walsh, one of our amazing community nurses who was having trouble paying for some petrol and food with the app on her phone after finishing work. She went outside the shop to try and sort out the problem when a lady came out and said: "Don't worry about it love. It's all paid for". Touched by the gesture Roxie told her story on Facebook asking if anyone knew who the kind-hearted stranger was. Staff from the Trust identified that it was Critical Care nurse Emi Tillett. Emi replied on Facebook "I'm glad I was able to help you. You're very welcome and community nurses are very much unsung heroes". To me Emi's thoughtfulness epitomises the staff we have in our organisation, as well as also underscores the appreciation for our community professionals that exists right across the Trust.

The Trust was also recently confirmed as one of 40 across the country to receive funding for new build projects from the Government's Health Infrastructure Programme. This is amazing news for local people who deserve to be treated in a twenty first century facility. I am also equally really delighted to confirm that the Trust has completed the purchase of Hardwick Manor. The home and its surrounding grounds are among four sites currently being considered as **potential future locations for a new West Suffolk Hospital**. The existing hospital buildings on Hardwick Lane were built in 1974 and have already long exceeded their intended 30-year life span. WSFT has invested heavily in their upkeep over recent years, but the time will soon come when they are no longer fit for purpose.

It is well known that our hospital was among thousands of buildings constructed in the 1970s using reinforced autoclaved aerated concrete (RAAC) planks. As a result, we have had to carry out an **extensive programme of inspections and running repairs** at our current site to ensure the safety of patients and staff. We have been open and transparent about the structural challenges our current site poses and our desire to move to a new, purpose-built location as soon as possible. This is why the decision to replace our main hospital site is such good news for local people.

To reiterate, however, Hardwick Manor is one of four sites currently undergoing detailed analysis and surveys to determine their suitability as potential locations for our new hospital and health and care facility. That work is ongoing and is due to complete in November, but in advance of its completion, a unique opportunity arose to acquire Hardwick Manor. I must stress that this does not make it any more or less likely to be chosen as our preferred location for the new hospital. However, it was prudent to purchase the site when it became available in order to keep all our options fully open. Whichever location we settle upon for our new build will be subject to the usual rigorous planning and public consultation processes. I also want to reassure our local community that we are committed to engaging with as many of them as possible in our plans for the new hospital. We want to ensure that what we provide is a perfect fit for the current and future health needs of the people of west Suffolk.

As plans to build the new health and care facility get underway I want to introduce you to all those involved in the development of the plans. This project is no mean feat and in order to develop the plans, co-ordinate the production of the clinical model and oversee the final build a project team, known as the **Future System team**, have been appointed. The team includes familiar and new faces which you will see across the site:

- Dr Gary Norgate, programme director
- Dr Helena Jopling, associate medical director
- James Butcher, senior operational lead
- Mark Manning, head of nursing
- Tracy Morgan, clinical workstream programme manager
- Caroline Giles, project management office lead
- Louise Kendall, administration support
- Emma Jones, communications and engagement lead
- Zoe Selmes, finance lead.

Jacqui Grimwood, Mike Bone and Claire Sorenson are leading the estates, IT and workforce components of the programme respectively. The approach being used to develop the clinical model is called co-production, using the input of staff, patients and system partners to develop the model together. The clinical services currently housed in the main hospital building have been split into 12 co-production workstreams, each with their own lead. The co-production leads have the task of forming planning groups to bring in the views and ideas of all the people who have an interest or viewpoint in each service.

We are also **working with our Governors** to recognise the important role they have in representing their public, staff and partner constituencies in this development. The role that Governors have in supporting engagement and sharing their views on this work is critical and sits alongside their responsibility to hold the Board to account for delivery. I would like to thank all of our Governors for their commitment and hard work. The role they have is already challenging but much of what they usual do has been doubly difficult this year as a result of COVID restrictions. They have responded as only they can embracing technology and working to support the Trust and never lose sight of their role in holding the Board to account. THANK YOU! We are in the process of undertaking three-yearly elections for our public and staff governors and I would encourage our public and staff members to use their vote.

It is also an exciting time for our **community colleagues across the county** as the move to WSFT IT support has finally begun. The first teams moved across to their new IT support last month. The IT engineers have been working hard to prepare for this and spent time on site at the wheelchair services base at Chantry Clinic in Ipswich, the Disability Resource Centre in Bury St Edmunds and in the main hospital, moving staff over from the previous provider's hardware and emails to new WSFT IT kit, emails and support. Over the next months we will be moving the rest of our community services to WSFT IT, spending time at each site and with each team to ensure it all goes smoothly. We have already had positive feedback from our community colleagues.

Our **patient portal online access services** for patients are also expanding, with new text services and greater access to records. We launched a pilot of our Patient Portal initially for just rheumatology patients, but have been gradually expanding the scheme. It is now available to any patient aged over 16 that has been a patient at the West Suffolk Hospital or used outpatient services at one of our community sites. People can now also sign up online without having to visit the hospital to show identity documents, after we added new digital identity checks.

Earlier this year the West Suffolk Alliance started its journey to implement and embed **quality improvement methods to drive improvements** in population outcomes which centre on leader, staff and user engagement. Since April the quality improvement (QI) team has been working to up the pace, and accelerate and extend adoption of QI into the integrated health and care partnership developed with and between primary care, mental health, local government and the voluntary and community sector. In order to achieve this, the West Suffolk Alliance has entered into a partnership with the Institute of Healthcare Improvement (IHI). The IHI is a non-profit organisation that was founded to improve healthcare worldwide by providing tools and resources to partner organisations through training sessions, conferences, and advisory services. The IHI takes a unique approach along with a vast amount of experience of working with health systems, countries, and other organisations to improve quality, safety and value in healthcare. Last month the team was delighted to host a three-day virtual foundational learning conference between the IHI and senior leaders and staff from the Alliance. The IHI team met with individuals and groups in the community to learn more about the work of the Alliance and the organisations and individuals who are contributing to its success.

Finally, I just want to highlight how proud we are that the **high quality of food at West Suffolk** Hospital was recognised in a national report led by Great British Bake Off judge Prue Leith. The celebrity chef has worked with NHS leaders to identify the best catering at hospitals and how to improve it in the future, and our food is mentioned as one of just two dozen best practice sites nationally. The report makes a number of recommendations around the quality and availability of food. It also says catering services should be a priority for new hospital building schemes such as ours. This though would never have been in doubt. Our on site, in-house catering team are a crucial part of the West Suffolk team providing nutritious food to both patients and staff and we are incredibly proud of the team!

9:50 DELIVER FOR TODAY

10. Operational report

To APPROVE the report

For Report

Presented by Helen Beck

Trust Board – 6th November 2020

Agenda item:	10			
Presented by:	Helen Beck, Executive Chief Operating Officer			
Prepared by:	Helen Beck, Executive Chief Operating Officer Alex Baldwin, Deputy chief operating officer Lesley Standring, Head of Operational improvement			
Date prepared:	28 October 2020			
Subject:	Operational Update Including: Phase 3 Recovery, Winter and Covid Planning, EU Exit and Community Services Updates			
Purpose:	x	For information		For approval

Executive summary:

This paper provides an update on the key operational areas of work during the month. This includes; planning for phase three recovery and progress against agreed trajectories, planning for winter including the potential of a second spike of Covid admissions, EU exit planning and community engagement in services updates.

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

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

Previously considered by:	Future planning meeting. Winter planning meeting Brexit Planning Group
Risk and assurance:	Failure to provide quality care to patients who require admission to hospital. Reputational risks around failure to achieve required standards and targets.
Legislation, regulatory, equality, diversity and dignity implications	

Recommendation: The board is asked to note the content of the paper.

Phase 3 Recovery

There is a significant amount of focus on delivery of the phase 3 recovery plan from both clinical and operational teams. Despite the ongoing loss of the elective surgical ward through October due to the structural repair work we have opened all main and DSU theatres and there has been significant improvement in our elective activity. The Trust has delivered 96% of last year's elective plan in the week ending 25 October and up to 81% overall for the month. F4 is scheduled to be opened again on Wednesday 4th November and no further ward closures are planned currently.

There is more work to do in Endoscopy where we have only achieved 75% recovery, despite insourcing activity, and day cases where we are averaging approximately 70% recovery.

Outpatient (first and follow ups) and diagnostics (CT and MRI) are also performing well against the targets. A relocatable CT scanner has been secured and set up behind the day surgery unit and a mobile MRI scanner is expected to be located at Sudbury and be operational from the beginning of December, to enable us to deliver activity to clear diagnostic backlogs and recover the 6 week diagnostic standard.

There are detailed plans in place for all specialties supported by weekly confirm and challenge sessions with divisional leads. There has been further focus on endoscopy and day case surgery in the past ten days and we expect to see significant improvements in both from the beginning of November.

52 week waits are now 1778 but the rate of increase is slowing reflecting detailed focus at patient level.

Progress

In conjunction with the information team we have developed a weekly Power BI report to track performance against the trajectories. All data as at 30/10/20.

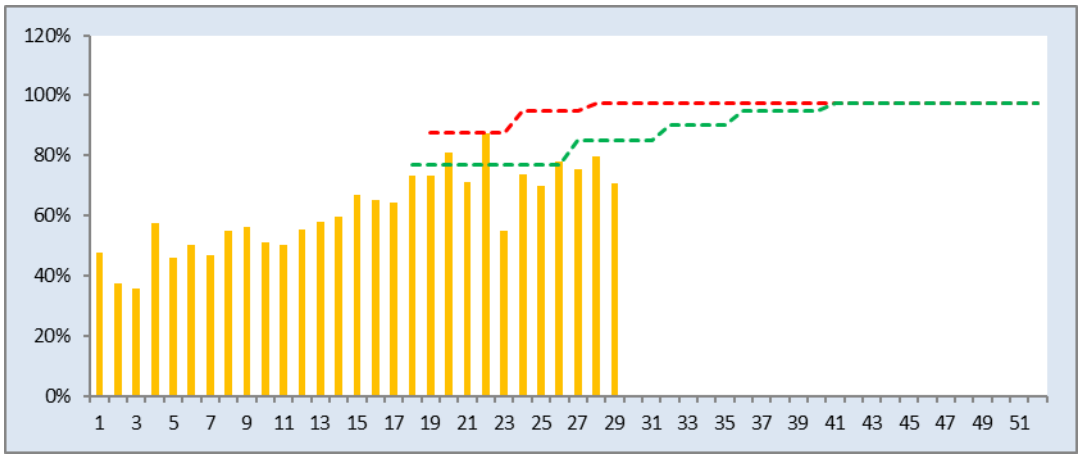


Chart 1: OP First- activity reflects a drop in referral numbers

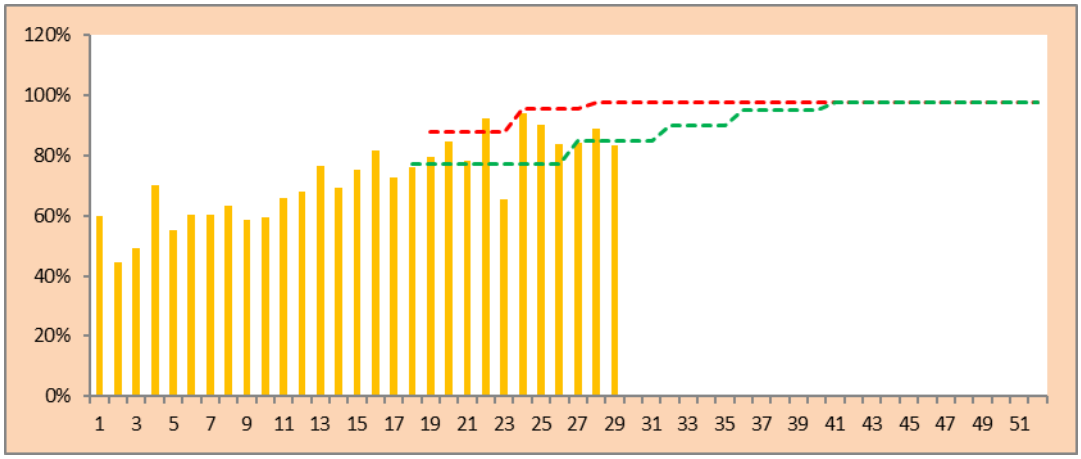


Chart 2: OP follow-up

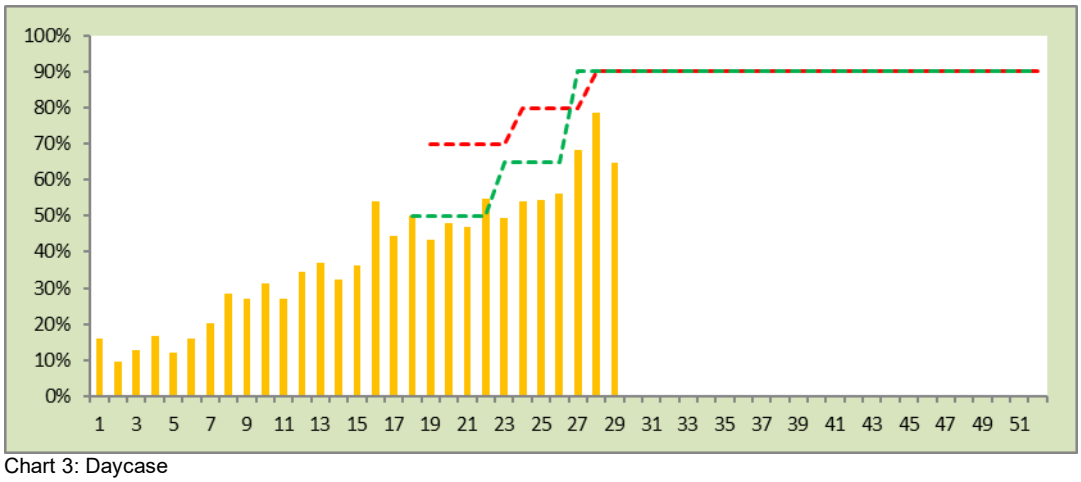


Chart 3: Daycase

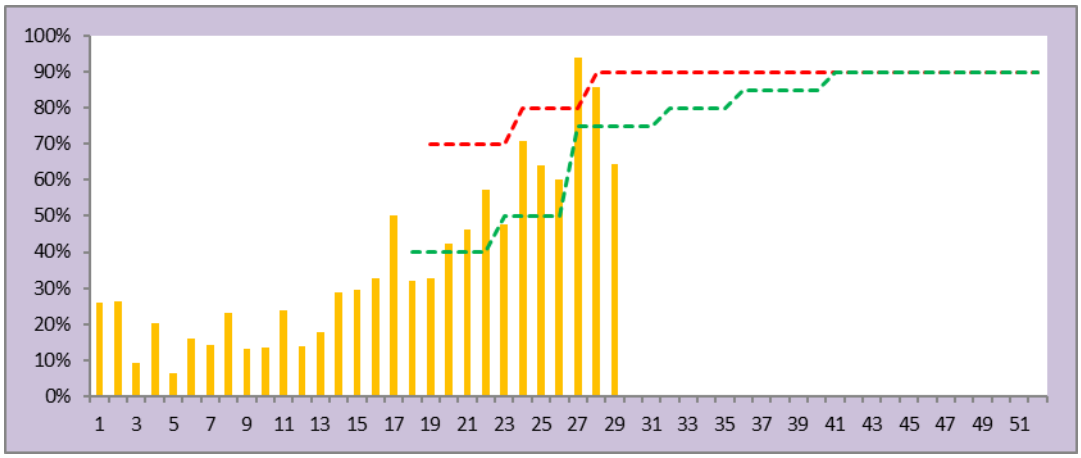


Chart 4: Elective

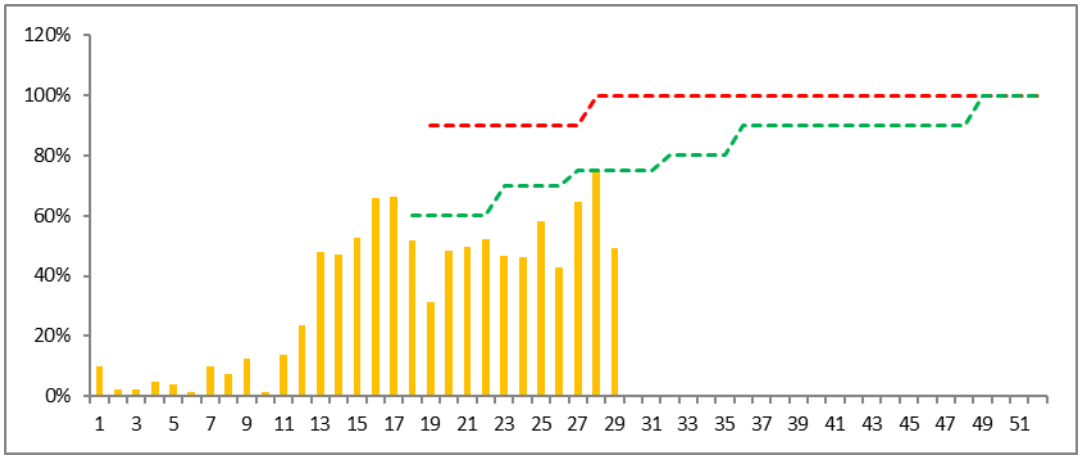


Chart 5: Endoscopy

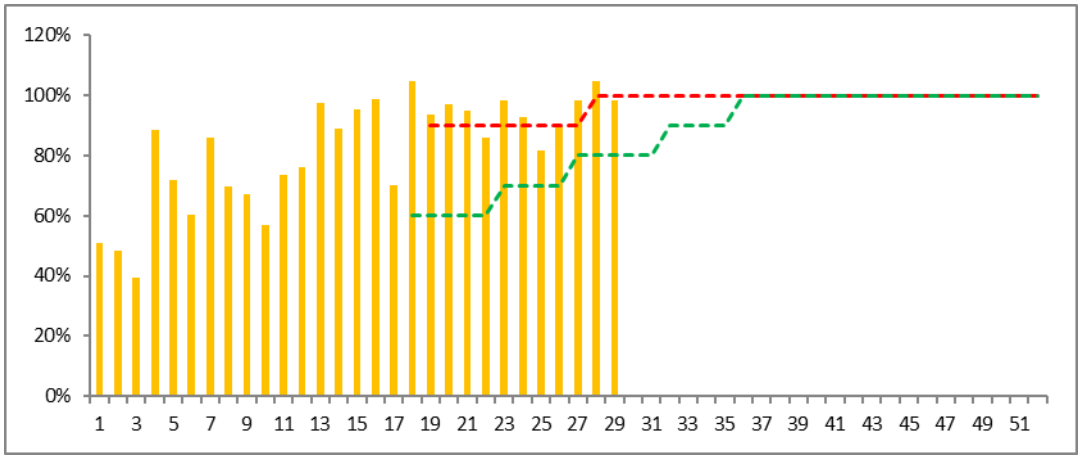


Chart 6: CT

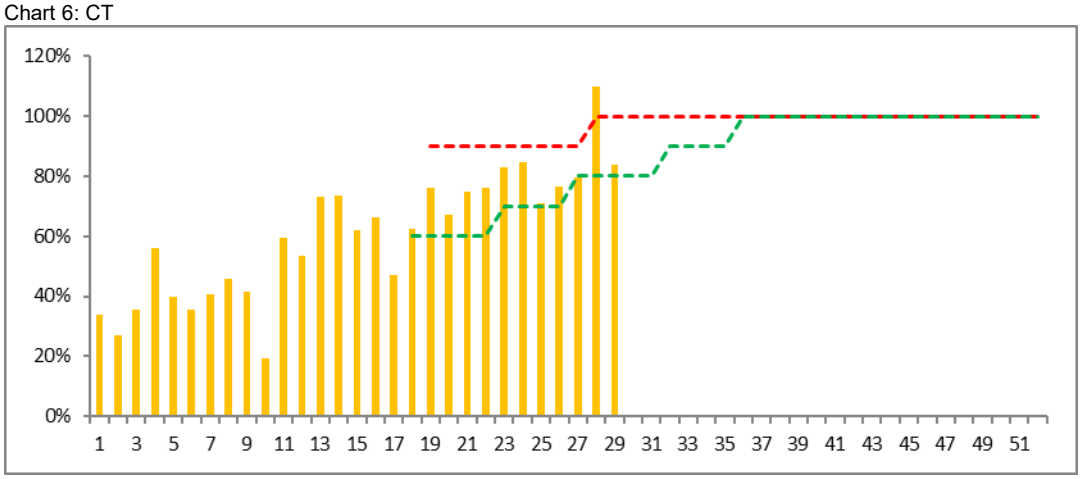


Chart 7: MRI

Winter planning including Covid activity

Given the rapidly changing situation, a verbal update will be given at the board meeting to outline current levels of covid activity within the Trust. At the time of writing Covid activity is being managed through wards F7 and F12 with plans in place to convert ward F10 to Covid activity when demand requires.

We are entering the final stages of winter planning. A presentation to TEG on Monday 2nd November set out the high level planning assumptions.

The trust plan will see a total of **511** general and acute beds available on site against an expected requirement for **588** based upon 92% bed occupancy. The gap is mitigated in full by additional community beds, spot purchased care capacity and an option to use additional capacity on site which is still to be confirmed. However, Covid demand is uncertain – our assessment is based on 13% contingency which equates to 38 beds. We are expecting to be asked to revise our model to account for 20% contingency to manage Covid demand given the numbers of patients being seen elsewhere. We have assumed a return of 100% pre Covid non-elective activity and 90% of the elective activity (as per phase 3 plans). It is far from certain what the impact of patient choice will be on demand in both categories will be.

Length of stay reductions of up to 26 beds have also been assumed in line with the latest discharge planning guidance from DHSC.

These plans assume the roof decant programme does not commence before 1 April 2020 and whilst there are no further ward closures planned currently, any change to this situation will negatively impact on our ability to deliver all of the anticipated activity as described in the plan. Detailed staffing plans have been developed and are progressing well to support the opening of additional winter escalation capacity when refurbishment of G9 completes in December. Internal moves will see G9 designated as the respiratory ward and G5 as winter escalation capacity.

The following risks have been identified in relation to the delivery of the winter plan:

- Covid demand is uncertain. Demand above 13% will have a significant impact on the trusts ability to deliver normal NEL and EL activity. We are working with PH team to refine the impact assessment.
- LOS reduction is dependent on full implementation of the enhanced discharge guidance, including D2A and annex a: criteria to reside.
- Lack of rapid Covid testing delays patient cohorting and decision making potentially increasing delays to discharge and LOS.
- Impact of regional critical care escalation plans The impact of regional critical care escalation criteria may mean that we have to surge in to F2 which in turn will impact delivery of our EL plans

The plan also provides a number of opportunities:

- The enhance discharge guidance provides an opportunity to work collaboratively across the system to improve patient transfers of care. Work is focusing on D2A and system wide pathway co-ordination.
- Frailty and older adult services can be enhanced through further collaborative work with community colleagues and supported by new facilities at Newmarket community hospital and at the front door.
- Maximising same day emergency care for all specialties.
- Continuing to embed sustainable 7 day services for adults and children.

EU Exit Planning

Notification of an EU Exit - end of transition period workshop to take place on Wednesday 4th November was received on Thursday 29th October. A verbal update of key points will be provided at board with a more detailed review at the November Scrutiny Committee.

Community Services Updates

Community services now have a co-produced plan in place to support resilience over winter. The community Covid SOP is updated as more information reaches us.

Work is underway with ReTHINK Partners to undertake a health and social care 10-week discovery programme as outlined in last month's board report. A Feedback workshop is planned in week 9 and the final report is due in week 10 (mid Dec). Further updates on the outcomes from this work will be provided in the January Board report.

We continue to develop a triumvirate approach with the senior leadership team consisting of Head of Nursing, Head of Therapy and ADO; the health team works closely with the Operational Lead for Social Care to collectively drive day to day decision making support to the system.

To support the community health care teams and provide resilience over winter, we have employed 4WTE agency nurses, and are currently looking to secure 2 more to ensure each locality has an additional flexible RN, they will support until April next year. In addition, we are preparing a test and learn with Homelink, a hospital from home service who will deliver doppler clinics to enable the teams to catch up on the backlog and be able to deliver a timely service moving forward.

Work is currently underway to use digital platforms to provide a better understanding of both capacity and demand and staff resource requirements and scheduling for community teams. This will inform substantive staffing requirements going forward to replace the planned temporary staffing put in place for this winter.

Newmarket Community Hospital will have 33 staffed beds by 23rd November this is an increase from the 19 last winter, Glastonbury court will remain at its 20 beds and at Marham House we are working closely with social care colleagues to ensure maximum capacity of 25 beds are utilised. A new GP contract to provide cover to the additional Newmarket beds for a three-year period has now been agreed.

To support Phase 3 recovery, we have in place crisis response within 2 hour of referral and reablement response with 3 days of referral. We are currently working on data dashboard to visually track KPIs, data points to monitor demand and capacity
We are also working with the Hospice to develop a locality community model to better support end of life care at home.

Recommendation

The board is asked to note the content of this report and agree the approach to winter planning

11. Integrated quality and performance report

To APPROVE a report

For Approval

Presented by Helen Beck and Susan Wilkinson

Trust Board Report

Agenda Item:	11			
Presented By:	Helen Beck & Sue Wilkinson			
Prepared By:	Information Team			
Date Prepared:	Oct-20			
Subject:	Performance Report			
Purpose:	**X**	**For Information**		**For Approval**

Executive Summary:

A new approach to Board reporting is underway and this version has been developed within the revised principles. The main visual differences this month includes the addition of a description field which provides a definition of the metric on display as well as some small amendments such as the addition of the current months figure for easier reading. The agreed plan for the future board report was to report by exception based on the performance of the metrics, which were to be monitored using statistical process control (SPC) charts. During the current time, SPC is not a useful tool given the significant changes in many areas which would distort performance and cause many to trigger the exception rules. To allow the principle of reporting by exception to continue the exception filtering will be a manual assessment rather than an automated one for the current time and has commenced for the first time in this report. For this reason, the content of the Board report may vary as indicators perform as expected and are removed or perform exceptionally and are added to the board report. Further planned developments include the addition of recovery trajectories and a further review of community metrics; these will be incorporated in future versions. This is an iterative process and feedback is welcomed.

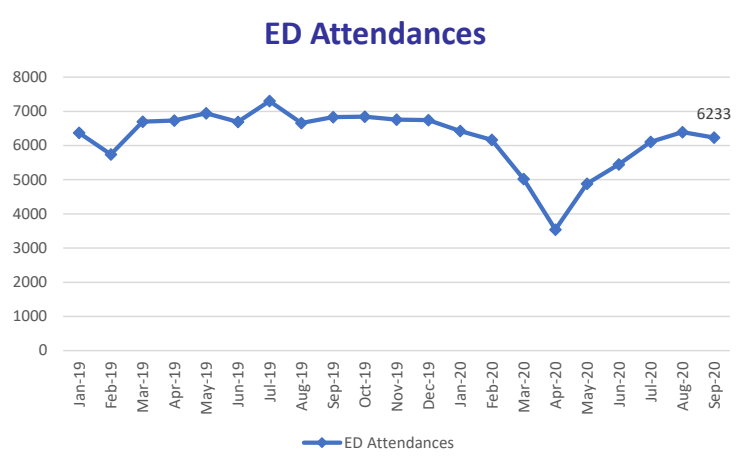
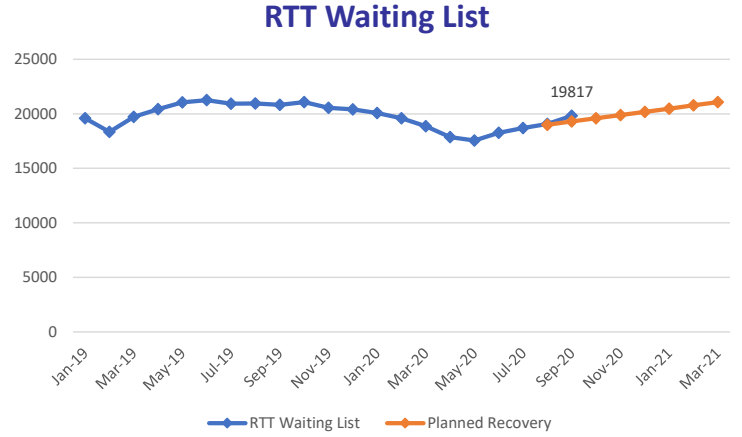
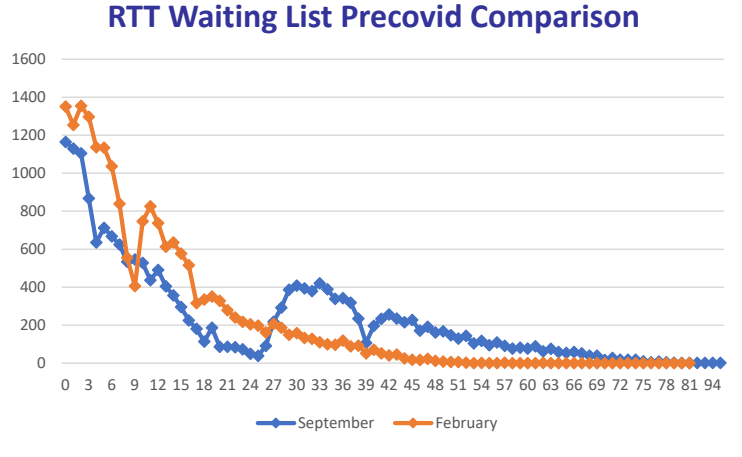
Trust Priorities [Please indicate Trust priorities relevant to the subject of the report]	**Delivery for Today**	**Invest in Quality, Staff and Clinical Leadership**	**Build a Joined-up Future**
	X		

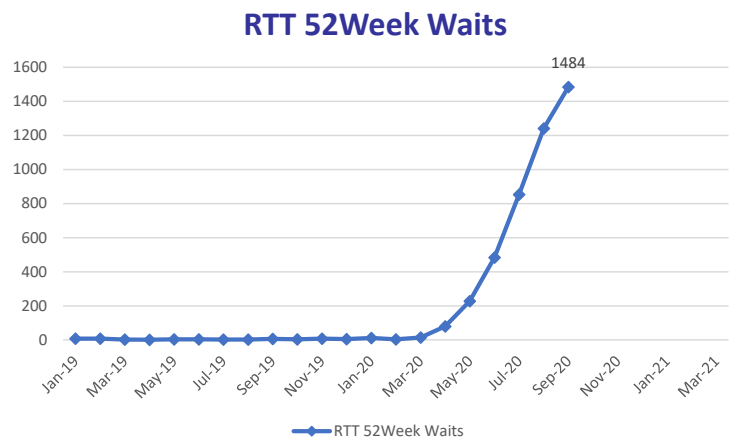
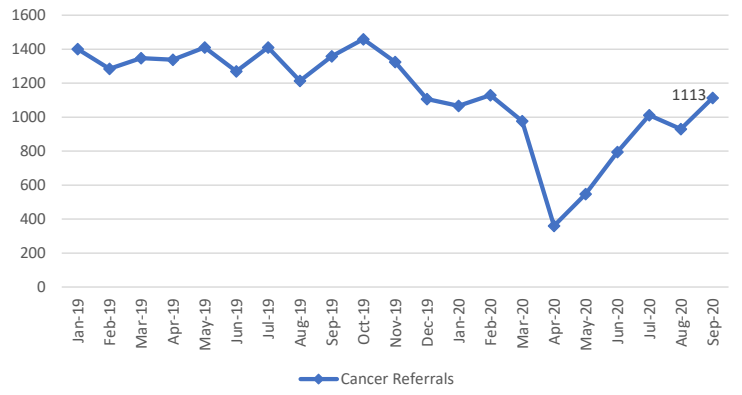
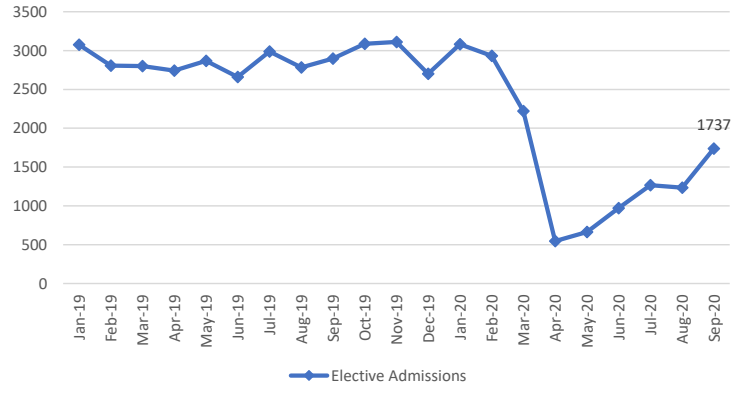
Trust Ambitions [Please indicate ambitions relevant to the subject of the report]	Deliver personal care	Deliver safe care	Deliver joined-up care	Support a healthy start	Support a healthy life	Support ageing well	Support all our staff
		X	**X**				**X**

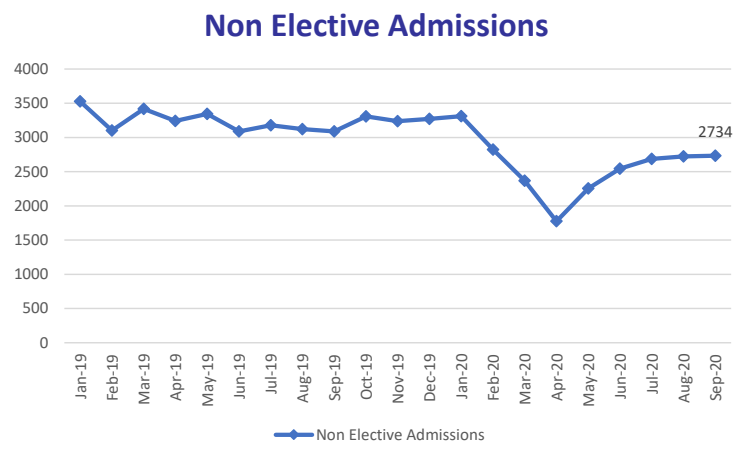
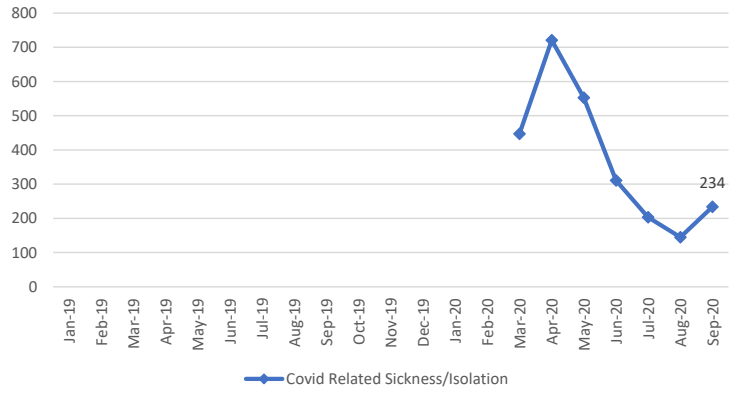
Previously Considered by:	
Risk and Assurance:	
Legislation, Regulatory, Equality, Diversity and Dignity Implications	

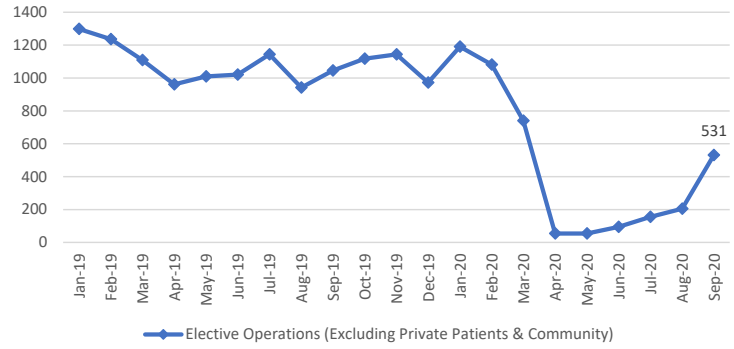
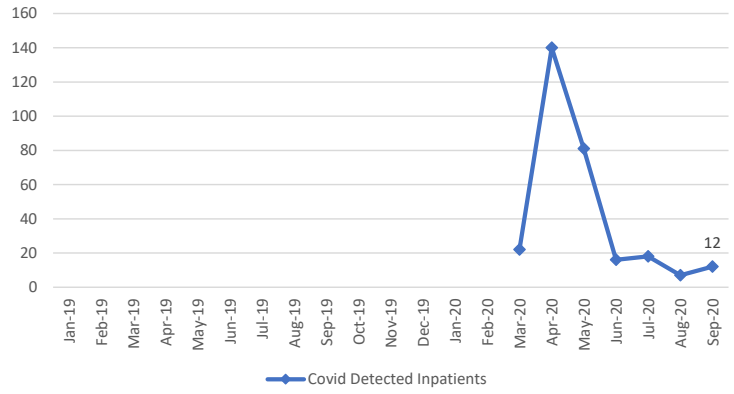
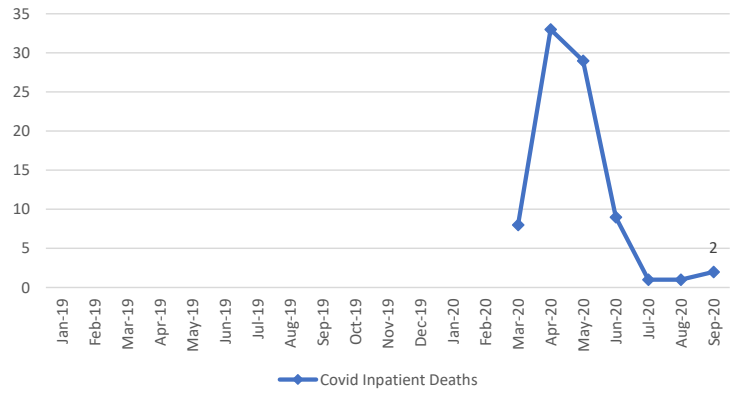
Recommendation:

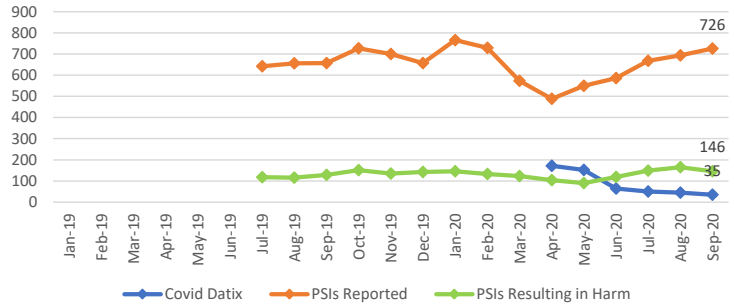
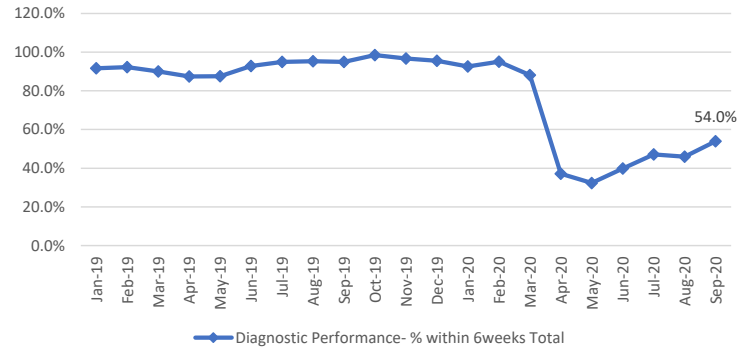
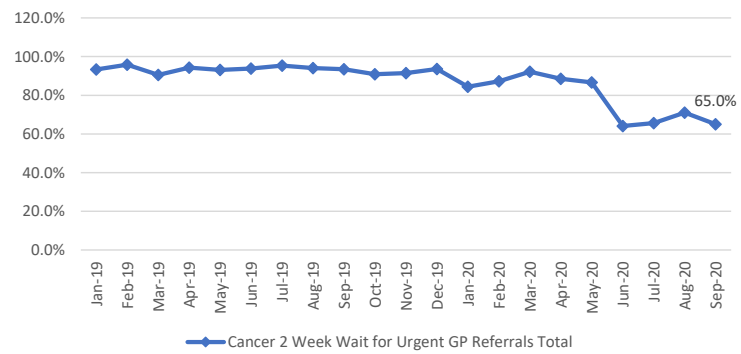
That Board note the report.

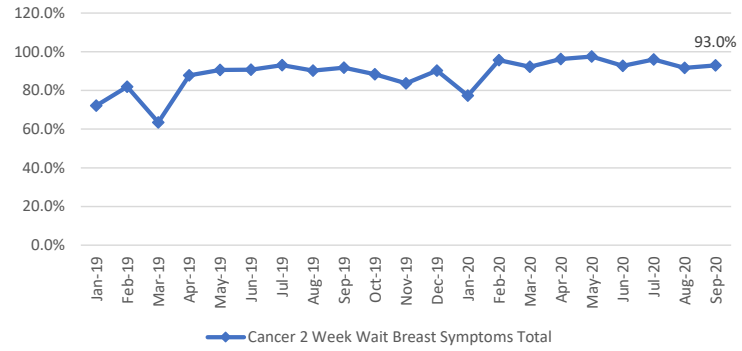
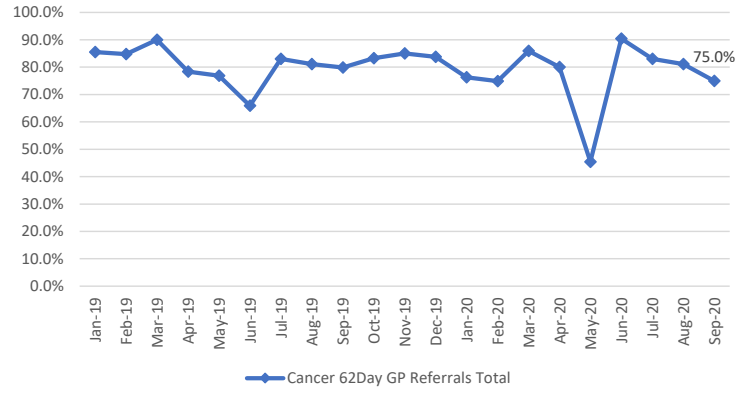
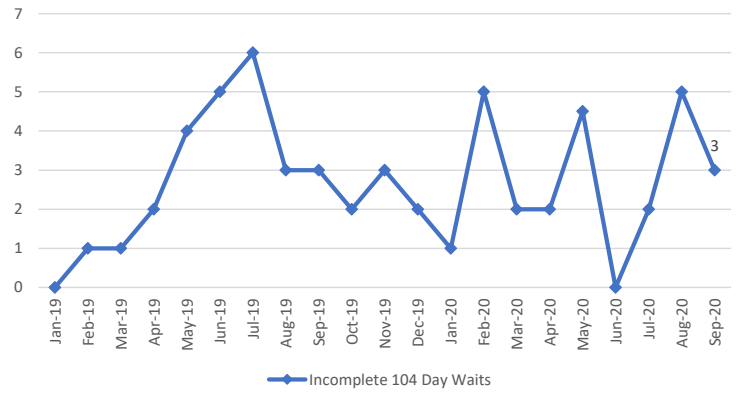
Board Report KPIs	Narratives
	There were 6233 attendances in ED in September compared to 6389 in August (a slight decrease of 156 patients 2.44%.) Although this is still lower than our pre-covid attendances, attendances are increasing to a more normal level (September 2020 saw 596 few attendances to ED than September 2019 - a decrease of 8.72%) 1670 patients were admitted in September compared to 1732 in August (decrease of 62 patients 3.5%.)
A count of the arrivals at the Emergency Department. This metric has no national target but is key to understanding demand for non elective services.	
	The waiting list has increased slightly in September from 19082 to 19817, a small increase in most surgical specialities has been seen, with General Surgery and Dermatology having the biggest increase. Referrals in these areas have continued to rise to pre-covid levels. The rise is in the front end of the pathway as the number of patients over 18 weeks has fallen in most specialities.
A count of the patients on the waiting list for treatment.	
	As can be seen the waiting list shape has changed for patients on an elective pathway, with a bulge of patients now waiting between 24-39 weeks and a significantly increased tail. As we continue with our elective recovery we do anticipate this tail to start to reduce, but we are still treating patients in clinical priority order.
A year on year comparison of the number of patients waiting for treatment.	

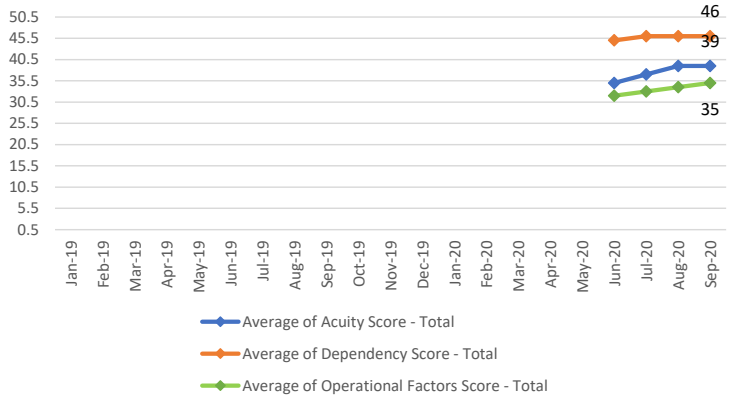
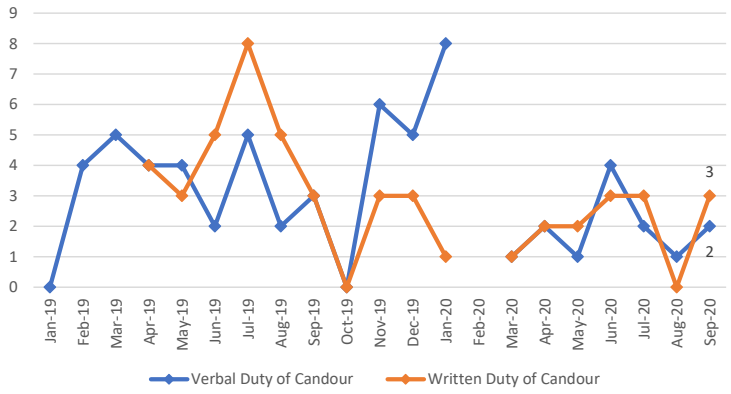
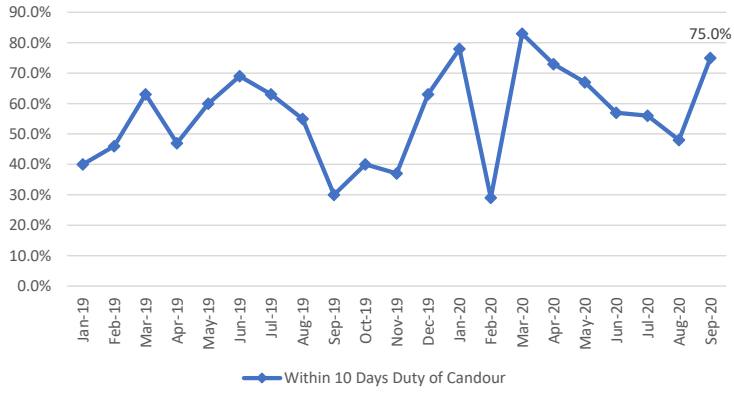
Board Report KPIs	Narratives
	The amount of patients over 52 weeks has risen again from 1242 to 1484 from August to September. Most of the patients over 52 weeks are those waiting for surgery and we have seen the biggest increase in General Surgery, Trauma and Orthopaedics, Ophthalmology and Gynaecology. There are plans to outsource some cataract surgery which will help with the reduction of 52 week waits for Ophthalmology.
A count of the number of patients who are waiting for treatment and have been waiting longer than 1 year for treatment. This is a national key performance indicator with a national expectation of 0.	
	As expected the cancer referrals rose again in September, after a slight reduction that is normally seen in August.
A count of the number of patients referred to the hospital with suspected cancer, requiring investigation. This metric shows the activity by month for cancer services, which informs the national metric which measures the number of these patients that were seen within 2 weeks (further in the performance pack).	
	As anticipated a significant increase in September 2020 due to the re-opening of DSU and Main theatres. As long as elective beds are protected, this should increase further into October. There is still work to do to increase Endoscopy utilisation, and a plan is in place to increase their utilisation with the opening of the 3rd room from November onwards.
A count of the number of patients that were admitted for an elective/planned procedure. This is a local metric used to monitor changes in activity.	

Board Report KPIs	Narratives
	Non elective admissions were 2734 in September which is a slight increase from 2724 in August (10 patients and 0.37% increase) but still lower than pre COVID levels. In comparison to September 2019, this is a decrease year on year in admissions of 11.44%.
A count of the number of patients who were admitted following an unplanned or emergency episode. This is a local metric used to monitor demand.	
	The Trust's 12 month cumulative absence as at the end of September 2020 is static at 3.8%, as it was in August 2020. This is a reduction from the reported position from April through to July 2020 which was 3.9%
A measure of staff sickness across the Trust. This includes community staff. This is a local metric to monitor the capacity of our workforce.	
	This chart illustrates the number of sickness episodes related to COVID-19. In September 2020 there were 234 episodes recorded which is an increase from August 2020 which was 145 episodes. This is due to the increased absence and sickness levels in the Trust which coincided with children returning to school in September.
A count of our staff who have been off sick with a covid related symptoms or to isolate. This is a local metric to monitor the impact of covid on our workforce.	

Board Report KPIs	Narratives
Elective Operations (Excluding Private Patients & Community)  This is a count of the number of operations that were carried out. This is a local measure to monitor our productivity and recovery from Covid.	As anticipated a significant increase in September 2020 due to the re-opening of DSU and Main theatres. As long as elective beds are protected, this should increase further into October.
Covid Detected Inpatients  This is a count of the number of patients admitted to the hospital who tested positive for Covid. This is a local measure to understand the local impact of Covid. This number is reported daily as part of national daily reporting requirements.	Small increase in numbers reflecting increased community prevalence. Modelling would suggest that this is likely to increase although timeframes are uncertain.
Covid Inpatient Deaths  A count of the number of patients who have died following a positive Covid result. This is a local metric to understand the local impact of Covid. This number is reported daily as part of national daily reporting requirements.	Number of reported deaths remains small at present in keeping with low prevalence of infection within the Trust.

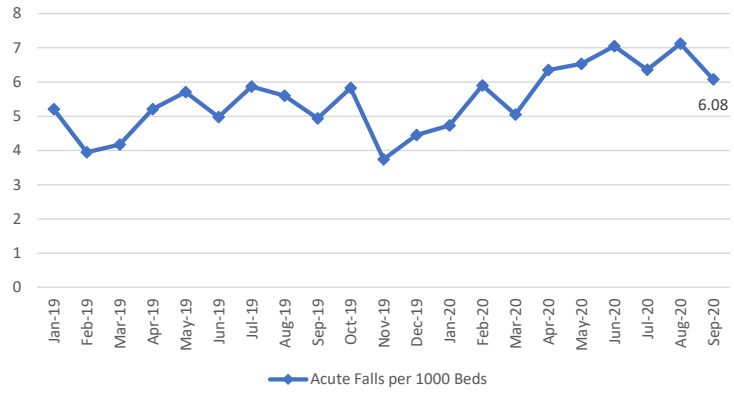
Board Report KPIs	Narratives
Patient Safety Incidents Reported (Total, Resulting in Harm and 'Related to COVID')  A count of the number of patient safety incidents reported in total, related to harm and those relating to management of Covid patients	The number of patient safety incidents reported in September rose however the number of those resulting in harm fell. There was also a fall in the number of incidents reported categorised as relating to a COVID patient. The incidents reported per 1,000 bed days remained comparable to recent months.
Diagnostic Performance- % within 6weeks Total  To measure compliance with the national standards for access to diagnostic treatment. This metric measures the percentage of patients who receive diagnostic treatment within 6 weeks of referral. The national standard is 99% to receive a diagnostic within 6 weeks.	Improvement in overall diagnostic performance but still impacted by Covid restrictions. Number of tests performed have increased significantly and are generally back to pre-covid levels. Mobile CT scanner has now arrived on site and expected to be operational W/B 26/10/2020. In addition, mobile MRI scanner has been approved and it has been provisionally agreed that this can be located at Sudbury Health Centre. Team working on getting this implemented. Both scanners will have a positive impact on imaging capacity. Endoscopy capacity gradually increasing but limited by Covid swabbing capacity, changes to booking processes and patient/household compliance with isolation. Work is on-going to reduce these constraints and also to re-introduce the 3rd endoscopy room capacity. The average diagnostic wait is currently at 13 weeks.
Cancer 2 Week Wait for Urgent GP Referrals Total  To measure compliance with the national standards for access to cancer diagnosis. This metric measures the percentage of patients who are seen within 2 weeks from referral from their GP for suspected cancer. The national standard is 93% to been seen within 2 weeks.	Drop in 2Week Wait performance, mostly due to Colorectal and Upper GI who are reliant on Endoscopy as a straight to test service, Colorectal compliance in particular is exceptionally low. This is discussed on a weekly basis and the suspected cancer patients are being given priority, however referral numbers for this area are higher than pre-covid, which means booking them in within 2 weeks is a challenge.

Board Report KPIs	Narratives
Cancer 2 Week Wait Breast Symptoms Total  This metric is a sub set of the national 2 week wait metric and measures those GP referrals specifically with breast symptoms. The target is the same as the overall 2 week wait of 93% of patients to be seen within 2 weeks.	Compliant for September.
Cancer 62Day GP Referrals Total  To measure compliance with the national standards for access to cancer treatment. This metric measures the percentage of patients receive cancer treatment within 62 days of referral by their GP. The national standard is 85% to have received treatment within 62 days.	Unvalidated position - however due to the numbers of breaches already allocated, likely to be around this number. The reason for the drop in compliance is that we are now diagnosing and treating the patients that have been in a backlog. There were also a number of patients who were shielding/unable to come in but needed to remain on a cancer pathway that were then able to come in for treatment in September.
Incomplete 104 Day Waits  A count of the number of patients who have waited longer that 104 days for treatment for cancer from GP referral. This is a national standard and is expected to be 0.	Although the amount of patients over 104 days is fairly static at around 26, the amount of patients over 104 days who had treatment reduced to 3 in September, the majority of the patients waiting over 104 days are still in the diagnostic phases.

Board Report KPIs	Narratives
Acuity Measures  A range of measures have been identified which are analysed to provide an overall acuity score, as displayed in this chart. This provides an overview of the acuity of admitted patients.	These metrics are derived from the electronic records (eCare) and though unvalidated, provide a trend of the acuity, dependency and operational pressures the inpatient beds are managing. Overall acuity and operational pressures continue to rise and this is reflective of the day to day demands on the organisation. Through September, attendances in the Emergency Department and admissions via emergency and elective pathways have increased, in some part, to pre-covid levels. Despite this, dependency levels remain static, though high. Many specialities are continuing to see high levels of complex, seriously unwell patients, potentially due to late presentation or delays in diagnostics as a result of the pandemic surge.
Duty of Candour  This is a count of the number of verbal and written duty of candour overdue for the reporting month (and earlier) as at the date of report issue	September saw a higher number of incidents requiring a Duty of Candour conversation than recent months (28 incidents compared to an average of 19 in the preceding 12 months). This was mainly as a consequence of increased numbers of pressure ulcers reported (see separate narrative). Despite this, the percentage competed within the 10 working day requirement rose to 75% in the month, the highest compliance since March 20. At the date of this submission there were still 2 cases awaiting a verbal Duty of Candour conversation and 3 where the follow up letter have not yet been sent. As always, these are being actively followed up within the divisions.
Within 10 Days Duty of Candour  The percentage of cases reported in that month where verbal duty of candour was completed within the nationally required 10 working day timeframe.	

Board Report KPIs

Acute Falls per 1000 Beds



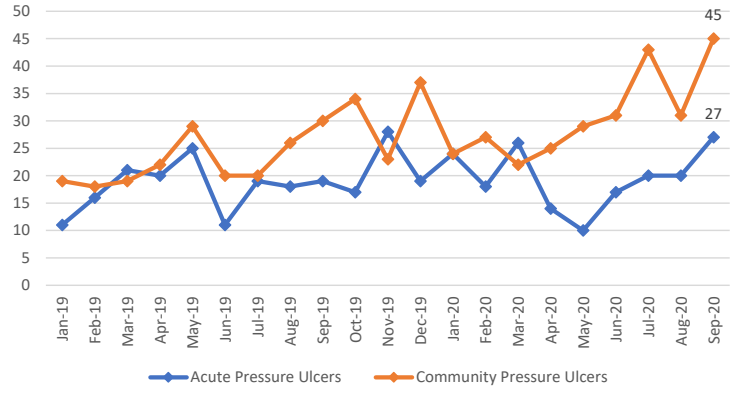
A measure of the number of falls in the acute hospital measured per 1000 bed days. Community falls are excluded from this metric.

Narratives

The total number of falls in September decreased by 11.6 %, from 69 in August to 61. Falls per 1000 bed days decreased from 7.12 to 6.08. Within September 44 falls resulted in no harm, 2 negligible, 12 minor, 1 moderate and 2 major harm. Of the major harms both patients sustained a Neck of Femur Fracture, both patients accidentally tripped whilst changing their clothes and had been risk assessed as independent and mobile.

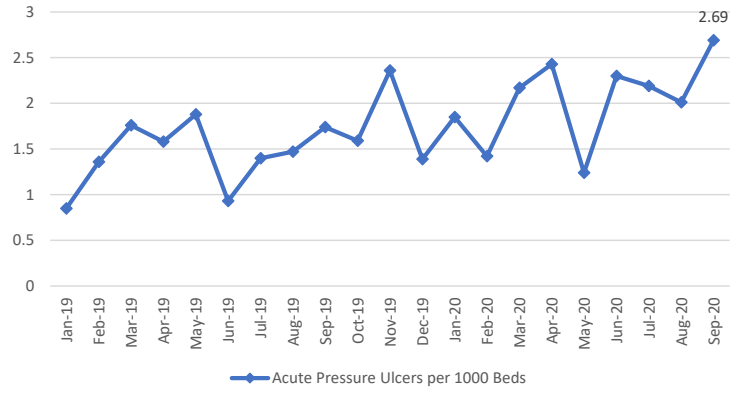
Requests for extra staff to support the provision of one to one care continue, though in many cases cannot be provided due to unavailability of staff. Senior nursing teams assess and re-deploy staff where appropriate. There remains a high prevalence of cognitively impaired patients who are at risk of falling; business cases are being prepared for a dementia support service and for replacement falls equipment. We have now appointed into the falls lead post, all ward areas have falls champions with a champions day arranged for 11th November 2020.

Pressure Ulcers



A count of the number of recorded pressure ulcers across the Trust. This metric will include those recorded in the acute hospital and community settings.

Acute Pressure Ulcers per 1000 Beds



A measure of the number of pressure ulcers in the acute hospital measured per 1000 bed days. Community pressure ulcers are excluded from this metric.

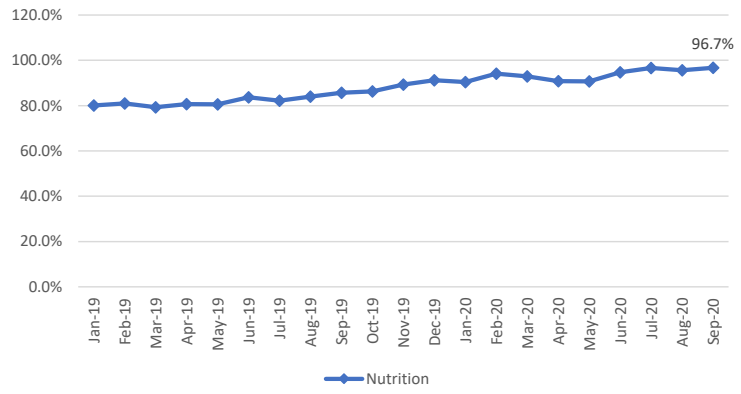
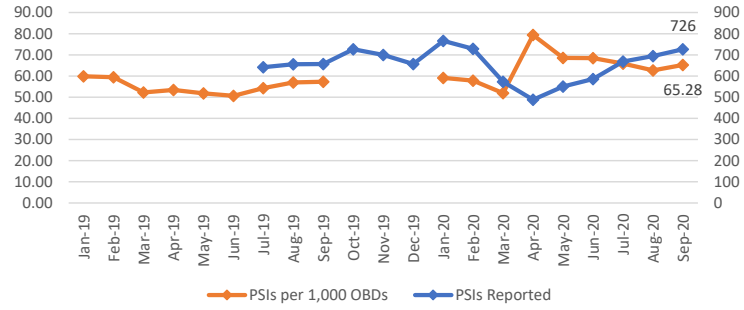
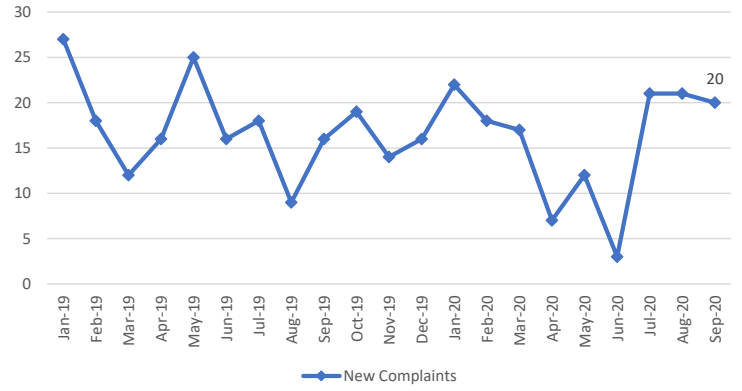
There was an overall increase of 37% in Pressure Ulcer occurrence in September although there were no Category 4 Pressure Ulcers reported. Community reported 45 and Acute 27 Pressure Ulcers respectively. The new patient safety audit model for Pressure Ulcer investigation in the Community, has identified contributory factors of patient frailty and non-concordance confirming the findings of recent SIs and soft intelligence from clinicians.

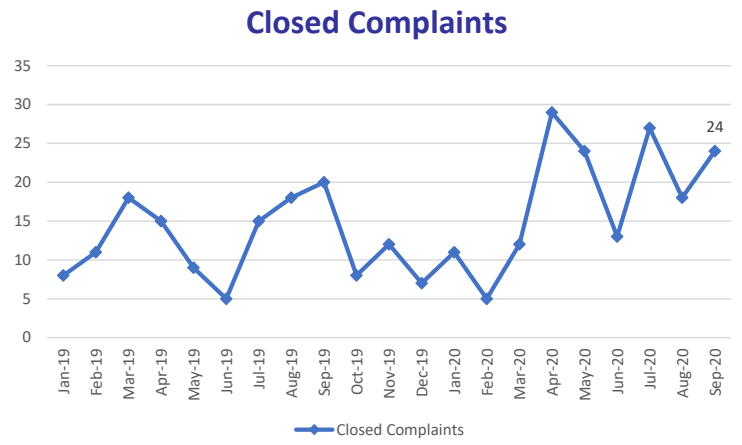
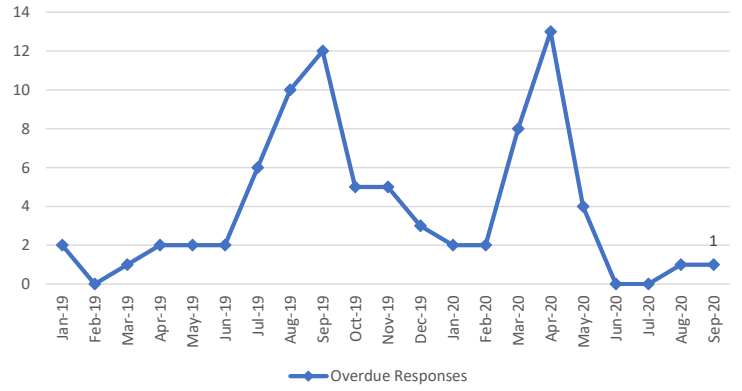
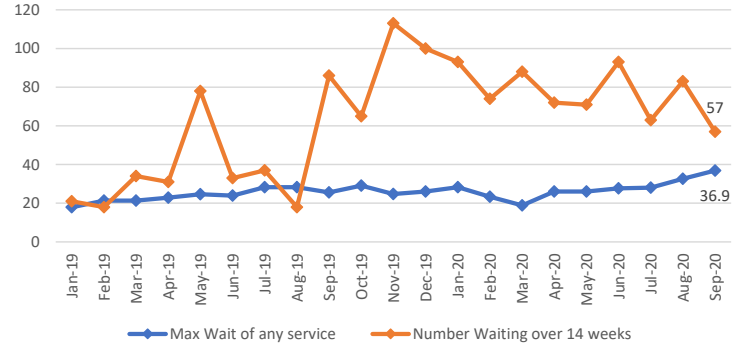
Improvement initiatives include:

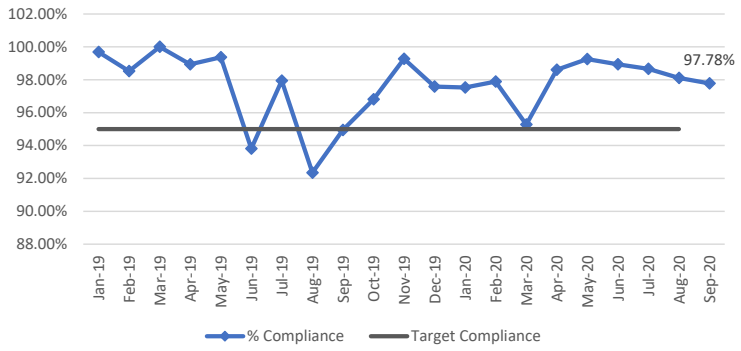
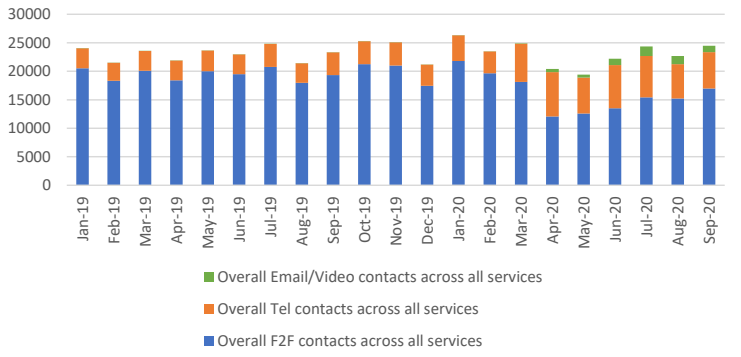
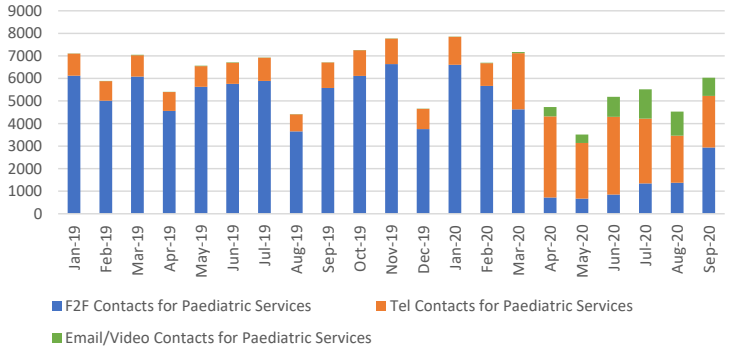
- Patient information pictorial resource for category 3 Pressure Ulcers, to encourage patients and carers to understand when to seek clinical advice.
- A webinar to increase clinician confidence in tackling non-concordance.
- Digital learning and ward-based, opportunist teaching in the WSH wards for clinicians is being well received

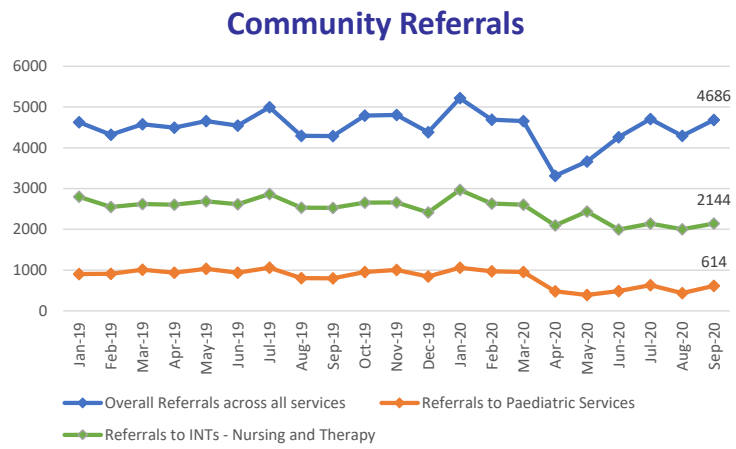
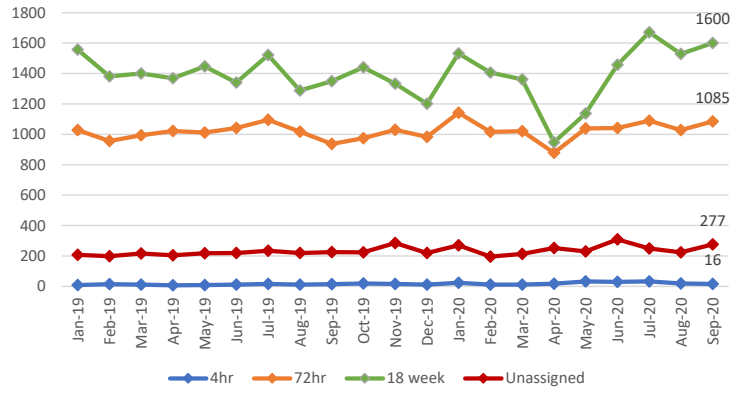
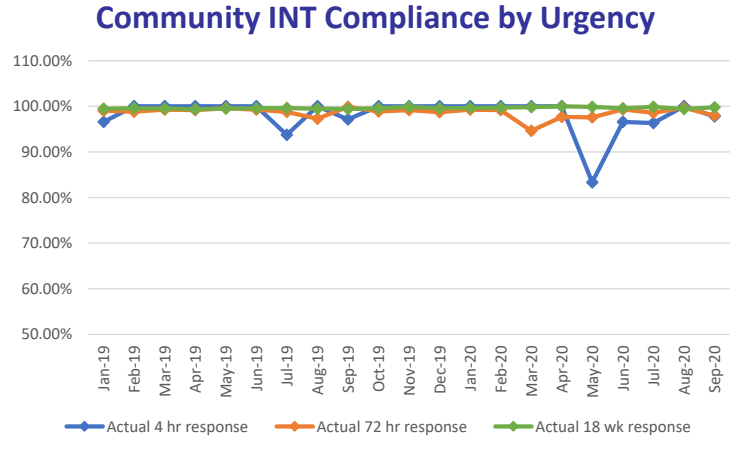
Within the acute inpatient areas staff report that continued reduced visiting may have impacted upon the motivation of patients to eat, drink and reposition regularly – however these are all monitored closely by risk assessment.

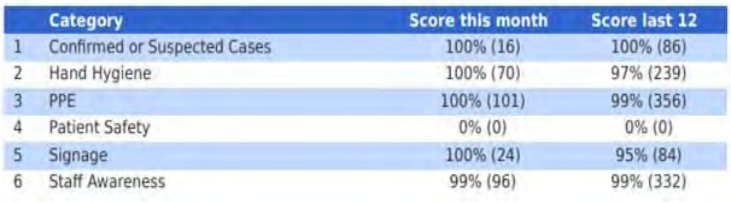
Of note, Critical Care have reported only 14 Category 2 Pressure Ulcers since March of which 12 were either device related or contributed to by patient positioning (proning); whilst all pressure ulcers are a regrettable occurrence, given the high levels of ITU activity in recent months, this is a testament to high quality care.

Board Report KPIs	Narratives
Nutrition  % of patients with a Malnutrition Universal Screening Tool (Adults)/Paediatric Yorkhill Malnutrition Score (Children) assessment completed within 24 hours of admission	There has been a slight improvement overall in compliance with nutrition risk assessment during September, with Paediatrics making some significant improvements. There has been a slight decline in performance on Ward F14, but this is being reviewed by the Senior Matron and actions are in place to improve compliance. However this reduction in performance has had minimal effect on the overall Trust compliance, due to the small number of patients affected. The Nutrition improvement group continues to focus on maintaining this performance but is also reviewing the quality of these assessments, as well as, reviewing the implementation and effectiveness of the care plans, promoting compliance with actual weights on admission and reviewing protected mealtimes. An audit will be conducted in November to review compliance with this process following a change in mealtime delivery to the wards several months ago.
Patient Safety Incidents (PSIs) Reported Total and per 1,000 occupied bed-days (OBDs)  A count of the number of patient safety incidents reported in total and as a percentage of occupied beddays to measure reporting rates	The number of patient safety incidents reported in September rose however the number of those resulting in harm fell. There was also a fall in the number of incidents reported categorised as relating to a COVID patient. The incidents reported per 1,000 bed days remained comparable to recent months.
New Complaints  New formal complaints received and accepted, this counts both West Suffolk Hospital and Community	A typically average month with 20 formal complaints received. The trend continued with 4 complaints for the emergency department. 2 of the 4 complaint relate to the values and behaviour of staff however it is proving difficult to find a more granular trend when reviewing the sub categories due to the variation. 1 of these complaints is currently being investigated as an SI. An increase for complaints for ward F3 during September, an increase of 3 compared to August. All four relate to orthopaedic surgery of which 2 of the 4 relate to delay or failure to diagnose and treat. 1 complaint related to an episode of care which happened in 2016 and the other complaint is currently being investigated as a SI. Other trends still reoccurring is the care and treatment relating to ward F11.

Board Report KPIs	Narratives
	24 complaints resolved in September an increase from 18 in August. More staff returned from Annual leave across the trust and the help of providing a timescale to respond to is also aiding our response rates.
Formal complaints signed off by the CEO, this counts both West Suffolk Hospital and Community	
	1 complaint was resolved over timescale due to 1 being an historic backlog complaint. We are working on this pot as a priority.
Any complaints which were sent outside of the given timeframe and no extension was agreed, this counts both West Suffolk Hospital and Community	
	In September 3 services have patients waiting over 18 weeks at the end of June: Paed SLT, Heart Failure and Wheelchairs. The maximum wait for each of these services are 36.86 weeks (increased from 32.57 in August), 14.86 weeks (decreased from 22.57 in August) and 23.00 weeks (same as August) respectively. Paed SLT and wheelchairs were both exceeding the wait times prior to COVID, these 2 services have papers and support from the CCG both in understanding demand and increasing resources. Heart Failure patients were in the shielding category so unavailable for assessment for April and May. The total number of referrals waiting over 14 weeks across ALL services has decreased from 83 in August to 74 in September.
Services covered: Adult SLT, Heart Failure, Neurology Service, Parkinson's Nursing, Wheelchairs, Paed OT, Paed Physio and Paed SLT, There are no patients waiting over 52weeks for treatment from referral, so community look at number of patients waiting over 14 weeks. Historically, 14 weeks was agreed on as an internal measure because it gives an approx. number of patients who would breach the 18 week target at the end of the next month.	

Board Report KPIs	Narratives
Community Non Consultant Led 18week Compliance  Services covered: Adult SLT, Heart Failure, Neurology Service, Parkinson's Nursing, Wheelchairs, Paed OT, Paed Physio and Paed SLT. RTT nationally is for consultant led services but the community services are required to report on compliance to 18 week Referral to Treatment locally to our CCG. Target is 95% of referrals are given a first definitive treatment within 18weeks	The aggregated % of patients treated within 18 weeks for all community services in September was 97.78% with the lowest individual service being Paed SLT at 93.94%.
Contacts for ALL Community Services (Adults and Paeds)  Activity is counted as a face to face/telephone/email/video contact with a patient/carer/parent which is clinically relevant. This means activity that a clinician carries out which is writing reports, liaising with other healthcare professionals is NOT counted as activity. This is in line with acute systems where there is an assumption that clinicians will carry out related activities that result from contact with a patient.	The total activity for community services has returned to pre-COVID levels although the ratio of face to face and other means of contact (telephone, video and email) has altered. The INTs activity is still based in face to face but some other services have moved to telephone contacts successfully.
Contacts for Community Paediatric Services  Activity is counted as a face to face/telephone/email/video contact with a patient/carer/parent which is clinically relevant. This means activity that a clinician carries out which is writing reports, liaising with other healthcare professionals is NOT counted as activity. This is in line with acute systems where there is an assumption that clinicians will carry out related activities that result from contact with a patient.	The Paediatric services have moved a high proportion of their activity to telephone and email/video contacts but they are still unable to carry out any group work due to social distancing requirements. There are also shortages in clinic availability in certain locations. The wearing of masks and social distancing means Speech and Language therapy is particularly hard to do. The services are reviewing all possible options.

Board Report KPIs	Narratives
	Referrals to the majority of the community services have returned to pre-COVID numbers.
There should be one reason per referral, i.e. if a patient is referred in to the INTs for 2 requirements either simultaneously or over time, eg leg ulcer dressing and phlebotomy, then there are 2 referrals.	
	Referrals to the INT services have returned to pre-COVID numbers, in particular the Green referrals have just moved above pre-Covid numbers though whether this will be long term is still to be seen.
Referrals into the Integrated Neighbourhood Teams have urgencies of Red (within 4 hours), Amber within 72hrs) and Green (within 18 weeks). These contractual urgencies are locally agreed pan Suffolk with the CCG and there is a 98% response target for Red, Amber and Green response times have a 95% threshold (These are local contractual targets)	
	All response thresholds were met in September
Referrals into the Integrated Neighbourhood Teams have urgencies of Red (within 4 hours), Amber within 72hrs) and Green (within 18 weeks). These contractual urgencies are locally agreed pan Suffolk with the CCG and there is a 98% response target for Red, Amber and Green response times have a 95% threshold (These are local contractual targets)	

Board Report KPIs	Narratives
Perfect Ward 	This table is not available for October as this was from Covid Perfect Ward audit (delay in informing email) Update on rest of Perfect Ward is: • Observation and Documentation Audit has been altered for adult wards and theatres & CCS and do be moved to weekly from 1st Oct • IPC audits have been made accessible to all matrons to help the IPC team with no Lead. Still quarterly audit • Staff Audit to be removed and switch for Medicine Management one run by Pharmacy – trailing in October
Perfect Ward Assessment Audits	

	Category	Score this month	Score last 12
1	Confirmed or Suspected Cases	100% (16)	100% (86)
2	Hand Hygiene	100% (70)	97% (239)
3	PPE	100% (101)	99% (356)
4	Patient Safety	0% (0)	0% (0)
5	Signage	100% (24)	95% (84)
6	Staff Awareness	99% (96)	99% (332)

12. Finance and workforce report

To ACCEPT the report

For Report

Presented by Craig Black

Board of Directors – 6 November 2020

Agenda item:	12			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	28th October 2020			
Subject:	Finance and Workforce Board Report – September 2020			
Purpose:		For information	x	For approval

Executive summary:
The planned position for the year is to break even. This will include receiving all FRF and MRET funding associated with meeting the Financial Improvement Trajectory (FIT)

We have submitted a revised activity plan. However, discussions over COVID related funding are ongoing and whilst there is uncertainty over COVID related expenditure and associated income our income and expenditure plan remains unchanged.

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

We continue to analyse our recurring expenditure in order to identify and take any action to improve any pressures that would otherwise arise in 2021-22.

In particular we are focussing on recurring staffing costs through establishment control and ensuring recurring 2020-21 CIPs are embedded before the end of the financial 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:	*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
September 2020 (Month 6)

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	£22.6m	adverse
EBITDA margin YTD	18%	adverse
Total PSF Received	£22.6m	accrued
Cash at bank	£26.4m	

Executive Summary

- The planned position for the year is to break even. This will include receiving all FRF and MRET funding associated with meeting the Financial Improvement Trajectory (FIT)
- We anticipate receiving all FRF and MRET funding associated with meeting the FIT
- We have either received or accrued income for all costs relating to COVID-19
- Our focus is on our underlying income and expenditure position in readiness for 2021-22

Key Risks in 2020-21

- Costs and income associated with revised activity plan
- Costs associated with increased capacity pressures relating to COVID-19, RAAC planks and winter pressures
- Delivery of £8.7m CIP programme

SUMMARY INCOME AND EXPENDITURE ACCOUNT - September 2020	September 2020 Budget £m	September 2020 Actual £m	September 2020 Variance F/(A) £m	Year to date Budget £m	Year to date Actual £m	Year to date Variance F/(A) £m	Year end forecast Budget £m	Year end forecast Actual £m	Year end forecast Variance F/(A) £m
NHS Contract Income	19.1	17.8	(1.3)	113.0	108.0	(5.0)	218.5	215.5	(3.0)
Other Income	3.0	1.8	(1.2)	17.8	16.3	(1.6)	36.2	27.1	(9.1)
Total Income	**22.1**	**19.6**	**(2.5)**	**130.9**	**124.3**	**(6.6)**	**254.7**	**242.6**	**(12.1)**
Pay Costs	15.6	15.1	0.5	95.8	99.5	(3.8)	191.4	190.4	1.0
Non-pay Costs	9.8	7.7	2.1	49.8	41.9	7.9	94.0	83.3	10.6
Operating Expenditure	**25.5**	**22.8**	**2.6**	**145.6**	**141.4**	**4.2**	**285.3**	**273.7**	**11.6**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA excl STF	**(3.3)**	**(3.2)**	**0.1**	**(14.7)**	**(17.1)**	**(2.4)**	**(30.7)**	**(31.1)**	**(0.4)**
Depreciation	0.7	0.6	0.1	4.0	3.6	0.4	8.1	8.1	0.0
Finance costs	0.3	0.3	0.0	2.0	1.9	0.1	3.9	3.7	0.2
SURPLUS/(DEFICIT)	**(4.3)**	**(4.1)**	**0.2**	**(20.7)**	**(22.6)**	**(1.9)**	**(42.7)**	**(42.9)**	**(0.2)**
Provider Sustainability Funding (PSF)									
PSF / FRF/ MRET/ Top Up	4.3	4.1	(0.2)	20.7	22.6	1.9	42.7	42.9	0.2
SURPLUS/(DEFICIT) incl PSF	**(0.0)**	**0.0**	**0.0**	**0.0**	**0.0**	**(0.0)**	**(0.0)**	**0.0**	**0.0**

FINANCE AND WORKFORCE REPORT – September 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 – September 2020

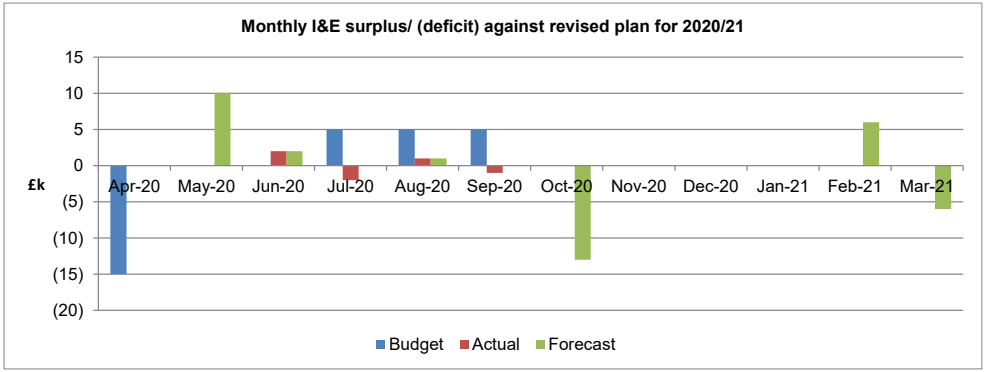
Income and Expenditure Summary as at September 2020

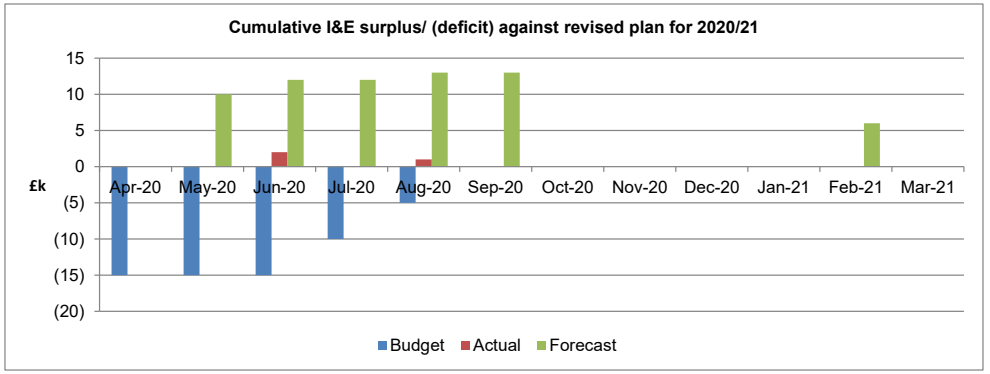
The reported I&E for September is break even, in line with NHSI guidance. Due to COVID-19 we are receiving top up payments that includes MRET and FRF. This ensures we break even YTD. The 'top up' for September is £4.1m (£22.6m YTD).

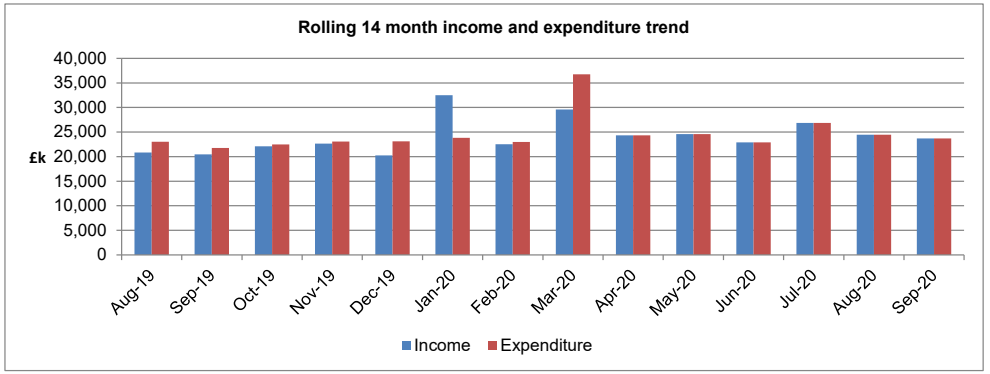
During September we submitted a revised activity plan (referred to as Phase 3). However, discussions over COVID related funding are ongoing and whilst there is uncertainty over COVID related expenditure and associated income our income and expenditure plan remains unchanged.

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)	(5)	1	6	⇔	Green
YTD surplus/ (deficit)	0	0	(0)	⇔	Amber
Forecast surplus/ (deficit)	(0)	2	2	⇔	Green
EBITDA (excl top-up) YTD	(4,345)	(4,120)	224	↓	Green
EBITDA %	(19.6%)	(21.0%)	(1.4%)	↓	Red
Clinical Income YTD	(118,979)	(113,463)	(5,516)	↑	Red
Non-Clinical Income YTD	(32,613)	(33,463)	850	↓	Green
Pay YTD	95,771	99,530	(3,760)	↑	Red
Non-Pay YTD	55,819	47,396	8,423	↑	Green
CIP Target YTD	4,370	2,270	(2,100)	↑	Red





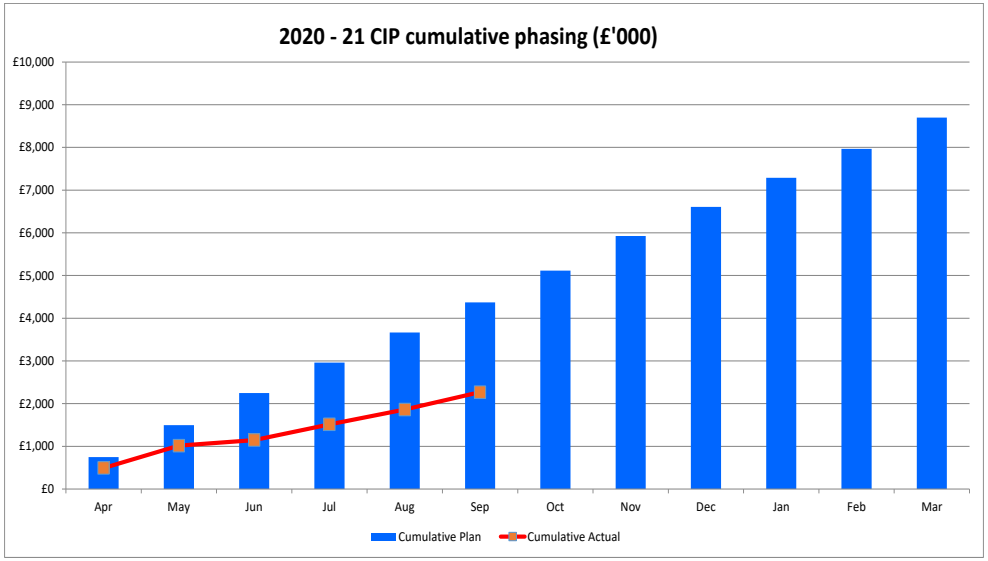


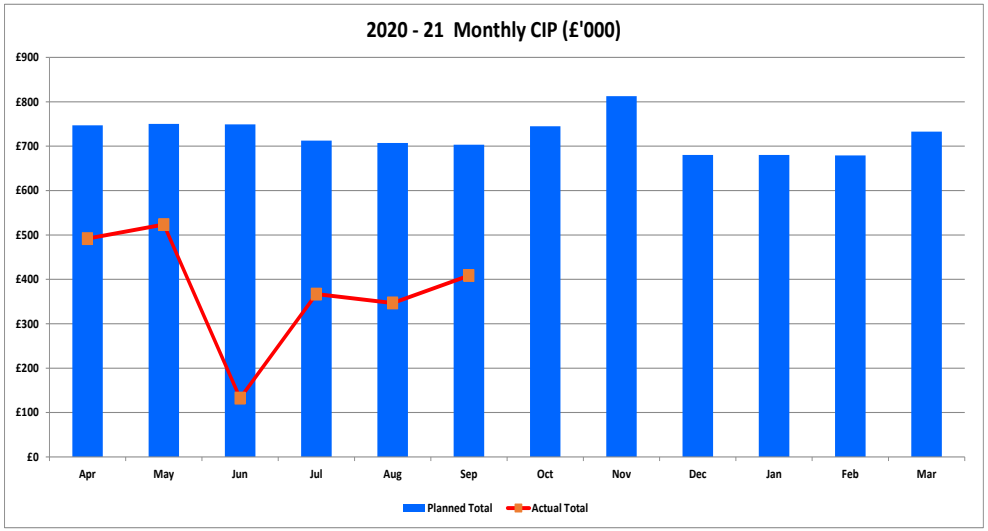
Cost Improvement Programme (CIP) 2020-21

In order to deliver the Trust's control target in 2020-21 we need to deliver a CIP of £8.7m (3.4%). The plan for the year to September is £4.37m (50.2% of the annual plan) and we achieved £2.27m (26.1%). This represents a shortfall of £2,100k.

Recurring/Non Recurring	2020-21 Annual Plan	Plan YTD	Actual YTD
	£'000	£'000	£'000
Recurring			
Outpatients	254	83	28
Procurement	492	246	256
Activity growth	200	100	100
Additional sessions	363	182	-
Community Equipment Service	510	255	205
Drugs	367	183	180
Estates and Facilities	172	102	57
Other	1,069	542	535
Other Income	493	246	33
Pay controls	327	137	97
Service Review	16	16	16
Staffing Review	819	356	308
Theatre Efficiency	302	151	-
Contract Review	50	25	-
Workforce	-	-	-
Consultant staffing	-	-	-
Agency	-	-	-
Unidentified CIP	991	482	-
Recurring Total	**6,424**	**3,105**	**1,814**
Non-Recurring			
Pay controls	580	356	375
Other	1,690	903	75
Estates and Facilities	6	6	6
Non-Recurring Total	**2,276**	**1,265**	**456**
Total CIP	**8,700**	**4,370**	**2,270**

Division	Divisional Target £'000	YTD Var £'000	Unidentified plan £ YTD	Unidentified plan £ year
Medicine	2,555	(1,172)	128	255
Surgery	2,029	(356)	101	203
W&C/CSS	1,847	(81)	0	0
Community	1,422	(199)	62	125
E&F	516	(193)	96	218
Corporates	331	(99)	95	191
Stretch	0	0	0	0
Total	**8,700**	**(2,100)**	**482**	**991**

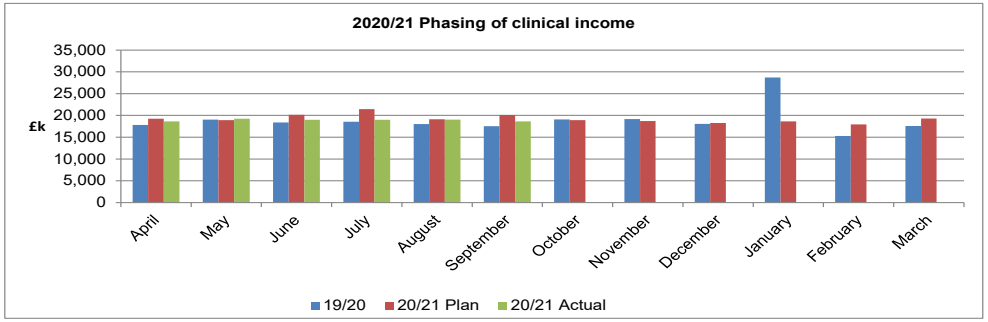




FINANCE AND WORKFORCE REPORT – September 2020

Income Analysis

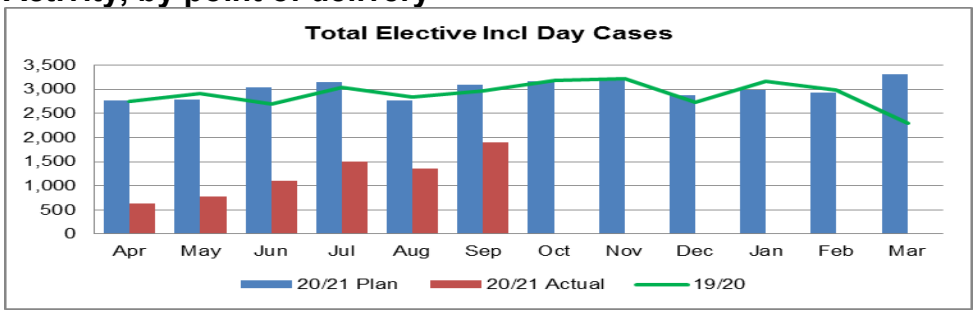
The chart below demonstrates the phasing of all clinical income plan for 2020-21, including Community Services. This phasing is in line with phasing of activity.

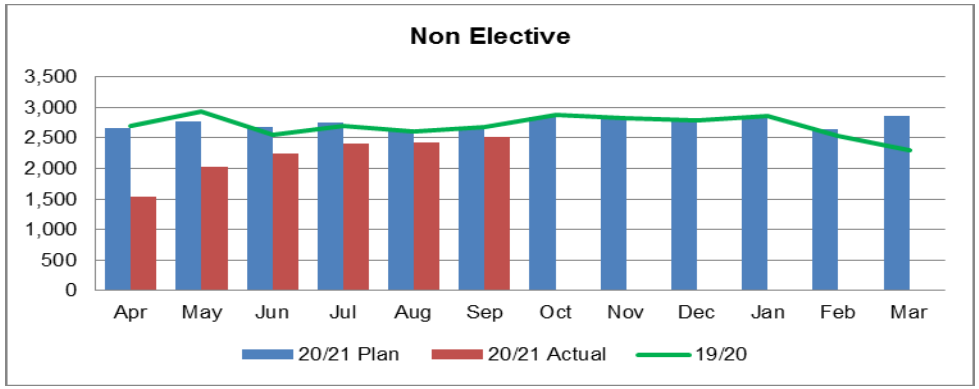


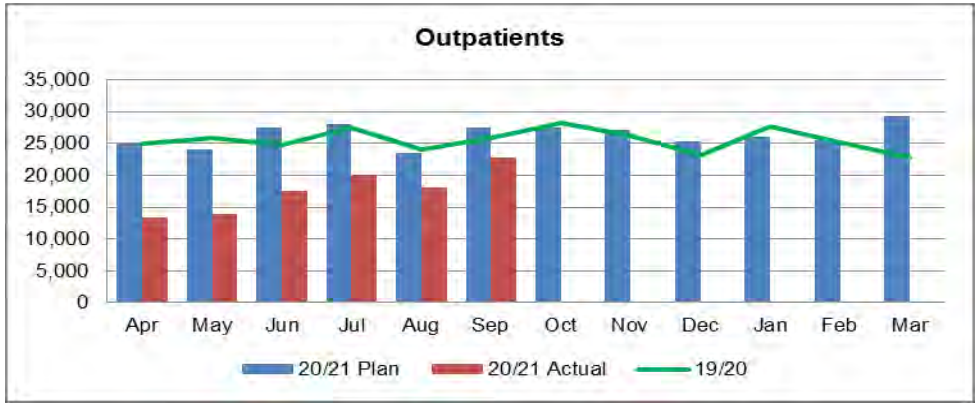
The income position was behind plan for September. The income was based on the national agreed block payments as set out by NHS England, these were put in place to give Providers assured income during the coronavirus period.

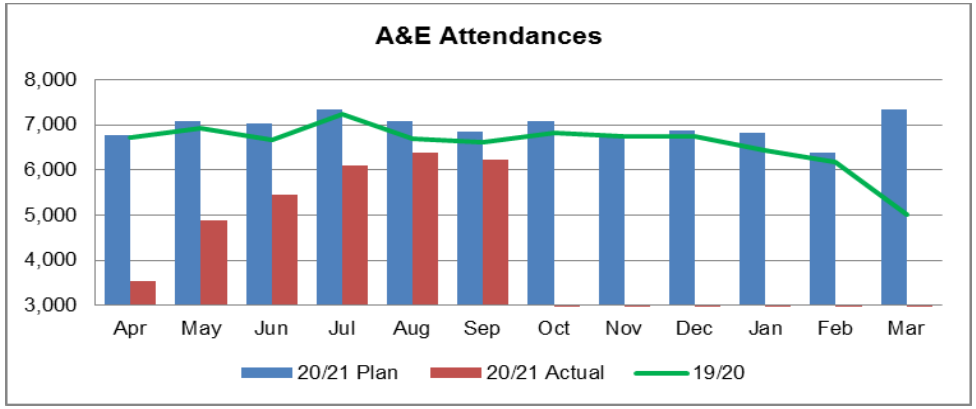
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	1,004	946	(58)	6,173	5,026	(1,147)
Other Services	3,517	3,868	351	20,857	37,037	16,180
CQUIN	0	0	0	0	0	0
Elective	2,959	1,894	(1,065)	17,020	5,805	(11,216)
Non Elective	6,384	6,717	333	38,675	38,115	(560)
Emergency Threshold Adjustment	(335)	(335)	0	(2,033)	(2,033)	0
Outpatients	3,342	2,500	(841)	18,902	10,657	(8,245)
Community	2,988	2,988	0	17,928	17,928	0
Total	**19,859**	**18,580**	**(1,279)**	**117,523**	**112,535**	**(4,988)**

Activity, by point of delivery

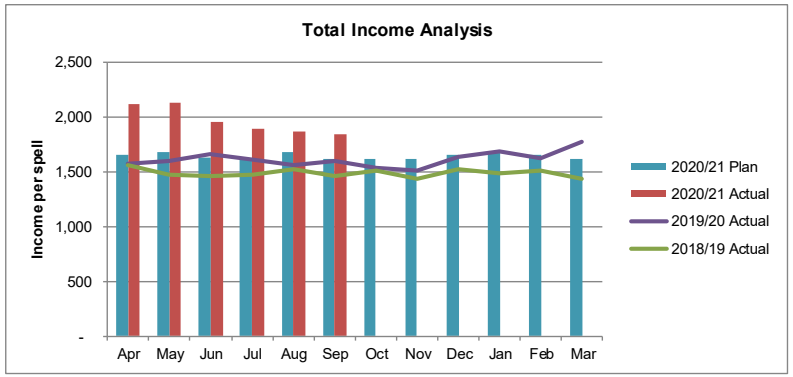


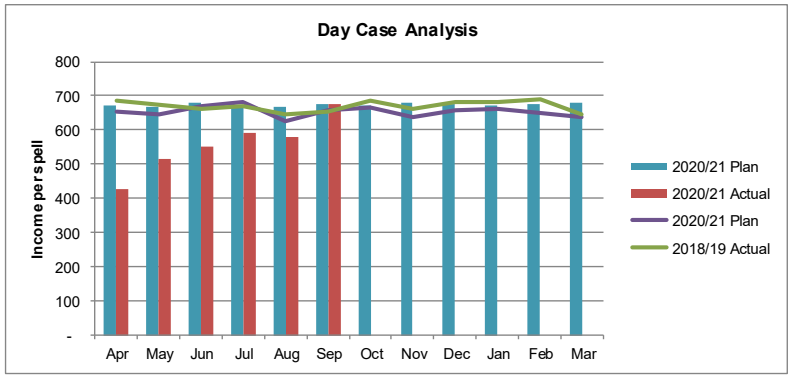


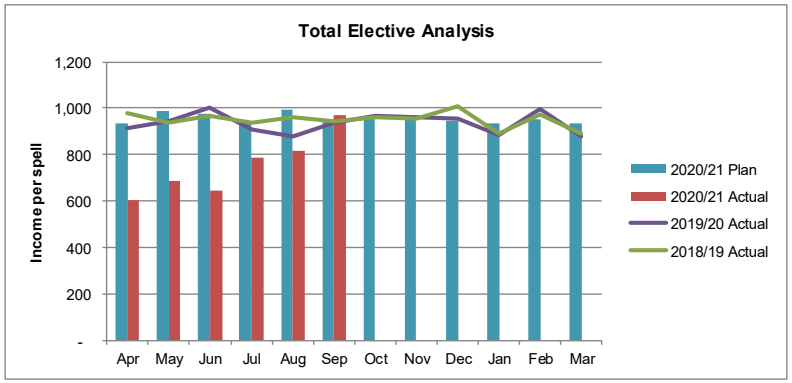


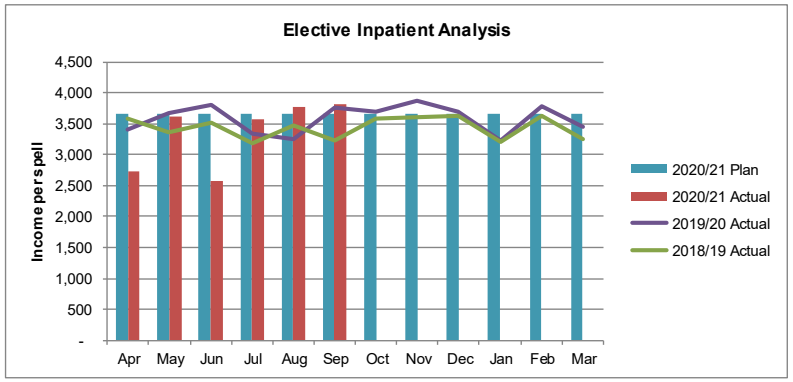


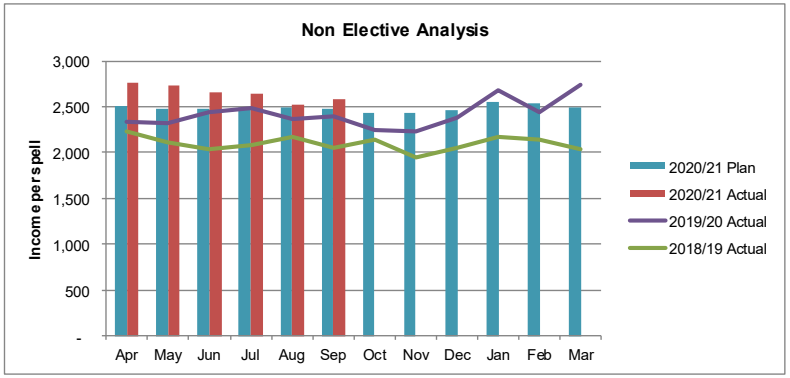
Trends and Analysis

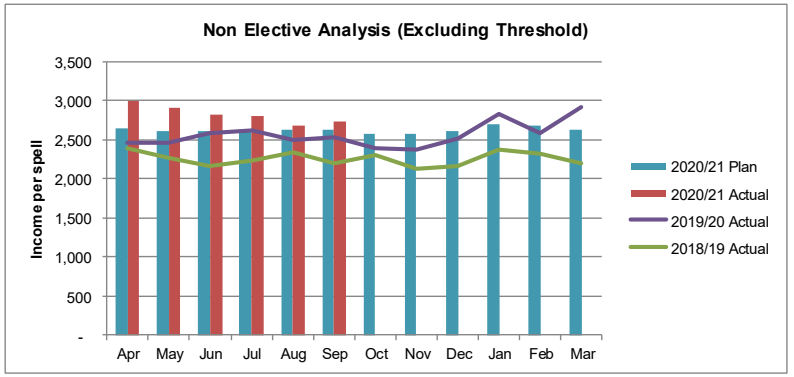










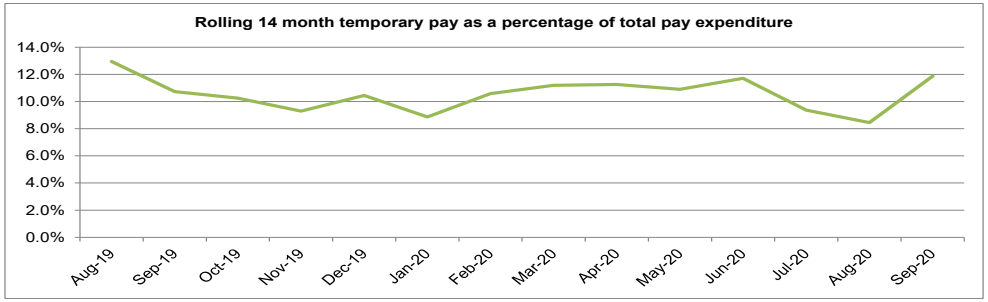


FINANCE AND WORKFORCE REPORT – September 2020

Workforce

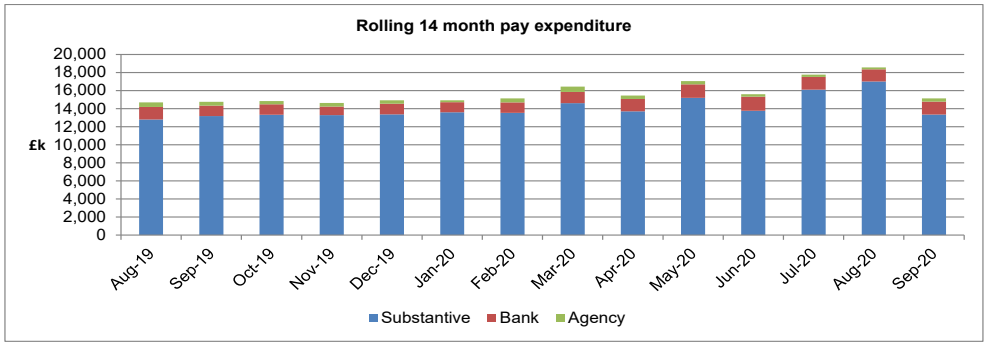
Monthly Expenditure (£)				
As at September 2020	Sep-20	Aug-20	Sep-19	YTD
	£000's	£000's	£000's	£000's
Budgeted Costs in-month	15,657	15,985	14,175	95,771
Substantive Staff	13,333	16,993	13,173	89,082
Medical Agency Staff	200	194	196	1,106
Medical Locum Staff	369	342	291	1,929
Additional Medical Sessions	236	263	176	1,772
Nursing Agency Staff	69	20	158	436
Nursing Bank Staff	418	400	350	2,504
Other Agency Staff	81	(10)	79	268
Other Bank Staff	237	201	144	1,247
Overtime	82	76	107	699
On Call	102	82	82	488
Total Temporary Expenditure	1,794	1,568	1,583	10,448
Total Expenditure on Pay	15,128	18,561	14,756	99,530
Variance (F/(A))	530	(2,576)	(580)	(3,760)
Temp. Staff Costs as % of Total Pay	11.9%	8.4%	10.7%	10.5%
memo: Total Agency Spend in-month	350	204	433	1,810

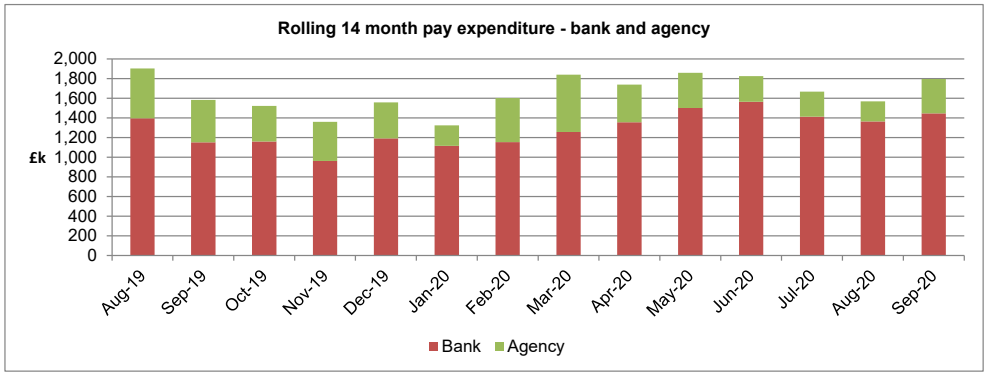
Monthly WTE				
As at September 2020	Sep-20	Aug-20	Sep-19	YTD
	£000's	£000's	£000's	£000's
Budgeted WTE in-month	4,071.2	4,069.6	3,871.2	25,308.3
Substantive Staff	3,745.4	3,781.3	3,550.7	22,593.9
Medical Agency Staff	13.3	15.2	11.9	103.7
Medical Locum Staff	28.0	33.7	29.3	167.4
Additional Medical Sessions	6.3	7.7	3.0	31.5
Nursing Agency Staff	16.8	7.2	22.4	91.3
Nursing Bank Staff	123.5	121.1	108.1	754.2
Other Agency Staff	10.1	8.8	18.9	56.2
Other Bank Staff	98.1	82.9	63.1	494.7
Overtime	23.1	21.6	31.3	190.7
On Call	6.8	7.3	7.6	40.9
Total Temporary WTE	326.0	305.7	295.4	1,930.6
Total WTE	4,071.4	4,087.0	3,846.1	24,524.5
Variance (F/(A))	(0.1)	(17.4)	25.1	783.8
Temp. Staff WTE as % of Total WTE	8.0%	7.5%	7.7%	7.9%
memo: Total Agency WTE in-month	40.2	31.3	53.1	251.2

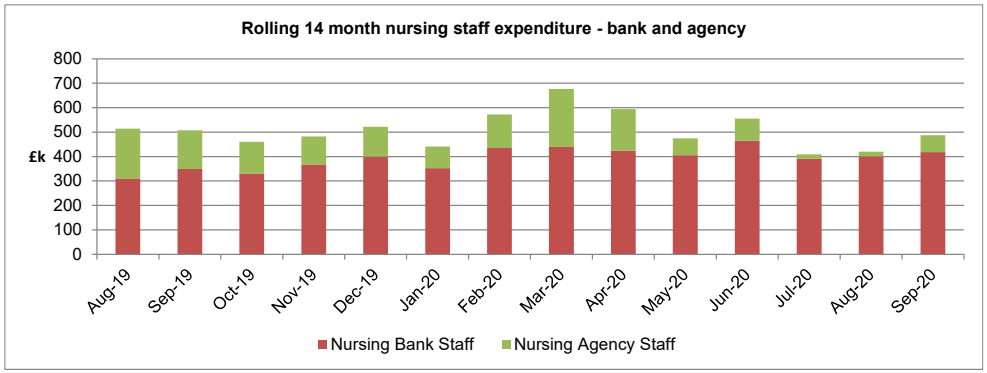


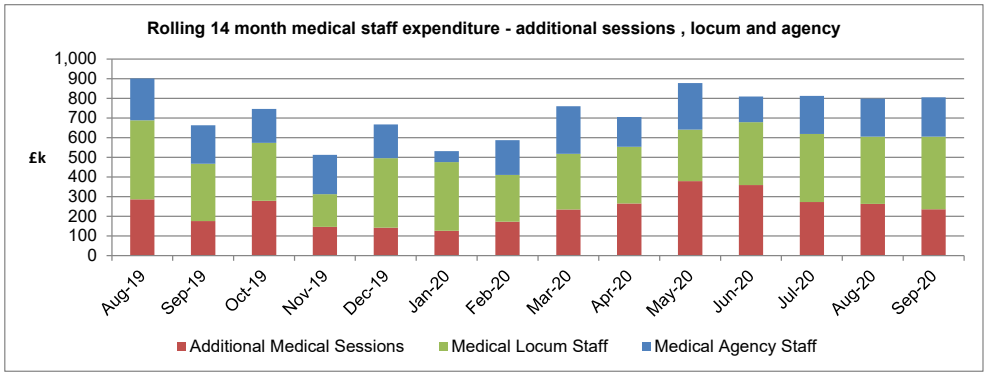
Pay Trends and Analysis

During August the Trust underspent by £530k on pay after adjusting for agency and annual leave accruals (£3.8m overspent YTD). This includes all Covid related pay costs.

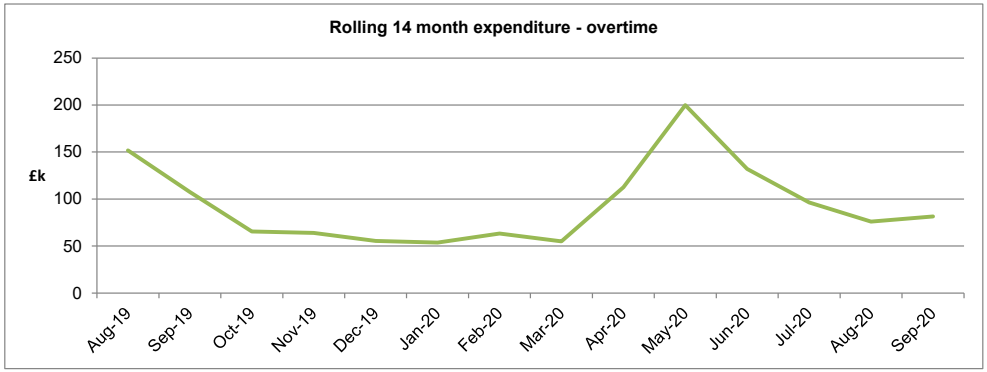








Expenditure on Additional Sessions was £236k in September (£263k in August)



FINANCE AND WORKFORCE REPORT – September 2020

Income and Expenditure Summary by Division

	Current Month			Year to date		
	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)
MEDICINE	£k	£k	£k	£k	£k	£k
Total Income	(7,424)	(6,938)	(485)	(44,248)	(35,045)	(9,203)
Pay Costs	4,262	4,427	(165)	25,434	28,980	(3,547)
Non-pay Costs	1,594	1,788	(194)	9,213	9,497	(283)
Operating Expenditure	**5,857**	**6,215**	**(359)**	**34,647**	**38,477**	**(3,830)**
SURPLUS / (DEFICIT)	**1,567**	**723**	**(844)**	**9,601**	**(3,432)**	**(13,033)**
SURGERY						
Total Income	(5,513)	(4,033)	(1,480)	(32,358)	(17,478)	(14,880)
Pay Costs	3,404	3,179	225	20,330	22,121	(1,791)
Non-pay Costs	1,174	1,079	95	6,697	4,901	1,796
Operating Expenditure	**4,578**	**4,258**	**320**	**27,027**	**27,022**	**5**
SURPLUS / (DEFICIT)	**935**	**(225)**	**(1,160)**	**5,331**	**(9,543)**	**(14,874)**
WOMENS AND CHILDRENS						
Total Income	(1,995)	(1,659)	(336)	(11,719)	(9,368)	(2,351)
Pay Costs	1,416	1,357	59	8,543	8,653	(110)
Non-pay Costs	168	182	(14)	1,028	1,038	(9)
Operating Expenditure	**1,584**	**1,538**	**46**	**9,571**	**9,690**	**(119)**
SURPLUS / (DEFICIT)	**411**	**121**	**(290)**	**2,148**	**(322)**	**(2,470)**
CLINICAL SUPPORT						
Total Income	(871)	(931)	60	(5,067)	(3,684)	(1,383)
Pay Costs	1,629	1,584	45	9,811	9,535	276
Non-pay Costs	1,094	1,121	(27)	6,619	6,640	(21)
Operating Expenditure	**2,723**	**2,705**	**18**	**16,430**	**16,175**	**255**
SURPLUS / (DEFICIT)	**(1,853)**	**(1,774)**	**79**	**(11,363)**	**(12,491)**	**(1,128)**
COMMUNITY SERVICES						
Total Income	(3,513)	(3,489)	(24)	(21,078)	(21,053)	(24)
Pay Costs	2,544	2,351	194	15,187	15,527	(339)
Non-pay Costs	962	1,224	(262)	5,781	7,462	(1,681)
Operating Expenditure	**3,507**	**3,575**	**(68)**	**20,968**	**22,989**	**(2,020)**
SURPLUS / (DEFICIT)	**6**	**(85)**	**(92)**	**109**	**(1,935)**	**(2,045)**
ESTATES AND FACILITIES						
Total Income	(473)	(242)	(231)	(2,574)	(1,138)	(1,437)
Pay Costs	902	893	9	5,406	5,673	(268)
Non-pay Costs	665	706	(41)	3,726	3,874	(148)
Operating Expenditure	**1,567**	**1,599**	**(32)**	**9,132**	**9,547**	**(415)**
SURPLUS / (DEFICIT)	**(1,094)**	**(1,357)**	**(263)**	**(6,557)**	**(8,410)**	**(1,852)**
CORPORATE						
Total Income	(6,658)	(6,400)	(258)	(34,493)	(59,069)	24,576
Pay Costs	1,499	1,336	163	11,061	9,041	2,019
Non-pay Costs	4,144	1,588	2,556	16,746	8,485	8,260
Capital Charges and Financing Costs	993	877	116	5,956	5,408	548
Operating Expenditure	**6,635**	**2,924**	**3,711**	**33,762**	**17,527**	**16,236**
SURPLUS / (DEFICIT)	**22**	**3,475**	**3,453**	**731**	**41,542**	**40,811**
TOTAL						
Total Income	(26,446)	(23,692)	(2,754)	(151,538)	(146,835)	(4,702)
Pay Costs	15,657	15,128	530	95,771	99,530	(3,760)
Non-pay Costs	9,801	7,687	2,114	49,811	41,897	7,914
Capital Charges and Financing Costs	993	877	116	5,956	5,408	548
Operating Expenditure	**26,452**	**23,692**	**2,760**	**151,538**	**146,835**	**4,703**
SURPLUS / (DEFICIT)	**(5)**	**1**	**6**	**0**	**1**	**0**

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Medicine (Sarah Watson)

The division is behind plan in month by £844k and £13.0m YTD.

Clinical income is behind plan in month by £470k and £9.1m YTD. This continues to be driven by the reduced activity (against plan) across the Trust as a result of COVID 19 and is witnessed in medicine across all types of activity (elective, non-elective & outpatient).

The gap between anticipated and actual activity continues to decrease (reflected in the financial position with a £0.5m gap in August compared to a £1.9m gap in June). This decrease is most notable within non-elective activity which was 3% behind plan (10% behind in July). The shortfall for elective & outpatient activity is 3% & 5% respectively in September. It is noted that this loss of divisional income is offset within the Corporate division due to the guarantees over the block contract.

With the effect of Clinical Income removed, Medicine division is recording an adverse variance against budget of £374k in month and £4.0m YTD. This variance continues to be driven by the additional costs of COVID (£62k) and unmet CIP schemes (£186k). The remainder of the variance is due to a number of one-off costs recognised in month (£56k) and an overspend in Drugs which is anticipated will be recovered within the financial year.

To date, the division has recorded £6.5m of expenditure towards COVID YTD, £2.9m is a result of additional costs being incurred due to COVID, £3.0m is using existing resources (e.g. medical wards) solely towards COVID. The remaining £1.1m is recognising the CIP schemes that are unable to be met due to COVID.

Surgery (Simon Taylor)

The division is behind plan in month by £1.2m in month and £14.9m year to date.

Surgery income underachieved against plan by £1,480k in month (£14,880k YTD). COVID has had a major effect on activity, in particular elective surgery. The Division is working hard to maximise patient numbers within social distancing requirements and increased complexity of patients. This has been further complicated through some patient's unwillingness to attend appointments in the hospital or to isolate for surgery.

Pay was underspent by £225k in month and overspent by £1,791k YTD due to COVID related pay costs.

Non-pay has also underspent significantly by £95k in month (£1,796k YTD) due to less activity being completed by surgery.

Surgery missed its CIP plan in month and has not identified a full plan because COVID planning took precedence. Further to this, due to the effect of COVID it is anticipated some of the Divisions CIP schemes will not be achievable, until normal service is possible. Surgery is working up a process to see which CIP's can be revived later this year.

Women and Children's (Darin Geary)
In month, the Division reported an adverse variance of £290k (£2,470k YTD).

COVID continues to depress activity with low levels of elective activity in Gynaecology and low levels of non-elective activity in Paediatrics. Consequently, income is behind plan by £336k in-month (£2,351k YTD).

Pay reported a £59k underspend in-month and an overspend of £110k YTD. In-month, the maternity service continued to have vacancies which created an underspend. Year to date, the overspend has been caused by additional COVID nursing support in F1 and the COVID related double running of antenatal clinics. The Division has a favourable underlying pay spend without the COVID costs.

Non-pay reported a £14k overspend in-month (£9k YTD). Non-pay costs have started to increase as the impact of COVID on activity has lessened.

Clinical Support (Darin Geary)
In September, the Division reported a favourable variance of £79k (£1,128k adverse variance YTD).

Income for Clinical Support reported £60k ahead of plan in-month and £1,383k behind plan YTD. This is because Radiology outpatient, direct access and breast screening activity has increased from the start of the year as the department has overcome many of the COVID related capacity constraints.

Pay reported a £45k underspend in-month (£276k YTD). In-month, the unbudgeted cost of the Microbiology locum was offset by lower than expected COVID related pay. Year to date, it has been difficult to fill vacancies in Radiology, Outpatients and Pharmacy. This has resulted in a consistent underspend against the budget.

Non-pay reported a £27k overspend in-month (£21k YTD). Non-pay costs have started to increase as the impact of COVID on activity has lessened.

Community Services (Michelle Glass)
The division reports an adverse variance of £92k in month (£2,045k YTD).

Income reported a £24k under recovery in month (£24k YTD). 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 continue to track and forecast the impact of COVID on the activity levels.

There was an in-month under spend on pay of £194k (£339k adverse YTD). £388k YTD has been incurred to support the division's response to COVID and the division has a favourable underlying pay spend without COVID costs. The division is utilising agency staff to cover some vacant roles in Integrated Therapy services and Community Health Teams. This is required to ensure service resilience, maintain capacity to meet increasing demand for services ahead of winter planning and to continue to support patient flow.

Non-pay reported an adverse variance of £262k in September (£1,681k YTD). £809k YTD has been incurred to support the division's response to COVID. The in-month and year to date position primarily reflects delays in the delivery of some CIP schemes due to the impact of COVID and an overspend on Community Equipment. Additional community equipment costs were incurred to provide the equipment needed to enable timely hospital discharges, including same day and out of hours. Additional community equipment costs were also incurred to support end of life patients to remain at home in line with the revised end of life patient strategy and to provide community equipment for additional external bed capacity procured. Equipment has been prescribed to enable patients to remain independent at home and prevent hospital admission. Other one-off costs were incurred to further support home and mobile working across our teams and community property costs. The division's estate costs are expected to exceed budget too, following the true up of 19/20 costs impacting 20/21 charges.

Phase 3 COVID recovery planning and linked service transformation is being used to inform the forecast; whilst some additional costs will be incurred to support our response and recovery, we also anticipate our learning from COVID to create opportunities for the cost improvement programme, which may continue to improve the division's position in the second half of the financial year.

Statement of Financial Position at 30 September 2020

STATEMENT OF FINANCIAL POSITION	As at 1 April 2020	Plan 31 March 2021	Plan YTD 30 September 2020	Actual at 30 September 2020	Variance YTD 30 September 2020
	£000	£000	£000	£000	£000
Intangible assets	40,972	48,993	41,380	42,565	1,185
Property, plant and equipment	110,593	148,457	120,695	117,317	(3,378)
Trade and other receivables	5,707	5,707	5,707	5,707	0
Total non-current assets	**157,272**	**203,157**	**167,782**	**165,589**	**(2,193)**
Inventories	2,872	3,000	3,000	3,027	27
Trade and other receivables	32,342	20,666	18,701	18,657	(44)
Cash and cash equivalents	2,441	1,510	10,010	26,421	16,411
Total current assets	**37,655**	**25,176**	**31,711**	**48,105**	**16,394**
Trade and other payables	(33,692)	(23,000)	(23,000)	(32,388)	(9,388)
Borrowing repayable within 1 year	(58,529)	(2,000)	(2,000)	(2,004)	(4)
Current Provisions	(67)	(67)	(67)	(60)	7
Other liabilities	(1,933)	(25,000)	(30,000)	(21,913)	8,087
Total current liabilities	**(94,221)**	**(50,067)**	**(55,067)**	**(56,365)**	**(1,298)**
Total assets less current liabilities	**100,706**	**178,266**	**144,426**	**157,329**	**12,903**
Borrowings	(52,538)	(45,000)	(45,000)	(54,143)	(9,143)
Provisions	(744)	(744)	(744)	(744)	0
Total non-current liabilities	**(53,282)**	**(45,744)**	**(45,744)**	**(54,887)**	**(9,143)**
Total assets employed	**47,424**	**132,522**	**98,682**	**102,442**	**3,760**
Financed by					
Public dividend capital	74,065	161,856	128,016	129,053	1,037
Revaluation reserve	6,942	6,942	6,942	6,942	0
Income and expenditure reserve	(33,583)	(36,276)	(36,276)	(33,553)	2,723
Total taxpayers' and others' equity	**47,424**	**132,522**	**98,682**	**102,442**	**3,760**

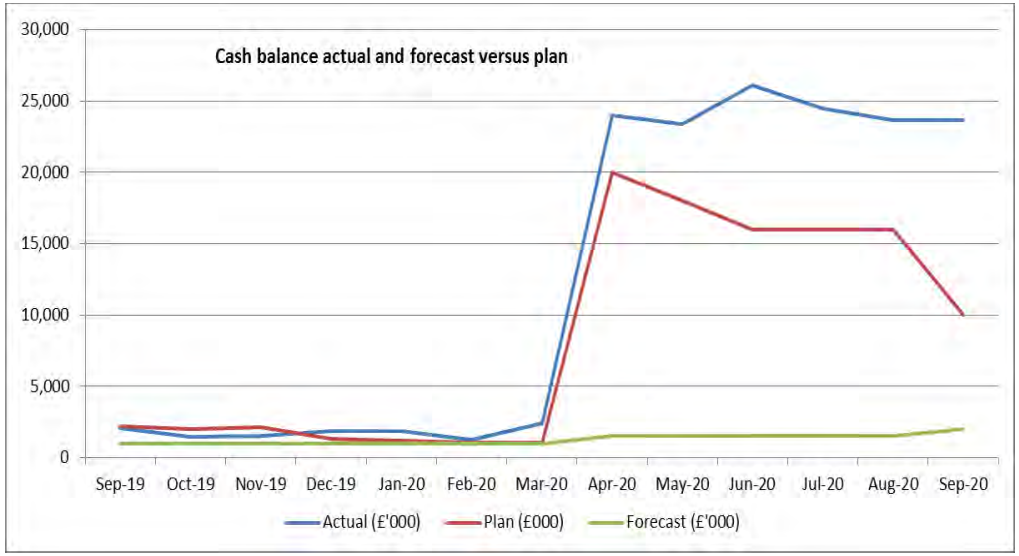
During month 6 the Trust's borrowing with DHSC that was classed as 'interim' was converted to PDC. An additional rolling working capital facility was also converted. In total, £54m was converted into PDC, which is reflected in the Balance Sheet above.

Contract payments continue to be received in advance during the current pandemic. These receipts are shown against other liabilities.

There have been no other significant movements since the previous month.

Cash Balance Forecast for the year

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



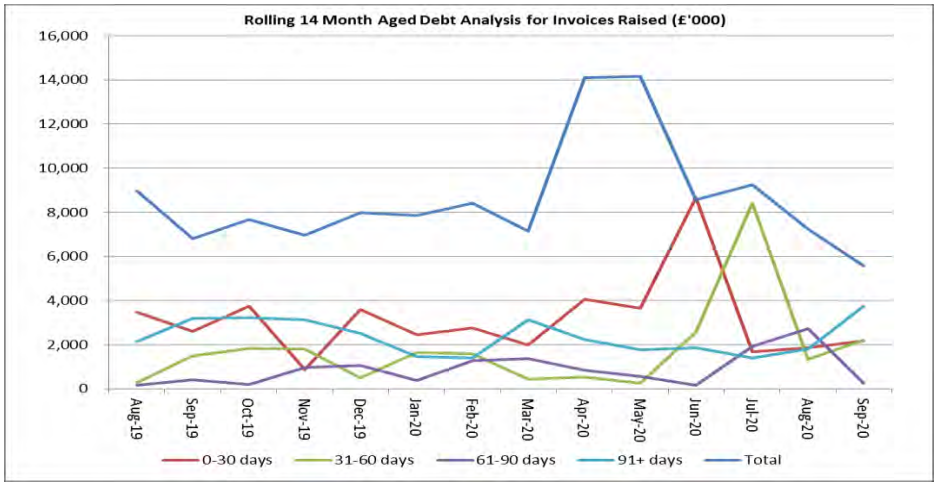
The cash balance has increased significantly and this is due to the current cash regime within the NHS. Contract payments have been paid in advance to ensure that there are adequate cash balances across the NHS and to ensure that payments to suppliers can be made quickly to keep the supply chain in full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

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

FINANCE AND WORKFORCE REPORT – September 2020

Debt Management

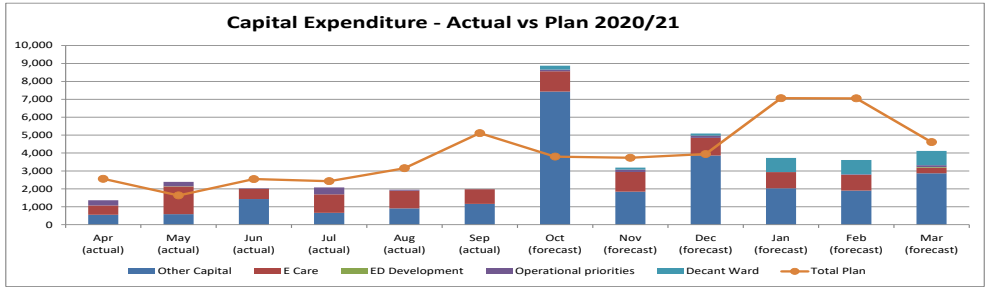
The graph below shows the level of invoiced debt based on age of debt.



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 is slowly decreasing each month. This is mainly due to the majority of NHS income being paid through block payments without the need for an invoice to be raised. The majority of the debts outstanding are historic debts. Over 78% of these outstanding debts relate to NHS Organisations, with 62% of these NHS debts being greater than 90 days old. We are actively trying to agree a position with the remaining corresponding NHS Organisations for these historic debtor balances.

Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Actual £'000	Aug Actual £'000	Sep Actual £'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	1,541	568	1,037	988	813	1,134	1,099	982	904	876	985	11,447
ED Development	0	16	0	0	0	0	0	0	0	0	0	45	61
Operational priorities	289	243	24	382	52	11	100	130	130	0	35	109	1,505
Decant ward	0	0	0	0	0	0	212	112	112	794	794	794	2,818
Other Schemes	558	590	1,431	661	911	1,165	7,428	1,847	3,865	2,032	1,908	2,185	24,581
Total / Forecast	1,367	2,390	2,023	2,080	1,951	1,989	8,874	3,188	5,089	3,730	3,613	4,118	40,412
Total Plan	2,562	1,632	2,546	2,430	3,151	5,113	3,799	3,734	3,945	7,063	7,053	4,608	47,636

The initial capital budget for the year was approved at the Trust Board Meeting in January. The capital programme is under constant review and there have been a number of amendments made since it was approved.

The Coronavirus pandemic has had a significant impact on the capital programme both in terms of the items on the capital programme and the timing. The ED scheme is now being deferred to 2020/21 and the decant ward has been delayed these are the main reasons for the reduction in the forecast capital expenditure figure. However, expenditure on the new hospital has been forecast. The prime focus of the programme has been to support the Coronavirus response with significant expenditure on medical equipment, building works and IT including greater provision of home working. The figures shown are as submitted to NHSI. The forecast is currently in line with the plan. Ecare figures have been updated to reflect the latest position following an initial review of the requirements.

The cost of the Capital Project for Theatre 1 has been amended since it was originally approved in 2018/19. The latest budget that was approved by the Board was for £925k. At the Capital Strategy Group meeting in October, the Estates Department presented a case for an increase in budgeted costs of £600k to enable the project to be completed. This was approved by the Capital Strategy Group. £300k is required for 2020/21 and £300k for 2021/22. Due to the value of this increase in budget, it was requested that the Board was notified of this.

10:30 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

13. People and organisational development (OD) highlight report

To APPROVE a report

For Approval

Presented by Jeremy Over

Board of Directors – Friday 06 November 2020

Agenda item:	13			
Presented by:	Jeremy Over, Executive Director of Workforce and Communications			
Prepared by:	Jeremy Over, Executive Director of Workforce and Communications			
Date prepared:	28 October 2020			
Subject:	People & OD Highlight Report			
Purpose:	✓	For information		For approval

Last month, to strengthen the Board's focus on how we support our people, grow our culture and develop leadership at all levels, the Board received its first People & OD Highlight Report. This has been developed further for this meeting of the Board to reflect more of the work that is ongoing and bring together various reports that the Board has routinely received into one place.

Notably this month the report brings before the Board our West Suffolk 'People Plan', setting out the approach and priorities for how we will support our people and develop our culture over the coming months.

The report also provides an opportunity for the Board to hear directly from two key individuals: Dr Ayush Sinha, our BAME Staff Network Chair, and Amanda Bennett, one of our two new Freedom to Speak Up Guardians, who will present a report.

In addition to discussing the content of the report, and related issues, continued feedback is welcomed as to the structure and content of this report and how it might be developed in future. This includes the frequency with which the Board would find it helpful to receive this report.

Appendices to this report are:
A: Our West Suffolk People Plan
B: Freedom to Speak Up Guardian report (Q2)
B(ii): Freedom to Speak Up policy
C: Staff Health and Well-being annual report
D: Guardian of Safe Working Hours quarterly report (Q2)
E: Mandatory training and appraisal quarterly report (Q2)

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*
		✓					✓
Previously considered by:	N/A						
Risk and assurance:	Research demonstrates that staff that feel more supported will provide better, higher quality and safer care for our patients.						
Legislation, regulatory, equality, diversity and dignity implications	Certain themes within the scope of this report relate to legislation such as the Equality Act, and regulations such as freedom to speak up / protected disclosures.						
Recommendation:	For information and discussion. Feedback is sought from the Board as to the future content and frequency of this report.						

Our West Suffolk People Plan – 'What Matters' to our staff

The Plan has been developed over the last month, drawn directly from the 'bottom-up' feedback from staff through our 'What Matters to You' programme and the learning from supporting staff through our enhanced staff psychological wellbeing service, and from the national People Plan and learning from Mersey Care's cultural transformation through adopting a 'just and learning culture'.

The plan is attached as appendix A. It has been deliberately structured around the five themes that were presented to us as a Board from the What Matters to You work, to ensure it is absolutely grounded in what staff told us during the summer.

'Being' is as important as 'doing' in relation to how the culture of an organisation is developed. In other words, it is important to define the right behaviours as well as actions. As such each of the five themes recognises the importance of leadership behaviours and identifies these. They have been drawn from staff feedback through WMTY, as well as the CQC well-led framework and the national NHS People Plan.

The Board is asked to endorse the plan and agree how it should be overseen and progress tracked.

A Just and Learning Culture

This work is embedded within the WSFT People Plan. At our 5 o'clock club session on 7 September, we heard Amanda Oates, HR Director at Mersey Care NHS Trust present the progress and learning from their organisation around **developing a just and learning culture**.

Just cultures that are restorative as opposed to retributive, are becoming increasingly recognised for their contribution in dealing with adverse events and serious incidents, managing employee relations, developing high performing teams and enabling the delivery of safe and continuous care.

The Board was updated last month on the plan to form a core team of individuals to lead this work at WSFT and the intention to take part in training that Mersey Care have developed with Northumbria University. The team has been formed and training dates booked for this month.

In anticipation of the progression of this work at WSFT at the time of writing we have currently paused all active formal HR investigations (disciplinary, grievance and bullying & harassment) to check that all restorative options have been explored prior to proceeding further.

Putting You First – October Awards

Jill Bunch, senior occupational therapist, EIT
Nominated by Mark Perry, assistant practitioner, EIT

Jill was on a visit to a patient in the community as part of the EIT rapid intervention vehicle service in order to try and prevent an admission where possible. Unfortunately, this patient was palliative and too unwell to remain at home, so had to be admitted.

As the patient's family was unable to visit him in ED, Jill visited him instead, to try to reduce his fear, give reassurance and to see a familiar face. She went above and beyond to reassure this palliative patient in a potentially stressful and busy environment.

Tracey McGavin, midwife
Nominated by Jessica Jeewa, smoking cessation specialist midwife

Tracey has a wonderfully positive aura, which helps to lift team spirits and puts the women and the families she cares for at ease.

I find Tracey so approachable and friendly with her colleagues and students, and look forward to working with her when she is on shift. She always makes the atmosphere enjoyable, light-hearted and fun, whilst remaining professional.

Tracey has a great ability to find common ground with the people she cares for and communicates in a way which is non-judgemental, respectful, relaxes people and makes them feel safe. She is a real credit to our team!

Tracey regularly receives positive feedback via on maternity's Facebook page:

"Tracey made us feel so comfortable and like nothing else mattered"

"Tracey was absolutely incredible, making me feel at ease, getting to know me and my husband and keeping everything so calm."

"Tracey could not have made me more relaxed. I honestly felt like I was the only patient they had to worry about."

Freedom to Speak Up

Appendix B to this report is the quarterly report from our Freedom to Speak Up Guardians. Amanda Bennett will attend the meeting of the Board to present this in person. Previously this report has been presented to the Board by the Executive Director of Workforce & Communications however it is important that the independence of the Guardian role is affirmed and the Guardians have the opportunity to develop their relationship with the Board and to present directly. I am grateful to Amanda for making herself available. James Barrett, joint guardian with Amanda, will also attend the Board at a future meeting.

Also attached to this report is **appendix B(ii)** which is our Freedom to Speak Up Policy. This document is crucial in that it sets out the Trust's and Board's position around the

fundamental importance of growing a speak up culture and how this is put into practice. The policy has been updated following recent changes in personnel and is presented to the Board for endorsement.

WSFT annual health and wellbeing report

The annual health and wellbeing report (**appendix C**) provides Trust Board members with an update on how this support is being provided and our assessment of its impact. Since March 2020 much of the focus of our health and wellbeing support for staff has been on the COVID-19 pandemic and our health and wellbeing plan 2019 - 21 reflects this. The plan is also embedded in our WSFT People Plan and has been updated following publication of the national NHS People Plan in the summer.

The most significant development in the last 12 months has been investment in the Staff Support Psychology Service to support the emotional and mental wellbeing of staff during the pandemic and beyond. The team has seen over 300 staff members and facilitated over 100 team sessions since March 2020. The learning from the service has been fed into the WSFT People Plan.

Despite the need to pause much non-pandemic activity, work has progressed in some areas including the 'My Pause' menopause support group, the Better for me, better for you campaign highlighting the importance of looking after ourselves as well as looking after our patients, families and friends, and the annual flu vaccination campaign.

It was disappointing to see NHS Staff Survey results showing that the percentage of staff believing the Trust is taking positive action on health and wellbeing fall (by 0.8%) in 2019. Further work is needed to understand why less than 40% of staff believes the Trust takes positive action on health and wellbeing – whether this is an issue of perception, communication or the value and appropriateness of what is provided – or a combination of all three.

It is also worth noting that when asked about whether their immediate manager takes a positive interest in their health and wellbeing, staff are more positive and the Trust's score remains consistently above the national average for comparable organisations and the general trajectory for the past five years has been upward. Equally the overall health and wellbeing theme score for the Trust, compiled from all questions in the survey relevant to health and wellbeing, was well above the national average again in 2019.

Flu vaccination campaign 2020

"On average, flu kills over 11,000 people each year – some years this number is much higher – and it hospitalises many more. This is anything but a typical year due to the potential impact of flu and COVID-19 circulating at the same time. It's now more important than ever that we act to protect ourselves, our teams, our families and patients from getting flu. We strongly urge you to take up the offer of free vaccination against flu as soon as possible; and to remind your patients to get their vaccine."

This is the clear message from national clinical leaders in the NHS as we approach what is likely to be an unprecedented winter period for the NHS and the country.

The first full month of our flu vaccination programme at WSFT has gone well with over **52%** of front-line staff (2750 vaccines) having taken up the offer of a vaccine thus far. The drop-in clinics and availability of the vaccine through peer vaccinators across the Trust continues.

Guardian of Safe Working Hours – report

The quarterly board report from Dr Francesca Crawley, Guardian of Safe Working Hours is attached as **appendix D**.

Mandatory training and appraisal

The Trust target for mandatory training is 90% (95% for Information Governance) up to date participation, to make provision for staff who fall into the reporting period but who are unable to undertake their training due to sickness or parental leave for example. The latest overall compliance figure as at the 8th October is **86%.**

A mandatory training recovery plan was presented to the Board in January 2020 and in March 2020 significant elements of mandatory training were paused due to COVID-19. In June 2020 the plan was updated to take account of the impact of COVID-19 going forward in 20/21 and into 21/22. A range of new ways of delivering mandatory training have been implemented including running sessions for community staff at Stow Lodge in Stowmarket, using MS Teams and running evening and weekend sessions for staff.

The Trust appraisal compliance target is set at 90%. The September 2020 compliance figure was **74.0%** a small increase on the figure reported in June 2020 (73.2%). Divisional compliance rates range from 85.6% in the Estates and Facilities Division to 61.2% in the Corporate Services Division. The appraisal action plan is being implemented. This includes support to divisional managers provided by the new HR Business Partners.

The full quarterly report is attached as **appendix E**.

Expanding student nursing placements at WSFT

Since the removal of the bursary the number of prospective students applying for pre-registration adult nursing programmes has reduced nationally. WSFT has traditionally hosted students from the University of Suffolk but has experienced a decrease in numbers over the past 3 years:

2017/2018	22
2018/2019	21
2019/2020	16

To mitigate against this reduction and to promote the organisation as a place to work, WSFT has also hosted students from the University of East Anglia since 2018 and this autumn has started to host students from Anglia Ruskin University. A review of all areas

that support pre-registration nursing students has allowed the organisation to increase the number of places that we can offer to educational institutes and this has been reflected in the successful application for additional funding from H.E.E to support placements. This year our educational providers have seen an increase in the number of prospective students applying for adult nursing programmes and this is reflected in the 50 students that we have agreed to host.

The £50,000 grant received from H.E.E will fund extra clinical practice facilitators to support pre-registration students in practice and provide additional IT equipment to ensure that students have access to our systems and processes particularly at times when working alongside other staff in office rooms may be difficult due to social distancing. Ensuring that our students receive a high-quality learning experience will encourage them to consider WSFT as a place to work following completion of their studies and entry to the NMC register.

Recent Consultant Appointments

Post:	Consultant in Plastic Surgery (replacement post)
Interview:	22 October 2020
Appointee:	[redacted]
Start date:	To be confirmed
Current post:	[redacted]
Previous Positions:	[redacted]
Post:	Consultant in Plastic Surgery (new post)
Interview:	22 October 2020
Appointee:	[redacted]
Start date:	To be confirmed
Current post:	[redacted]
Previous Position:	[redacted]

Introducing the HR business partner role at WSFT

The HR business partner role is a new one to the Trust that will provide professional support to our divisional teams in order to help them place people and workforce issues at the heart of how we plan our services and deliver care, across the full employment pathway. HR business partners will support and influence the workforce and change agenda, using technology and workforce analysis to provide professional people advice and services. By building strong relationships across the organisation HR business partners will support our divisions to build the best teams and plan the West Suffolk workforce of the future; promoting a just and learning culture in everything we do.

Recruitment has gone well and from Monday 2 November we welcome the full HR business partner team who will be aligned to our divisions as follows:

Pippa Smith – Community and Corporate
Adam East – Medicine
Juliette Maguire – Surgery
Sarah Turner – Women's, Children's and Clinical Support Services

Jeremy Over
Executive Director of Workforce & Communications
October 2020

NHS
West Suffolk
NHS Foundation Trust

What Matters to our Staff: Our WSFT People Plan

October 2020

Putting you first

Introduction

- The NHS needs more people, working differently, in a compassionate and inclusive culture
- For West Suffolk we think this is best achieved by bringing together one plan that incorporates all of our priorities and actions
- It is informed by:
  - Our ‘What Matters to You’ programme (survey and discovery workshops)
  - A survey of medical staff led by our Better Working Lives Group
  - Learning from our staff psychological support service
  - The national NHS People Plan
  - How other organisations have grown a just and learning culture
  - The progress as we embed the recommendations of our Jan 2020 CQC report

What Matters to our staff

- The experience of working during a pandemic has transformed the lives of all our staff – at work and at home
- We wanted to know what matters to them as we look ahead, learning from their experiences over the past six months
- We did this through learning from:
  - A survey for all of our staff (1,400 responses)
  - A supplementary survey of our medical staff (250 responses)
  - Discovery workshops to listen to our staff experiences and wishes (60 sessions)
  - Non-attributable feedback from our staff psychological support team (over 300 staff interactions)
- The teams leading this work presented this feedback to the Board structured around 5 overarching themes

What Matters to our staff – 5 themes

1. The importance of great line managers
2. Creating an empowered culture
3. Building relationships and belonging
4. Appreciating all of our staff
5. The future and recovery

“We are the NHS” - The NHS People Plan

- In July the NHS for England published its People Plan for the remainder of the 2020/21 year, and beyond
- It sets out actions to support transformation across the whole NHS, for individual NHS employers, local systems and national NHS bodies
- Its four priority themes are:
  - Looking after our people
  - Belonging in the NHS
  - New ways of working and delivering care
  - Growing for the future

- At the heart of the plan is the ‘People Promise’ – what we all should be able to say about working in the NHS, if we can’t already, by 2024
- The actions highlighted within the plan can be aligned to our What Matters to You themes

A Just and Learning Culture

- We want to learn from other NHS organisations who have grown their culture and the practical steps they have taken
- At our 5 o'clock club session in September we heard from Mersey Care NHS Trust about how they have transformed their response to incidents and people management concerns by adopting a just and learning culture, focusing on restorative justice
- Just cultures that are restorative as opposed to retributive, are becoming increasingly recognised for their contribution in dealing with adverse events and serious incidents, managing employee relations, developing high performing teams and enabling the delivery of safe and continuous care
- The culture of our organisation was reflected in the What Matters to You feedback, including how we empower and support people

Continuing to learn from our CQC report

- We responded to our CQC report published earlier this year by developing a Quality Improvement plan that incorporates the recommendations made in relation to culture and staff support
- These were:
  - *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*
  - *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.*
- Specific actions to respond to these recommendations are overseen by our Improvement Programme Board
- We will continue to sustain and embed these improvements and these actions will be incorporated into this wider WSFT People Plan

Our WSFT People Plan – taking action

- What Matters to You provides a clear framework for our WSFT People Plan, based on the feedback of over 2,000 of our staff
- The national NHS People Plan includes a wide range of initiatives that, in general, map to our 5 WMTY themes
- In common with the national People Plan, it makes sense to identify a plan for the next six months
- We need to strike the right balance between a stretching plan but one that is deliverable
- We want to prioritise the things that staff talked about, as well as identifying those actions in the national plan that will have the most positive impact at WSFT
- The next 5 slides provide a summary of what we will work on, together

WMTY1: The importance of great line managers

NHS West Suffolk NHS Foundation Trust

Why it matters: We saw and heard lots of examples of great line managers and how they kept their staff informed and supported during COVID. The positive impact a good manager can have on staff and the value they bring is clear. We want to help every line manager to be great

What we will work on:

1) Promote the value of great line management
2) Support and develop existing and future WSFT line managers
3) How we ensure all consultant medical staff have a designated line manager and benefit from that
4) Focus on how line managers can make flexible working the norm for all staff

Leadership behaviours to support this work:

- Demonstrate a compassionate and inclusive style of leadership and management
- Build an inspiring shared purpose for the team/s you lead
- Always be open to feedback to inform personal development
- Support the individual needs of staff to make flexible working the norm

What happens next:

1) Promote the value of great line management
- Define what good looks like for WSFT – including from perspective of staff members
- Listen to what support managers need and feed into our plans

2) Support & develop existing & future WSFT line managers
- Review our training and development offer for line managers
- Promote 360 tools available to enable feedback
- Use the staff survey to support individual line manager development
- Introduce the HR business partner role to WSFT, to coach and support managers and divisional teams

3) Line management support for consultant & SAS-grade medical staff
- Agree with clinical directors and medical staff committee how this is put in place for all senior medical colleagues
- Provide support and development for those taking on these roles
- Undertake the Medical Engagement Survey

4) Focus on how line managers make flexible working the norm for all staff
- Review Flexible Working policy in line with NHS People Plan and enhance carer's leave
- Normalise conversations about flexible working for individual staff, including at induction

WMTY2: Creating an empowered culture

NHS West Suffolk NHS Foundation Trust

Why it matters: You have told us it can feel like a 'top down' culture in the organisation currently, where subject matter experts feel unable to influence what we do. This is not how we want the organisation to feel

What we will work on:
1) Develop a Just and Learning Culture
2) Support every member of staff to feel safe and secure to speak up and raise concerns
3) Strengthen our quality and safety leadership and governance

The leadership behaviours that support this:
- Always be curious to learn and improve
- Listening to staff and hearing their stories
- Actively encourage staff to speak up
- Show respect for and empowerment of subject matter experts
- Celebrate innovation

What happens next:

1) Develop a Just & Learning Culture
- Learn lessons from Mersey Care through 5 o'clock club leadership event
- Train a core team to lead our work on this
- Pause current HR cases to check all restorative options have been considered
- Improve our HR policies and incident review processes to ensure they facilitate a just and learning approach
- Support managers to develop the skills needed to respond with a just and learning perspective when something goes wrong

2) Support every member of staff to feel safe to speak up and raise concerns
- Appoint new Freedom to Speak Up Guardians
- Implement separate action plan as part of our Trust Improvement plan (by Dec '20)

3) Strengthen our quality and safety leadership and governance
- Implement new structure, systems and processes, co-produced with our subject matter experts and divisional teams
- Recruit to new posts in divisions to support teams to deliver on quality and safety

WMTY3: Build relationships & belonging at WSFT

NHS West Suffolk NHS Foundation Trust

Why it matters: We want WSFT to feel inclusive for everyone, especially for BAME colleagues– including making sure our leadership reflects our diversity. What Matters to You also showed that we need to do much more to bring acute and community together so that we create a single organisation and culture. There are still clear divides between these two parts of WSFT.

What we will work on:

1) Continue to make WSFT an inclusive place to work
2) Ensure our leadership reflects our diversity
3) Support for and engagement with our community staff
4) Zero tolerance of bullying, harassment and violence in the workplace

The leadership behaviours that support this:

- Demonstrate inclusive leadership, ensuring every single person feels valued
- Build empathy, to gain understanding of what it's like in someone else's shoes
- Do not walk past and ignore behaviours that contradict the values of West Suffolk and the wider NHS

What happens next:

1) Make WSFT an inclusive place to work
- Promote and take forward our equality, diversity & inclusion action plan
- Ensure our staff networks feed into Trust decision making
- Review our recruitment and promotion practices

2) Ensure our leadership reflects our diversity
- Support BAME and staff with a disability to access and benefit from leadership development programmes
- Publish progress against the Model Employer goals

3) Support for and engagement with our community staff
- Listening and feedback programme (Oct '20)
- Promote understanding of our community services across the other parts of WSFT

4) Zero tolerance of bullying, harassment and violence
- Build on our 2019 action plan through implementing national work around bullying and harassment and violence, to be published in March 2021 and Dec 2020 respectively

WMTY4: Appreciating all of our staff

NHS West Suffolk NHS Foundation Trust

Why it matters: You told us that we need to do more to make you feel appreciated, particularly for staff that are not working on the front line. You told us how much you appreciated the extra things we did to look after you during COVID. However not everyone was aware that they could access these things – and some staff felt excluded. We also need to do more to help our colleagues that are and have been shielding at home.

What we will work on:

1) Prioritise staff safety in relation to COVID / Winter 20/21
2) Strengthen support for our staff's physical and mental well-being
3) Provide practical support to demonstrate appreciation for staff
4) Promote and support our volunteers

The leadership behaviours that support this:

- Promote the importance of staff health, safety and well-being at work and how it fundamentally benefits patient care
- Enable all team members to access help and support when they need it
- Recognise and value the contribution that every team member makes

What happens next:

1) Prioritise staff safety in relation to COVID / Winter 20/21
- Ensure risk assessment processes remain up to date
- Provide advice and education around PPE that remains as simple as possible
- Flu vaccination programme from Oct 2020

2) Strengthen support for our staff's physical and mental well-being
- Implement our staff wellbeing plan for 2019-2021
- Dedicated project to enhance support for staff in stressful times project
- Grow & learn from our Psychological Wellbeing service

3) Practical support to demonstrate our appreciation for staff and the pressures they face
- Identify more physical space for staff to take a break
- Maintain free car parking for those that have access

4) Promote and support our volunteers
- Implement a plan to support their safe return to their roles
- Consider new volunteering roles learning from national work of Helpforce
- Review and implement the National Learning Hub for Volunteering, launched by H.E.E

WMTY5: The future and recovery

NHS West Suffolk NHS Foundation Trust

Why it matters: You have told us that you are fearful of recovery and how we will return to old levels of activity when we have social distancing and PPE to factor in. And you have told us you are tired. You have also told us you would like to keep home working (for those that are able to do so)

What we will work on:
1) Support staff as we recover services
2) Recruitment and education plans for our future workforce
3) Support home working
4) Continue the listening that started with What Matters to You

The leadership behaviours that support this:
- Pro-actively seek to understand the issues, challenges and priorities affecting staff – everyone's voice counts
- Genuinely consult and communicate with staff and teams in developing plans for future
- Positively collaborate in system-wide work

What happens next:

1) Support staff as we recover services
- Clear communication of how services are being restored, what is changing and why
- Involve staff in decisions around redeployment and changes to work arrangements

2) Recruitment and education plans for our future workforce
- Strengthen our workforce planning process, in support of our clinical divisions
- Ensure that recruitment and education plans reflect the needs and risks identified through workforce planning
- Play our part in workforce planning across the ICS, including opportunity for our staff to support 'surge'

3) Support home working
- Update our policy and guidance for home workers
- Ensure access to technology
- Provide guidance for managers who are managing teams working remotely

4) Continue the listening that started with What Matters to You
- Support a team of facilitators to deliver a regular programme of What Matters to You staff sessions
- Share progress of implementing our People Plan with staff

Freedom to Speak Up: Guardian's Report October 2020

Introduction

Following Nick Finch stepping down as Freedom to Speak Up (FTSU) Guardian in June 2020, Dr Francesca Crawley undertook the role as interim Guardian for the remaining Quarter 1 (April – June) and Quarter 2 (July – September). Two new Guardians have now been appointed; Amanda Bennett who commenced in post 1st October 2020 and Dr James Barrett who starts in post 1st November 2020. Amanda and James will initially be working to assist the implementation of recommendations from the RSM internal audit report into FTSU and working with the Trust to develop a Just and Learning culture.

Data

Quarter 1: April, May, June 2020

There were no reports of concerns raised with the Guardian during this period.

Quarter 2: July, August, September 2020

3 concerns were raised to the guardian:

Area of concern	Staff Group	Directorate	Includes patient safety/quality	Includes bullying and/or harassment	Action Taken	Lessons learnt
FTSU process	Maintenance and Ancillary	Estates and Facilities	No	No	Ongoing communication	Ongoing
Smoking on WSH site	Not disclosed	Not disclosed	No	No	Investigation complete and item in green sheet to remind staff	
Outcome of Datix	Nursing and Midwifery	Not disclosed	Yes	No	Ongoing Investigation	Ongoing

Learning

Although it is early to draw any conclusions, the low numbers of concerns raised may be indicative of action required to promote the FTSU agenda. Since promotion of FTSU via the Green Sheet, other social media, and staff visits through the single month of October, the Guardian has received 4 new concerns raised, compared to 3 in the previous 6 months.

Initial Actions and Reflections

Improving record keeping and reporting processes

The internal audit report raised concerns relating to the collation and recording of data. Following this, the HR Team have established a database to record all formally raised concerns which are received via the Chief Executive, Senior Independent Director, the anonymous reporting portal, any other routes e.g. Non-Executive Directors and the FTSU guardian. All data is anonymised as consent to share concerns is not always sought or given. This database will allow for thematic analysis of data and areas of concern to be highlighted. A summary of this data was presented to the Board in September 2020 as part of the Governance Department Quality and Learning report.

The National Guardians Office (NGO) are clear that only concerns raised via the Guardian route are to be recorded in the data submitted to the NGO. As anonymous concerns and concerns raised with the Chief Executive, Senior Independent Director or other NEDs are not currently part of the Guardian route, these have been omitted from the data returned to the NGO for the last two quarters.

It has been identified that there was no clear way for staff to report anonymously to the FTSU Guardian. Following discussions between the Deputy Director of Workforce (Learning and OD) and the FTSU Guardian, the EDWC has agreed that as of 1st November 2020, anonymous reporting via the guardian route will be available via the intranet portal (previously managed by the Deputy Directors of Workforce) or letter sent care of the Education Centre.

Initial Reflections

A warm welcome has been enjoyed by Guardian Amanda Bennett on joining the Trust. Senior management and executives all reported a strong commitment to promoting a culture in which staff feel safe to report their concerns and confident that action will be taken as a result.
This commitment has been witnessed on two occasions: Initially, during a Nursing and Midwifery Clinical Council meeting when a ward manager was asked about an incident, she reported she had "done something wrong". Her senior manager was quick to support the individual and look at the system processes that surrounded the incident and identify changes that had since been put in place so a similar incident would not reoccur. The senior manager and the ward manager were then further supported by the Chief Nurse who thanked both nurses and re-iterated that all incidents would be looked at to identify learning for the system rather than to blame individuals.
On a second occasion, when the Guardian approached the Deputy Chief Nurse, requesting an investigation into two concerns, the response was immediate; where comprehensive answers to one concern were given on the first day of raising the concern and an investigation started into the other concern.

The Guardian joined the CEO for a walk around the WSH site to meet staff and ask, "*What does freedom to speak up mean to you?"* Whilst many staff reported that they would feel confident speaking up and were able to articulate what it meant to them, two staff indicated that they would be afraid to share these opinions widely.

It is intended that the Guardians will maintain visibility and continue to promote their role as independent and impartial and a route to speaking up in a safe, confidential way.

Planned Actions

The following actions are either underway or planned to start within the next month.

- Develop clear process for investigating concerns across all directorates.
- Finalise clear process for recording FTSU concerns in line with NGO guidance and which correlates to existing database.
- To ensure a consistent approach, common language and collation of data, regular meetings to be arranged with: key managers, staff networks, staff representatives, unions, Senior Independent Director, Guardian of Safe working, Datix lead, patient safety and

patient experience groups, Medical Staff Committee, Nursing and Midwifery Clinical Council and the CQC.

- Inductions will be attended followed by a six-month check-in to gather intelligence relating to barriers and enabling factors regarding FTSU.
- Joined with Eastern Region FTSUG network to share best practice and learn from regional and national Trusts.
- Maintain visibility and accessibility by offering FTSU “drop ins” and visiting the community teams and the hospital site where safe and appropriate to do so.
- Review education opportunities for staff in relation to FTSU.

Amanda Bennett
Lead Freedom to Speak Up Guardian
30.10.2020

West Suffolk NHS
NHS Foundation Trust

Trust Policy & Procedure **Document Ref No: PP(20)056**

FREEDOM TO SPEAK UP - WHISTLEBLOWING - STAFF CONCERNS ABOUT PATIENT CARE AND OTHER HEALTHCARE RELATED MATTERS

For use in:	**All areas of Trust**
For use by:	**All Staff**
For use for:	**"Whistleblowing" (Staff Concerns About Patient Care and Other Healthcare Related Matters)**
Document Owner:	**Director of HR & Communications**
Status:	**Approved**

Contents

Speak up – we will listen

Speaking up about any concern you have at work is really important. In fact, it's vital because it will help us to keep improving our services for all patients and the working environment for our staff.

You may feel worried about raising a concern, and we understand this. But please don't be put off. In accordance with our duty of candour, our senior leaders and all Trust board members are committed to an open and honest culture. We will look into what you say and you will always have access to the support you need.

This policy

This 'standard integrated policy' was one of a number of recommendations of the review by Sir Robert Francis into whistleblowing in the NHS, aimed at improving the experience of whistleblowing in the NHS. It is expected that this policy (produced by NHS Improvement and NHS England) will be adopted by all NHS organisations in England as a minimum standard to help to normalise the raising of concerns for the benefit of all patients.

Our local process has been integrated into the policy/adheres to the principles of this policy and provides more detail about how we will look into a concern.

What concerns can I raise?

You can raise a concern about **risk, malpractice or wrongdoing** you think is harming the service we deliver. Just a few examples of this might include (but are by no means restricted to):

- unsafe patient care
- unsafe working conditions
- inadequate induction or training for staff
- lack of, or poor, response to a reported patient safety incident suspicions of fraud (which can also be reported to our local counter-fraud team: contact the Local Fraud Office on ext:2963 or your LCFS Mark Kidd: on 07528970251 or mark.kidd@nhs.net
- a bullying culture (across a team or organisation rather than individual instances of bullying).

Remember that if you are a healthcare professional you may have a professional duty to report a concern. **If in doubt, please raise it.** Don't wait for proof. We would like you to raise the matter while it is still a concern. It doesn't matter if you turn out to be mistaken as long as you are genuinely troubled. This policy is not for people with concerns about their employment that affect only them – that type of concern is better suited to our grievance policy
http://staff.wsha.local/CMSdocuments/TrustPolicies/PDFs/1-50/PP(18)035Grievances.pdf

Feel safe to raise your concern

If you raise a genuine concern under this policy, you will not be at risk of losing your job or suffering any form of reprisal as a result. We will not tolerate the harassment or victimisation of anyone raising a concern. Nor will we tolerate any attempt to bully you into not raising any such concern. Any such behaviour is a breach of our values as an organisation and, if upheld following investigation, could result in disciplinary action. Provided you are acting honestly, it does not matter if you are mistaken or if there is an innocent explanation for your concerns.

Confidentiality

We hope you will feel comfortable raising your concern openly, but we also appreciate that you may want to raise it confidentially. This means that while you are willing for your identity to be known to the person you report your concern to, you do not want anyone else to know your identity. Therefore, we will keep your identity confidential, if that is what you want, unless required to disclose it by law (for example, by the police). You can choose to raise your concern anonymously, without giving anyone your name, but that may make it more difficult for us to investigate thoroughly and give you feedback on the outcome.

Who can raise concerns?

Anyone who works (or has worked) in the NHS, or for an independent organisation that provides NHS services can raise concerns. This includes agency workers, temporary workers, students, volunteers and governors.

Who should I raise my concern with?

In many circumstances the easiest way to get your concern resolved will be to raise it formally or informally with your line manager (or lead clinician or tutor)1. But where you don't think it is appropriate to do this, you can use any of the options set out below in the first instance. If raising it with your line manager (or lead clinician or tutor) does not resolve matters, or you do not feel able to raise it with them, you can contact one of the following people (Annex A: sets out an example of how a local process might demonstrate how a concern might be escalated):

- Our **Freedom to Speak Up Guardian**. This is an important role identified in the Freedom to Speak Up review to act as an independent and impartial source of advice to staff at any stage of raising a concern, with access to anyone in the organisation, including the chief executive, or if necessary, outside the organisation. The Lead Freedom to Speak up Guardians are Amanda Bennett and Dr James Barrett and you can contact them by emailing FreedomToSpeakUp.Mailbox@wsh.nhs.uk. You can also contact Amanda on 07896 929086.

- You can report your concern anonymously by filling in the **anonymous web-based reporting form** here, giving us as much detail as you can. You do not have to leave your name, but what you write will be seen by the **Freedom to Speak Up Guardians**, Amanda Bennett and Dr James Barrett. If do want to leave your name and contact details there is an option for you to do so.

There are a number of other ways you can raise concerns:

- Our **Patient Safety Team,** led by Dan Spooner, Deputy Chief Nurse daniel.spooner@wsh.nhs.uk

- Call ext. 2612 internally or 01284 712612 to leave a message on our **anonymous reporting phone-line**. You do not have to leave your name, but your message will be listened to by a member of the patient safety team. We have no way of identifying who you are or where you have called from unless you choose to tell us. Any issues you raise will be passed to the best

person or department to address your concern. It's not compulsory to leave your contact details, but if you do someone will contact you to acknowledge your concerns and then later on to let you know the outcome.

If you choose to raise a concern through either of the above two routes and do give us your name, we will not share your concern with anyone else without getting your permission first (unless what you have told us suggests you or others could be at risk of harm).

If you still remain concerned after this, you can contact:

- Our **executive director** with responsibility for whistleblowing: Jeremy Over, Executive director of Workforce & Communications. Jeremy.over@wsh.nhs.uk
- Our **chief executive** Stephen Dunn Stephen.Dunn@wsh.nhs.uk
- Our **non-executive director** with responsibility for whistleblowing Dr Richard Davies. You can email him at rg.davies@cantab.net

All these people have been trained in receiving concerns and will give you information about where you can go for more support. If for any reason you do not feel comfortable raising your concern internally, you can raise concerns with external bodies, listed on page 5.

If you want to discuss your concern confidentially and informally you can talk to one of our Trusted Partners. These are volunteer members of staff who can give impartial, confidential advice and a listening ear - you will find details here

Advice and support

Details on the local support available to you can be found here;
http://staff.wsha.local/Intranet/Documents/Q-Z/StaffSupporters/Staffsupporters.aspx

However, you can also contact the Whistleblowing Helpline for the NHS and social care, your professional body or trade union representative.

How should I raise my concern?

You can raise your concerns with any of the people listed above in person, by phone or in writing (including email). Whichever route you choose, please be ready to explain as fully as you can the information and circumstances that gave rise to your concern.

What will we do?

We are committed to the principles of the Freedom to Speak Up review and its vision for raising concerns, and will respond in line with them (see Annex B).

We are committed to listening to our staff, learning lessons and improving patient care. On receipt the concern will be recorded and you will receive an acknowledgement within two working days. The central record will record the date the concern was received, whether you have requested confidentiality, a summary of the concerns and dates when we have given you updates or feedback.

Investigation

Where you have been unable to resolve the matter quickly (usually within a few days) with your line manager, we will carry out a proportionate investigation – using someone suitably independent (usually from a different part of the organisation) and properly trained – and we will reach a conclusion within a reasonable timescale (which we will notify you of). Wherever possible we will carry out a single investigation (so, for example, where a concern is raised about a patient safety

incident, we will usually undertake a single investigation that looks at your concern and the wider circumstances of the incident[3]). The investigation will be objective and evidence-based, and will produce a report that focuses on identifying and rectifying any issues, and learning lessons to prevent problems recurring.

We may decide that your concern would be better looked at under another process; for example, our process for dealing with bullying and harassment. If so, we will discuss that with you. Any employment issues (that affect only you and not others) identified during the investigation will be considered separately.

Communicating with you

We will treat you with respect at all times and will thank you for raising your concerns. We will discuss your concerns with you to ensure we understand exactly what you are worried about. We will tell you how long we expect the investigation to take and keep you up to date with its progress. Wherever possible, we will share the full investigation report with you (while respecting the confidentiality of others).

Records management

All records relating to your concern will be retained securely. Any emails or other correspondence you send us or we send you relating to your concern will be retained for two years after the date of the conclusion of action on your concern.

How will we learn from your concern?

The focus of the investigation will be on improving the service we provide for patients. Where it identifies improvements that can be made, we will track them to ensure necessary changes are made, and are working effectively. Lessons will be shared with teams across the organisation, or more widely, as appropriate.

Board oversight

The board will be given high level information about all concerns raised by our staff through this policy and what we are doing to address any problems. We will include similar high level information in our annual report. The board supports staff raising concerns and wants you to feel free to speak up.

If your concern suggests a Serious Incident has occurred, an investigation will be carried out in accordance with the Serious Incident Framework.

Review

We will review the effectiveness of this policy and local process at least annually, with the outcome published and changes made as appropriate.

Raising your concern with an outside body

Alternatively, you can raise your concern outside the organisation with:

- **NHS Improvement** for concerns about:

- how NHS trusts and foundation trusts are being run
- other providers with an NHS provider licence
- NHS procurement, choice and competition
- the national tariff

- **Care Quality Commission** for quality and safety concerns
- **NHS England** for concerns about:
  - primary medical services (general practice)
  - primary dental services
  - primary ophthalmic services
  - local pharmaceutical services
- **Health Education England** for education and training in the NHS
- **NHS Protect** for concerns about fraud and corruption.

Making a 'protected disclosure'

There are very specific criteria that need to be met for an individual to be covered by whistleblowing law when they raise a concern (to be able to claim the protection that accompanies it). There is also a defined list of 'prescribed persons', similar to the list of outside bodies on page 5, who you can make a protected disclosure to. To help you consider whether you might meet these criteria, please seek independent advice from the Whistleblowing Helpline for the NHS and social care, Public Concern at Work or a legal representative.

National Guardian Freedom to Speak Up

The National Guardian can independently review how staff have been treated having raised concerns where NHS trusts and foundation trusts may have failed to follow good practice, working with some of the bodies listed above to take action where needed.

Appendices

Appendix A – Example process for raising and escalating a concern
Appendix B – A vision for raising concerns in the NHS
Appendix C – Additional West Suffolk NHS Foundation Trust Process
Appendix D – Procedure for managing allegations of abuse against children and vulnerable adults.

Author(s):	HR & Communications
Other contributors:	Trade Union Representatives
Approvals and endorsements:	Corporate Risk Committee
Consultation:	Trust Council
Issue no:	8
File name:	Charlie S: Personnel/Policies/2016/PP(16)056 Whistleblowing - staff concerns about patient care
Supercedes:	PP(17) 056
Equality Assessed	Yes
Implementation	Policies will be checked by HR Manager. Distribution to all Managers. Published on the Intranet.
Monitoring: (give brief details how this will be done)	Implementation, compliance and effectiveness of this policy will be monitored by Trust Council. 100% of any complaints received into the HR Directorate will be handled in line with the policy and will be recorded on the Complaints Database held by HR.
Other relevant policies/documents & references:	Fraud, Financial Irregularities and Corruption Policy, PP173
Additional Information:	None

Appendix A: Example process for raising and escalating a concern

Step one
If you have a concern about a risk, malpractice or wrongdoing at work, we hope you will feel able to raise it first with your line manager, lead clinician or tutor (for students). This may be done orally or in writing.

Step two
If you feel unable to raise the matter with your line manager, lead clinician or tutor, for whatever reason, please raise the matter with our local Freedom to Speak up Guardian. The Lead Freedom to Speak Up Guardians are Amanda Bennett and Dr James Barrett who can be contacted via FreedomToSpeakUp.Mailbox@wsh.nhs.uk

This person has been given special responsibility and training in dealing with whistleblowing concerns. They will:

- treat your concern confidentially unless otherwise agreed
- ensure you receive timely support to progress your concern
- escalate to the board any indications that you are being subjected to detriment for raising your concern
- remind the organisation of the need to give you timely feedback on how your concern is being dealt with
- ensure you have access to personal support since raising your concern may be stressful.

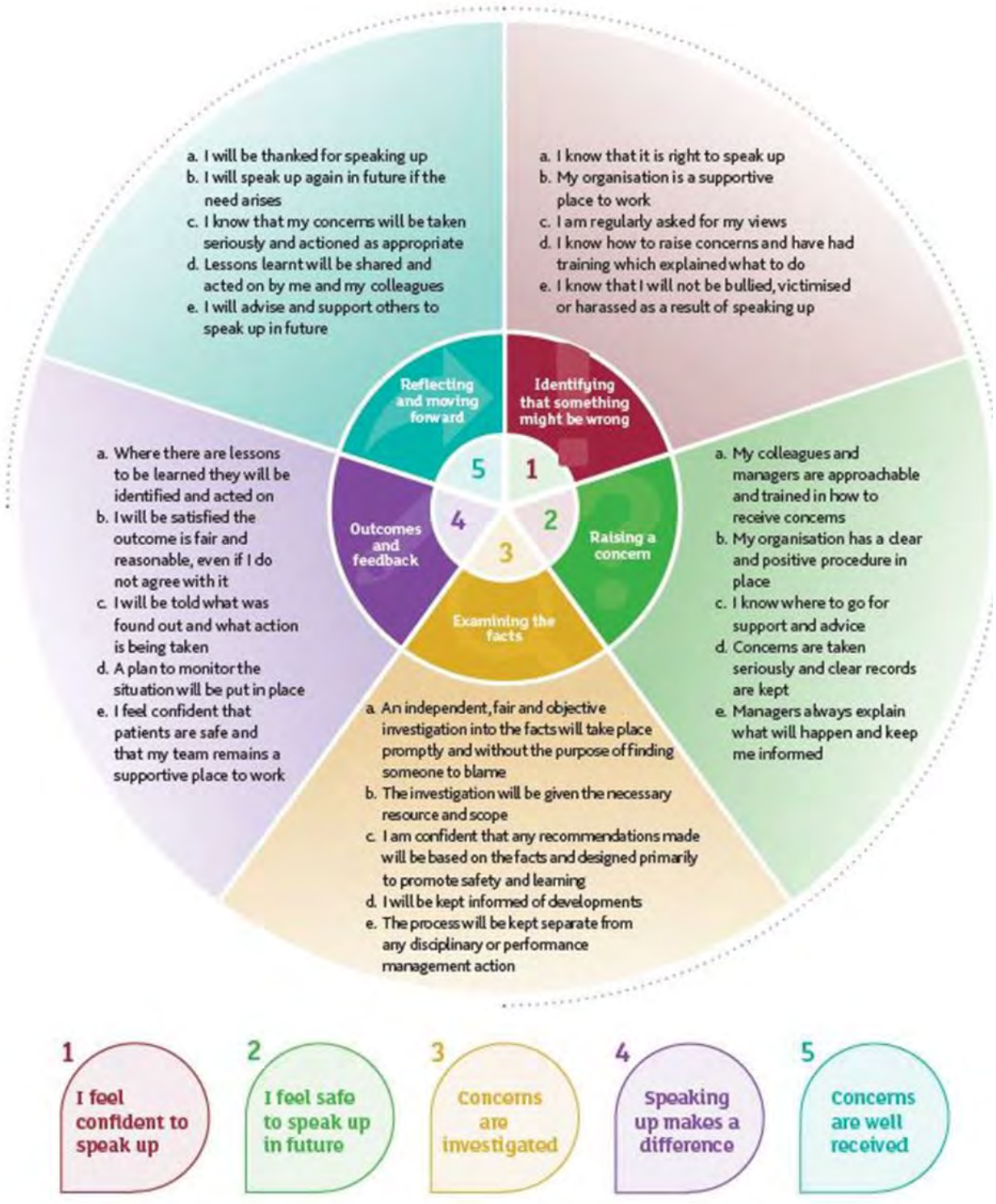
If you want to raise the matter in confidence, please say so at the outset so that appropriate arrangements can be made.

Step three
If these channels have been followed and you still have concerns, or if you feel that the matter is so serious that you cannot discuss it with any of the above, please contact:

- nursing director: Susan Wilkinson susan.wilkinson@wsh.nhs.uk
- chief executive: Stephen Dunn stephen.dunn@wsh.nhs.uk ,
- medical director: Nick Jenkins nick.jenkins@wsh.nhs.uk (*responsible officer)*, or
- Dr Richard Davies rg.davies@cantab.net (nominated Non-Executive Director).

Step four
You can raise concerns formally with external bodies.

Appendix B: A vision for raising concerns in the NHS



Source: Sir Robert Francis QC (2015) *Freedom to Speak Up: an independent report into creating an open and honest reporting culture in the NHS*.

Appendix C: Additional West Suffolk NHS Foundation Trust Process

1. POLICE AND LOCAL COUNTER FRAUD SPECIALIST INVOLVEMENT

If the police and/or the Trust local counter fraud specialist are simultaneously conducting their own enquiries, the Manager investigating the concern for the Trust should make every effort to conduct his/her own investigation in co-operation with theirs. If there seems to be a danger that investigations by the Trust may prejudice police or local counter fraud specialist enquiries or court proceeding, the Trust should consult the police, the local counter fraud specialist and their own legal advisors before proceeding. The police/local counter fraud specialist should not have a veto on investigation that the Trust properly believes should be conducted at the same time as police/local counter fraud specialist enquiries. If the Trust and the police/local counter fraud specialist disagree on the action the Trust proposes to take, the matter should be referred to the Department of Health.

If the police/local counter fraud specialist decides not to institute criminal proceedings, Managers must themselves consider what further investigation and action is needed; in particular, whether disciplinary action is necessary. If the police/local counter fraud specialist decides not to proceed, it does not follow that the Trust has no need to act. In deciding what to do, Managers should at all times consider how best to safeguard patients' interests. Court verdicts depend on the jury being 'sure beyond all reasonable doubt' that an offence was committed. NHS Trust need not use such a strict burden of proof when determining how best to protect patients. The Trust local counter fraud specialist may as a result of his/her work present evidence to Managers to support disciplinary action.

2. RIGHTS OF STAFF AGAINST WHOM A CONCERN HAS BEEN RAISED

Any member of staff against whom a complaint is made must be given the opportunity to explain his or her actions. Before doing so, staff should be told of their right to consult the Trade Union or Professional Association to which they belong. Staff are entitled to know the findings of any investigations in which they are involved. If they are dissatisfied with the outcome or the way in which the complaint has been handled, they may appeal, using the Trust's Grievance Procedure.

Managers should take care to see that there is no confusion between the operation of this concerns procedure and the disciplinary procedure. If, in the course of an investigation into a complaint, it begins to emerge that counselling or disciplinary action may be needed, the Manager conducting the investigation will again inform the member of staff concerned of his or her right to be represented.

Managers must not permit investigation of concerns to drift imperceptibly into disciplinary proceedings. They must therefore inform staff of the status of any interviewing or questioning, and disciplinary procedure interviews must only take place when fair and reasonable conclusions can be drawn from the investigations which have taken place.

3. RIGHTS OF STAFF RAISING THEIR CONCERNS

Staff who raise a concern about patient care are also entitled to know the outcome of their concerns. If they are dissatisfied with the outcome, or the way in which their concern has been handled, they should be referred to the guidance in the main procedure for staff concerns about patient care. It is very important that staff who raise concerns on behalf of patients in good faith should be free from any victimisation or harassment. Managers at all levels must take responsibility for ensuring that staff who express concern about standards of care do not suffer as a result.

Staff who raise a concern should be informed of their right to be represented or aided by a representative of their Trade Union or Professional Association during the investigation and any disciplinary proceedings resulting from their concern. They should also be told of their right to have a friend, a tutor or a Trade Union Representative to advise or support them at any meeting or interview at which their concern is discussed or investigated.

4. KEEPING EVERYONE INFORMED

When allegations involve patients, the Chief Executive or the Chief Operating Officer will write to them, or where this is impracticable, their carers/representatives, to inform them of the nature of the allegations. Once the investigation and any resulting disciplinary proceedings have been concluded, he or she will write to inform the patient/carer/representative of the outcome. If the follow-up of the concern is protracted the patient/carer/representative should be kept up to date with developments. Likewise, in the case of non-patient concerns, the staff involved and their trade union/professional association representatives should be kept up to date with developments.

5. INFORMING PROFESSIONAL ORGANISATIONS

Employment in certain professions, which are regulated by statutory bodies is conditional upon continuing registration (e.g. GMC, NMC, HPC). The Trust has a duty to report appropriate incidents of serious misconduct or serious performance issues, involving such staff, to the relevant regulatory body. This duty shall be exercised quite separately to any disciplinary action by the Trust and as with criminal charges; the Trust is not obliged to await the outcome of any processes undertaken by the Regulatory Bodies, before taking its own disciplinary action.

Appendix D

ARRANGEMENTS FOR MANAGING ALLEGATIONS OF ABUSE AGAINST PEOPLE WHO WORK WITH CHILDREN AND VULNERABLE ADULTS OR THOSE WHO ARE IN POSITIONS OF TRUST

Introduction

These guidelines outline the process for dealing with allegations of abuse made against a person who works with children and young people in accordance with 'Working together to safeguard Children', Appendix 5, 'A Guide to interagency working to safeguard and promote the welfare of children 2006' and 'Safeguarding children and safer recruitment in Education 2007'. It also outlines the process for dealing with allegation of abuse in relation to vulnerable adults in accordance with "No Secrets" (2000) and the Suffolk Interagency policy for the protection of vulnerable adults.

Scope

This procedure covers employees, volunteers and regular visitors who work with children or who are in a position of trust.

It covers conduct either at work or in the individual's personal or professional life that might indicate their unsuitability to work with children and vulnerable adults, i.e. they may have:-

a) Behaved in a way that has harmed or may have harmed a child or vulnerable adult.
b) Possibly committed a criminal offence against or related to a child or vulnerable adult.
c) Behaved in a way that indicates he/she is unsuitable to work with children or vulnerable adults.

Process

The manager receiving such an allegation should report it to the Executive Director of Workforce and Communications or designated officer immediately.

The Executive Director of Workforce and Communications or designated officer will consider the following issues.

i) Could the allegation become a police investigation of a possible offence?
ii) Could it be subject to an enquiry and assessment by Children's Social Care about whether a child is in need or protection or need of services? Or in the case of a vulnerable adult that may require protection, does it require the involvement Adult Safeguarding Officers or Social Services.
iii) Could it be subject to an enquiry by those officers responsible for Adult Safeguarding or Social Services concerning the protection of a vulnerable adult?
iv) Could it potentially be the subject of a disciplinary action under the Trust's Disciplinary Policy and Procedure?

If the allegation meets any of the criteria set out in i, ii or iii above then the Executive Director of Workforce and Communications will contact the local authority designated officer within 1 working day of having received the allegations. Contact details of the Local Authority Designated Officer are held in the HR and Communications Directorate. Out of hours e.g. weekend – to contact Executive Director on call.

Suspension

Suspension should be considered in accordance with the Trust's Disciplinary Policy and Procedure and advice should be sought from a senior HR Officer.

Initial Consideration

The Executive Director of Workforce and Communications will discuss the case with the local authority designated officer and where necessary obtain additional information.

In cases where the local authority designated officer considers there may be grounds for the allegation and there is a case where a child is suffering or likely to suffer, they will discuss the case further with the Police.

These discussions will also involve the Trust's Executive Director of Workforce and Communications or designated senior officer.

Action Following Consideration

Disciplinary Action

If following consideration by the Executive Director of Workforce and Communications and the local authority designated officer and the police, it is determined that the allegations does not involve a possible criminal offence, the Executive Director of Workforce and Communications will revert to the Trust's Disciplinary Policy and Procedure.

If no formal disciplinary action is required, appropriate action will be taken by the Trust within 3 working days.

If a Disciplinary Hearing is required and no further investigation is necessary, a hearing should be convened in accordance with the Trust Disciplinary Policy and Procedure (subject to availability of all relevant parties).

If further investigation is required the Executive Director of Workforce and Communications will discuss this with the local authority designated officer to determine the most appropriate person to undertake the investigation.

In some cases it may be agreed that someone independent from the Trust may be the most appropriate person to conduct the investigation. In such cases the investigating officer will aim to provide a report within 10 days to the Trust.

On receipt of the report the Executive Director of Workforce and Communications will consider if a hearing is required and if so this should be convened in accordance with the Trust Disciplinary Policy and Procedure.

If the case is also subject to a children's social care enquiry then their evidence should also be considered when determining disciplinary action.

At all points during the investigation the local authority designated officer should liaise with the Trust to provide advice and support.

Cases subject to police investigation

In such cases the police will aim to complete their enquiries as quickly as possible.

They will set a review date to assess progress which will include consultation with the Crown Prosecution Service to decide whether or not to proceed with the investigation. Wherever possible the review will be within 1 month of the initial meeting.

If the police decide to proceed with further investigations, additional progress review dates will be established.

Keeping the employer informed

The police should inform the Trust and the local authority designated officer straightaway when:

a) A criminal investigation and any subsequent trial has been completed.
b) When a decision has been made to close an investigation without charge or further action.
c) Not to prosecute following charges being made.

In these circumstances the local authority designated officer will discuss the case with the Executive Director of Workforce and Communication to determine if disciplinary action is appropriate.

In cases where it is determined that disciplinary action is appropriate, the police and social care will wherever possible pass relevant information to the Trust.

If the person is convicted of an offence the police will inform the Trust immediately.

Action on Conclusion of a Case

If an allegation is substantiated and the person is dismissed, or the local authority or employer ceases to continue with the persons services, or the person resigns or ceases to provide their services, the local authority designated officer should discuss with the Director or HR and Communications whether the individual should be referred to the DsES for consideration of List 99 action or to the Protection of Children Act list or the Protection of Vulnerable Adults List.

If it is appropriate to make a referral this should be done within 1 month. If the individual is subject to registration or regulation by a professional body or regulator, the local authority designated officer should advise on whether a referral to the appropriate body is required, and the form and content of that referral.

Return to Work following Suspension

Employees returning to work following allegations of this nature will require support in order for their return to be successful. The provision of mentor and phased return may be appropriate.

Review of Cases

The Executive Director of Workforce and Communications and the local authority designated officer will review cases to identify any actions that can be put in place that will improve the safeguarding of children or the protection of vulnerable adults.

Health and Wellbeing Annual Report 2020

Introduction

Promoting the health and wellbeing of all our staff is important to support them in delivering excellent care for our community as well as it being as a marker of a good employer. This annual report provides Trust Board members with an update on how this support is being provided and an assessment of its impact.

The West Suffolk Wellbeing Plan 2019 – 2021 is attached as **appendix A**. This is a 'live' document which provides focus and direction for our work as well as capturing the detail of the wealth of health and wellbeing support already available to staff. The plan is regularly reviewed by the Health and Wellbeing Steering Group and was last reviewed by members following the meeting held on 23rd September 2020. Updates to the plan since the last annual report in November 2019 are highlighted in italics. Since March 2020 much of the focus of our health and wellbeing support for staff has been on the COVID-19 pandemic and the plan reflects this. It has also been updated following publication of the NHS People Plan in the summer.

Development of the staff health and wellbeing plan since November 2019

Health and Wellbeing support in response to the COVID-19 Pandemic

A wide range of psychological and practical support has been provided to support staff during the pandemic. This includes:

Psychological support

- A staff support psychology service was established for all WSFT staff at the end of March 2020 based on the business case that had been developed as part of the 2019 – 2020 Wellbeing Plan. The service is led by Emily Baker, Consultant Clinical Psychologist.

- Since March the team has seen over 300 staff members and run over 100 team sessions. Initially, many of these were one off appointments for people in acute distress, but once the first wave passed, the referrals were for ongoing anxiety, stress, relationship or team dynamic issues and exhaustion. The team have seen similar levels of anxiety, PTSD and trauma symptoms as they predicted (from the staff groups that were directly treating COVID patients or were redeployed) but in addition have seen many staff who were shielding and have found the isolation or the return to work distressing, as well as many members of staff with 'long COVID'. This last group is a particular challenge as there are not yet established pathways for support for them from a physical health point of view.

- Recently there has been a noticeable increase in self referrals, as the adrenaline from the first wave has worn off and the fatigue from a lack of access to usual activities that improve wellbeing takes its toll. As we go through the second wave the team expects to need to provide both one off psychological first aid and ongoing support.

- The team was initially staffed by redeployed clinical psychologists from paediatrics and a trainee clinical psychologist, plus additional consultant psychology time. Additional investment has been agreed for the service and once fully established, the team will be 5.0 WTE psychologists or psychological therapists. Staff have initially been appointed on one or two-year fixed term contracts. The service is being evaluated and this will inform decision making about longer term investment and development.

- Face-to-face and telephone counselling has also been provided through our employee assistance programme 'Care First'.

Practical support

- Staff with vulnerable people in their household were provided with free of charge hotel and hospital accommodation.
- Free hot drinks for staff all day at WSH. Packs of tea/coffee sent to staff working in community settings. Free food for staff working at night
- Free car parking
- A number of 'calm rooms' were provided on the WSH site for staff who need a quiet space for relaxation and reflection. Service needs have resulted in these rooms being repurposed and work is underway to make them a permanent resource for staff.
- The trust carer's leave policy has been temporarily changed to provide up to 3 days paid leave in a year to staff. This reflects the impact of the pandemic on staff with caring responsibilities where carer support systems, including schools and nurseries have been closed due to Coronavirus. Going forward the Trust special leave policy is being reviewed.
- Providing staff with access to discounts and resources through a dedicated staff coronavirus advice and guidance extranet
- Providing access to information about childcare locally through the Suffolk County Council Family Information Service

Occupational health services

- Our occupational health service has provided and supported an 'individual staff risk assessment for COVID-19' tool that has supported the identification of risk factors for all Trust staff to
- A risk assessed process was put into place to support the return to the workplace of shielding staff with the pause of shielding in August.

COVID-19 vaccination

- Preparation is underway in anticipation of the need to deliver a COVID-19 staff vaccination programme and we will be working in partnership with our occupational health provider to deliver the vaccination for staff if/when a vaccine is available

Non-pandemic health and wellbeing activities

In addition to the activities specifically to support staff during the pandemic other developments have continued:

Better for me, better for you

This campaign is being developed by the Trust Communications Team and our registrar in public health to highlight the importance of looking after ourselves as well as looking

after our patients, families and friends. Staff have been invited to tell their stories of how they have made positive changes for their physical or mental health

My pause
The trust menopause support group has continued to provide support for staff, including a workshop on managing anxiety in menopause led by Dr Emily Baker, Consultant Clinical Psychologist and an information stand in 'Time Out'.

Occupational health services
We have continued to work with Cambridge University Hospital NHS Trust who provides our occupational health services. Our agreement has been in place for a number of years and we are currently undertaking a review of the specification of services with CUH.

Flu vaccination programme
Delivery of a successful flu vaccination programme is a high priority in 2020. Sufficient vaccine has been purchased for all Trust staff and a range of strategies put in place to make it as easy as possible for staff in all locations to access vaccination.

Evidence of impact

Our evaluation framework has a mix of structural, process and outcome indicators. This is attached at **Appendix B**. The impact of COVID-19 in seen in some indicators where activity has been paused and no data is available – notably in relation to supporting the physical wellbeing of staff e.g. smoking cessation.

In addition to the significant take up of the internal staff support psychology service there has been increased use counselling from our employee assistance programme 'Care First'.

Although our staff survey 2019 result predate the COVID-19 pandemic and the activities put in place to support staff it is disappointing to see that the percentage of staff believing the Trust is taking positive action on health and wellbeing fell again (by 0.8%) in 2019. Further work is needed to understand why less than 40% of staff believes the Trust takes positive action on health and wellbeing – whether this is an issue of perception, communication or the value and appropriateness of what is provided – or a combination of all three.

It is also worth noting that when asked about their immediate manager takes a positive interest in their health and wellbeing staff are more positive and the Trust's score remains consistently just above national average for comparable organisations and the general trajectory for the past five years has been upward. Equally the overall health and wellbeing theme score for the Trust, compiled from all questions in the survey relevant to health and wellbeing, was well above the national average again in 2019.

Denise Pora
Deputy Director of Workforce (Learning and Organisation Development)
26th October 2020

Appendix A

West Suffolk Wellbeing 2019 – 2021

Leadership

Trust Ambition 7 *Support all our staff*

Our Health Work and Wellbeing Strategy ensures we have a consistent and positive approach to employee wellbeing throughout the Trust

Current services and support

- Health and Wellbeing Steering Group meets quarterly to provide oversight and strategic direction
- Better Working Lives Group (sub group of H&WB Steering Group) focussing on the wellbeing of medical staff
- Updates to the Trust Board twice a year
- Talent Management Strategy provides career management for all to enable all staff to achieve their potential
- Leadership and management development for line managers to provide them with the skills they need to support their staff
- Shining Light Awards held annually to celebrate the achievements of staff
- Wellbeing co-ordinator role and Assistant Communications Manager support wellbeing activities

Action 2019 to 21

- Promote personal stories of self-improvement to encourage staff engagement through Better for me, better for you campaign to be developed by the Communications team. Initially 5 staff stories to be publicised in West Suffolk and Newmarket Hospitals. *Paused due to COVID-19. Launched in Greensheet October 2020.*
- Identify and address particular issues facing community staff in accessing wellbeing support. *Health and wellbeing offer promoted at Community staff inductions*
- *Identify a Wellbeing Guardian for the Trust to look at the Trust's activities from a health and wellbeing perspective and act as a critical friend (**NHS People Plan**)*
- *Ensure all staff have a health and wellbeing conversation and a personalised plan (**NHS People Plan**)*
- *Provide all new starters with a health and wellbeing induction (**NHS People Plan**)*

Mental Health **Trust Ambition 5** *Support a healthy life* **Trust Ambition 7** *Support* all our staff

It is important for all staff to be aware of the importance of supporting mental health and mental wellbeing and that they have access to support and information as required

Current services and support

- Care First Employee Assistance Programme provides access to information, advice and counselling
- Trust library provide resources for mental wellbeing, including mood boosting books for their uplifting qualities, Books on Prescription providing self-help techniques, colouring materials for mindfulness.
- Mental Health for Managers training (103 participants in 2019) and mental health awareness and emotional first aid workshops for staff (108 participants in 2019)
- Wellbeing Workshop for medical staff (25 participants - 9 and 10 September 2019)
- Mindfulness training at Grand Round 50 medical staff attended April/May 2019
- Freedom to Speak up Guardian in place since 2017 and range of other options via 'staff supporters'
- Tea and Empathy – giving staff on-the-day access to 1:1 support from a colleague if they have had a bad day and want to talk
- Trusted partners – provide a listening ear and independent advice to staff with concerns including bullying and harassment and inclusion
- Chaplaincy provides pastoral and spiritual support in times of need

Action 2019 to 21

- Action plan to tackle bullying and harassment built on learning from 2019 Summer Leadership Summit and internal survey to be implemented, including anonymous reporting, mediation support and unconscious bias training. *Action plan implementation started: accredited mediation available, progress reviewed with divisions Sept.19 through PRM meetings. Progress of action plans to be reviewed by HR Business partners and in light of just culture plans.*
- Trust inclusion strategy objectives 2019 – 21 and supporting action plan include taking action to support the mental health wellbeing of staff. *Inclusion action plan being implemented. Mental health awareness training sessions delayed due to COVID-19. Sessions set up starting in November 2020.*
- Doctors 'burnout' surveys – action to be taken by Better Working Lives Group. *Wellbeing session arranged for medical staff January 2021*
- Survey of medical staff to explore the impact of IT systems on working lives and opportunities to improve experiences – action to be taken by Better Working Lives Group. *COVID-19 survey carried out and results fed back.*

- Development of a business case for in-house clinical psychology to support staff mental health, including debriefing of individuals and teams – led by Better Working Lives Group. *Complete Business case implemented and expanded Staff Support Psychology Service in place to support staff during COVID-19 pandemic and beyond.*
- *Evaluation of staff psychology support service two-year pilot programme.*
- *Provide support for staff facing challenging and stressful times, including SUI, coroner's cases and trauma.*

Life Style **Trust Ambition 5** *Support a healthy life* **Trust Ambition 7** *Support all our staff*

We aim to support people through all individual lifestyle choices, habits and behaviour which in turn impact on their wellbeing

Current services and support

- Engagement with Suffolk County Council Health Promotion Campaign Planning
- WSFT Smoke Free Environment
- One Life run Stop Smoking Clinics on site weekly
- NHS Health Checks. One Life Suffolk on site monthly to provide free health checks for staff aged between 40-74
- Health Walks One Life Suffolk
- One Life Suffolk weight management course for staff who meet BMI criteria
- Physical activity- WSFT Staff currently run Circuit Exercise and Tae Kwando classes on site aiming for ease of access to staff members and encourage physical activity.
- Active travel. One element is the national Cycle-to-Work scheme, purchasing cycling goods tax-free.
- Healthy Eating. Time Out staff restaurant provides healthy choices and has won Eat Out, Eat Well award.
- Preceptorship Days and other Training/workshops include the Wellbeing Market Place which provides information regarding WSH staff benefits and available support services also road showing I.T systems and programmes.

Action 2019 to 21

- Physical activity - Explore opportunities to provide further exercise options on site for staff e.g. Tai Chi. *Paused during COVID-19 pandemic*
- Supporting staff to stop smoking – WSFT will be actively promoting Stoptober in October 2019. *Complete*
- Seek agreement for One Life presence on site once a fortnight to help promote services and provide support and information to staff and patients as required. *Paused during COVID-19 pandemic to be reinstated when One Life can provide the service*
- Healthy eating – catering team exploring vegan options in Time Out. *Promotions paused due to COVID-19*

Focus on: MSK Musculoskeletal **Trust Ambition 5** *Support a healthy life* **Trust Ambition 7** *Support all our staff*

We aim to support all members of the workforce in preventing MSK injury through various methods including education, providing equipment and moving and handling techniques. We support staff return to work and encourage self-care is encouraged

Current services and support

- Specialist Physiotherapy self-referral service for staff
- Moving and Handling Team provide assessment, training and specialist advice for staff
- Monthly information/advice to be provided by Physio and published in staff Greensheet

Action 2019 to 21

- Wellbeing Coordinator and Moving and Handling Advisor are looking into Desk exercises (stretching) to support staff, predominantly those sitting at a work station.

Focus on: Preventing Flu **Trust Ambition 5** *Support a healthy life*

Throughout the flu season we offer and provide our staff with the Flu vaccination

Current services and support

- Flu Strategy
- Follow NHS checklist for beat practice management checklist for public assurance via trust Boards.

Action 2019 to 21

- 2019/20 flu season – target of 80% vaccination of frontline/patient facing staff. *80% achieved. 2020 flu season target of 90% of frontline/patient facing staff vaccinated. Campaign launched with additional flu vaccination stations and strategies to give all staff easy access to vaccination. Sufficient vaccine purchased for all staff.*

Life Experiences and Ill Health **Trust Ambition 5** *Support a healthy life* **Trust Ambition 7** *Support* all *our staff*

Life experiences and ill health will have a completely different meaning to each individual employee. We aim to holistically support staff through generalised life events (e.g. menopause, caring responsibilities) as well as specific health conditions

Current services and support

- The Trust has a range of policies and guidance to support staff and enhance a healthy workplace culture
- Health and Wellbeing Focus Group quarterly.

Action 2019 to 21

- Improving the working lives of disabled staff – Workforce Disability Equality Standard action plan developed, including establishing a disabled staff network, reviewing policies and supporting reasonable adjustments. *Open forum/network meeting held Sept.19 to discuss WDES. Disability leave policy presented to Trust Council Sept.19 for comments.*
- Menopause workshop – additional workshop in 31 October 2019, explore setting up a menopause support network. *Further workshop arranged for November 2020 with on-going promotion of resources and support.*
- Family Carer Workshops for those caring for elderly friends or relatives. *Paused for COVID-19*
- Handling stress and anxiety workshop 20 September 2019. *Workshop held. Further events paused for COVID-19*
- Mental health awareness and emotional first aid workshops for staff and managers – build on 2019 activities. *Mental health awareness training sessions delayed due to COVID-19. Sessions set up starting in November 2020.*
- Supporting parents of children facing mental health difficulties in support of the Director of Public Health for Suffolk's Annual Report 2019 "Suffolk through a child's eyes" *Registrar in public health to initiate action from Autumn 2020*
- *Provide practical support to staff during the COVID-19 pandemic. Following provided for staff: food packages, free tea/coffee at WSH, tea/coffee packages sent to community teams, free car parking on trust sites, free accommodation on and off side for staff with vulnerable people in their households and those with long distances to travel, access to information about childcare via Suffolk County Council Family Information Centre, extended staff meal times for hot food and free hot food at night, temporary change to carers leave policy providing up to 3 days paid carers leave, calm rooms to provide space for staff to relax and reflect, information about support available, including external support e.g. wellbeing apps, discounts etc. via staff extranet available on any device.*

Financial Wellbeing

Trust Ambition 7 *Support all our staff*

We are aware of the impact and implications that negative financial situations can have on people and seek to offer access to practical support

Current services and support

- 'Neyber' financial wellbeing service. Details are available to staff via the intranets and Neyber staff attend special events on site as required.

Action 2019 to 21

- Preceptorship marketplace 18th December 2019. Event held
- *National NHS Finance Health and Wellbeing offer launch promoted to all staff via Greensheet October 2020*

Absence Management

Trust Ambition 7 *Support all our staff*

We will support the physical and mental wellbeing of all our staff to help minimise absence from work

Current services and support

- Absence Management Training is held x4 yearly, is also available ad-hoc on request.
- Bradford Factor scores used for absences.
- Return to work interviews conducted, appropriate support provided alongside specific risk assessments taking into an individual's health status. Reasonable adjustments are available to employees in line with recommendations for relevant professionals.

Action 2019 to 21

- OH contract review – ensure staff have timely access to occupational health services to support remaining at and returning to work. *Review underway*
- Promotion of occupational health services – self referral by staff and raising line manager awareness of the support available to them *active promotion paused due to COVID-19*
- Workforce Disability Equality Standard action plan – supporting staff with disabilities, explore potential for a disability leave policy. *Draft policy presented to Trust Council Sept.19 being finalised*
- The Improving Employee Health, Wellbeing and Attendance Policy is currently being reviewed, with phased returns being an element of

focus. *Process for arrangements for staff to agree a phased return without automatic involvement of Occupational Health agreed and communicated to managers in January 2020. Initial plan for a six month trial extended to one year due to COVID-19. Review due January 2021*

Safe Environments **Trust Ambition 5** *Support a healthy life* **Trust Ambition 7** *Support all our staff*

We aim to provide all staff with a safe working environment

- Health and Safety training provided to all staff relevant to their role at induction and on-going mandatory training
- Restrictive Physical Intervention (RPI) Team. A specialist team undertakes Restrictive Physical Intervention (RPI) to provide support to staff when they are nursing clinically confused patients who become violent and aggressive.
- Management of Violence and Aggression Policy covers a wide range of issues around the creation of a safe working environment for staff through the prevention and management of physical and non-physical violence and aggression.
- All areas/departments of the hospital are required to have a Health & Safety Link person.

Action 2019 to 21

- *AccessAble to develop guide to courtyard gardens at West Suffolk Hospital with recommendations matrix to ensure gardens are available to as many staff as possible. Initial implementation planned for July 2020 delayed due to COVID-19. Planned for summer 2021.*

- *Develop individual staff risk assessment tools to facilitate joint understanding and decision making in relation to the individual risk of occupational exposure to COVID-19 and measures needed to reduce it to as low as is reasonably practicable. Risk assessment tool developed in March 2020 and updated in the light of evidence. All staff required to undertake risk assessment. Process has been supported by occupational health advice where needed. Additional tool and resources developed to support the return to work of shielding staff.*

APPENDIX B

West Suffolk Wellbeing 2019 – 2021: Staff health and wellbeing evaluation framework and dashboard

Structures and Processes	Outputs	Outcomes
Physical wellbeing		
NHS health checks delivered	Staff set quit dates with on-site stop smoking service Flu vaccine coverage	NHS Staff survey - % experiencing work-related MSK problems
Emotional and mental wellbeing		
Tea & Empathy rota Trusted Partner role Staff Supporters promoted	Uptake of Care First Staff attend training supporting health and wellbeing Contacts with staff support psychology service	NHS staff survey - % experiencing work-related stress
Overall		
Quarterly staff focus groups Greensheet articles Staff led initiatives enabled Resources for staff in intranets Regular targeted health and wellbeing promotions/campaigns Better Working lives group	NHS Staff survey – health and wellbeing and morale themes – overall Trust performance in comparison with other similar organisations (possible from 2019 survey) NHS staff survey - % of staff believing the Trust takes positive action on health and wellbeing	Sickness absence rate • Total • 0-3 days • % declared stress, anxiety, depression Turnover (as an indicator of staff satisfaction) NHS staff survey - % coming to work despite not feeling well enough NHS staff survey - % agree or strongly agree immediate manager takes interest in health and wellbeing

1. **Structures and processes**

NHS Health Checks Delivered

Target: 10 clinics available with 80 checks carried out per annum
Progress: October 2018 to September 2019: 12 clinics available, 9 clinics ran and 45 checks carried out. One Life Suffolk currently unable to provide more up-to-date data.

Tea and Empathy rota: In place and now business as usual. A full rota has been maintained throughout the pandemic.

Trusted Partner role: Additional Trusted Partners recruited from October 2018 to broaden range of lived experience of staff available to provide support to others through this role.

Staff Supporters: 'Staff Supporters' branding developed and promoted throughout the trust via intranets and posters to provide staff with a single point for accessing support.

Quarterly staff focus groups/market places: October 2019 to March 2020
31/10/19 Menopause workshop
18/12/19 Preceptorship marketplace
Focus group plans 2020: Summer – healthy meals on a budget, Winter – men's health – paused due to COVID-19

Greensheet articles: Regular items covering all aspects of health and wellbeing in the branded 'Your Health and Wellbeing' section. These have continued throughout the pandemic.

Regular/targeted health and wellbeing promotions and campaigns: calendar of planned events and campaigns to be supported has been agreed. This includes planned campaigns by specialist Trust teams. Paused due to COVID-19

Enabling staff led initiatives: Staff feel able and encouraged to initiate activities to support other staff:
LGB&T+ network
Disabled staff network – open forum session held on 2/9/2020

Period boxes in trust toilets to support 'end period poverty' Menopause support network – Q&A session with Ellie Stewart, Uro Gynae clinical nurse specialist 17/2/2020, Managing Anxiety During Menopause session with Dr Emily Baker, Consultant Clinical Psychologist 5/11/2020 Art Class 11/5/2020 – postponed due to COVID-19 BAME network established in May 2020
Resources for staff on intranets: New sections on 'anti-burnout' resources and menopause resources added since October 2018. Dedicated wellbeing section on COVID-19 staff extranet.
Better Working Lives Group: Better working lives group set up in October 2018 as a sub-committee of the Health and Wellbeing Steering group focusing on the health and wellbeing of medical staff

2. Output indicators

Staff set quit dates with on-site stop smoking service: One Life Suffolk currently unable to provide data

Flu vaccination coverage (frontline staff) CQUIN – Improve update of 'flu vaccination. Measure is uptake by frontline clinical staff *Cut-off date for calculation of total was end December in 2016/17 but end February in following years	**2016/17***	**2017/18**	**2018/19**	**2019/20**	**2020/21**
	Target = 75%	Target = 70%	Target = 75%	Target = 80%	Target = 90%
	64.6%	74.67%	75.1%	80.3%	

Care First: new clients accessing care first services	**Nov 2019**	**Dec 2019**	**Jan 2020**	**Feb 2020**	**Mar 2020**	**Apr 2020**	**May 2020**	**Jun 2020**	**Jul 2020**	**Aug 2020**	**Sep 2020**	**Oct 2020**
		15			17			28		Not yet available		

Care First: Total calls – telephone counselling	27	41	55	Not yet available
	20	50	42	Not yet available

Care First: Face to face session				
Care First: Total calls – telephone information service	4	1	2	Not yet available
Contacts with Care First have increased during the COVID-19 pandemic. The introduction of the Staff Support Psychology service may have reduced the additional demands and other national psychological support services may also have had an impact. The numbers of staff using Care First in past months indicate it is providing a useful additional alternative to staff seeking support.				
Staff Support psychology service				
• Over 100 team sessions held March to October 2020 • Over 300 members of staff have consulted service March to October 2020				
Staff attend training supporting health and wellbeing:				
• One-day mental health awareness and emotional first aid workshop dates set for 2020 – 21: 4 workshops for a total of 48 participants • Two-day Wellbeing Workshop for medical staff held 4 and 5 February 2020 – 22 medical staff attended a further workshop is planned for January 2021.				

National NHS Staff Survey Morale theme		**Best**	**WSFT**	**Average**	**Worst**
	2018	6.7	6.4	6.1	5.4
	2019	6.7	6.6	6.1	5.5

National NHS Staff Survey Health and wellbeing theme		**Best**	WSFT	**Average**	**Worst**
	2018	6.7	6.4	5.9	5.2
	2019	6.7	6.4	5.9	5.3

National NHS Staff Survey Does your organisation take positive action on health and wellbeing?		**2015**	**2016**	**2017**	**2018**	**2019**
	Best	52.1%	52.2%	51.5%	46.7%	45.4%
	WSFT	37.9%	40.1%	42.0%	39.3%	38.5%
	Average	30.7%	32.0%	31.7%	27.8%	28.2%
	Worst	14.8%	18.2%	19.1%	15.3%	16.0%

Comments: It is disappointing to see that the % of staff believing the Trust is taking positive action on health and wellbeing fell again (by 0.8%) in 2019. Further work is needed to understand why less than 40% of staff believes the Trust takes positive action on health and wellbeing – whether this is an issue of perception, communication or the value and appropriateness of what is provided – or a combination of all three.

OUTCOME INDICATORS

3. Outcome indicators

Sickness absence 1.9.2019 to 31.8.2020:

Most sickness absence time lost due to:

1. Anxiety, stress, depression, other psychiatric illness 20.3%
2. Unknown/not specified 12.6%
3. Cold, cough, flu/influenza 11.6%
4. Gastro-intestinal problems 10.3%
5. Other known causes, not classified elsewhere 8.0%

In the period September 2019 to August 2020 the **total absence % FTE** ranged between 3.37% and 4.68%. The Trust stretch target is 3% total absence FTE.

Uncertified 0 – 3 day sickness absence range September 2019 to August 2020 0.28 % FTE to 0.89 % FTE

Staff turnover rate: 7.39% (DPSC September 2020)
Trust target: 10.00%

National NHS Staff Survey		**2015**	**2016**	**2017**	**2018**	**2019**
In the past 12 months have you experienced musculoskeletal problems as a result of work activities?	**Worst**	33.5%	34.4%	34.6%	37.8%	36.2%
	WSFT	21.2%	22.8%	21.3%	24.7%	23.1%
	Average	25.1%	25.6%	25.8%	28.7%	29.7%
	Best	19.2%	18.6%	19.7%	20.2%	21.5%

Comments: WSFT figures remain consistently below the national average and show a decrease on the 2018 survey.

National NHS Staff Survey In the last 12 months have you felt unwell as a result of work related stress?		**2015**	**2016**	**2017**	**2018**	**2019**
	Worst	44.9%	44.2%	45.9%	46.7%	46.3%
	WSFT	33.3%	34.4%	32.9%	34.9%	36.5%
	Average	36.0%	35.3%	36.7%	38.9%	39.8%
	Best	24.7%	25.3%	27.9%	28.9%	31.3%
Comments: WSFT figures remain consistently below the national average for comparable organisations but the upward trend on this indicator seen in the 2018 survey continues, which is of concern.						
National NHS Staff Survey In the last three months have you ever come to work despite not feeling well enough to perform your duties?		**2015**	**2016**	**2017**	**2018**	**2019**
	Worst	65.2%	62.9%	63.0%	64.3%	62.3%
	WSFT	53.2%	54.0%	51.4%	51.0%	51.9%
	Average	56.8%	55.2%	56.4%	56.9%	56.8%
	Best	44.6%	47.6%	47.6%	47.6%	48.0%
Comments: WSFT figures remain consistently below the national average for comparable organisations which is positive.						
National NHS Staff Survey My immediate manager takes a positive interest in my health and wellbeing		**2015**	**2016**	**2017**	**2018**	**2019**
	Worst	58.3%	57.2%	59.1%	57.6%	55.5%
	WSFT	65.6%	66.8%	67.8%	68.4%	71.3%
	Average	64.2%	65.6%	66.8%	66.9%	68.1%
	Best	70.4%	73.3%	72.4%	74.1%	77.8%
Comments: WSFT figures remain consistently just above national average for comparable organisations and the general trajectory for the past five years has been upward which is positive.						

QUARTERLY REPORT ON SAFE WORKING HOURS

DOCTORS AND DENTISTS IN TRAINING

1st July 2020 – 30th September 2020

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]

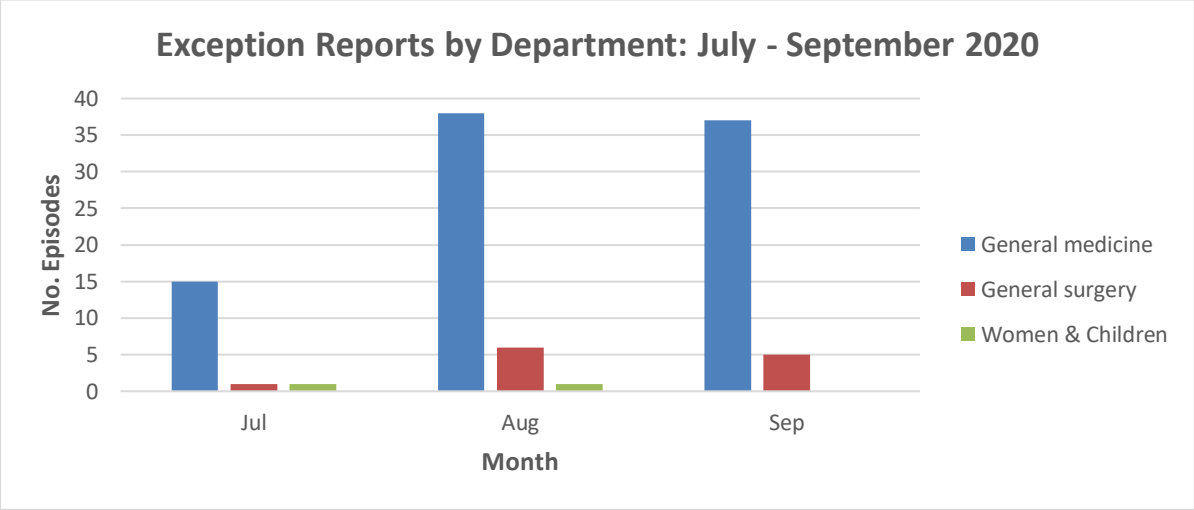
1. Exception reporting: 1st July – 30th September 2020

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	0	0	41	58
	F2	0	1	0	37	55
	GP/ST/CT	0	0	0	9	15.5
	ST3+	0	0	0	1	2
Surgery	F1	0	0	0	6	10
	F2	0	0	2	4	7.5
Woman & Child	FY2	0	0	0	1	1
	GP/ST/CT	0	0	0	1	2
Total		0	**1**	**2**	**101**	**151**

Exceptions reports by month and department



b) Work schedule reviews for period 1st July 2020 – 30th September 2020

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

The work schedules were reviewed in April and May by PGME, the College Tutors and Service Managers. The additional areas required by the updated T&C's for mandatory training and inductions have been added for the August intake.

2) Immediate Safety Concerns: 1st July 2020 – 30th September 2020

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 July 2020 – 30th September 2020

TABLE 1: Shifts requested between 1st July 2020 – 30th September 2020 by 'reason requested'

Locum Bookings by REASON REQUESTED								
Department	**Rota Compliance and Induction Cover**	**Leave (Annual, Carers, Study and Interview, bereavement)**	**Sickness and Reduced Duties**	**Extra**	**COVID-19 Additional Dependency**	**COVID-19 Self-Isolation**	**Vacancy**	**Grand Total**
Anaesthetics	1	10	1			2		14
Emergency Medicine	12	90	9	120	29		307	567
ENT	3			1	7		7	18
General Medicine	34	64	24	79	7	4	88	300
General Surgery	19	19	11	4	7		24	84
Obs & Gynae	2	5	16			1	16	40
Ophthalmology			3			1	6	10
Paediatrics	14	4	56			3	5	82
T&O							3	3
Urology		2		3				5
TOTAL	85	194	120	207	50	11	456	1123

TABLE 2: Shifts requested between 1st July 2020 – 30th September 2020 by 'Agency / In house fill'

Filled by NHS / Agency		
Department	**NHS**	**Agency**
Anaesthetics	14	
Emergency Medicine	449	118
ENT	18	
General Medicine	218	82
General Surgery	84	
Obs & Gynae	40	
Ophthalmology	10	
Paediatrics	64	18
T&O	3	
Urology	5	
Grand Total	905	218

4) Vacancies – 1st July 2020 – 30th September 2020

In July, the Trust ran on COVID rota's which utilised the doctors available.

HR has provided details of current junior doctor vacancies for August and September:

Department	Grade	August	September
Emergency Dept	ST3+	6	6
Emergency Dept	FY2	0	1
Anaesthetics	ST3+	1	1
Medicine	ST3+	3	2
Medicine	ST1-2	1	1
Paediatrics	ST4_	1	0
Total		**12**	**11**

5) Fines – 1st July 2020 – 30th September 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.

There have been no fines this quarter and the total breach fines paid by the Trust from August 2017 to date are £13,137.75. The Guardian Fund currently stands at £7,033.14.

Matters Arising

- There was a rise in exception reports in August and September. This was partially a result of new doctors joining the trust, some of whom had just graduated, some new to the UK and nearly all unfamiliar with our electronic records and how things are done in the trust. A couple of individual doctors were identified as struggling and these individuals have been supported both by their ward teams, their educational supervisors and myself.
- There have been two ER highlighting lack of support during service commitments. These were raised by one F2 trainee. I have met the trainee together with the CD and service manager for surgery and the HR manager. It was agreed that additional support should be provided out of hours. In the short term this would need to be additional locally employed doctors, but in the longer term the surgical team are hoping to develop a physicians associate role in general surgery.
- The junior doctors would like to thank the trust for the continued provision of free hot drinks 24/7 and free food at night. It has been confirmed that this will continue at least until the end of the financial year.
- They would also like to thanks the trust for agreeing to site a mess within the new ED build. This will provide a central point within the hospital for rest and socializing and is hugely welcome!
- There is a national directive to provide time within contracted hours for junior doctors to do audit/ portfolio work (akin to SPA time for consultants). This has been dealt with differently between WSH departments. The BMA has suggested that WSH is ahead of all other east of England trusts in trying to implement this. So far, no junior doctor has raised an exception report around this.
- The trust has appointed two new FTSU Guardians one of whom has contacted the JDF to speak at one of the junior doctor forums- thank you.

Appraisal and mandatory training update October 2020

Purpose

This paper provides the Board with the latest reported position in relation to staff appraisal participation and completion of mandatory training.

Appraisal

- The Trust appraisal compliance target is set at 90%; the September 2020 compliance figure is 74.09% a small increase on the figure reported in June 2020 (73.18%). See **Appendix A**.

- At the start of the pandemic managers were advised that appraisal should continue for non-medical staff when they and their staff had capacity for this. Where there is not the capacity the requirement to conduct at least an annual appraisal was suspended for the duration of the COVID-19 crisis. This position on non-medical staff appraisal will be reviewed again in September 2020.

- Appraisal is now paused until April 2021 for all consultants, SAS doctors and trust doctors with the exception of doctors whose validation was not up-to-date at the end of March 2020.

- An action plan is in place to support an increase in compliance. **See Appendix B**. The plan has been reviewed in light of the impact of COVID-19. The HR Business Partners will all be in post by early November and will work with divisional managers to support completion of appraisals.

Mandatory Training

- Whilst the expectation is that all staff are up to date in all domains of mandatory training, the Trust target is set at 90% (95% for Information Governance) compliance to make provision for staff who fall into the reporting period, but who are unable to undertake their training due to sickness or parental leave for example.

- The latest compliance figure as at the 8th October is 86%. See **Appendix C**.

- A mandatory training recovery plan was presented to the Board in January 2020. In March 2020 significant elements of mandatory training were paused due to the COVID-19 crisis and guidance was issued to managers and staff. In June 2020 the recovery plan was updated in the light of the impact of COVID-19. See **Appendix D**. This plan will continue to be updated as the situation develops.

- New ways of delivering mandatory training are being embraced. The Postgraduate Medical Education Team have had good success with TEAMS to provide fire training for both junior doctors and consultant medical staff for fire training and are exploring using it for blood transfusion. Conflict resolution training has also been provided virtually for staff.

- Evening and weekend sessions have been arranged for basic life support and manual handling. Sessions for community staff have been arranged at Stow Lodge in

Stowmarket. Ward based training is now taking place for both manual handling and resus. A move to single sessions has been introduced to maximise numbers on courses.

Denise Pora, Deputy Director of Workforce (Learning and Organisation Development)
Claire Debman-Smith, Workforce Development Manager
Emma Bell, Education and Training Co-ordinator

29th October 2020

Appendix A

Appraisal compliance September 2020 – Trust target 90%

Division	Total Assignments	Total Applicable Staff	Total Applicable Staff Expired	Total appraisals due within 3 months	Total New Starters	Total Maternity	Divisional Compliance Rate
Clinical Support Division	451	393	86	127	48	10	**78.12%**
Community Division	928	731	174	215	165	32	**76.20%**
Corporate Services Division	412	335	130	45	66	11	**61.19%**
Estates & Facilities Division	408	361	52	127	44	3	**85.60%**
Medical Division	1055	812	203	135	219	24	**75.00%**
Surgical Division	732	605	207	114	110	17	**65.79%**
Women and Child Division	321	263	55	38	45	13	**79.09%**
Trust total	**4307**	**3500**	**907**	**801**	**697**	**110**	**74.09%**

Appendix B – Appraisal Action Plan

Item	Requirement	Action	Update	Completion date	Responsibility
1	90% compliance for all areas within the trust	Dedicated support to those areas struggling to reach 90%	Workforce and HR provide individual support to those areas struggling to improve compliance, as well as executive support to improve take up. Paused due to workload increases resulting from COVID-19 pandemic and staff vacancies. Review September 2020. HR business partners to work with divisional teams from November 2020 onwards.	Paused – restarting November 2020	HR Business Partners
2	Improve the Trust system for recording appraisal meetings.	Implement ESR manger and supervisor self-service by 01.04.20	The trust is currently working towards ESR manager self – service, which will give all managers the responsibility to log appraisals for their own reports/ staff. This will remove the potential for appraisal information to be mislaid. Go live was due on 1.4.2020 but has been postponed due to the impact of COVID-19. A new go live date is to be agreed.	Paused	Deputy Director of Workforce (HR)
3	Overall compliance at 90%	Ensure all staff who are at work receive an appraisal on an annual basis	Implementation of agenda for change pay progression policy which will require all staff to have an up to date appraisal recorded on ESR. National decision made for implementation to be paused due to COVID-19.	Paused	Workforce Team HR
4	All appraisers have the required training to undertake appraisal meetings	Training is provided for all appraisers	Support managers/ appraisers with on-going delivery of both refresher and initial training sessions. Appraisal training is paused due to COVID-19. Training to be re-started and provided by e-Learning be available by 28.2.2021. Earlier provision of limited face-to-face training also being explored.	28.2.2021	HR and Education and Training Team
5	Encourage a culture of appraisal within the organisation	Raise the profile of appraisal compliance throughout the trust	Dashboard on appraisal compliance to be produced for green sheet, raising the profile of appraisals and positive reinforcement for good practice	On hold, pending outcome of other actions	Workforce Team Communications Team
6	Support Streamlining for junior doctors.	Engage with regional streamlining projects. Provide opportunities for mitigation where streamlining is not currently in place	Revision of induction timetable to include West-Suffolk specific mandatory training courses (complete) Work with Trusts across region to achieve best possible data transfer through Electronic Staff Record (ESR) system Utilisation of study leave for completion of any outstanding mandatory training modules within first 6-8 weeks (in place)	Green WSFT actions complete regional work paused	Medical staffing team and Medical Education Manager

Appendix C Subject Matter - High Level Mandatory Training Analysis September 2020

Row Labels	Match	No Match	Grand Total	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
179|LOCAL|Infection Control - Classroom|	2014	57	2071	96%	96%	97%	98%	98%	97%	96%	96%	94%	95%	96%	97%
179|LOCAL|Security Awareness|	4137	227	4364	92%	96%	96%	96%	95%	95%	95%	94%	94%	94%	95%	95%
179|LOCAL|Equality and Diversity|	4129	235	4364	92%	93%	94%	94%	94%	94%	93%	93%	93%	93%	94%	95%
NHS|MAND|Safeguarding Children Level 3 - 1 Year|	535	33	568	83%	84%	84%	84%	87%	90%	89%	88%	91%	90%	91%	94%
179|LOCAL|Major Incident|	4043	321	4364	87%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	93%
NHS|MAND|Safeguarding Children Level 1 - 3 Years|	3975	389	4364	93%	93%	93%	92%	92%	92%	90%	89%	90%	89%	90%	91%
179|LOCAL|Slips Trips Falls|	2598	262	2860	86%	86%	89%	87%	88%	88%	88%	89%	89%	89%	89%	91%
179|LOCAL|Blood Bourn Viruses/Inoculation Incidents|	2188	227	2415	88%	89%	89%	88%	88%	89%	89%	89%	88%	88%	89%	91%
179|LOCAL|Safeguarding Adults|	3950	414	4364	90%	89%	90%	90%	89%	90%	89%	88%	89%	89%	90%	91%
NHS|CSTF|Preventing Radicalisation - Basic Prevent Awareness - 3 Years|	3939	425	4364	90%	90%	91%	90%	90%	91%	89%	89%	89%	89%	90%	90%
179|LOCAL|Safeguarding Children Level 2|	3930	434	4364	92%	92%	91%	91%	92%	93%	90%	90%	90%	90%	90%	90%
179|LOCAL|Health & Safety / Risk Management|	3907	457	4364	91%	91%	92%	91%	91%	92%	90%	90%	89%	89%	89%	90%
179|LOCAL|Infection Control - eLearning|	2133	273	2406	91%	90%	91%	90%	90%	91%	88%	88%	88%	88%	87%	89%
179|LOCAL|Information Governance|	3867	497	4364	90%	91%	92%	93%	91%	91%	83%	84%	85%	84%	84%	89%
NHS|CSTF|Preventing Radicalisation - Prevent Awareness - No Specified Renewal|	2644	359	3003	83%	84%	87%	86%	85%	87%	87%	87%	87%	88%	87%	88%
179|LOCAL|Conflict Resolution - elearning|	908	137	1045	88%	88%	90%	90%	89%	89%	87%	86%	87%	87%	86%	87%
179|LOCAL|Fire Safety Training - Classroom|	3783	581	4364	90%	89%	90%	90%	90%	88%	86%	85%	85%	85%	86%	87%
179|LOCAL|Medicine Management (Refresher)|	1543	265	1808	86%	87%	87%	86%	87%	87%	87%	86%	86%	85%	84%	85%
179|LOCAL|Moving and Handling Non Clinical Load Handler|	306	55	361	73%	91%	94%	93%	93%	94%	90%	90%	86%	88%	87%	85%
179|LOCAL|Moving & Handling - elearning|	971	228	1199	81%	86%	86%	86%	85%	86%	84%	84%	85%	83%	82%	81%
179|LOCAL|Fire Safety Training - eLearning|	3360	1004	4364	87%	87%	89%	89%	88%	88%	81%	80%	78%	78%	77%	77%
179|LOCAL|Conflict Resolution|	1297	551	1848	76%	78%	77%	77%	76%	76%	76%	75%	73%	72%	72%	70%
179|LOCAL|Blood Products & Transfusion Processes (Refresher)|	1198	523	1721	75%	78%	78%	76%	77%	77%	75%	74%	72%	69%	68%	70%
179|LOCAL|Basic Life Support - Adult|	1588	1210	2798	82%	83%	87%	86%	85%	84%	74%	71%	63%	59%	57%	57%
179|LOCAL|Moving and Handling - Clinical|	1392	1080	2472	83%	84%	87%	87%	84%	84%	75%	72%	63%	58%	56%	56%

Appendix D – Mandatory Training Recovery Plan

Item	Requirement	Action	Update	Completion date	Responsibility
1	Review of Mandatory Training Subjects	Address increase of mandatory training compliance.	A full review of all mandatory training courses has taken place to ensure appropriateness and renewal period. All changes were managed in a safe, auditable way, placing patient and employee safety as the top priority.	Complete	Mandatory Training Steering Committee
2	Update OLM following Mandatory Training Review	Update ESR and staff records to reflect requirements	A full Trust review of mandatory training requirements needs to take place to ensure staff have the correct training assigned to them for their role. Paused due to increased COVID-19. Work due to restart in December 2020 to scope size of project and deadline.	Paused due to COVID-19	Education and Training Team
3	Improve access to e-learning modules	Implement necessary changes to server to improve access and usability of e-learning system.	The Education and Training team have worked with IT to find a solution to the issues that were being experienced with e-learning. The Education and Training team have transferred the majority of the eLearning packages onto Articulate and have a plan in place to ensure the outstanding modules are uploaded by 31 December 2020. Possible delay due to Issues accessing and updating modules whilst on the WSH site. This issue has been raised with IT.	31.12.2020	Education and Training Team
4	Support streamlining for junior doctors	Continue to engage with streamlining projects	Revision of induction timetables to include West-Suffolk specific mandatory training courses. Other streamline activities currently paused at regional level.	Complete	Lorna Lambert, Rota co-ordinators
5	Managers to have direct access to staff performance information including mandatory training	To implement ESR (Electronic Staff Record) Supervisor Self Service	Implementation plan agreed with full roll out planned by March 2020. Roll out put on hold due to COVID-19 impact. New implementation date to be agreed.	Paused due to COVID-19	Workforce Team HR
6	Community training data to be reviewed	It has been raised that some community data does not seem to be accurate within the ESR system and does not match local records, specifically from Paediatrics	Community Leads to provide the Education and Training Team with details of those records/individuals which do not match or are inaccurate in OLM. The Education and training Team to investigate and then update as appropriate.	31.12.2020	Education and Training team

Item	Requirement	Action	Update	Completion date	Responsibility
7	COVID-19 recovery plan – new starters (all staff excluding junior doctors)	Non-medical clinical induction including mandatory training elements continued during pandemic with shift to e-learning where possible	Changes have resulted in significant increase in workload for E&T team, rescheduling training and increased enrolment in e-learning, this will be on-going for the foreseeable future. Risk to approach caused by lack of capacity of facilitators and education centre capacity with social distancing result in significant reduction in numbers trained at workshops. Proposal to allow for increased numbers through 1m+ distancing with mitigating PPE declined by Strategic Group. Process in place to monitor e-learning completion by staff.	Complete	
		Trust induction elements of mandatory training – all converted to e-learning, except fire delivered as a face-to-face standalone session.	Trust induction to be set up as single certificated course – this will reduce administrative workload. Member of staff redeployed from Volunteers Service to be trained to support this. eLearning package to be put together by the education and training team.	31.12.2020	Education and Training Team
8	COVID-19 recovery plan – refresher training for non-medical clinical staff	Refresher training reduced to subjects requiring annual refresher for period August to December 2020 due to constraints of facilitator availability and social distancing requirements.	Face-to-face update mandatory training paused from 26 March to 31 July 2020 for all non-medical staff groups, excluding midwives. Refresher training for midwives recommenced in July 2020. Refresher training for other non-medical clinical staff recommences in August 2020.	Complete	Education and Training Team Departmental Managers
9	COVID-19 recovery plan – refresher training for non-clinical staff	Majority of training is e-learning. Face-to-face sessions will recommence in August 2020.		Complete	Education and Training Team Departmental managers
10	COVID-19 recovery plan senior medical staff	To review the consultant slide set	The consultants slide set needs to be reviewed and updated by the Education and Training Team.	31.12.2020	Education and Training Team with Deputy Medical Director
11	Review model of provision of non-	Develop new model for non-medical clinical mandatory training updates	The decision has been made that single sessions for mandatory training will carry on until at least	31.1.2021	Education and Training Team with

Item	Requirement	Action	Update	Completion date	Responsibility
	medical clinical mandatory training to ensure staff remain compliant but are not undertaking training more frequently than required.		March 2021. A new timetable will be presented at the December Mandatory training Steering Committee for discussion and approval.		Mandatory Training Steering Committee
12	Increase bank staff mandatory training compliance	To continue with monthly reporting and ensure action plans are agreed.	Following the bank mandatory training reports meetings will be held with all relevant department leads to discuss their action plans and identify any support needed.	31.1.2021	Education and Training Team with West Suffolk Professionals Manager and Medical Staffing Manager

14. Quality, safety and improvement reports

To APPROVE the reports

Presented by Susan Wilkinson

14.1. Maternity quality & safety performance report

For Approval

Trust Open Board – November 2020

Agenda item:	14.1			
Presented by:	Sue Wilkinson, Executive Chief Nurse/ Karen Newbury, Head of Midwifery			
Prepared by:	Karen Newbury – Head of Midwifery/Rebecca Gibson Compliance Manager			
Date prepared:	26th October 2020			
Subject:	Maternity quality & safety performance report			
Purpose:	X	For information		For approval

Executive summary:

This report presents a new document to enable board scrutiny of Maternity services and receive assurance of ongoing compliance against key quality and safety indicators.

This report contains:

- Maternity dashboard **(Annex A)**
- Maternity Safety Highlight Report incorporating CNST Maternity incentive scheme **(Annex B)**
- Other Maternity indicators including those incorporated elsewhere in board reporting schedule

- Staffing report (CNST requirement) **Minute the receipt (Annex C)**
- Evidence of the Maternity services methods of gathering user feedback and working with service users report (CNST requirement) **Minute the receipt (Annex D)**
- Perinatal Mortality Tool quarterly report for sign-off (CNST requirement) **Minute the receipt (Annex E)**

Maternity are working towards the development of a Quality and Safety approach supported by a strategy and improvement plan. This will be linked to the Trust overall quality plans (including the patient safety & learning and patient experience strategies) and will connect learning and actions within Maternity. As well as key safety, quality and performance indicators, this will incorporate clinical effectiveness and national best practice (NICE, RCOG publications, national and local audits, etc.) as well as a structured quality dashboard which is in the final stages of development to be shared in future reports. The draft strategy will be subject to consultation within Maternity and the wider trust safety, quality and experience teams.

Maternity dashboard

There are 85 indicators of maternity safety & quality which are regularly reported and reviewed at the monthly Maternity Governance meetings. A sub-set of these which make up the Performance data-set are provided as a board level performance Also attached as Appendices

Performance and Governance dashboard (see Annex A). It is proposed that these become part of the trust-wide IQPR in future months. Any performance variation requiring action or escalation of the wider data-set will be reported on an exception basis in future maternity performance reports to the board.

In September there were five indicators categorised as Red and six as Amber. Excluding number of births/babies the RAG rating is based on the National Maternity Perinatal Audit 2016/2017 data and does not reflect new guidance and practices, in particular Saving Babies Lives Care Bundle v2.

Indicators	Narrative
Total Women Delivered	This is variable month by month.

Total Number of Babies born at WSH Midwifery Led Birthing Unit (MLBU) Births	With the increased number of induction of labours this is affecting the number of women eligible to birth in the birthing unit
Total number of Instrumental Deliveries	This is an isolated variance from previous months.
Inductions of Labour (ex pre-labour & twins)	With the full implementation of SBLCBv2 and an increase of gestational diabetes this is to be expected.
Grade 1 Caesarean Section (Decision to delivery time met)	All non-compliant cases reviewed. This reflects one case that was recorded as a grade 1 however treated as a grade 2. All present at review felt this was a grade 2 section and therefore did meet the decision to delivery time standard
Midwife to birth ratio	High staff absence due to COVID
1 to 1 care in labour	This relates one woman who was an inpatient on the antenatal ward who progressed quickly and therefore did not receive 1 to 1 care until she was urgently transferred to labour suite.
Supernumerary Labour Suite Co-ordinator	Current process for capturing data subjective and does not explain rationale/length of time. Birthrate+ acuity tool training complete and to 'go-live' 1st October to capture meaningful data.
Unit Closures	There were staff shortages however the escalation policy was followed and additional midwives called in from the community. Acuity and number of women resulted in the decision to close the unit. 4 women were redirected to another unit in this time-frame.
Completion of Who Checklists	The main area of non-compliance was the signature out, majority surgeons. Emails sent to all non-compliant individuals.

CNST Maternity incentive scheme

Now in its third year, the maternity incentive scheme supports the delivery of safer maternity care through a '10 steps to safety' framework underpinned by an incentive element to the trust's contributions to the CNST (clinical negligence scheme for trusts). Updated 30th September 2020 with revised submission dates and additional requirements. See Annex B Maternity Safety Highlight Report for current performance against the 10 indicators.

Local audit / monitoring

Currently a report is submitted monthly to the CQC for the indicators highlighted within the Section 29A letter. Compliance has been high and any areas of non-compliance have been addressed and documented within the report. Results from October 2020 report;

- MEOWS observation overall compliance rate was 99% however there is a slight reduction in compliance for labour suit triage and ward F11. This is reflective of the department challenges due to high acuity and reduced staffing levels this month, however the ward managers are monitoring by taking an active role in the audit process and discussing any non-compliance with individual staff members.
- Pain scores were 100% compliant in all areas.
- NEWTT scoring has dropped from 100% to 98% compliance. Ward managers are monitoring and actioning as above.
- Domestic abuse questions in the antenatal period are 97.5% complaint however in the postnatal period has dropped to 90% compliance. Team leads are monitoring and discussing non-compliance with individual staff members.
- Smoking status recorded at 36 weeks was 74% compliant. One team consistently achieves 100% compliance and will share their approach with all other teams to achieve the overall standard.

Other Maternity indicators including those incorporated elsewhere in board reporting schedule

- Maternity safe staffing report – Quarter 1&2. See Annex C

The midwifery establishment meets the recommendations of the nationally recognised BirthRate Plus tool. Due to internal promotion there are still some vacancies, however due to recent successful recruitment this have been filled we are just awaiting start dates.

Labour Suite co-ordinator supernumerary status requires a methodical process for collating the data. BirthRate Plus acuity tool has been purchased and training commenced. Due to go-live in October.

1:1 Care in labour compliance monitored monthly and any non-compliance is investigated. 5 women in April 2020 did not receive 1:1 care in labour due to not attending the unit due to COVID. 1 woman in September 2020 did not receive 1:1 care, she was an inpatient on the antenatal ward who progressed quickly and therefore did not receive 1 to 1 care until she was urgently transferred to labour suite. All other months 100% compliance was achieved.

Midwife to birth ratio- BirthRate Plus recommends 1:27.7, National Standard is 1:28. In July and September 2020 we exceeded this ratio due to staffing shortages relating to COVID. All other months in Quarter 1& 2 the standard was met.

Red Flags in relation to midwifery staffing are monitored on a daily basis via the maternity safety huddle. The reasons for Red Flags were as follows:

- 6 delays in continuation of induction of labour due to high activity on labour suite
- 2 delays in performing category 2 emergency caesarean section
- 1 delay in transfer to theatre for repair of 3rd degree perineal tear.
- 1 unit closure requiring 4 women to have their care diverted to the Norfolk and Norwich University Hospital Trust.

Planned versus actual midwifery staffing levels is recorded on E-Roster however until the templates are correct this will not provide accurate data. Action in place to review and amend staffing templates.

Specialist Midwives in post constitutes to 9% of the total midwifery workforce which is in line with BrithRate Plus methodology.

- Maternity serious incidents in September - 0

These are normally reported in the closed board 'serious incidents, complaints, claims and inquests' report on a monthly basis. This includes details of the incident, duty of candour status and whether it is reportable to the HSIB or for local investigation. There were no SIs reported in Maternity in September.

- HSIB

The trust participates in HSIB reviews of care according to the national definitions. There are currently two WSFT HSIB Maternity investigations. Two draft reports have been received by the trust an MDT meeting has taken place to discuss any safety actions and findings. Both have met the criteria of a serious incident reportable to STEIS. There is currently an action plan for all the HSIB reports (which were received earlier in 2020) and update is provided quarterly in the board quality & learning report.

- Participation in national clinical audits

MBRRACE Saving Lives, Improving Mothers' Care – Rapid report: Learning from SARS-CoV-2--related and associated maternal deaths in the UK – Baseline assessment is in progress and action plan to follow.

- Evidence of the Maternity services methods of gathering user feedback and working with service users. See Annex D

  Overview of the standards given.

  Evidence required has been met.

  Compliance with standards all met except the remaining actions from the CQC patient survey which are being addressed in the month of September.

- Learning from incidents / learning from deaths

The learning from Maternity serious incidents are included within the quarterly open board 'quality & learning' report and this report will, in future, also include self-assessment against the findings and recommendations of HSIB reports received (for WSFT local cases or country-wide maternity thematic reports). In addition, standalone subject-specific reports have been reported upon in the past.

- Perinatal Mortality Review Tool (PMRT) Report see Annex E

The report outlines the details of perinatal deaths occurring within the Trust and the reviews and actions

of these from July 2020-September 2020 and includes previous ongoing investigations from Quarter 1.

Outstanding investigation reported in Quarter 1 was an early neonatal death under HSIB investigation – draft report received 21st September 2020. Multi-disciplinary team meeting was held on 5th October 2020 to discuss the safety recommendations and findings and develop an action plan.

Summary of Perinatal deaths reported in Quarter 2 – one Intrauterine death at 32 weeks gestation on the 28th August 2020. This case did not meet the HSIB reportable criteria. Local investigation ongoing until post-mortem report is completed. Initial findings from multi-disciplinary meeting identified two actions however neither of these would have changed the outcome.

- CCG/NHSE/I Assurance Visit

Assurance visit 25/09/2020 had a very positive outcome with a number of elements able to be evidenced as moving into business as usual. Report of recommendations and subsequent improvement plan to be presented in next month's report.

- NHSI – Improvement Officer Mai Buckley appointed to the WSFT for Maternity. Mai will be supporting the team in meeting all of the concerns/actions raised by the CQC.

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:	Women's Health Governance
Risk and assurance:	
Legislation, regulatory, equality, diversity and dignity implications	

Recommendation:
The Board to discuss content

Annex A – Maternity dashboard

	Green	Amber	Red	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Total Women Delivered	>208 or <216	>216 or <208	> 224 or <2 00	178	180	187	174	183	202
Total Number of Babies born at WSH	>208 or <216	>216 or <208	> 224 or <2 00	179	182	190	175	187	204
Twins		No target		1	2	3	1	4	2
Homebirths	2.5%	2% or less	Less than 1%	5 2.8%	7 3.9%	5 2.7%	3 1.7%	2 1.1%	6 3%
Midwifery Led Birthing Unit (MLBU) Births	≥20%	19- 15%	14% or less	3 1.7%	12 6.7%	26 13.9%	22 12.6%	20 10.9%	27 13.4%
Labour Suite Births	77.5%	69% - 74%	68% or less	170 95.5%	161 89.5%	154 82.4%	149 85.6%	161 88%	169 83.7%
Total Caesarean Sections	<26.%		> 22.6%	34 19.1%	36 20%	56 29.9%	46 26.4%	43 23.5%	48 23.8%
Total Elective Caesarean Sections	11%	>11% -13%	13% or more	14 7.9%	14 7.8%	23 12.3%	14 8%	20 10.9%	20 9.9%
Total Emergency Caesarean Sections	14.3%	14.4%-14.9%	15% or more	20 11.2%	22 12.2%	33 17.6%	32 18.4%	23 12.6%	28 13.9%
Total Instrumental deliveries	12% - 14%	>14% - 15%	> 15%	9.6%	10.6%	7.0%	8.6%	11.5%	14.9%
Inductions of Labour (ex pre labour & twins)	<31%	>31% -32.9%	>33%	39.9%	35%	32.6%	36.2%	39.3%	38.1%
Grade 1 Caesarean Section (Decision to Delivery Time met)	100%	96 - 99%	95% or less	100%	100%	100%	100%	100%	91%
Grade 2 Caesarean Section (Decision to delivery time met)	80%	76 - 79%	75% or less	57%	81%	67%	95.4%	78%	83%
Postpartum Haemorrhage 1500 mls or more	<3.5%	3.5% - 3.8%	> 3.8%	1.7%	1.1%	8%	4.0%	2.7%	2.5%
Shoulder Dystocia	2	3-4	5 or more	3	7	4	4	5	2
Total women delivered who breastfed babies with first 48 hours	>80%	75-80%	<75%	76.7%	72.8%	78.4%	71.4%	79.2%	82.2%
1 to 1 Care in labour	100%	96-99%	95% or less	97.4%	100%	100%	100%	100%	99.5%
Supernumerary Labour suite co-ordinator	100%			100%	100%	No data	84%	74%	Insuff data
Midwife to birth ratio	1:30		1:32 or more	1:26	1:26	1:27	1:30	1:27	1.31
Completion of WHO checklists	100%	90%	80%	No data	No data	93%	96%	96%	90%
Unit Closures	0		1	0	0	0	0	0	1

Annex B – Maternity Safety Highlight Report for October 2020 (September data)

Maternity Safety Highlight Report

Trust: West Suffolk NHS Foundation Trust | September data | Date: 16/10/2020

10 Steps-to-safety	
1	Perinatal review tool
2	MSDS
3	ATAIN
4	Medical Workforce
5	Midwifery Workforce
6	SBLCB
7	Patient Feedback
8	Multi-professional training
9	Safety Champions
10	Early notification scheme

SBLCB V2	
1	Reducing smoking
2	Fetal Growth Restriction
3	Reduced Fetal Movements
4	Fetal monitoring during labour
5	Reducing pre-term birth

CQC MUSTs
Monitoring ambient room temperatures in drug rooms
Monitoring of women's records/audited monthly
Carbon monoxide monitoring in line with trust policy
Women asked about domestic violence in line with trust policy
Observation tool for women attending triage on labour suite and the MDAU
Implement a national monitoring vital observation tool for new born babies on labour suite and F11
Carry out daily checks of resuscitation equipment
Clinical guidelines are up to date

Number of	
Serious Incidents this month	On-going SI's
0	2
DATIX	Outstanding DATIX
57	4
Out of date guidelines	
3	

ANNEX C – NHS Resolution Maternity Incentive Scheme
Safety Action 5: Midwifery Staffing

Report Title	Can you demonstrate an effective system of midwifery workforce planning to the required standard?
Report for	Approval and Information
Report from	Maternity Services
Lead for Safety Action	Karen Newbury – Head of Midwifery Chris Colbourne – Maternity Advisor
Report Author	Chris Colbourne – Maternity Advisor
Date of Report	12th October 2020
Submitted to:	Head of Midwifery for Divisional Review 19th October 2020

The purpose of this report is to provide evidence and give board assurance that work undertaken and being undertaken within the maternity service demonstrates progress towards meeting safe staffing standards within the midwifery service.

An action plan that outlines the required activities to achieve the objectives of Safety Action 5 is contained in Appendix 1 of this report. This action plan will be monitored at the Women's Health Governance Group and Divisional Board and reports will be presented for discussion and ratification at the meetings held in October 2020? and April 2021. The report and action plan will then be submitted for inclusion on the Trust Board agenda in November and May where progress will be overseen and monitored.

Background

In 2015, The National Institute for Health and Care Excellence (NICE) published the guideline Safe Midwifery Staffing for Maternity Settings (NG4). This document was developed in response to findings from key national enquiries into care in England in particular the Francis report (2013) and Keogh Review (2013). Updated in 2019, the guideline aims to improve maternity care by giving advice on monitoring staffing levels and actions to take if there are not enough midwives to meet the needs of women and babies in the service. The guideline covers safe midwifery staffing in all maternity settings including at home, in the community, in hospital inpatient and outpatient settings, irrespective of whether care is led by midwives or obstetricians.

Written to be used by all staff involved in the provision of maternity care, the guideline offers recommendations in relation to required organisational needs, on setting the midwifery establishments, how to assess the difference between the number and skill mix of midwives needed, the number of midwives available, ongoing monitoring and evaluation of midwifery staffing requirements.

In 2018, NHS Resolution introduced a maternity incentive scheme to support the delivery of safer maternity care, comprising of a total of 10 Maternity Safety Actions. Safety action 5 focusses on midwifery staffing and asks if the Trust can demonstrate an effective system of midwifery workforce planning to the required standard. This report responds to that question by providing detail of the minimum evidential requirements needed to meet this standard. These include information on:

- BirthRate Plus assessment, including any action plans and progress arising from any identified deficits.
- Status of the labour suite co-ordinator in relation to being supernumerary.
- Provision of 1-1 care in labour.
- Midwife to birth ratio
- Monitoring of Red Flags in relation to midwifery staffing.
- Details of planned versus actual midwifery staffing levels.
- The BirthRate intrapartum acuity tool (app)
- Details of the specialist midwives employed.

1. BirthRate Plus assessment

A full BirthRate Plus (BR+) assessment was completed in April 2019 which demonstrated the actual funded establishment of clinical midwives was in line with their recommendations. Within the BR+ report, it highlights that staffing in smaller maternity units may require senior management to set minimum staffing levels to safely staff all clinical areas.

Following Care Quality Commission inspection, the Trust have invested significantly in maternity services, by increasing the establishment of Band 7 midwives. The impact of this is described in more detail in sections 2 & 7 below.

The overall funded establishment for midwifery services in 2020/21 is **110.21** WTE midwives, including specialist and managerial posts.

The breakdown by clinical area and grade of midwife is as follows:

Midwifery Establishments 2020/21					
	Band 8	**Band 7**	**Band 6**	**Band 5**	**TOTAL MW**
Community Midwifery		4	28.58	1.27	33.85
Total Community		**4**	**28.58**	**1.27**	**33.85**
Ante Natal Clinic	0	0.8	3.24	0	4.04
Hospital Midwifery	0	16.92	33.33	8.92	59.17
Midwifery Management	3	8.4	1.75	0	13.15
Total Hospital	**3**	**26.12**	**38.32**	**8.92**	**76.36**
GRAND TOTAL	**3**	**30.12**	**66.9**	**10.19**	**110.21**

To validate the funded establishment against the minimum staffing levels, an exercise has been undertaken to ensure the number of midwives employed is sufficient to staff all clinical areas. The calculations, based on required minimum staffing levels, does enable safe staffing to be deployed, providing all vacancies are filled.

ACTION: The funded establishment against vacancies will continue to be monitored monthly via the current vacancy control processes. Recent recruitment has been successful, with the service attracting new Band 6 and 5 midwives which has filled all current vacancies.

2. State of the Labour Suite Co-ordinator in relation to being supernumerary

Safer Childbirth (RCOG 2007) states that each labour ward must have a rota of experienced senior midwives as labour ward shift co-ordinators, supernumerary to the staffing numbers required for 1:1 care to ensure 24-hour managerial cover. It defines their role as being pivotal in facilitating communication between professionals and in overseeing appropriate use of resources. The role of labour suite co-ordinator is nationally recognised as being at Band 7.

Supernumerary status of the labour suite co-ordinator is defined as the co-ordinator not having a caseload. Anecdotal evidence revealed supernumerary status was not being achieved by the service in 2019 with subsequent investment in Band 7 labour suite co-ordinators being supported by the Trust Board. In total, an additional 5.8 WTE Band 7 for labour suite has been funded and appointed into.

Monitoring of the supernumerary status of the labour suite co-ordinator has been slow to get established. Review of the bleep holder role is being undertaken with plans to make this role more accountable for monitoring operational safety and quality elements of the service.

Was the Labour Suite Coordinator Supernumerary? Standard = 100%			
Date	**Yes:**	**No:**	**% compliance**
April	30	0	100%
May	31	0	100%
June	No data		
July	27	4	84%
August	23	8	74%
September	No data		

The methodology for collating the supernumerary status of the labour suite co-ordinator has always been subjective and is reliant on opinion rather than factual information. With the introduction of safety huddles, the status is now discussed amongst the team, but remains skewed and is not robust.

The service has faced significant challenges because of staff absences and shielding of staff due to Covid-19. Whilst a Band 7 labour suite co-ordinator has been on every shift, the supernumerary status has not been guaranteed. This was particularly difficult in September with a number of staff having to self-isolate because of potential Coronavirus in their homes.

The BirthRate Plus app for acuity has been trialled and funding agreed. Training has taken place with the teams and will commence, this more robust data collection on staffing and acuity, in October 2020. This will include supernumerary status of the labour suite co-ordinator.

ACTION: Implementation of BR+ acuity app in Q3. Monitoring of staff in post against funded establishment to continue monthly alongside proactive vacancy management.

3. Provision of 1:1 care in labour

NICE published a Quality Statement on 1:1 care in 2015 (QS105 Intrapartum Care; updated 2017) which states that women in established labour have 1:1 care and support from an assigned midwife. Established labour is defined as the presence of regular painful contractions and progressive cervical dilatation from 4cm. For service providers, 1:1 care in labour means that a woman in established labour is cared for by a midwife who is just looking after her. She might not have the same woman for the whole labour, but the service needs to ensure there are enough midwives on duty every 24-hour period to enable this to happen.

Monitoring of this standard is undertaken using the maternity clinical information system Euroking. Midwives enter the information as part of their delivery records and this information is collated monthly and reported on the service dashboard.

Did women receive 1-1 care in labour? Standard = 100%			
Date	**Yes:**	**No:**	**% compliance**
April	173	5	97.4%
May	180	0	100%
June	187	0	100%
July	174	0	100%
August	183	0	100%
September	202	1	99.5%

Compliance for the 12 months from April 2019 to March 2020 was 100%.

ACTION: 1:1 care in labour compliance will continue to be monitored monthly through Euroking and reported on the service dashboard.

4. Midwife to birth ratio

The monthly midwife to birth ratio is calculated using information from both e-roster for staffing and Euroking for activity.

The Head of Midwifery undertakes responsibility for this, with the calculations being based on the actual number of midwives working rather than the funded establishment. This is the most accurate way of calculating the true midwife to birth ratio as it enables adjustments to be made for vacant posts, staff on long-term sickness and maternity leave. Likewise, midwives employed for additional hours or on a bank contract are included to formulate a realistic measure of the number of available midwives. This is then measured against the actual births each month and reported on the service dashboard. The figure will fluctuate month on month, due to activity and availability of midwives.

The BirthRate Plus funded establishment gives an overall achievable ratio of 27.7 births to 1 WTE MW. The service has set a ratio of 1 WTE to 28 births as the standard to be achieved, which is in line with national standards.

MW to Birth Ratio Standard = 1:30	
Date	**Ratio**
April	1:26
May	1:26
June	1:27
July	1:30
August	1:27
September	1:31

The increase in establishment has had a positive effect on the ratio. During 2019/20 the ratio was above 1:28, in 8 months out of 12.

ACTION: The MW to birth ratio will continue to be monitored and reported monthly on the service dashboard. In September, there was a high number of staff absence due to COVID, and therefore this is reflected in the midwife to birth ratio for this month. Recruitment for bank midwives has occurred to assist with any further increase in midwife absence.

5. Monitoring of Red Flags in relation to midwifery staffing

Red Flags in maternity services are defined as ‘warning signs that something may be wrong with midwifery staffing’. The Red Flag incidents associated with maternity services are as follows:

RED FLAGS relating to midwifery staffing:
Delayed or cancelled time critical activity
Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing)
Missed medication during admission to hospital or MLBU
Delay of more than 30 minutes in providing pain relief
Delay of 30 minutes or more between presentation and triage
Full clinical examination not carried out when presenting in labour
Delay of two hours or more between admission for induction and beginning process.
Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)
Any occasion when one midwife is not able to provide 1:1 care in established labour
Unable to facilitate women's choice of birthplace
Labour suite co-ordinator not supernumerary.

Number of Red Flags reported each month	
Date	**Number**
April	0
May	0
June	3
July	4
August	2
September	1

The reasons for Red Flags were as follows:

- 6 delays in continuation of induction of labour due to high activity on labour suite
- 2 delays in performing category 2 emergency caesarean section
- 1 delay in transfer to theatre for repair of 3rd degree perineal tear.
- 1 unit closure requiring 4 women to have their care diverted to the Norfolk and Norwich University Hospital Trust.

Red Flags are currently discussed and recorded at the daily safety huddle. Actions taken to mitigate and escalate are documented and the team ensure reporting via the Datix system has taken place. Care is reviewed by the risk team to assess impact and identify trends.

ACTION: Red Flags will continue to be monitored through the daily safety huddle until the implementation of the BirthRate Acuity App when the Red Flags will be reported through this tool. Datix will continue to be submitted with themes and trends monitored and highlighted by the midwifery risk team.

6. Details of planned versus actual midwifery staffing

The service currently publishes the daily record of number of staff on duty against the minimum staffing levels expected in each clinical area. This data is not retained. E-Roster gives more detailed information on the numbers of staff on duty, absences, and unfilled shifts but accurate data extraction from E-Roster is currently not possible because there are flaws in set up of the rules and templates.

ACTION: Review rules and templates on E-Roster to enable the system to generate accurate reports on planned versus actual staffing levels. The service should move towards having report production with accurate data by Q4.

7. The BirthRate Plus intrapartum acuity tool (app)

The maternity service currently has no formal system for recording acuity. Options have been explored in recent months to determine the most effective and efficient way of measuring this and the BirthRate app was considered the most suitable option. Many maternity services have implemented this app and funding has been agreed to implement at West Suffolk.

The BirthRate intrapartum app will determine the acuity of the service. Acuity is described by BirthRate Plus as ‘the volume of need for midwifery care at any one time based on the number of women in labour and their degree of dependency’. Data on women’s clinical need and the number of available midwives is inputted into the system every 4-hours by the labour suite co-ordinator or the unit bleep carrier.

A positive acuity score reassures the service that the staffing is adequate to meet the clinical needs of the women on labour suite at that time, with a negative score highlighting potential issues that will need action and possible escalation. Additional advantages of the BirthRate app will give information on the supernumerary status of the labour suite co-ordinator as well as collecting data on the Red Flags.

Whilst the BirthRate app will not provide information on all elements of activity and staffing on labour suite, it will give the service managers clearer insight than is currently available. Trends in activity will be identifiable and the live information from the app will support early intervention and escalation, with the potential of safer staffing levels and availability of robust evidence.

ACTION: Training of labour suite co-ordinators and those senior midwives undertaking the bleep carrying role undertaken in September, with implementation from October 2020. Training of champions for the app in each clinical area to provide support function also planned.

8. Specialist Midwives in post

The Trust have invested in the number of specialist midwife posts which not only brings the service in line with other services, but also enable the quality and safety function to be more responsive and effective. The service now has strengthened its risk team, added to the practice development function which will impact positively on training across all professional groups and established a bereavement midwife post.

The service now has the following Band 7 specialist midwives:

- 1.20 WTE antenatal and newborn screening midwives (2 x 0.60)
- 1.80 WTE practice development midwives. (1 x 1.00, 1 x 0.80)
- 1.80 WTE risk midwives. (1 x 1.00, 1 x 0.80)
- 1.00 WTE clinical effectiveness midwife
- 0.80 WTE bereavement midwife
- 0.80 WTE MW for vulnerable women particularly with mental health issues (funded externally)
- 0.60 WTE safeguarding midwife.

The funded establishment totals 8.40 WTE.

1.2 WTE Band 7 establishment has been reserved to support the PMA function of the service once the midwives have completed their training later in 2020. A part-time post of diabetes specialist midwife is currently being developed.

The Band 6 specialist midwives comprise:

- 0.60 WTE infant feeding midwife
- 0.40 WTE fetal monitoring MW
- 0.80 WTE smoking cessation midwife externally funded for one year.
- 0.60 WTE Clinical Practice Facilitator (funded by HEE)

The funded establishment totals 1.75 WTE.

All specialist midwives and clinical mangers will have a clinical component to their role contributing to the care of women. How this is attributed, depends on the role function, and contracted hours the specialist MW works and is discussed and agreed between the specialist MW and their line manager. This needs to be managed fairly and equitably, to ensure the specialist function of the midwives' roles is not eroded. Specialist MW will also contribute to the service escalation plan at times of heightened activity and acuity.

When taking this into consideration, the pure management element of their roles, constitutes 9% of the total midwifery workforce, which is in line with BirthRate Plus methodology.

ACTION: The service will continue to monitor the roles of specialist MW at WSH and make recommendations for change or additional posts as clinical care indicates. The escalation policy will be reviewed to ensure it reflects current practices and staffing levels.

9. Conclusions

The maternity service has taken steps to ensure the recommendations from the BR+ report have been analysed and actions have been taken to address the findings.

There is a need to embed the monitoring processes to ensure information on staffing levels, vacancies, acuity, safety and workload are recorded accurately and in a timely way. This will enable themes and trends to be identified and acted upon.

The introduction of Continuity of Carer will change current practices significantly. Future monitoring will need to ensure new systems and processes are monitored robustly to ensure safe standards of care and safety are maintained.

ANNEX D

Maternity Incentive Scheme
Ten Maternity Safety Actions

Report Title	Report for Safety Action
Report for	Approval and Information
Report from	Maternity Services
Lead for Safety Action	Karen Newbury – Head of Midwifery Beverley Gordon – Project Midwife West Suffolk Maternity Voices Partnership
Report Author	Beverley Gordon – Project Midwife
Date of Report	10/09/20
Submitted to:	Head of Midwifery for Divisional Review 10/9/20

10. Report Title:
Evidence of the Maternity services methods of gathering user feedback and working with service users

11. Purpose of the Report
To provide evidence of user involvement in developing the maternity services.

12. Background

Year 3 - Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Required standard:
User involvement has an impact on the development and/or improvement of maternity services.

Minimum evidential requirement for Trust Board:
Evidence should include: Acting on feedback from, for example a Maternity Voices Partnership.
User involvement in investigations, local and or Care Quality Commission (CQC) survey results.
Minutes of regular Maternity Voices Partnership and/or other meetings demonstrating explicitly how a range of feedback is obtained, the action taken and the communications to report this back to women.

Validation process:
Self-certification to NHS Resolution using the Board declaration form.

What is the relevant time period?
From Friday 20 December 2019 until Thursday 17 September 2020

What is the deadline for reporting to NHS Resolution?
Thursday 17 September 2020 12 noon

Evidence Required
Minimum evidential requirement for Trust Board evidence should include:

• Use of Care Quality Commission National Maternity Survey results

• Terms of Reference for your Maternity Voices Partnership

• Minutes of Maternity Voices Partnership meetings demonstrating explicitly how feedback is obtained and the consistent involvement of trust staff in coproducing service developments based on this feedback

• Evidence of service developments resulting from coproduction with service users

• Written confirmation from the service user chair that they are being remunerated for their work and that they and other service user members of the Committee are able to claim out of pocket expenses

Notes

Technical guidance
What is the Maternity Voices Partnership?
A Maternity Voices Partnership is a multidisciplinary, NHS working group for review and co-production of local maternity services. For more information see:
• Implementing Better Births, Chapter 4 and Appendix B.
• National Maternity Voices

We are unsure about the funding for Maternity Voices Partnerships
Maternity Voices Partnerships can be organised/funded through commissioners and in such circumstances, there is no need for duplication by providers (although trust participation is still required).

13. Compliance with Standards

Evidence Required	WSH compliance	Progress Report	Evidence Source
Use of Care Quality Commission National Maternity Survey results.	Partially	CQC report received but no actions confirmed as at 10/9/20	Action Plan being addressed – few actions are outside of maternity remit.
Terms of Reference for your Maternity Voices Partnership.	Yes		Integral to the Annual report from NVP and updated
Minutes of Maternity Voices Partnership meetings demonstrating explicitly how feedback is obtained and the consistent involvement of trust staff in coproducing service developments based on this feedback.	Yes		Minutes received, MVP meetings currently suspended. Facebook page active.
Evidence of service developments resulting from coproduction with service users.	Yes	15 step and survey reports seen but no evidence of actions	15 steps actions discussed at MVP meeting 5/8/20.
Written confirmation from the service user chair that they are being remunerated for their work and that they and other service user members of the Committee are able to claim out of pocket expenses.	Yes		Received 26/5/20

14. Conclusions

The West Suffolk MVP is very active in supporting women and the services led by the Trust. The meetings are well attended with a number of lay members as well as WSH staff attending.

Some actions from the surveys and reviews of services during the 15 steps have been delayed due to disruption during the pandemic management within the Trust. These are now being reviewed and progress made where possible. There is a commitment by all to be responsive to the needs of women and their families during pregnancy, childbirth and in the postnatal period.

During the Covid-19 crisis, members were pivotal in continuing to provide support on-line and by phone to any woman and their family needing this. MVP meetings have been recommenced as lockdown has been eased and they are being held virtually.

15. Recommendations

- Review all actions from surveys and 15 steps in order to respond to input from users if at all possible.
- Continue to offer virtual attendance at MVP meetings as an alternative to face to face attendance.
- Complete further 15 steps reviews in all clinical areas once safe to do so – possibly February 2021, one year since last review.
- Process of review of results and formulation of action plan if required to be formalised to 6 weeks after results received. The report and actions should be submitted to Women's Health Governance Group for approval to presentation at Divisional Board and then Trust Board – either through Patient Experience Lead/meetings or the HoM monthly reports to the Board. There should also be evidence that these are presented at MVP meetings with monitoring of any actions overseen by this group.
- Complete update report on compliance with this Safety Action (7) in February 2021

16. Action Plan

Action plan lead	Name: Karen Newbury	Title: Head of Midwifery	Contact:

Recommendation	Actions required	Action by date	Person responsible	Comments/action status
1. Review actions from CQC survey to ensure these have been completed	Review actions taken as a result of the CQC survey and monitor progress against these.	31/10/20	Gill Walsh, Interim Matron	In progress
2. Review all actions from surveys and 15 steps in order to respond to input from users if at all possible.	Table action plans from surveys at Governance group meetings and ensure responses are presented at MVP meetings	On-going	Karen Newbury	Agenda and minutes reflect monitoring of progress on actions.
2. Continue to offer virtual attendance at MVP meetings as an alternative to face to face attendance.	Terms of reference include attendance at meetings by all methods	31/12/20	MVP chair and meeting facilitator	Minutes and Terms of Reference reflect change to this.
3. Complete further 15 steps reviews in all clinical areas once safe to do so – possibly February 2021, one year since last review.	Monitor progress of actions from February 2020. Schedule next review February 2021	28/2/21	MVP chair Karen Newbury	
4. Process of review of results and formulation of action plan if required to be formalised to 6 weeks after results received. The report and actions should be submitted to Women's Health Governance Group for approval to presentation at Divisional Board and then Trust Board – either through Patient	Develop/update SOP or strategy to indicate standards for responding to assessments and reviews	31/12/20	Clinical Risk & Governance Team in Division and Trust	

	Experience Lead/meetings or the HoM monthly reports to the Board. There should also be evidence that these are presented at MVP meetings with monitoring of any actions overseen by this group.				
5.	Complete update report on compliance with this Safety Action (7) in February 2021	Update this report	28/2/21	Karen Newbury and Clinical Risk & Governance team in the Division	
6.	Complete actions from the LMS Women's survey during Covid19 lockdown.	Implement changes required as a result of the women's survey of views during the Covid 19 pandemic.	31/12/20 – update actions and monitor progress	Midwifery Matrons	

14.2. Infection prevention and control assurance framework

For Approval

Board of Directors – 6 November 2020

Item no.	14.2			
Presented by:	Sue Wilkinson Exec Chief nurse			
Prepared by:	Rebecca Gibson – Compliance Manager			
Date prepared:	October 2020			
Subject:	Infection prevention and control assurance framework			
Purpose:		For information	x	For approval

Executive summary:

This report provides a monthly update on the progress to achieve compliance with the NHSE ICT COVID-19 board assurance framework. It sets out progress since the September meeting.

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:	IPC task & finish group
Risk and assurance:	As per attached assurance framework
Legislation, regulatory, equality, diversity and dignity implications	NHSE
Recommendation: Receive this report for information	

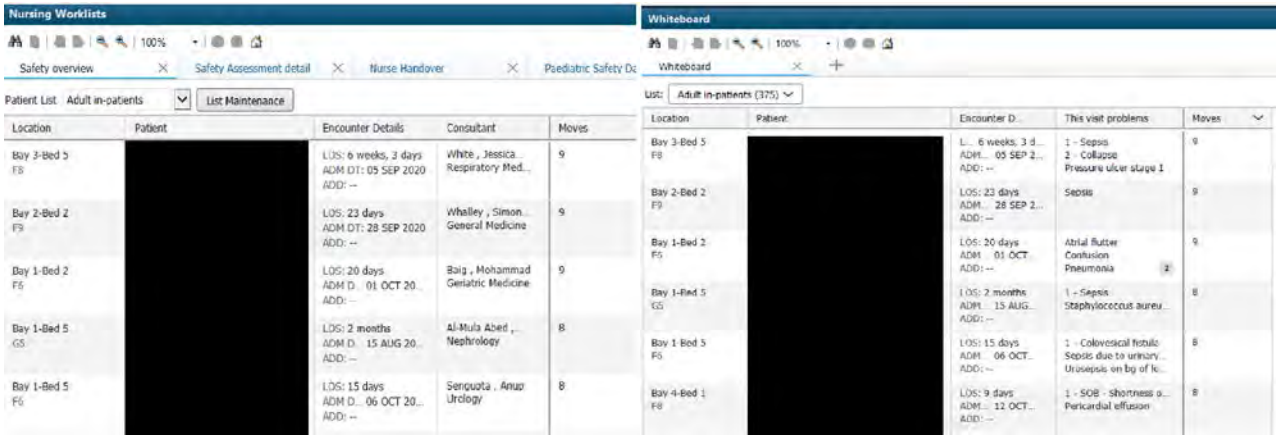
NHSE/I Infection prevention BAF

Patient moves

From a COVID-19 BAF perspective the requirement is *1.2 patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission*

The reduction in excessive / unnecessary patient moves has also been highlighted through recent SI reports, as a theme in learning from deaths reviews and as a concern in complaints. There is a current ongoing safety improvement project looking at the wider aspects of patient moves.

eCare now captures and records the number of patient moves (see screenshots below) on the safety dashboard and the whiteboard. This does include in ward moves (i.e. between bays).

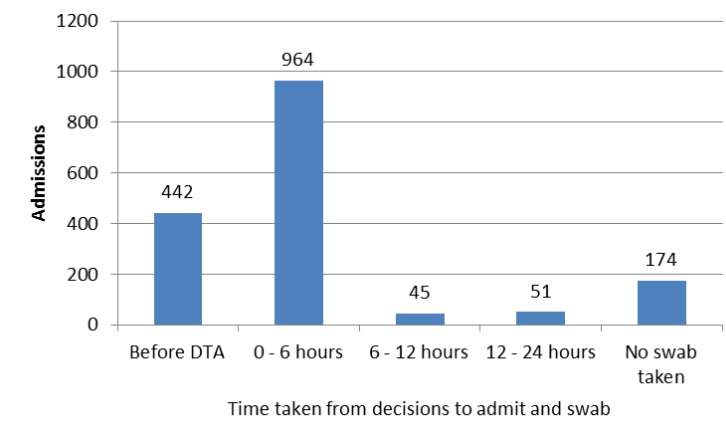


The system is not currently able to report totals (e.g. patients in September who have had >5 moves during an inpatient stay). It does however provide a source of information for staff to prevent excessive individual patient moves when looking to manage timely bed-flow.

There is a patient safety & quality table-top review of ward moves scheduled for November and a more detailed update on the project will be provided within the November board quarterly quality & learning report.

Timely taking of swabs

This chart shows the data for September admissions from A&E arrivals and contains the time between the decision to admit (DTA) to the time of the patient's swab in minutes.



84% of patients had a swab taken within 6 hours of the DTA including 26% whose swab was taken prior to the DTA.

Of those 51 patients whose swab was taken > 12 hours after DTA, none were confirmed as COVID-19 positive. Only one of the 45 patients whose swab was taken between 6 – 12 hours had a positive COVID-19 swab (an F11 patient).

Further review needs to be undertaken on those patients who did not have a swab taken to understand the reasons for this.

Ref	Quality standard	Key lines of enquiry	Compliance	How would we evidence this?	Gaps in assurance	Mitigating actions
1.1	1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users	infection risk is assessed at the front door and this is documented in patient notes	Compliant	1. ED Signage is in place processes have been in place since January 20202. Surgery in place pre surgical checklist3. Maternity/EPAU - All women are asked the COVID symptom questions on the phone prior to admission. If the woman has any symptoms she is admitted to one of the Labour Suite single rooms. It is documented on a Triage form4. (if not admitted via ED) F14 woman are assessed over the phone and if any symptoms the site manger would be informed.		
1.2		patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	Compliant	Whiteboard amendment made to enable tracking and exception reporting for out-of-hours moves or >3 moves. Patient flow policy describes process. [Sept update] eCare records moves although this cannot be run as an exception or monthly assurance report at this time. A table-top review is planned in November as part of the wider 'reducing unnecessary patient moves' project		
1.3		compliance with the national guidance around discharge or transfer of COVID- 19 positive patients	Compliant	Documented local guidance Evidence of updates from national guidance Notes from strategic meeting Daily staff COVID briefing		
1.4		all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	Compliant	1. PPE trained. Mask training records available2. Access to PPE. Stock levels of all COVID areas that are checked twice daily between 8am and 9am and then between 4pm and 5pm by Purchasing. Purchasing daily records of available PPE, including issues and stock levels		
1.5		national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	Compliant	Minutes of tactical command central repository and initiate through tactical command meeting. Posters & online training sessions ad hoc as required and always when an area is designated Covid 19 affected		
1.6		changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	Compliant	Report into Scrutiny NED Covid briefing open closed board		

Ref	Quality standard	Key lines of enquiry	Compliance	How would we evidence this?	Gaps in assurance	Mitigating actions
1.7		risks are reflected in risk registers and the board assurance framework where appropriate	Partial	Examples of current risk register entries: Management of outbreaks and cases of infection in the Trust (15), Keeping staff and visitors safe from Healthcare acquired infection (HAI) (184), Conducting clinical tasks on pts, thereby increasing the risk of hospital acquired infections to pts, staff & visitors (189), Impact of Managing COVID-19 (Coronavirus) on Trust business as usual activity (4168)	Not all elements of the BAF fully described in risk assessments	Currently in progress. On completion, compliance status will move to Full
1.8		robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	Compliant	IPC Manual (in date with no guidelines outstanding).RCA reports of other infections (e.g. Cdiff)		
2.1	2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	Compliant	All Covid affected/designated areas are orientated and trained prior to accepting patients. Head of nursing for Medicine and Infection Prevention Team conducted a multi-disciplinary meeting / training with staff prior to an area becoming 'COVID Affected 'Posters / information available in clinical areas. Many processes follow existing Infection Prevention guidance and policies. Daily FFP3 mask fitting sessions provided to address those who did not attend the team meeting / training		
2.2		designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to COVID-19 isolation or cohort areas	Compliant	Housekeeping training records Can be subject to spot check audit		
2.3		decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	Compliant	policies / procedures in place which comply with national guidance		
2.4		increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	Compliant	cleaning records / audits demonstrate compliance with at least twice daily cleaning, more if required		

Ref	Quality standard	Key lines of enquiry	Compliance	How would we evidence this?	Gaps in assurance	Mitigating actions
2.5		attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas	Compliant	cleaning records / audits demonstrate compliance with at least twice daily cleaning, more if required		
2.6		cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	Compliant	cleaning records demonstrate cleaning with chlorine base products as per national guidance		
2.7		manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products	Compliant	Adherence to manufacturers guidance		
2.8		'frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and contaminated with secretions, excretions or body fluids when known to be	Compliant	cleaning records / audits demonstrate compliance with at least twice daily cleaning, more if required		
2.9		electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily	Compliant	All undertaken by housekeeping (and when required clinical team) except staff's personal mobile phones and tablets.		

Ref	Quality standard	Key lines of enquiry	Compliance	How would we evidence this?	Gaps in assurance	Mitigating actions
2.10		rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	Compliant	cleaning records in conjunction with respective staff groups for appropriate timing of cleans		
2.11		linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	Compliant	All areas have alginate bags for infectious linen and staff are aware of the process to add an outer linen bag. Portering staff will not remove alginate bags alone		
2.12		single use items are used where possible and according to single use policy	Compliant	Single use items are purchased as a priority by the purchasing department as a standard for the Trust. Where a reusable item is required there is a process for establishing the protocol for this		
2.13		reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance	Compliant	Single use items are purchased as a priority by the purchasing department as a standard for the Trust. Where a reusable item is required there is a process for establishing the protocol for this		
2.14		review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission	Partial	Not all areas have forced ventilation and therefore rely on natural ventilation via windows being open	Air circulation minimal, Restrictors on windows in place as per safety risk assessment	No fans in any waiting areas. Windows open Bars (allowing wider window opening) being trialled

Ref	Quality standard	Key lines of enquiry	Compliance	How would we evidence this?	Gaps in assurance	Mitigating actions
3.1	3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	arrangements around antimicrobial stewardship are maintained	Compliant	Antimicrobial Pharmacist reports: End of year CQUIN report, Antibiotic annual strategy, Electronic training packs for AMS + gentamicin + vancomycin, all of which as well as other antimicrobial guidance is available on the hospital formulary, AMS proposals have been written and awaiting Consultant Microbiologist approval, AMS Nurse champions, Pharmacist led AMS ward round, PCT – this will most likely adapt given the COVID pandemic, Urgent AMS and antimicrobial matters are discussed with a core group within AMG remotely for urgent approval, All antibiotic guidelines on the pink book are up to date, Antimicrobial considerations have been discussed in the COVID trust guideline. Microguide, All pink book guidelines are matched on Microguide. All changes to the above will be accompanied by appropriate comms to relevant practitioners. Some mandatory training sessions are going to be recorded for people to access from home.Reporting recommencing for Q2		
3.2		mandatory reporting requirements are adhered to and boards continue to maintain oversight	Compliant	See 3.1		
4.1	4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support	implementation of national guidance on visiting patients in a care setting	Compliant	Copy of guideline which has been developed in line with the changes to National Guideline on visiting. SOP publicised to staff in patient areas		
4.2		areas in which suspected or confirmed COVID-19 patients are being treated are clearly marked with appropriate signage and have restricted access	Compliant	Signage in place for the Covid areas Additional signage available should ward area allocation change in the future		
4.3		information and guidance on COVID-19 is available on all trust websites with easy read versions	Compliant	On trust website		

Ref	Quality standard	Key lines of enquiry	Compliance	How would we evidence this?	Gaps in assurance	Mitigating actions
4.4	or nursing/medical care in a timely fashion	infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	Compliant	Transfer document eCare record		
5.1	5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people	front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection, as per national guidance	Compliant	Signage, Evidence of working processes in place		
5.2		mask usage is emphasized for suspected individuals	Compliant	Masks are provided for patients if they do not have one. Mask signage in place and masks available for all at all entrances to hospital buildings		
5.3		ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff	Compliant	Screens are being placed on reception desks		
5.4		for patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible	Compliant	Previously reported as partially compliant now moved to full. Isolation achieved through cohorting on dedicated ward (or side room on specialty ward if required). Patient and Visitor Test and Trace SOP in place		
5.5		patients with suspected COVID-19 are tested promptly	Compliant	All suspected patients are tested. Clinical care records and swab dates		
5.6		patients who test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced	Compliant	Patients with suspected Covid are moved to a Covid affected area. Bays are closed and contacts identified and tested. Bed flow and clinical care records record this		

Ref	Quality standard	Key lines of enquiry	Compliance	How would we evidence this?	Gaps in assurance	Mitigating actions
5.7		patients who attend for routine appointments and who display symptoms of COVID-19 are managed appropriately	Compliant	Patients are asked if they have symptoms on arrival and advised to return home and request a swab if the appointment is non urgent and rebook.		
6.1	6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection	all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	Compliant	Each area has access to the guidance and posters are in place both demonstrating the correct processes, advising on top tips and links to the guidance. Areas are trained on a rolling programme when designated as Covid areas Presentation from Infection Prevention Team and Head of Nursing for Medicine to discuss COVID and the challenges that this posed. Question and answer session provided / FFP3 Mask Fitting / Donning and Doffing training and posters / RAG rating posters to establish individual area risks to support practice / Social distancing		
6.2		all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation, and on how to safely don and doff it	Compliant	FFP3 Mask Fitting / Donning and Doffing training records		
6.3		a record of staff training is maintained	Partial	Training records are kept for induction and mandatory training (both of which cover infection prevention) and the data is reported as a standard. Mask training records also available	COVID training in Mar-June did not have records maintained though attendance numbers were good in all cases	All future training sessions to have attendance records taken
6.4		appropriate arrangements are in place so that any reuse of PPE in line with the CAS alert is properly monitored and managed	Compliant	through policies and procedures		

Ref	Quality standard	Key lines of enquiry	Compliance	How would we evidence this?	Gaps in assurance	Mitigating actions
6.5		any incidents relating to the re-use of PPE are monitored and appropriate action taken	Compliant	Datix incident reporting system		
6.6		adherence to PHE national guidance on the use of PPE is regularly audited	Compliant	audits		
6.7		staff regularly undertake hand hygiene and observe standard infection control precautions	Compliant	Audit data		
6.8		hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	Compliant	Hand dryers in public toilets only. Estates have turned them off & Put up 'Out of Order Notices. Estates have put up hand towel dispensers & HK's will manage topping paper towel dispenser		
6.9		guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	Compliant	Posters on hand hygiene are available in all toilets		
6.10		staff understand the requirements for uniform laundering where this is not provided on site	Compliant	Regularly highlighted in the daily briefing. Posters are in changing areas to highlight the actions staff need to take if ensure (pictorial as well as text).		
6.11		all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance, if they or a member of their household displays any of the symptoms	Compliant	Regularly highlighted in the daily briefing spot check audits		

Ref	Quality standard	Key lines of enquiry	Compliance	How would we evidence this?	Gaps in assurance	Mitigating actions
7.1	7. Provide or secure adequate isolation facilities	patients with possible or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	Partial	Within the limits of the estate areas are designated in order of greatest ability to comply with the guidance. F7 the only acute ward with doors to bays and the greatest number of single rooms is the acute Covid ward. G4 furthest away from any other ward area and a stand alone facility is the other Covid affected ward.	As described in RR15 risk assessment	Single rooms prioritised according to risk of infection; duty IPN workload. Side room lists occupancy lists completed daily circulated Sheeting provides barrier to bays
7.2		areas used to cohort patients with possible or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	Compliant	SOP for designated cohorting arrangements		
7.3		patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Compliant	as per trust policies		
8.1	8. Secure adequate access to laboratory support as appropriate	testing is undertaken by competent and trained individuals	Compliant	spot audit / training records		
8.2		patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	Compliant	All admitted patients are swabbed at the point of admission either on ED or AAU. We can now evidence this by asking Information team to pull a number of patients on a particular date and the date they initially had a swab. [Sept update] Data for September shows good compliance within a 6 hour timeframe		

Ref	Quality standard	Key lines of enquiry	Compliance	How would we evidence this?	Gaps in assurance	Mitigating actions
8.3		screening for other potential infections takes place	Compliant	Screening for other organisms remains as per National Guidance and in line with the guidance issued to ensure sufficient laboratory time available for Covid 19 Some restriction of micro lab processing however this is in line with the RCOPath guidance		
9.1	9. Have and adhere to policies designed for the individual's care and provider organisations that will help prevent and control infections	staff are supported in adhering to all IPC policies, including those for other alert organisms	Compliant	Alert organisms are identified by the Laboratory and the Microbiologists and flagged to the Infection Prevention Nurses and entered onto the IPN lab queue for action The electronic patient record includes Flag/alert for historic alert organisms. Out of hours the Microbiologists will action. Trust has obtained ICNET once installed this will make alert organism tracking more robust		
9.2		any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	Compliant	Daily staff briefing COVID tactical meetings (minuted)		
9.3		all clinical waste related to confirmed or possible COVID-19 cases is handled, stored and managed in accordance with current national guidance	Compliant	Orange stream infectious waste is the predominant waste stream for the Trust and therefore compliant		
9.4		PPE stock is appropriately stored and accessible to staff who require it	Compliant	Purchasing review all areas daily to ensure that PPE is in the correct store. Trust Resource Group meet weekly to oversee and Lead attends Tactical		
10.1	10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection	staff in 'at-risk' groups are identified and managed appropriately, including ensuring their physical and psychological wellbeing is supported	Compliant	Central held copies of risk assessments and list of all staff to confirm RA have been done		
10.2		staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	Compliant	training record		

Ref	Quality standard	Key lines of enquiry	Compliance	How would we evidence this?	Gaps in assurance	Mitigating actions
10.3		consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance	Compliant	Matron of the day records and monitors staff movement between areas across the organisation		
10.4		all staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	Compliant	assurance / walkabout visits assurance visits need to be set up all staff are made aware through communication		
10.5		consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	Compliant	assurance visits/ staff questioning		
10.6		staff absence and wellbeing are monitored and staff who are self-isolating are supported and able to access testing	Compliant	Many examples of how this is in place. Interviews with staff and/or the teams supporting them can provide additional assurance Clinical psychologist and team now fully recruited with extra staff in post (team structure available)		
10.7		staff who test positive have adequate information and support to aid their recovery and return to work	Compliant	See 10.6		

14.3. Improvement programme board report

For Approval

Trust Open Board – 6 November 2020

Agenda item:	14.3			
Presented by:	Sue Wilkinson, Executive Chief Nurse			
Prepared by:	John Connelly, Head of PMO			
Date prepared:	25 October 2020			
Subject:	Improvement programme board report			
Purpose:		For information	X	For approval

The Improvement programme board meeting, held on **12th October 2020**, considered the following:

- Receive and consider reports from senior responsible officer (SRO) cluster groups. This included approval of issues escalated from the groups and proposed changes to the improvement plan
- Review the updated improvement plan - the version received was updated based on the approved changes from the cluster groups (**Annex A**)
- Consideration of additional items to be added to the improvement plan – none were identified at the meeting but it was agreed to develop a simple process to support this going forward
- Reviewed the forward plan

A summary of key issues and outcomes from the meeting include:

Five change requests submitted for approval at October IPB were approved including:

- Moving two plans from Amber to Green (Plan 27 - Clinical Guidelines in Maternity & Plan 31 – Competing and Recording Pain Assessments)
- Moving one plan from Red to Amber (Plan 3 / 4.3 – Incident Reporting).
- Extending project end date for Plan 15 – ED Resuscitation Equipment & Medication Checks by one month to 31.10.20 as there are slight delays given changes to IT support staff
- Plan 18 (Local inductions for Bank and Agency staff) reverts to the original 31.12.20 end date as there are no training interdependencies with Mandatory Training

An additional five plans were moved from Complete (Black) to BAU (Blue) at October IPB based on the reporting update following the co-produced Maternity Review in September. The plans moving to BAU (Blue) include:

- Plan No 21: Maintaining women's records
- Plan No 23: Domestic violence questions
- Plan No 25: New Born's monitoring vital observations tool
- Plan No 26: Resuscitation Equipment checklists in Maternity

Maternity Plan No 22 cannot move to BAU as the actual test for Co2 monitoring is still on hold nationally due to Covid-19, as this is an aerosol generated procedure. Plan No 24 (Vital observations tool for women) will require further assurance before progressing to BAU.

- Karen Newbury received high praise from the visiting assessors for her work in the Maternity department

- A favourable draft interim internal audit programme report was received and presented at IPB with two minor management actions, including IPB approval of the Improvement Plan and updating the Terms of Reference with the agreed IPB Membership.

- A final management action to introduce a Consideration Log had was addressed before October IPB. A Cross Cutting Log (presented in Appendix 5 in the IPB Pack) was approved by IPB to ensure wider relevant improvements are made across the organisation based on lessons learned elsewhere.

- An action was taken to identify the divisional Triumvirate Leads by the next IPB meeting in November which will enhance the cross cutting / lessons learned improvement process

- BAU Plans will also be reviewed on a quarterly basis via IPB to ensure improved standards are maintained

- Metrics will be agreed by the IPB regarding measurable outcomes from the organisation's cultural development work in Plan 1.

A Medicines Management review would be undertaken at the Trust on 20th October, adopting the same co-production approach with the CCG. A reporting update will be presented at the November IPB

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	X	X	X	X
Previously considered by:							
Risk and assurance:							
Legislation, regulatory, equality, diversity and dignity implications	See individual references throughout the document						

Recommendation:

1. Note the report and contents
2. Approve the updated Trust improvement plan (Annex A)

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale
1	The trust must take definitive steps to improve the culture, openness and transparency throughout the organisation and reduce inconsistencies in culture and leadership. To include working relationships and engagement of consultant staff across all services.	1. Implement Trust-wide staff engagement project to elicit feedback to inform decision-making, including establishment of a BAME Staff Network. 2. Establish an executive team development programme, including 360. 3. Utilise the medical engagement scale to better understand and support improvement for the factors underpinning clinical engagement. 4. Establish a staff psychological support service to enhance well-being support for our teams. 5. Provide an organisational development update to the Board.	Stephen Dunn	Jeremy Over	Green	**30.11.20**	**Update 12.10.20: Plan remains on track to complete Nov '20. key actions presented below (1 - 9) in response to stated improvement actions.** **1. 'What Matters to You' captured feedback from over 2,000 staff with 5 key themes arising. Shared Trust-wide through Green Sheet on 4.9.2020.** **2. Draft People Plan for WSFT incorporating WMTY, Just Culture and national People Plan developed and shared at TEG on 5.10.2020. To be shared widely for feedbac during October, for approval at next Trust Board.** **3. Board Development programme in place; proposal for next steps with Chair. Revised Executive Director objectives for 2020/21 to be agreed this month including 36 feedback process.** **4. Plan for M.E.S in place. Intention to do this in partnership with BWLG who have raised queries that ideally need to be resolved prior to launch.** **5. Staff Psychological Support service established and operational. Recruitment to expand the team in progress. Feedback from service fed into culture plans. Progr shared with ICS who want to learn from our model and approach as part of a wider system-wide bid for resources.** **6. BAME and Disabled staff networks set-up. Comms support to improve profile in place. Annual E&D report to TEG and Board in September.** **7. 4xHRBPs recruited and commencing during period Sept-Nov 2020, aligned to clinical divisions.** **8. Workforce director report submitted to Board with positive feedback on 2.10.2020 with further feedback sought for development of format** **9. Plan submitted to H.E.E. detailing actions to respond to the concerns raised by the review.** **Other Updates via SRO Cluster and Planning Reviews:** **- Merseycare NHS Trust presented their 'Just and Learning Organsation' findings at the 5 o'clock club. We have reserved ten places on the next training programme in November.** **- HR Business Partners recruited to support cultural improvemt with review and implementation of HR policies that is consistent.** **- The detail of the improvement actions has been enhanced following feedback from CQC.** **- 2020 national NHS staff survey launched this month. Concern re. survey 'fatigue' coming quickly on the heels of WMTY.** **- Weekly COVID workforce and staff support engagement meeting continues to meet** **- Medical Director leading on clinical director role development**
2	The trust must ensure the culture supports the delivery of high quality sustainable care, where staff are actively encouraged to speak up raise concerns and clinicians are engaged and encouraged to collaborate in improving the quality of care.	1. Recruitment a new Lead Freedom to Speak Up Guardian, who in turn will develop a network of Speak Up ambassadors. 2. Implement lessons learned from external review of whistle blowing matters	Stephen Dunn	Jeremy Over	Green	30.11.20	**Update: 07.10.2020:** **1. Interviews for FTSU Guardian completed 11.08.2020. Amanda Bennett & James Barrett appointed. Publicised in Green Sheet 2.10.2020. AB commenced 1.10.2020, J 01.11.2020. Contact arrangements in place.** **2. Further Speak Up plans and improvements detailed in separate project plan within IPB pack.** **3. External review in progress. Information gathering phase still ongoing.** **4. Proposal for the future oversight and governance arrangements for workforce and culture to be developed, to include option of a WSFT People Board, mirroring ICS Regional arrangements.** **5. Staff consultation programme undertaken to support Pathology transfer. Dedicated HR support in place.** **6. Anaesthetics team have fed back to execs following consideration of report's recommendations. Execs to discuss this and further supportive actions on 07.10.2020.** **7. Task and Finish Group to enhance support for staff in stressful times established. Plans to elicit feedback from staff to inform the action plan.** **Other Updates via SRO Cluster and Planning Reviews:- The detail of the improvement actions has been enhanced this month following feedback from CQC.**
3	The trust must ensure that processes for incident reporting, investigation, actions and learning improve are embedded across all services and that risks are swiftly identified, mitigated and managed. The trust must ensure that incident investigations and root cause analysis are robust and that there are processes for review, analysis and identification of themes and shared learning.	1. Review of current incident pathways and their compliance to highlight areas for improvement. Include the outcome of this review in the design of new pathways as an integral element of the implementation of the Patient safety & improvement framework (PSIRF) 2. Ensure all divisions are supported to achieve these outcomes through the central patient safety / clinical governance team	Susan Wilkinson	Lucy Winstanley	Amber	31.12.20	**Update 12.10.20:** **Request to IPB is to approve the move the overall Plan RAG to Amber as work is progressing within constraints of:** **- National PSIRF programme** **- WSFT review of Patient Safety and Quality** **Expectation PSIRF document accounting for organisational changes complete 31.12.20** **1. Trusts Patient Safety and Learning Strategy document is on intranet - will be informed/updated with outputs from internal PS&Q review and Project Group** **- WSFT PSIRF Project group formed first meeting first week August 20.** **- Co-production with PSIRF being developed at ICS meeting in partnership with Trust.** **- Regional and National meetings have recommenced following Covid-19.** **- Heads of PS, Clin Gov, Human Factors, LfD and QI have established an internal informal forum and will continue to work closely together through structure review** **- Review of (non SI) incident pathways / addressing untimeliness of investigations is dependent on PSIRF work** **2. A PSIRP stakeholder consultation will be undertaken when draft is complete. There have been two PSRIP Project Group meetings and a third planned to develop the document which will need to be signed off via the Trust Board.** **- JD for divisional Governance Manager under review taking in to account divisional / service level requirement to support consistency ref: incident investigations, lear and improvement** **- PS, Human Factors, QI, LfD working together to establish framework for regular shared learning bulletins and events on track for Aug 20** **- PSIRF education, training to be rolled out**
4.1	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - clinical audit is monitored and reviewed to drive service improvement.	1. Review and define opportunities to improve the current organisational pathways for recording and reporting on local and national audit participation including consideration of a new bespoke audit information system. 2. Working with divisions, develop a structure to enable the inclusion of audit actions within wider divisional improvement plans 3. Widen the scope of clinical effectiveness to address all elements of national best practice including but not limited to NICE guidance, Royal college publications, HSIB and other national best practice publications	Nick Jenkins	Rebecca Gibson	Red	**31.12.20**	**Update 12.10.20:** **- Audit actions guide being trialled in maternity and will be rolled out to other divisions if successful.** **Completion of key corporate and divisional clinical audit programme actions subject to appointment of clinical effectiveness / audit facilitator and so the overall RAG r Red given the level of current assurance that the plan will be delivered within the current timeframe.** **- Clinical effectiveness / audit facilitator recruitment process ongoing.** Update: 07.09.20:Approval required from IPB to extend project completion date by three months as certain Clinical Audit actions are tied in with the wider Trust Quality & Patient Sa review which is taking longer to complete that was initially expected. - A co-production approach will be adopted going forward to deliver an agreed Patient Safety and Quality Governance structure at the Trust.

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4.2	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - mortality reviews are monitored and reviewed to drive service improvement.	1. Set up the National Medical Examiners service which will review all deaths and agree a reporting pathway into the trust for any cases requiring further review. 2. Supported by the appointment of a Learning from deaths (LfD) caseload manager; 3. Implement the LfD strategy including the specific action to streamline and centrally capture learning from local M&M reviews	Nick Jenkins	Jane Sturgess	Green	31.3.21	**Update 12.10.20:** **1. Medical Examiners service set up with agreed case transfer pathways in to Trust where cases require further review** **2. Medical Examiner's now in post. One MEO to be appointed to complete recruitment. LfD Caseload Manager interviews w/c 05.10.20.** **3. Embedded strategy will be evidenced by 3 - 6 month service evaluation given potential impact of Trust PS&Q review to further change pathways. Pathways, policies people are moving in to place in line with completion timeframe extended to March '21 given interdependency with QI team. However, processes in place and actions complete to ensure that mortality reviews are being monitored and reviewed to guide service improvement hence plan is green.** Request to IPB is to agree to an extension date to 31.03.21 as whilst there is a structured QI improvement plan progressing at pace, the support required to ensure a robust QI plan partly dependent on when it (the QI team) is fully recruited to, including recruitment for senior staff departing the central team. - ME to LfD case transfer pathway complete and under review re embeddedness - Preparing to go to advert for the LfD Team (Clinical reviewers) and Caseload Manager is advertised on NHS Jobs this week - Service evaluation embedding evidence being collected re implementation of LfD plan - Divisional leads discussing divisional governance for the M&M to LfD case transfer pathway / agree standard process. Pathway maybe subject to further change due to wider Trust safety and quality restructure and so BAU may extend to 6 months rather than 3. Pathway updates to go in to LfD policy by Dec 20. - PALS to LfD case transfer pathway progressing in September with meeting taking place this week between clinical lead and patient experience team and on track - Last appointed Medical Examiner starting 14.09.20. Recruitment is in progress for the final ME officer
4.3	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - incidents are monitored and reviewed to drive service improvement.	1. Through participation in the national pilot for the implementation of the Patient safety & improvement framework (PSIRF) design pathway for monitoring, investigation and review of outcomes from incident reporting 2. Implement the trust patient safety & learning strategy developed in 2019	Susan Wilkinson	Lucy Winstanley	Amber	31.12.20	**See No 3**
4.4	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - complaints are monitored and reviewed to drive service improvement.	1. Undertake NHSE&I patient experience framework assessments across the whole Trust 2. Review of divisional reporting of actions and learning from complaints, including accurate recording of service improvement linked directly to changes as a result of feedback	Susan Wilkinson	Cassia Nice	**Complete**	31.10.20	**Update 12.10.20:** **The overall RAG is expected to move to BAU (Blue) in November based on 3 months compliance data being collected in terms of attendance at divisional board meetin Divisional board minutes to be presented to PEC to demonstrate BAU.** **- The plan is to return to IPB in November with an ongoing BAU assurance plan e.g. review sample of learning and testing the implementation with divisions. The outpu form part of the quarterly report to PEC and IPB.** Update 14.09.20: - All actions complete - Team attending divisional board meetings to evidence BAU - Quaterly 'You Said/We Did' ward posters prepared to demonstrate engagement with patient feedback. There will be a running programme for these to be updated and displayed evidence ward-level service improvement, as a direct result of feedback.
5	The trust must ensure that effective process for the management of human resources (HR) processes, including staff grievances and complaints, are maintained in line with trust policy. To include responding to concerns raised in an appropriate and timely manner and ensuring support mechanisms in place for those involved.	The management of HR processes, including investigations, will be strengthened by embedding the following in practice: 1. Monitoring time lines for each case 2. Reviewing cases that are not progressing in a timely fashion, taking action where possible. 3. Actions to be recorded on the database and effectiveness reviewed at subsequent fortnightly Case Review meetings. 4. Escalate cases where there is a significant delay to the Executive Director of Workforce for review in regular meeting with Deputy Director of Workforce 5. Consider use of external investigators where there is a lack of internal investigatory resources 6. HR Policies will be reviewed to ensure a more kind and compassionate approach that is aligned to a 'just' culture.	Jeremy Over	Claire Sorenson	Green	**31.03.21**	**Update 12.10.20:** **- HR Business Partners are currently being appointed to lead on adopting and embedding kind, compassionate and inclusive processes and ways of working.** **- HR Business Partners will be aligned and support all divisions and corporate services across the Trust.** **- HR Business Partners will also support a planned review and development of HR policies to ensure they are written and advise kind and compassionate investigation which are followed by managers and leaders across the Trust** **[Policies for Review by January 2021: Disciplinary, Capability, Improving Health, Wellbeing and Attendance, Grievance, Bullying and Harassment, Freedom to Speak U Appraisals, Organisational Change]. Other policies will be identified for review in February and March 2021.** **- Merseycare HR policies received and will be reviewed as a benchmark for our own HR policies** **- Formulataion of an Investigation Toolkit is progressing and due to complete in November '20, utilising a working group.** **- The wider HR Team will support our managers to ensure delivery of compassionate and timely HR Investigations, effectively supporting staff through the investigatio process.** **- A training programme provided by Merseycare and Northumbria will take place in November** **- A pre investigation assessment process is currently being introduced to ascertain whether informal interventions and measures are taken rather than launching a forr investigation process.**
6	The trust must ensure that robust processes are embedded for patient follow up appointments and those on surveillance pathways. To include systems and process for regular oversight and assurance that patients are not being lost to follow up across all specialties within the organisation.	1. Design process for follow up booking 2. Recruit two new members of staff in TAC for all ward booking follow ups. Write SOP for Endoscopy. 2. Update all relevant Standard Operating Practices for Follow Ups and Surveillance. Write SOP for Endoscopy. 3. Identify and deliver any training needs within each specialty and Endoscopy 4. Design process for virtual surveillance booking of patients 5. Clinic Patients Missing Follow Ups - e-Care work 6. Prepare Communications piece for Green Sheet/Staff Briefing 7. Agree Go-Live date and communicate to all relevant parties	Helen Beck	Hannah Knights	Red	31.3.21	**Update 12.10.20:** **- Expectation is that the overall RAG will move to Amber at October SRO Cluster.** **Follow Ups:** **- 10/15 SOP's completed also identifying future improvements as part of an iterative process.** **- Use of Cymbio dashboard going well to capture patients who have not had an outcome from their clinical appointment from January 2019 to date.** **A weekly Outpatients Steering Group is reviewing the patients that were not outcome the previous week.** **-E Care Missing Follow Up's list being reviewed / additional resource being identified to complete within timeframe.** **This is mainly a DQ exercise in the first instance.** **Surveillance:** **- e-Care worklist for Surveillance Patients being trialled in vascular with a view to roll out to other services if successful.** **- Process to escalate overdue Surveillance will be presented at department meetings, divisional boards and weekly access meetings** **- No of Surveillance patients being held by services have been collected to establish impact of Covid-19 on surveillance pathways.** **- Prioritised SOP's in Urology and Vascular as identified in audit are complete pending approval** **Outpatients:** **- Options appraisal completed. The message centre pathway will remain with the secretaries when appointments cannot be booked at the time. Revised SOP in draft a be launched with training plan once SOP approved.** **Ward Follow Ups:** **- SOP complete awaiting final approval via Health Records Committee.**

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7	The trust must take definitive steps to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant.	The main themes from the actions plans are: 1. RTT Reporting – update to the reporting solutions to remove as many as possible of the manual workarounds within RTT reporting. Requires support from Cerner on technical fixes and testing by the WSFT Information Team. 2. RTT Training – working with users of the system and patient pathway trackers to ensure accurate information recorded relating to RTT pathways. 3. Data Quality – work to ensure there is a programme in the organisation to focus specifically on DQ. 4. Theatres Information – development of the initial theatres dashboard after end user pilot to version 2.	Craig Black	Nickie Yates	Green	31.12.20	**Update 12.10.20: No Update** **Update 07.09.20: Request IPB approval based on progress regarding collation of RTT training data and data quality work to move Plan 7 from Amber to Green based o 20 completion timeframe.** **- Next steps rationalise plan before next SRO Cluster'** Update 03.08.20: 1. RTT Reporting: workarounds with significant risk addressed - modifications built in to system hence relevant actions BAU (Blue). A bespoke e-learning package is being consider those still outstanding from Ideal Health. **Update 10.08.20: Workaround issues identified by CQC addressed so this element is BAU given that the actions have defined outcomes. [Blue]** 2. RTT Training: Remains amber. List of trained / not trained will be reviewed at next cluster and agree training compliance threshold. **Update 10.08.20: Plan is to bring data rega those requiring training and training delivered and set agreed compliance target at next cluster. Update 07.09.20: Accurate percentage of those trained from which BAI be determined not yet available but information is being gathered. Meeting 31.08.20 re producing new e-learning through external company to monitor compliance with training. Cut-down e-learning training versions produced for clinicians. Support for specialties needing more training taking place as 1-1s via MS Teams. [Green]** 3. Data Quality: Data Quality strategy going to IG Steering Group 05.08.20 and agreement is crucial to completing the action at which point the overall RAG for Plan No 7 can move Green and the embedding evidence will for the DQ Strategy will be required. **Update 10.08.20: Draft DQ strategy went to IGST which is the forum this work will progress. Up 07.09.20: Further engagement with key stakeholders required before returning to IGSG in October and then to TEG. End date Dec 20 so project is Green.** 4. Theatre Dashboard live and approved via Trust Board. Use of dasboard embedded so can move to **Blue**
8	The trust must continue to develop information technology systems and integration across the community services	1. Submit Business case for approval at Trust Board 2. Appoint Project Manager 3. Establish programme reporting governance to Digital Board 4. Undertake technical reviews at Community Sites 5. Undertake infrastructure upgrades including service migration, provision of laptops and remote access solution 6. Monitor programme delivery	Craig Black	Mike Bone	Blue	31.12.20	Update 31.07.20: Change Control: End date moved to 31.03.21 with additional item No 5 in MB Plan version 31.07.20 for IPB approval 10.08.20 Update 03.08.20: 1. Business Case approved at Trust Board in March 20 2. Project manager appointed 3. Programme Reporting to the Digital Board is now an embedded process 4. Reviews of technical requirements in Community completed 16.07.20 which can be evidenced. 5. Infrastructure upgrades have been signed off and are being implemented. 6. Programme delivery being monitored via Digital Board and key risks and mitigations identified including partner (NEL CSU) Community data storage/transfer. Move Plan 8 to Black. IPB approval required. Update 10/08/20: IPB approved move to Black as all CQC requirements have been met although it is acknowledged improvement of Community IT will be a permanently ongoing p **Update 10.08.20: The plan contains actions with defined outcomes in line with the agreed actions and these are already operational and so the IPB has agreed to move plan to Blue (BAU) whilst acknowledging that improvement and change in Community IT will be permanantly ongoing.**
9	The trust must continue to take action to improve performance against national standards such as the 18 week referral to treatment (RTT) standard, six week diagnostic standard ad access standards related to suspected and confirmed cancer management	1. Develop business cases for Orthopaedics, Ophthalmology, General Surgery and Gynaecology 2. Business Cases to include up to date demand and capacity models, outline plans and costings to reduce current backlog, whilst balancing demand to enable the services to meet the national standard. 3. Continue to update Action Plans for all other specialities on a monthly basis 4. Review and monitor plans at new RTT steering group meeting with the ADO's, Weekly Access Meeting and Cancer PTL Meeting 5. Develop comprehensive action plan for Endoscopy now demand and capacity exercise complete for review at new bi-weekly Endoscopy oversight meeting	Helen Beck	Hannah Knights	Red	31.3.21	**Update 02.09.20:** **Request to IPB is that Plan 9 is removed from list of plans reviewed in detail at IPB as the actions are no longer valid and the work is being covered in other forums. Otherwise the plan actions would need a complete rewrite to include activity monitoring, new action plans and remove the development of business cases (2).** **Updates discussed in 02.09.20 SRO cluster meeting:** **<u>Cancer</u>** **- System demonstration planned w/c 07.09.20 to develop cancer training strategy** **<u>Diagnostics</u>** **- Work continuing to assess the impact of new guidance on post polypectomy and post cancer resection surveillance guidance. Now reviewing patients due 2024** **<u>RTT:</u>** **-RTT Business Cases awaiting approval for CT, MRI, Endoscopy re Covide Recovery** **-RTT Action Plans will be revirewed in detail at the weekly access meetings from 09.09. Plan information including revised waiting lists, actions and risks to recovery.** **- Further amendments will be made to the RTT National Validation Programme participation information. First upload was completed 27.08 followed by contact with th national team 27.08. So far only a few records are coming back requiring additional validation.**
10	The trust must ensure that the duty of candour is carried out as soon as reasonably practicable, in line with national guidance	1. Continue to highlight key areas of non (or late) compliance via the IQPR and divisional performance reporting pathways. 2. Seek staff feedback on reasons for non (or late) compliance with DoC to identify opportunities for improvement using QI methods 3. Enable staff to fully achieve the remit of the Being Open framework through provision of training and support recognising that the patient / family conversations can be emotive and distressing both for the families but also the clinicians providing that message on behalf of the organisation	Susan Wilkinson	Lucy Winstanley	Red	31.12.20	**Update 12.10:20** **Plan subject to same constraints as Plan 3 with development of the Trust's Patient Safety and Quality Agenda.** **-- DoC Mandatory training and education will be provided for consultants, senior nursing staff, senior managers and executive directors regarding offering effective an empathetic apologies to patients and families where there has been harm or a serious incident as part of Trust wide safety education syllabus** **- Review of PS&L strategy now reflects data sources, training requirements and consideration of document through PSIRF** **- Registration of DoC Improvement Plan, Datix review and introduction of data in PRM all complete,** **- IQPR/compliance monitoring on track but not embedded** **- Matrons and CD meetings will be part of escalation mechanism** **- Daily briefings have been key in improving timeliness of completion / also reporting in PRM** **- DoC work is continuing. The actions are designed to improve what currently doing. Challenge is to understand how better to support staff to complete the DoC and th compliance is timely including complex patient groups and this is being addressed in the new strategy.** **Request to move to Amber will be subject to achieving agreed compliance levels.**

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11	The trust must ensure effective processes are in place to meet all the requirements of the fit and proper persons regulation	1. Put in place clear procedures that ensure full compliance with all FPP requirements and record keeping, including recruitment, ongoing declarations and appraisal. 2. Implement structured reporting and audit of compliance through the audit committee.	Jeremy Over	Angie Manning	Green	30.11.20	**Update 12.10.20:** **Internal audit complete. Currently awaiting auditor report. The completion timeframe is 30.11.20 at which time any actions in response to the audit should be complete the plan will move to Black.** Update 09.09.20: The request to the IPB is to agree to move the project end date to 30.11.20 from 31.08.20 at which point the plan should move from Green to Black as the interna auditors are on site to review the Fit & Proper Person processes that have been put in place. Time will be required for auditor feedback and to make any suggested changes to proc At that point the reporting structure to audit compliance through the audit committee can commence for a period to move the plan to BAU. Update 13.07.20: The small number of identified gaps within personal files have been of senior appointments have been rectified. Adequate processes are now in place. Assurance being undertaken for most recent executive (acting) and NED appointments Update 21.07: 1. Remaining action in plan to fully document recruitment process for NED's and Executives to be completed by 31.08.20. This requires a one month extension to be at IPB. 2. Process will be auditable from September 20 Update 10.08.20: extension approved at IPB; on track as above
12	The trust must ensure that mandatory training attendance, including training on safeguarding of vulnerable children and adults, improves to ensure that all staff are aware of current practices and are trained to the appropriate level	1. Build, review and implement the mandatory training recovery plan with tracking to ensure 90% compliance	Jeremy Over	Denise Pora	Amber	31.05.21	**Update 12.10.20: Multiple additional activities are in place to improve Mandatory Training compliance including Moving and Handling, Resuscitation and Conflict Resol for both Acute and Community staff. The e-learning opportunities have been capitalised but there are still risks regarding room capacity and a greater staffing capacit with winter approaching. The divisions will be engaged with the diverse training offer and compliance rates monitored to enable staff to take the required time off to complete their mandatory training.** Update 09.09.20: Compliance slightly down on last month. Mandatory training requirements have increased due to additional winter pressure recruitment and additional provision bei made. This is exacerbating existing capacity issues (facilitators and accommodation). Exploring options for new ways of delivery including OOH and external providers. Issues of st attending at short notice and courses running under capacity being addressed via MTSG.
13	The trust must ensure staff complete patient risk assessment to identify patients at risk of deterioration and risk assessments for day to day care activities.	Put eCare change requests in place to amend: 1) Changes to triage form, mandate safeguarding concerns yes/no box 2) Changes to triage form, mandate falls history/risk of yes/no box, to then generate ED falls assessment if yes ticked 3) Changes to ED safety checklist, to mandate all fields, to add n/a column, to move pressure area assessment from 2nd hr to 1st hr, to add drop down box on pressure area assessment to choose from skin intact, DTI, category 1-4 (to be able to choose more than one) 4) To mandate observation, pain score fields on triage form for both adult & paediatrics 5) To communicate changes to staff 6) To complete weekly audits to monitor compliance 7) To request compliance data from the information team 8) To have 1-1 with staff to identify areas of concern and address if required 9) Add to perfect ward 10) Monitor through weekly compliance audits and regular communications with ED staff re changes and be proactive with feedback re further changes	Susan Wilkinson	Ian Pridding	Blue	31.8.20	**Update 12.10.20:** **SW to provide 3 months data for LN. LN to provide external assurance re ED data. Assurance visit will be planned reporting back to IPB Dec '20.** **- Plan 13 will move to appendix 6 for BAU Plans from November as holding place for Blue (BAU) Plans within the pack.** **- Appendix 6 will inform Appendix 2 Schedule of Embeddeness to include BAU quarterly reviews** Update 14.09.20: Request to IPB to move Plan 13 to Blue (embedded) as 3 months compliance data is in place and process to address compliance issues embedded - All actions complete and 3 months compliance data now received from information team. - A 4% - 7% dip was identified overnight between+S26 9pm - 4am with the lowest compliance at 93% on Fridays. - This is being addressed by the co-ordinators - Weekly compliance audits are in progress - Safety checklist also added to the Perfect Ward App
14	The trust must ensure staff record medication temperatures and escalate any concerns in line with its medications policy.	1) Pharmacy to audit all fridge temperatures in Emergency Department. Actions to address issues resulting from temperature audit: - Introduction of trays into the fridge to keep stock together to minimise time looking for drugs - Pharmacy Assistant responsible for stock replenishment to return all excess fridge stock to pharmacy to improve airflow within the unit - Assess requirement of rigid cold blocks in fridge and remove if unnecessary - Installation of more accurate external fridge thermometers on advice of pharmacy - Request monthly audits from pharmacy to ensure continued compliance 2) Ambient temperature monitoring Ensure appropriate systems and processes are in place to monitor ambient room temperatures in areas where drugs are stored and appropriate escalation processes where required. Actions to address issue: - Installation of thermometers in all rooms used for storage of drugs. - Introduction of ambient room temperature checking on to existing fridge temperature checks - Compliance to be audited within monthly perfect ward assessments 3) Escalation of increased temperatures Ensure appropriate escalation of increased temperatures to Unit Manager to ensure appropriate action taken Actions to address issues - 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	Susan Wilkinson	Dona Bowd	Complete	31.08.20	**Update 12.10.20: Evidence gathering process underway. Expectation is that plan moves to BAU November 2020.** **Update 14.09.20:** **All actions complete. Data gathering in progress including daily manual checks and monthly Perfect Ward audits.**
15	The trust must ensure that staff records in relation to equipment and medication checks are completed.	1) Review of documentation for equipment and medication checks Departmental review of existing documentation with a view to simplifying checklists and improve compliance. 2) Review of online checking duplication of paper and online checking was causing confusion and impact on compliance. 3) Long term strategy to replicate improved paper checklist on to the online system. 4) All changes communicated to staff via email and hot topic	Susan Wilkinson	Dona Bowd	Green	**31.10.10**	**Update 12.10.20: Request to IPB is to extend project completion timeframe by one month to 31st October. Changes in IT staffing mean that final tweaks to template sti to be completed with a go-live date 1st November 2020.** Update 14.09.20: - Final action on plan now green. No further delays are expected and so IT will finalise and upload online customised chacking template for ED by the end of September '20, in line w extended completion timeline for the overall plan, as agreed at August IPB.

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale
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.	Controlled drugs and storage of patients own mediciation 1. Review of existing policiies (confirmed as fit for purpose) 2. Ensure staff awareness of procedures and put in place systematic review of compliance 3. Ensure effective action is taken to address individual or themes of non-compliance Ambient room temperatures 1. Email communication to all staff to remind to escalate high temperatures to Unit Manager (regular escalations since communication.) 2. Issue included in weekly hot topics discussed at all handovers. 3. Unit manager informs pharmacy of any escalations to ensure appropriate actions if required. 4. Long term strategy: Trust wide consideration of centralised temperature monitoring	Susan Wilkinson	Simon Whitworth	Black	31.10.20	**Update 12.10.20:** **Request to IPB is to move plan to Black (complete). All actions complete preparing to move to BAU assurance process in November.** **- Plan to run 3-month BAU audit from Nov '20 with Perfect Ward App calibrated is on track with the pharmacy team piloting use of the audit tool presently so that BAU c achieved by Feb '21.** Update 14.09.20 Final incomplete action in plan changed to include inspections using Perfect Ward App rather than mock inspections and will complete in line with overall plan completion timeframe 31.10.20. - Audits now happening on wards / appropriate monitoring arrangements in place for the plan to move to Blue (BAU) from 31.08.20 and will be reviewed further at next cluster. - Actions are happening to clarify the messaging across to relevant ward staff, including managers and matrons, to ensure the actions are being implemented consistently across the organisation. Update 21.07.20: - Inspection regime has been developed incorporating Covid-19 measures - ready to enact by 31.10. Final amber action 4 could therefore go green on plan. - Challenge to find messaging strategy ref medications management better than already in place but will review further till end August - further consideration will be given ref how e-C PW App could be used to develop messaging
18	The trust must ensure that all bank and agency staff have documented local inductions.	West Suffolk Professionals 1. A generic trust induction checklist is to be enhanced and re-implemented for all new agency and bank workers. This will be followed up with a local area induction to be completed during first worked shift. 2. Agency and Bank workers will complete local area induction on the commencement of their first shift. 3. If additional shifts are undertaken in different areas, it is the expectation of the trust that a local induction will be conducted for each new area worked. 4. All bank staff training is to be reviewed and recorded on OLM. Medical Staffing 1. All Agency staff are given induction booklets before their first day, which they are required to sign and return a statement confirming they have read and understood this on their first day. 2. Bank medical staff are formed by current training and trust doctors, therefore are covered by local induction process. Ad hoc audits will be undertaken by WSG and MS with findings reported to HRD on a quarterly basis	Jeremy Over	Chris Nevill / Helen Kroon	**Green**	**31.12.20**	**Update 12.10.20:** **The end date for the plan will revert to 31.12.20 as there are no training interdependencies with the Mandatory Training Plan. The expectation is that the overall RAG fo programme will move to Black (complete) in Dec '20 as planned.** **The Medical Staffing plan has been reviewed. These actions are also complete. Three months compliance is data required to move to BAU. Actions include ensuring agency medical workers receive an induction booklet prior to their first day and that a return is signed on the first day of work confirming that the induction booklet ha read. The Trust will also ensure that all Trust and non-Trust bank workers are captured by the induction process.** Update 08.09.20: - A detailed review of Plan No 18 has been undertaken since the last IPB with the new WSP management team. The outcome is that the current overall status should remain green subject to the approved extension with 80% actions black or green with no red actions. - However, the request to IPB is that the project end date is extended to 31.05.21 as the review of training action will complete in line with Mandatory Training Plan No 12. - The plan will now be reviewed with the Medical Staffing lead regarding the three relevant improvement actions. The WSP plan provides a specific response to the first four improv actions with action 4 requiring an extension to the overall delivery plan to review and record training.
19	The trust must ensure that medicines are stored securely within the main and day surgery theatre department.	1. Identify storage requirement and purchase cupboards 2. Local audits planned whilst areas accessible re Covid-19 3. Identify cupboard locations and estates to hang cupboards 4. Risk assessments can then take place 5. Perfect Ward App to be introduced to ensure compliance	Helen Beck	Irene Fretwell	Green	31.10.20	**Update 12.10.20: Co-production / joint working assurance visit agreed for 20.10.20 as agreed at Sept IPB.** **- PMO assurance / engagement plan also agreed to ensure DSU plan completion.** **- The current expectation is that the plan will move to Black in October with BAU assurance process agreed as part of joint working assurance 20.10.20.** **Updates below (10.09.20) stand for main theatres also and so plan is on track to complete 31.10.20. BAU assurance process will be agreed as part of 20.10.20 assuran visit.** Update 10.09.20: 1. Complete. Storage requirement identified and cupboads purchased and as an action with a defined outcome this action is already BAU. However, project has gone beyond the i ask with additional cupboards purchased to standardise anaesthetics rooms. These additional anaesthetics cupboards arrived at the end of August. 2. Drug co-ordinated security / cupboard lock checks are now part of the handover process and the end of day checks. 2 Months evidence still required as part of embedding proce August audit shows 100% compliance in Main Theatres re department drug security checks. Checking process and Handover template including drug check questions supplied. 3. This action is complete re the initial action but as outlined in point 1 above the process is ongoing for the additional anaesthetics cupboards. 4. The overall plan can move to Black when the Risk Assessment process in DSU has been clarified. The PMO will coordinate a 3 way meeting with Main Theatres and the DSU to status given the current end date 31.10.20 5. Perfect Ward questions on template have been collated for a final review with with Theatres and DSU for further input and so this action is on plan to complete within timeframe.
20	The trust must improve monitoring ambient room temperatures in drugs rooms.	1. MDT meeting to access temperature monitoring options available 2. Prepare baseline assessment of ambient temperatures in Clinical Area 3. Investigation cost associated with automated temperature monitoring equipment and Air conditioning 4. Ordering of Max/Min room temperature thermometers 5. Creation of Ambient temperature monitoring record book for clinical areas 6. Creation of Ambient temperature monitoring email address for wards to use to report temperature exclusions 7. Distribution of max/min room temperature thermometers to inpatient clinical areas 8. Ordering of second batch of Max/Min room temperature thermometers 9. Distribution of second batch of max/min room temperature thermometers to inpatient clinical areas 10. Creation of MedicBleep ambient temperature reporting message group 11. Creation of Perfect Ward monitoring tool for Ambient temperature monitoring 12. Completion of Risk Assessment of actions if high ambient temperatures recorded	Susan Wilkinson	Simon Whitworth	Complete	28.2.20	**Update 12.10.20:** **Co-production / joint working assurance visit agreed for 20.10.20 as agreed at Sept IPB.** **- The Maternity deep dive recommendation is to move the maternity element in plan to BAU monitoring based on evidence seen.** **- The current expectation is that the plan will move to Black in October with BAU assurance process agreed as part of joint working assurance 20.10.20.** Update 06.10.20: In line with Plan No 16, the plan to run 3-month BAU audit from Nov '20 with Perfect Ward App calibrated is on track with the pharmacy team piloting use of the audit tool presently s BAU can be achieved by Feb '21. This BAU process will ensure all sequential out of range temperatures are logged on Datix. - The piece of work to develop a business case re centralised electronic temperature monitoring system is ongoing. The solution will initially ensure that the blood bank is MHRA com in terms of temperature monitoring. Update 14.09.20 Final incomplete action in plan changed to include inspections using Perfect Ward App rather than mock inspections and will complete in line with overall plan completion timeframe 31.10.20. - Audits now happening on wards / appropriate monitoring arrangements in place for the plan to move to Blue (BAU) from 31.08.20 and will be reviewed further at next cluster. - Actions are happening to clarify the messaging across to relevant ward staff, including managers and matrons, to ensure the actions are being implemented consistently across the organisation. Update 21.07.20: - Inspection regime has been developed incorporating Covid-19 measures - ready to enact by 31.10. Final amber action 4 could therefore go green on plan. - Challenge to find messaging strategy ref medications management better than already in place but will review further till end August - further consideration will be given ref how e-C PW App could be used to develop messaging

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale
21	The trust must improve monitoring of women's records and ensure that a greater number of records are audited monthly.	Audit programme to be put into place including sampling methods and timescales	Susan Wilkinson	Karen Newbury	Blue	28.2.20	**Update 12.10.20: Update 12.10.20: Maternity Deep Dive completed 25.09.20. Report will be presented at October IPB as part of BAU assurance process.** Update 10.08.20: Deep dive approach agreed at IPB as part of assurance to move plans to Blue (BAU). Update 08.07.20: The recommendation is that Plan's 21, 23, 24, 25 are submitted to the Improvement Board for approval to move the RAG from Black (Complete) to Blue (BAU) as Clinical Quality Midwife has been appointed with responsibility for undertaking monthly audits. Sample sizes and audit dates are agreed and the findings are presented monthly at th Women's Health Governance Board and the Women & Children's Divisional Board going forward. Update 13.07.20: Actions are complete. Midwife appointed to undertake audits. Need to see assurance results to progress through Board to move to BAU. - A maternity deep dive will be undertaken by KN, SW, LN, JR reporting back at next IPB with 3 mont hs data as evidence Update 21.07.20: - All maternity actions complete. - Plans in place for Quality Assurance visits and building BAU Plan+S32 - SW has met with Wendy Matthews, Lisa Nobes and Frances Bolger and confirmed they will bring an assurance review framework to IPB for approval to undertake the assurance
22	The trust must ensure that carbon monoxide monitoring assessments and records are in line with trust policy..	Monitor compliance through audit and (when required) action to address non-compliance	Susan Wilkinson	Karen Newbury	Complete	28.2.20	**Update 12.10.20:** **Actual test for Co monitoring levels is still on hold nationally due to Covid as this is an aerosol generated procedure. Mitigation is limited to asking questions only but monitoring is in place to ensure that questions are being asked with question and answer documented.** Action implemented, assurance testing ongoing. Recognised that pandemic has impacted on our ability to deliver this monitoring - this is mitigated through appropriate referral to th smoking cessation advisor. **Update 08.07.20: The RAG for Plan 22 cannot move from Black to Blue (BAU) given national stop on carbon monoxide monitoring assessments through pandemic.**
23	The trust must ensure that women are asked about domestic violence in line with trust policy.	Monitor compliance through audit and (when required) action to address non-compliance	Susan Wilkinson	Karen Newbury	Blue	28.2.20	**Update 12.10.20: Maternity Deep Dive completed 25.09.20. Report will be presented at October IPB as part of BAU assurance process.**
24	The trust must ensure that they implement a nationally recognised monitoring vital observations tool for women attending triage on labour suite and the maternity day assessment.	1. Project plan for the implementation of MEOWS first in the maternity areas (complete) and then in the wider hospital for peripartum ladies (including the wider group of miscarriage, termination and ectopic pregnancies) 2. Continue to monitor compliance through audit and (when required) action to address non-compliance	Susan Wilkinson	Karen Newbury	Complete	28.2.20	**Update 12.10.20: Maternity Deep Dive completed 25.09.20. Report will be presented at October IPB as part of BAU assurance process.**
25	The trust must ensure they implement a national recognised monitoring vital observations tool for new born babies on the labour suite and F11 ward.	1. Project plan for the implementation of NEWTTS (complete) 2. Continue to monitor compliance through audit and (when required) action to address non-compliance	Susan Wilkinson	Karen Newbury	Blue	28.2.20	**Update 12.10.20: Maternity Deep Dive completed 25.09.20. Report will be presented at October IPB as part of BAU assurance process.**
26	The trust must ensure they carry out daily checks of resuscitation equipment.	1. Key actions are to remove paper checking of resuscitation equipment and replace with electronic checking	Susan Wilkinson	Karen Newbury	Blue	31.1.20	**Update 12.10.20: Plan is to move overall RAG to Blue (BAU) at end of October when 3 months data will have been collected. A booklet for all audit processes is in plac** Action implemented, assurance testing ongoing **Update 07.07.20:** Plan No 26 can be submitted for approval at IB to move the RAG from Black to Blue (BAU). - Paper checking is no longer used in the department. The following checks were originally put in place: - F11 Ward Manager check daily - Labour suite co-ordinators to check daily - Service Manager to check weekly compliance in all areas A Clinical Quality Midwife has also been appointed with responsibility for overseeing checks **Update 13.07.20: Again actions virtually complete (31/34) guidelines prepared) and midwife in place to complete audit checks.**
27	The trust must ensure clinical guidelines are up to date.	1. Through the divisional leadership review and update all clinical guidelines and issue through the approval pathway 2. Put in place systematic system to support the management, reporting and monitoring of clinical guidelines across the Trust to ensure they are kept up to date	Susan Wilkinson	Divisional Triumvirate	Green	31.10.20	**Update 12.10: Request to IPB is to move Plan RAG from Amber to Green. Only three guidelines remain to be completed and the expectation is that these will be compl by the end of June '20.** Update 23.06.20: 29/36 guidelines updated in maternity. Project plan being prepared to roll-out new technology to support management of clinical guidelines. Update 23.06.20: Clarity needed re divisional engagment via Tri Update 21.07.20: - Maternity guidelines nearing completion **Update 18.08.20:** **- Tri-divisional representatives will feed in on this as the matter is organisation-wide** **- Discussed at the Quality Group 18.08.20**
28	The trust must ensure patients can access the service when they need it and receive the right care promptly in line with national targets.	See No 9	Helen Beck	Helen Beck with ADOs	Red	31.3.21	See No 9

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale
29	The trust must ensure diagnostic test results are available in a timely manner.	Review reporting arrangements for relevant diagnostics services. Ensure appropriate escalation procedures are in place for delays. Address the negative impact of COVID on diagnostic testing and reporting.	Helen Beck	Helen Beck	Black	31.12.20	**Update 12.10.20: Update 12.10.20: Radiology performance report received for Sept 20 for presentation at Oct IPB as part of BAU assurance process.** **- Plan is to share Diagnostics waiting times with patients.** Update 14.09.20: IPB approve move to Black Update 03.09.20: - Request to IPB is to move the Plan to Black (Complete) as all actions are complete and can now be audited. - SOP regarding timely results for clinics has been reviewed and performance reporting has also been resolved.
30	The trust must ensure there is an effective process in place for monitoring patients requiring a follow up appointment and for those on surveillance pathways.	See No 6	Helen Beck	Hannah Knights	Red	31.03.21	25.06.20 Overall status Red pending collation of new documentation re COVID backlogs
31	The trust must ensure staff complete and record patient pain assessments in patient records.	1. Issue reminder to teams regarding the importance of undertaking pain assessments for end of life patients 2. Review of core template on SystmOne to ensure that it is fit for purpose 3. Written guidance on completion of core assessment template on SysmOne 4. Share written guidance with clinical teams 5. Identify SuperUsers to support training on the correct use of the core template and embedding within teams 6. Update staff via CREWS divisional quality report 7. Include audit of completion of Pain Assessment via Perfect Ward App	Helen Beck	Michelle Glass	Green	31.12.20	**Update 12.10.20:** **Request to IPB is to move plan to Green as the Task and Finish Group has met as planned and agreed when pain assessments will be undertaken, compliance rates an reporting and monitoring arrangements. Full details are available. The agreements have also been included in a communications document as a user guide.** Update 01.10.20: The plan to achieve compliance is to engage and listen to a group of clinicians regarding what and how often a pain assessment should be undertaken as community clinicians meet with patients very regularly. Compliance rates will be agreed with clinicians through engagement commencing 02.10.20. Agreed compliance rates will then be monitored including th of the PW App. Update 23.09: Plan updated following meeting with Sandra Webb. Actions can be delivered within timeframe 31.12.20 Update 14.09.20: Plan moves to Amber following IPB. Plan to be updated with additional actions to achieve and measure compliance with agreed compliance rate. Update 03.09.20 Request to IPB is to move Plan No 31 from Green to Black as the plan has been completed but has not delivered the required level of compliance and therefore additional actions a being led by the Head of Nursing and the senior nursing team for the division to address this issue via a rapid Task & Finish Group.

14.4. Nursing staffing report

For Approval

Trust Board – November 2020

Agenda item:	14.4			
Presented by:	Susan Wilkinson, Executive Chief Nurse			
Prepared by:	Susan Wilkinson, Executive Chief Nurse, and Daniel Spooner Deputy Chief Nurse			
Date prepared:	September 2020			
Subject:	Quality and Workforce Report & Dashboard – Nursing September			
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 September 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'

1. Introduction

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

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

Since March 2020 the NHS has had to deal with the Coronavirus outbreak. Coronavirus has become a global health emergency. Matrons and Heads of Nursing and Midwifery review staffing on a daily basis to ensure; sufficient ward care capacity, to support the surge in critical care capacity, with appropriate estate, equipment, expertise and support in place to deal with the increase demands that coronavirus has created. This paper will identify the safe staffing and actions taken for the month of September 2020.

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

2. Nursing Fill Rate

The Trust's safer staffing submission has been submitted to NHS Digital for September within the data submission deadline. Table 1 below shows the summary of overall fill % for this month and for comparison the previous two months. The full table of fill rates can be seen in Appendix 1a and 1b. Fill rates are RAG rated to identify areas of concern (Purple >100%, Green: 90-100%, Amber 80-90%, Red <80.

	Day		Night	
	Registered	Care Staff	Registered	Care staff
Average fill rate for July 2020	102%	101%	101%	117%
Average fill rate for August 2020	103%	95%	98%	109%
Average fill rate for September 2020	99%	89%	96%	107%

Table 1

This data, generated from health roster is reviewed by Heads of Nursing and mitigations and rationale for under or over fill is provided to the executive nurse team. It should be noted that due to the challenges of Covid, including, ward closures, staff redeployment and short-term establishment increases have contributed to some variances in fill rate data. Overfill rates have reduced again in September reflecting the data cleansing that the Deputy Chief Nurse and matrons are completing is providing a more informed picture.

On interrogation of these fill rates there are many variations in how shifts are recorded and redeployed effectively. Staff are redeployed if shortfalls as identified by the Matron of the day, however this is not uniformly reflected in staff moves within the eRoster, therefore fill rates are currently not an accurate reflection

of actual roster activity. In October, the inaugural roster 'check and challenge' meetings commenced and this months unify data was reviewed. Areas over RN 100% fill where reviewed to ensure wards have sufficient control on staff utilisation and areas under 90% were also explored to understand why and mitigations were put into place to support staff and patient safety. Appendix 1 provides a ward by ward breakdown of fill rates.

3. Care Hours per Patient Day (CHPPD)

CHPPD is a measure of workforce deployment and is reportable to NHS Digital as part of the monthly returns for safe staffing (Appendix 1)

CHPPD is the total number of hours worked on the roster by both Registered Nurses & Midwives and Nursing Support Staff divided by the total number of patients on the ward at 23:59 aggregated for the month (lower CHPPD equates to lower staffing numbers available to provide clinical care).

Benchmarking CHPPD with other organisations is difficult as patient mix, establishments and ward environments all contribute the outcome. Ward by ward CHPPD can be found in appendix 1. By itself, CHPPD does not reflect the total amount of care provided on a ward nor does it directly show whether care is safe, effective or responsive. It should therefore be considered alongside measures of quality and safety (NHSI, 2020).

4. Sickness

Sickness levels for Nursing/Midwifery and support staff have been impacted in the initial months of Covid 19, both April and May saw increase in absences in both Nursing and support staff, these are demonstrated in chart 2. There has been a small increase in sickness for this month, driven by a higher increase in sickness by additional clinical services (non registered support staff or health care support workers), sickness from RNs has seen a slight reduction overall. (Table 2b).

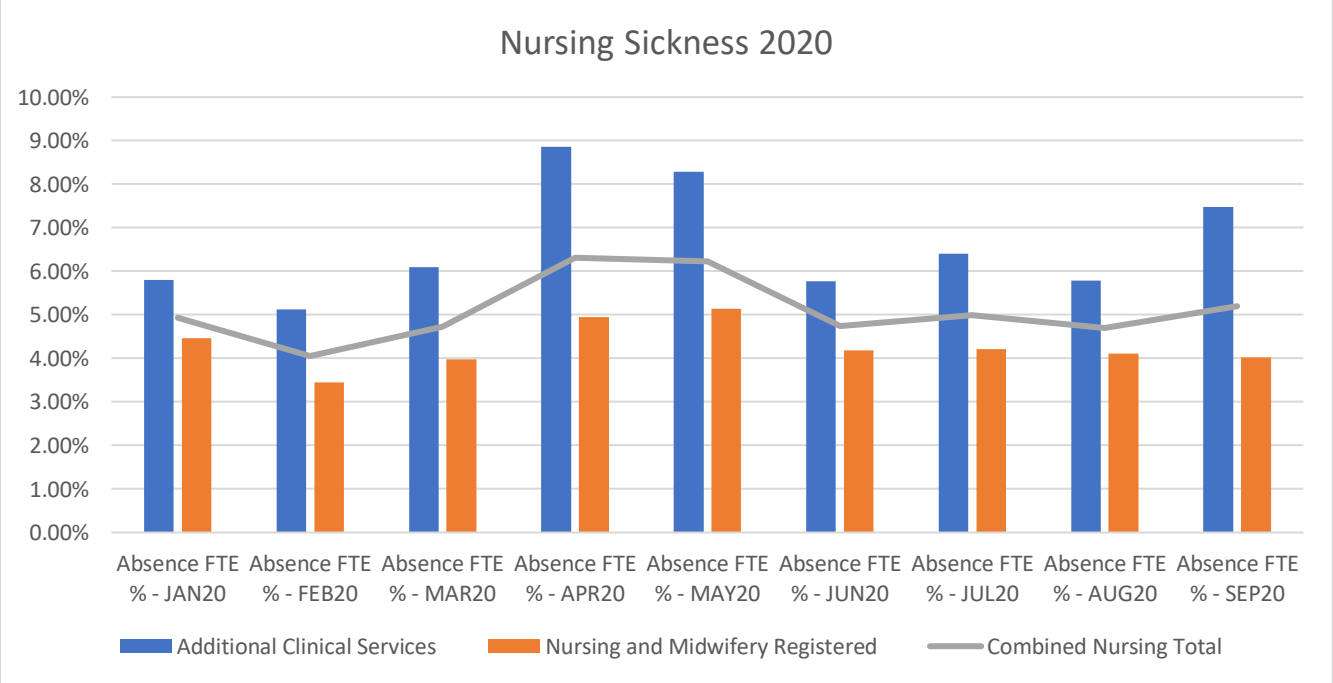


Chart 2.

	March	April	May	Jun	July	August	Sept
Unregistered staff (support workers)	6.18%	8.81%	8.34%	5.69%	6.41%	5.82%	7.48%
Registered Nurse/Midwives	3.98&	5.14%	5.61%	4.78%	4.37%	4.31%	4.02%
Combined Registered/Unregistered	4.76%	6.42%	6.55%	5.10%	5.90%	4.84%	5.20%

Table 2b

Challenges to providing safe staffing have also been exacerbated by staff that are required to self-isolate, either due to exposure to covid 19 or due to a member of their household being symptomatic. This is captured separately to sickness and is demonstrated below (chart 3). The number of nursing staff required to self-isolate has seen as small increase. This has potentially been driven by the opening of schools in early September.

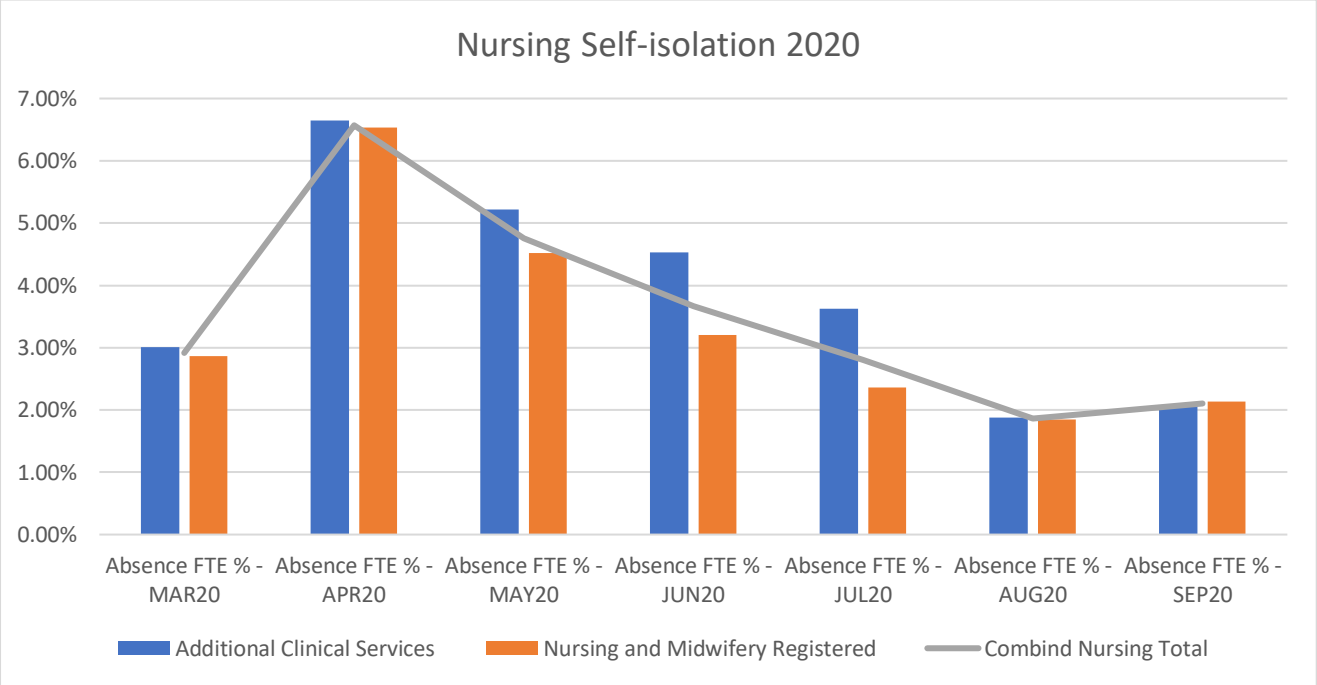


Chart 3

5. Patient Flow and Escalation

Good patient flow is central to patient experience, clinical safety and reducing the pressure on staff. It is also essential to the delivery of national emergency care access standards. (NHSI 2017). Ward closures and moves can add additional staffing challenges and opportunities and are documented below

Ward Closures in September: F4 elective surgical ward remains closed and was based on F2 to provide elective orthopaedic surgery – the capacity on F2 is reduced to 7 beds. Staff were redeployed to assist shortfalls within the division.

Ward Moves in September: F5 moved to F6 on 01/09/2020 to facilitate structural survey and essential estate repairs on F5. Works finished and completed, F5 (on F6) moved back to F5 on 21/09/2020.F6 (on ward F4) moved back to F6 on 23/09/2020

Staffing is reviewed daily across all divisions by the 'Matron of the day'. This role is the escalation point for all wards to raise issues regarding staffing shortfall or concerns. The Matron ensures that all areas are supported and staff are redeployed from areas of low activity or acuity to support where needed.

6. Recruitment and retention

Vacancies

Registered nursing: Using budgeted versus contracted staff there is a shortfall of 82.5registered nurses however this is improved by substantive staff that have been reflected in the coronavirus support costs. The net vacancy rate is 40.1 WTE substantive under budgeted establishment (Table 4). It should be noted that the cross charging and representation of substantive staff against covid19 cost makes identifying an overall trust vacancy rate challenging. As mentioned in last month's paper the finance team have cleansed the data to remove non-nursing costs from these figures to provide an accurate picture of nursing vacancies for month

6. This has resulted in an overall vacancy rate of 6.4%. Included in this data is AAU and cardiac centre which was previously not recognised as an inpatient area.

	Ward Nursing	Sum of Actuals Period 1 (April)	Sum of Actuals Period 2 (May)	Sum of Actuals Period 3 (June)	Sum of Actuals Period 4 (July)	Sum of Actual Period 5 (Aug)	Sum of Actual Period 6 (Sept)	Sum of CURRENT MONTH VARIANCE
RN Substantive	Ward	485.7	519.4	510.9	518.6	537.0	542.8	82.5
	CV19 Costs	98.2	79.8	97.1	68.0	50.2	42.4	(42.4)
Total: RN Substantive		**583.8**	**599.2**	**608.0**	**586.6**	**587.2**	**585.2**	**40.1**

Table 4

On review of individual wards, areas with a notable shortfall of staff would be maternity services, currently carrying a vacancy of 12.21 WTE (21%). There are currently 9 WTEs that are in recruitment pipeline that are expected to commence in the trust by November which will greatly improve the staffing ratio. Other areas of concern is ward G1 although this is much smaller WTE vacancy of 6.34WTE this equates to 23% vacancy. A breakdown of ward by ward vacancies can be found in Appendix 2.

Unregistered nursing: On review of the vacancy rate of unregistered support staff, this is also demonstrating an under establishment of 7.6 WT. This has also had a data cleanse and no longer reports an over establishment. On review of individual areas there escalation ward F10 budget is not appearing on ledger since agreement and adding to overfill figures. It is likely that the trust is see in an under establishment of approx. 25 to 30 WTE HCAs.

	Ward Nursing	Sum of Actuals Period 1 (April)	Sum of Actuals Period 2 (May)	Sum of Actuals Period 3 (June)	Sum of Actuals Period 4 (July)	Sum of Budget Period 5 (Aug)	Sum of Budget Period 6 (Sept)	Sum of CURRENT MONTH VARIANCE
Nursing Unregistered Substantive	Ward	264.0	275.8	288.0	307.5	320.2	330.7	50.1
	CV19 Costs	129.4	102.6	109.0	102.5	80.1	42.4	(42.4)
Total: Nursing Unregistered Substantive		**393.4**	**378.4**	**396.9**	**409.9**	**400.3**	**373.2**	**7.6**

Table 5

<u>Overseas Nurse recruitment</u>:

Three OSN commenced in the organisation in September and will join induction in October following 2 weeks of isolation. The education team supported their isolation with care packages, regular virtual meetings and pastoral care. This was well received by the new staff members and have been welcomed into the trust well. These are the final nurses from WSH's successful Philippine recruitment campaign. Recruitment of overseas nurses will continue on a smaller scale as per NHS people plan. The scope of this program will be reviewed by the deputy chief nurse and deputy HR director.

New starters

	July 2020	August 2020	September
Registered Nurses	4	6	10
Non-Registered	5	6	14

Table 6: Data from HR and attendance to WSH induction program

Recruitment continues with rolling adverts for medical and surgical areas. Harder to recruit areas are working with HR and communications team to design bespoke adverts for hard to recruit areas.

7. Quality Indicators

Falls

Falls per 1000 bed days have reduced in September. However, this is not considered a positive trend at this point. The falls practitioner which was put back out to advert has been successfully recruited to with an internal candidate. As this post holder commences they will focus on reviewing incidence to identify themes, trends and proactive measures to address contributary factors to patient falls.

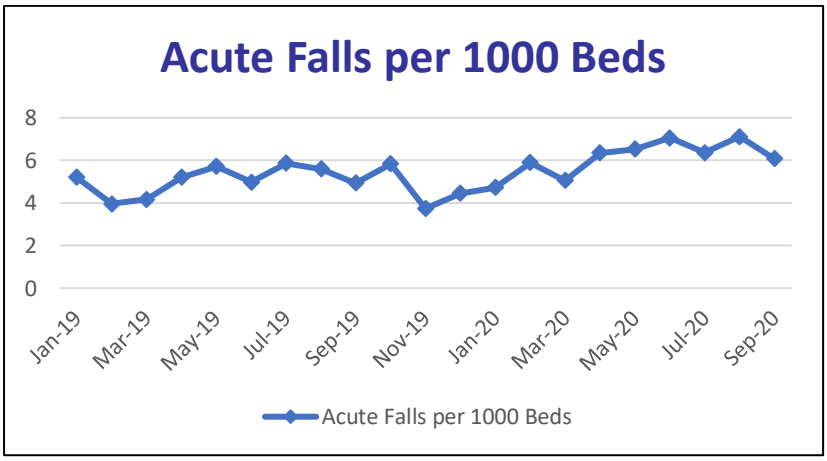


Chart 6

Pressure Ulcers

September saw a rise in the number of Hospital Acquired Pressure ulcers (HAPU) since May 2020 (Chart 7). This in part will be due to patient activity returning to normal but the picture is concerning. The highest incidence this month is on G8 (Stroke), whose vacancy rate is 16%, which will mean some reliance on temporary staffing. The Trust is currently collaborating with the senior nursing teams and specialist teams to create a harm free care collaborative that will focus on using QI methodology to focus on ward based improvements. A full ward breakdown of incidences and locations can be found in Appendix 3.

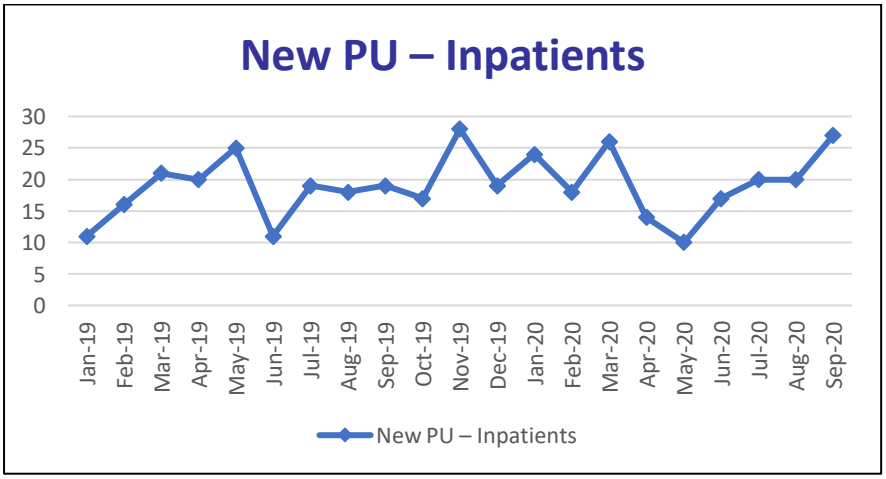


Chart 7

8. Compliments and Complaints

Table 8 demonstrates the incidence of complaints and compliments for this period. There has not been an increase in complaints compared with the previous months. This month's themes mainly refer to staff attitude and also an increase in complaints from patients on MSK pathways with delays in treatment/diagnosis. The complaints team are working proactively to ensure that complaints are responded to quickly and have reduced active complaints from 120 (in March 2020) to 50.
Positively, patient compliments have increased this month and is the highest number received in the last six months.

	Compliments	Complaints
April 2020	14	8
May 2020	14	9
June 2020	8	3
July 2020	7	21
August 2020	18	21
September	20	20

Table 8

9. Maternity Services

Red Flag events

NICE Safe midwifery staffing for maternity settings 2015 defines Red Flag events as negative events that are immediate signs that something is wrong and action is needed now to stop the situation getting worse. Action includes escalation to the senior midwife in charge of the service and the response include allocating additional staff to the ward or unit. Appendix 4 illustrates red flag events as described by NICE. Red Flags are captured on Datix and highlighted and mitigated as required at the daily Maternity Safety Huddle

- There was 1 Red flag in September – closure of the unit due to high volume and acuity of women. The unit shut for just under 24 hours. In this time four women were redirected to the Norfolk and Norwich for their care.

Midwife to Birth ratio

In September 2020 the Midwife to Birth ratio was 1:31 this is the upper limit of a safe ratio, Birthrate+ recommend a Midwife to Birth ratio of 1:27.7. Safe staffing was further challenged by schools reopening and a number of staff having to isolate due to children being sent home with proposed Covid 19 symptoms, or provide childcare for children that were isolating.

Supernumerary status of the labour suite co-ordinator

This is a requirement for CNST 10 steps to safety and was highlighted as a 'should' from the CQC report Jan 2020. The band 7 labour suite co-ordinator should not have direct responsibility of care for any women. This is to enable the co-ordinator to have situational awareness of what is occurring on the unit and is recognised not only as best but safest practice.

In September the data was incomplete and therefore not able to provide the compliance for this month. This will be reported within a separate midwifery paper where mitigations and additional narrative will be provided.

10. Establishment Review

As per NQB (2016) recommendations and strengthened by the developing workforce safeguards document (NHSE, 2018), acute providers are expected to formally review nursing establishments biannually. It is acknowledged that while individuals' areas have adjusted nursing establishments to reflect changes in patient group and acuity, a formal nursing establishment, using a nationally recognised tool has not been

delivered since 2016. The audit commenced in early September and will conclude in October. The full establishment review of adult inpatient areas will be presented to board in November. Areas within this review include;

- Adult inpatient wards
- Paediatric inpatient ward
- AAU
- Accident and Emergency
- Community assessment beds (CAB)

The audit rollout was extremely successfully with great engagement from the nursing body. Submissions and data collection were extremely efficient, enabling the output meetings to be arranged swiftly in October These meets will be held to review the findings with the ward teams and triangulate the audit output with quality indicators and professional judgement, concluding with an overall recommendation for the individual ward/department.

11. Resource Management

Following Lord Carters review in 2016/18 operation productivity is improved when eRostering is used to its fullest potential (NHSE, 2020). WSH has had eRostering in use for many nursing teams for a while formal oversight has been light. In order to better identifying improvements and best practice monthly meetings between the Deputy Director of Nursing, eRostering team have been scheduled to commence in October as planned. An improvement plan will be created following these meetings and will be shared within the October safe staffing paper.

12. Recommendations and Further Actions:

- Note the information on the nurse and midwifery staffing and the impact on quality and patient safety
- Note the content of the report and that mitigation is put in place where staffing levels are below planned.
- Note the content of the report is undertaken following national guidelines using research and evidence-based tools and professional judgement to ensure staffing is linked to patient safety and quality outcomes.
- Note the work commenced with the clinical teams to ensure accuracy of eRoster to illustrate accurate fill rates and robust management of nursing resource

Appendix 1. Fill rates and CHPPD. September 2020 (adapted from unify submission)

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each day	RNS/RMs	Non registered (care staff)	Overall
Name	Day Reg Planned Hrs	Day Reg Actual Hrs	Day Unreg Planned Hrs	Day Unreg Actual Hrs	Night Reg Planned Hrs	Night Reg Actual Hrs	Night Unreg Planned Hrs	Night Unreg Actual Hrs	Day Reg Fill Rate	Day Unreg Fill Rate	Night Reg Fill Rate	Night Unreg Fill Rate				
Rosemary Ward	698.75	993.75	1,035.00	1,028.25	690.00	700.00	525	751.5	142	99%	101%	143%	595	2.8	3	5.8
Glastonbury Court	683.50	806.00	1,000.50	1,078.00	655.50	713.00	524.00	520.50	118	108%	109%	99%	600	2.5	2.7	5.2
AAU	2070.5	1933.333	2400.983	1476.983	1725	1634	1380	1199.5	93	62%	95%	87%	479	7.4	5.6	13
Cardiac Centre	2,756.00	2,491.75	1,334.00	1,225.00	1,725.00	1,540.50	690.00	606.00	90	92%	89%	88%	636	6.3	2.9	9.2
F10	1,380.00	1,254.00	1,383.00	1330.25	1035	1010.75	1040	1274.5	91	96%	98%	123%	752	3	3.5	6.5
F8	1,380.00	1,391.00	1,377.25	1,204.75	1368.5	1,306.50	1,034.50	1,104.00	101	87%	95%	107%	773	3.5	3	6.5
F12	545.50	599.25	326.50	261.50	690.00	654	345.00	360.50	110	80%	95%	104%	227	5.5	2.7	8.3
F7	1,357.00	1,350.00	2,027.50	1,424.25	1,380.00	1298.5	1,720.50	1,426.50	99	70%	94%	83%	448	5.9	6.4	12.3
F9	1,380.00	1,361.50	2,061.00	1,612.00	1,035.00	1,007.00	1,375.50	1,477.00	99	78%	97%	107%	934	2.5	3.3	5.8
G1	2,547.40	2,410.42	795.00	828.50	690.00	691.00	345.00	325.25	95	104%	100%	94%	325	9.5	3.6	13.1
G3	1,366.00	1,462.25	2,057.00	2,139.83	1,035.00	1,071.00	1,035.00	1,690.00	107	104%	103%	163%	948	2.7	4	6.7
G4	1379	1,313.25	2,031.00	1,993.75	1032.5	959	1373.5	1410	95	98%	93%	103%	907	2.5	3.8	6.3
G5	1388.767	1372.833	2,046.00	1,971.50	1035	1003.767	1081	1566.5	99	96%	97%	145%	948	5.5	3.7	3.2
G8	2071	1975.25	1698.5	1662.667	1380	1362.133	1035	1225.583	95	98%	99%	118%	800	4.2	3.6	7.8
Critical Care	2,678.00	2,737.00	341	329.75	2,593.50	2,636.25	77.00	88.5	102	97%	102%	115%	191	28.1	2.2	30.3
F3	1,375.50	1,373.00	2,045.00	1,856.25	1,035.00	978.50	1380	1403	100	91%	95%	102%	953	2.5	3.4	5.9
F4	725.00	706.5	513.00	399.5	667	622	517.5	493	97	78%	93%	95%	385	3.5	2.3	5.8
F5	1,367.00	1,369.00	1,375.00	1,212.50	1,035.00	1036	685	621	100	88%	100%	91%	647	3.7	2.8	6.6
F6	1,633.00	1,672.00	1573	1369.25	1,035.00	927.50	690	644	102	87%	90%	93%	699	3.7	2.9	6.6
F11	3966.45	3675.317	1343	1054	2872.5	2448.233	1080	798.5	93	78%	85%	74%	-	-	-	
Neonatal Unit	1,059.00	1,086.50	180	161	936.00	913.00	204	204	103	89%	98%	100%	81	24.7	4.5	29.2
F1	1,181.75	1,300.75	690	671.25	1,035.00	1,115.50	0	230	110	97%	108%	230%	133	18.2	6.8	24.9
F14	714	741	84	108	720	720.5	0	0	104	129%	100%	n/a	112	13	1	14
Total	35,703.12	35,375.65	29,717.23	26,398.73	27,405.50	26,348.63	18,137.50	19,419.33	99	89%	96%	107%	12461	4.9	3.6	8.6

Appendix 3. Ward by ward vacancies (September 2020)

RAG: Red >15%, Amber 10%-15%, Green <10%

Ward/Department	Registered Nursing			
	Budgeted Establishment	Actual Establishment	Vacancy rate	Percentage Vacancy rate
AAU	30.1	30.8	0.67	-2%
Accident & Emergency	64.0	56.7	7.37	12%
Cardiac Centre	40.7	37.3	3.34	8%
Glastonbury Court	11.7	10.9	0.79	7%
Critical Care Services	45.4	43.8	1.62	4%
Day Surgery Wards	12.1	10.2	1.93	16%
F14	12.6	11.2	1.40	11%
Hospital Midwifery	59.2	47.0	12.21	21%
Neonatal Unit	21.4	18.0	3.37	16%
Rosemary ward	12.4	12.3	0.13	1%
Respiratory Ward	23.7	21.1	2.60	11%
Ward F1 Paediatrics	20.4	20.3	0.08	0%
Ward F3	22.2	17.7	4.50	20%
Ward F4	15.8	13.9	1.88	12%
Ward F5	22.2	19.4	2.77	13%
Ward F6	24.0	18.8	5.16	22%
Ward F9	19.3	17.4	1.89	10%
Ward G1	27.7	21.3	6.34	23%
Ward G3	19.5	18.5	0.99	5%
Ward G4	19.5	20.3	0.78	-4%
Ward G5	19.4	18.3	1.06	5%
Ward G8	27.5	23.0	4.51	16%

Ward/Department	Non Registered Nursing (HCSW)			
	Budgeted Establishment	Actual Establishment	Vacancy rate	Percentage Vacancy rate
AAU	28.3	21.5	6.85	24%
Accident & Emergency	26.5	22.2	4.30	16%
Cardiac Centre	15.7	13.7	2.03	13%
Glastonbury Court	12.6	12.0	0.65	5%
Critical Care Services	1.9	1.9	0.00	0%
Day Surgery Wards	1.6	1.2	0.42	26%
F14	1.0	1.0	0.00	0%
Hospital Midwifery	15.6	15.1	0.50	3%
Neonatal Unit	3.6	4.3	0.64	-18%
Rosemary ward	13.5	15.1	1.63	-12%
Respiratory Ward	18.0	18.5	0.49	-3%
Ward F1	7.2	6.7	0.50	7%
Ward F3	25.8	22.9	2.96	11%
Ward F4	12.9	7.1	5.84	45%
Ward F5	12.9	11.9	1.05	8%
Ward F6	14.8	12.7	2.08	14%
Ward F9	25.8	21.1	4.66	18%
Ward G1	10.5	9.8	0.73	7%
Ward G3	25.6	22.3	3.24	13%
Ward G4	25.4	24.9	0.50	2%
Ward G5	25.8	23.5	2.26	9%
Ward G8	20.6	18.9	1.76	9%

Appendix 3: Ward by Ward breakdown of Falls and Pressure ulcers September

HAPU

	Cat 2 (Minor)	Unstageable (Moderate)	Total
Total	**27**	**1**	**28**
G8	5	0	5
F3	3	0	3
F9	3	0	3
G3	3	0	3
G5	3	0	3
Cardiac Centre	2	0	2
F10	2	0	2
F6	2	0	2
G1	0	1	1
G4	1	0	1
F8	1	0	1
F7	1	0	1
AAU	1	0	1

Falls

	Harm					
	None	Negligible	Minor	Moderate	Major	Total
Total	**65**	**3**	**16**	**1**	**2**	**87**
G3	7	0	2	0	0	9
Rosemary	7	1	0	0	1	9
G5	5	0	2	1	0	8
Cardiac Centre	3	1	2	0	0	6
F3	5	0	1	0	0	6
F7	4	0	2	0	0	6
AAU	5	0	1	0	0	6
G8	5	0	0	0	0	5
F10	3	0	0	0	1	4
F6	4	0	0	0	0	4
G1	2	0	2	0	0	4
Glastonbury Court	3	0	1	0	0	4
F8	3	1	0	0	0	4
F12	2	0	0	0	0	2
F5	2	0	0	0	0	2
G4	2	0	0	0	0	2
AEC	1	0	0	0	0	1
CHT Bury Town	1	0	0	0	0	1
Emergency Department	0	0	1	0	0	1
F9	0	0	1	0	0	1
Outside General Areas	0	0	1	0	0	1
Physiotherapy Department	1	0	0	0	0	1

Appendix 4: Maternity Red Flag Events

Missed medication during an admission
Delay of more than 30 minutes in providing pain relief
Delay of 30 minutes or more between presentation and triage
Delay of 60 minutes or more between delivery and commencing suturing
Full clinical examination not carried out when presenting in labour
Delay of two hours or more between admission for IOL and commencing the IOL process
Delayed recognition/ action of abnormal observations as per MEOWS
1:1 care in established labour not provided to a woman

11:10 BUILD A JOINED-UP FUTURE

15. Integration report – Q2

To APPROVE the report

For Approval

Presented by Kate Vaughton and Helen Beck

West Suffolk NHS Foundation Trust Board Meeting

Friday 6th November 2020

Agenda item:	15			
Presented by:	Kate Vaughton, Director of Integration			
Prepared by:	Jo Cowley, Senior Alliance Development Lead, WSCCG Sandie Robinson, Associate Director of Transformation, WSCCG Lesley Standring, Head of Operational Improvement, WSFT			
Date prepared:	19/10/2020			
Subject:	West Suffolk Integration Update			
Purpose:	X	For information		For approval

Executive summary: This paper provides an update on the progress being made with integration in the West Suffolk system including specific transformation projects. This is a combined paper on Alliance development and transformation.

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:	*WSCCG Govering Body*
Risk and assurance:	
Legislation, regulatory, equality, diversity and dignity implications:	

Recommendation:
The Board are asked to note the progress being made on individual initiatives and collaborative working across the system.

West Suffolk Integration Update

West Suffolk NHS Foundation Trust Board Meeting

6th November 2020

1.0 Introduction

1.1. This paper provides a quarterly update for the Board about activity to transform services and outcomes for people within the West Suffolk Alliance area. A number of different teams contribute to the report, from across the CCG, the hospital and Alliance partners.

1.2. Alliance partners continue to seek to build on changes made during the past six months where these are in line with the Alliance strategy. The first part of this report outlines some of the key changes in services and ways of working that have taken place during the previous quarter. The next section shows how the Alliance has been working as part of the wider Integrated Care System, (ICS), for example contributing to phase 3 recovery planning which was co-ordinated ICS wide as well as to other NHS England requirements for example winter planning. The final section of the report updates the Governing Body on Alliance business, governance, leadership and quality improvement

2.0 Building on service changes and experience through the past six months.

2.1. **Rehab support** - A partnership between West Suffolk Foundation Trust (WSFT), Allied Health Professionals Suffolk and Abbeycroft Leisure is helping to provide additional support for people who need ongoing care after a stay in hospital, particularly those who have had Covid-19, where a rehabilitation need was identified post hospital. Together we have also co-produced a programme to support 450 patients whose elective trauma and orthopedics operations were cancelled in March 2020; this is both a communication plan/process and set of online and face to face resources (exercise classes) to help patients who are on WSFT waiting lists, and aims to create a 'community'. These resources are available for ongoing harm review by WSFT as well. This has been worked up through the MSK partnership and operations board and includes pathways into other services if needed – for example exercise classes and support through Abbeycroft Leisure.

2.2. **Additional physical activity to support falls prevention and respiratory rehab** - In addition Abbeycroft Leisure will be providing classes thanks to funding from the West Suffolk Clinical Commissioning Group and West Suffolk Foundation Trust. This will enable them to deliver two frailty/falls prevention classes per week and 9 hours Exercise on GP Referral (individual programming) in each of the six Alliance localities. There will also be an expanded timetable of respiratory rehab classes (virtual) which will now be free at the point of delivery. Further contact will be made with those on the Community waiting list to triage and signpost appropriate activity.

2.3. **Rapid intervention vehicle (RIV)** - In the spirit of Alliance working, East of England Ambulance Service Trust and WSFT have been running a project to support reduction in demand on Emergency Department (ED) and avoidable unplanned, non-elective admissions. RIV service incorporates a Specialist Paramedic/Emergency Care Practitioner (ECP) and a Therapist (from the Early Intervention Team) responding to individuals requiring support who are at risk of attending ED/being admitted to the acute hospital and would otherwise not have the opportunity of the provision of timely and appropriate intervention to remain in the community. The service is utilised by GPs, care homes and the ambulance service through inter-crew referrals. The majority of patients are supported by the service to remain in their own home rather than be admitted to hospital. We are

currently working with NSFT to assess the feasibility of add a mental health practitioner into the team.

2.4. **Think 111 First** - As part of the Think 111 First programme, patients will be able to be directly booked from NHS 111 into in and out of hours GP services, as well as ED and a range of secondary care specialties. This means the patient will be seamlessly transferred to another service without having to make the appointment themselves receiving the right care, in the right place at the right time.

2.4.1. Work is progressing across the ICS to implement direct booking by the nationally mandated deadline of 1st December. A business case has been submitted to NHSE for funding to recruit the additional staff required in NHS 111 to meet the expected 10% increase in activity as a consequence of Think 111 First.

2.4.2. We are also working to explore how we can meet the mandated 20% reduction in 'unheralded' activity (self-presenters) at the front door through enhanced streaming processes.

2.5. **Virtual ward** - Following the enhanced support at home test and learn a list of recommendations have been compiled to ensure the learning is taking into business as usual. The main areas either being retained or recommended to being retained include:

- Integrated Neighborhood Team (INT) coordinator function with oversight from all Electronic Patient Records
- Community matron extension to cover 7-day service
- Community matron extension to cover responsive care
- Responsive community care offer review
- Improved Multi-disciplinary Team (MDT) coordination and culture

Case study – Virtual ward supports dementia patient discharged home after hospital stay

A gentleman with dementia was transferred to the West Suffolk Community Services ward with #NOF following a fall. The patient was not thriving on the ward as he was disoriented and losing the ability to wash and dress himself. He was distressed when his wife was not with him and his wife was concerned that he was losing personal care skills due to a lack of routine.
The community services team felt that even though he still needed therapy, it would be much better for him to recover from the fall at home if support was available. The patient was discharged into a virtual ward on a Friday with the enhanced support at home coordinator attending the daily board round.

The coordinator arranged twice daily care to begin on the Friday evening through contact with Home First, and for the community matron and Occupational Therapist (OT) to go out to assess the patient at home. They also delivered medication as it had not arrived in time and contacted the physio to see if they could see the patient the following week.

The OT took equipment to the home - wheeled commode, Mowbray and rollator frame. The community matron went out to see the patient (with a physio from Mildenhall) and asked for care to be increased to x3 to mobilise and toilet patient at lunchtime. They also made a continence referral for the patient and asked for dietary information be sent to the patient's home. The community matron followed up by calling the patient's wife to ensure all was ok.

The virtual ward worked very well with the support of both the coordinator and the clinical staff.

Virtual ward impact feedback

The virtual ward has had a positive impact for a number of patients including those at the End of Life. A summary of phrases used by people to describe the enhanced support at home INT service offer highlights:

- MDT working
- Quick response
- Reduced unneeded support visits
- Risk assessments for carers shared
- Home First additional resource input/flexible with urgent care needs
- Able to stay at home

Patient quotes have been received through cases involving specialists that include district nurses, community matron, therapists, physios and carers. The main themes are:

- The service was definitely helpful - everything I needed was given to me and the care could not have been better. It was useful knowing that the service was there – I felt so well cared for. Thank you!
- I was able to get home earlier from hospital with services in place very quickly. Everyone was very helpful and cheerful. The coordinator saw me before I went home which was reassuring. Everything including extra equipment was at my house within an hour of coming home.
- Checking my vital signs regularly stopped me from calling the GP with problems. I was looked after extremely well with a nurse checking on me regularly. Physio helped me gain mobility.
- I think I would have ended up in hospital without the nurse keeping an eye on me and giving me extra help.
- It would help patients to have an idea of the time that carers will be coming to their home.
- Staff feedback received was very positive with support to continue with discharging patients from ward directly to the virtual ward:
- The coordinator is a fantastic asset with so many skills that support integration and early identification of patients via their presence at board round.
- The Enhanced Support Team offers greater continuity, so patients receive a more reactive and productive level of support.
- Communication is key – we have built up trust between us with open and honest discussions about patients.
- Benefits have included saving bed days and a reduction in emotional stress for patients.

There is potential around GP step up service to inpatient bed and transfer to virtual ward – being co-located helps.

2.5.1. Further evaluation points can be found as **Appendix 1.**

2.6. **Telehealth** - Telehealth has expanded from the test of concept to now provide 20 remote monitoring devices across a variety of community services (community matrons, COPD, Heart failure, Cardiac rehabilitation). There is also work to review the end to end respiratory pathway for COPD to include an early supported discharge option. This has been part of the ICS digital bid and it is anticipated that after the March 2021 contract end this can continue in a business as usual format.

2.6.1. GPs also have a greater range of digital options including video conferencing for practices to consult patients, and equipment and licenses which allow them to access records more flexibly.

Case studies - Telehealth helps identify evidence to support diagnosis

1. One patient was put on the telehealth device as part of the virtual ward and diagnosed as bradycardic at night. They were referred to cardiologist and are now receiving the appropriate management plan.

2. A patient on the COPD and heart failure caseloads was put on a Current Health telehealth device in May as part of the Covid-19 project to monitor patients remotely instead of entering their homes – to reduce contact that may put this vulnerable group at risk.

3. The patient prior to the device being used was complaining about desaturation of oxygen levels over night and yet the usual methods of monitoring had not identified any evidence to support this. The kit was fitted and used to support assessment. Within a few days the reading highlighted a drop-in heart rate over night, which was thought to be due to the heart medication the patient was taking. Since a reduction in their digoxin prescription, there are signs of improved readings and patient reported symptoms.

2.7. **Virtual Clinics -** We have been working with clinicians across community and acute services to switch to virtual consultations where appropriate. This includes video and telephone appointments. The following provides some statistics for July which provides a baseline for virtual outpatient activity. This narrative also describes ongoing actions to support clinicians to work virtually, and in particular for video calls.

2.7.1. Acute - In July there were 38,519 booked appointments across all specialties (including therapies). The following shows the breakdown for how many of these clinics were completed virtually:

Total clinics booked in July	Video call	Telephone call
38,519	472 (1.24%)	12,608 (32.73%)

This shows overall performance of c34% for number of clinics that are being implemented virtually rather than face to face.

2.7.2. Our uptake for video consultations is still quite low in the acute. We will be relaunching the programme in October; with the learning we have had from rapid implementation during Covid-19 with a view to increasing this. This will include reviewing how we use the system, training and at the elbow support for clinicians while learning to use.

2.7.3. For the specific high-volume specialties identified in the spreadsheet the figures for usage in July are:

	No clinics booked	Video	Telephone	% video	% telephone
General surgery	837		83	0.00%	9.92%
Urology	1513		460	0.00%	30.40%
Ophthalmology	3712		96	0.00%	2.59%
Gynae	1329		43	0.00%	3.24%
T&O	2618	5	829	0.19%	31.67%
ENT	1655	5	697	0.30%	42.11%
Dermatology	1983	9	315	0.45%	15.89%
TOTALS	13647	19	2523	0.14%	18.49%

2.7.4. In addition, 1032 video consultations have been delivered across community services.

2.8. **General Practice** - Some changes made during the height of the pandemic have been stood down, but with the ability to re-initiate if needed. For example, hot hubs and rooms and the Covid-19 home visiting services managed by the Suffolk GP Federation. The CCG

continues to monitor emerging risks in primary care, including through a daily Teams meeting with practice managers.

2.8.1. A Care homes Local Enhanced Service (LES) is now in place and every care home (including CQC rated LD homes) has been allocated a primary care clinical lead and aligned to a PCN with weekly (remote) check ins with the homes being held. 96% of care homes have been set up with NHS.net accounts and iPads and vital signs equipment supplied to support videoconferencing linking to primary care, acute trusts and community health teams. GPs are working with community colleagues and personalised care and support plans for residents are being developed.

2.8.2. Pharmacy and medication support to care homes continues and Structured Medication reviews are being undertaken as per the Care homes LES which cover aspects of the SMR criteria outlined on the Directed Enhanced Service (DES) and directing towards Centre for Pharmacy Postgraduate Education courses signposting which have been made widely available. The Care home Support team have been supporting Care homes both proactively and reactively and integrated working across the system through the Covid-19 response. A business case is in development to extend the EIT nurse and therapist until 31st March 2021 (posts currently fixed term until 31st December 2020).

2.8.3. Respiratory/breathlessness training rolled out with community therapists as well as Safer Nutrition and Hydration online training and deconditioning training (pan Suffolk) in development.

2.9. **End of Life -** The West Suffolk End of Life Strategic group is now meeting with its new broader membership in place. This helps to ensure a whole system view is taken of any planning, changes and initiatives that affect death, grief and bereavement.

2.9.1. Although demand did increase during Covid-19, we have now seen activity levels return to pre-Covid levels. The group are aware of the need to be part of, and aware of, system plans to increase elective activity levels and reduce waiting times, which will impact on the need for aftercare and treatment support for some palliative conditions.

2.9.2. The collaborative working that was achieved during Covid-19 is now being embedded into permanent arrangements that will see the hospice specialist nurses aligned to localities, additional resources being put into community health teams that have a specific role in EOL care working alongside the hospice nurses (who will cease to be viewed as a separate resource, but will be part of the community health team).

2.9.3. The additional resources (nurses and care assistants) from Covid-19 monies have been made permanent posts, this has enabled the Early Intervention team to increase the number of staff on shift overnight, so that EOL patients and families will experience less delays, increased time allocation for visits and better continuity of staff.

2.10 **Winter pressures -** A planning process has been going on to identify risks and preparations for winter. This has involved partner organisations submitting their plans to the CCG for collation.

2.10.1. Alongside this, the West Suffolk Alliance is running a winter planning forum, using the weekly West Cell meetings which involve all Alliance partners. The forum takes a whole system approach to winter, getting an understanding of the current risks and pressures from different perspectives and ensuring that action is taken to deal with the questions that are being raised.

2.10.2. This very agile approach to winter demand picks up learning from the pandemic, and focuses on fast resolution of issues, whether this is about data collection, service changes or the sharing of information. Immediate areas of focus include: bed use in the community and the services needed to support higher levels of need, resilience in our Integrated Neighbourhood Teams, and how we work with our voluntary and community sector partners more effectively.

3.0 Working as part of the wider ICS system

3.1. Health and care partners have been working together with other Alliance members and across the ICS footprint on the recovery planning for our system. A large piece of work has gone on to respond to the letter from Simon Stevens, NHS Chief Executive of the NHS and Amanda Pritchard, NHS Chief Operating Office of the NHS sent out on the 31st July 2020.

3.2. As this process develops it will provide the Alliance with a comprehensive set of actions and data to show how, in particular but not exclusively, the health system is recovering from the pandemic.

3.3. Aligned to the recovery discussions Alliance partners are collaborating on an approach to winter pressures. This will ensure that we can make the best use of resources and have a shared understanding of risk. We will be carrying out scenario planning to help system partners think through our response to different levels and types of pressure and focus on key areas such as end of life provision and vaccination.

4.0 Alliance business

4.1. **Quality Improvement** - The West Suffolk Alliance partners have signed up to a quality improvement approach which will support system transformation and a patient focus. The team, based at West Suffolk Foundation Trust, have been working with Alliance partners to ensure that the Alliance Delivery Plan has specific and measurable aims, and that transformational activity within the plan uses a consistent model for improvement. As well as one on one coaching and advice the team are providing training sessions through the autumn months.

4.1.1. Norfolk and Suffolk Foundation Trust are already using this approach and are able to bring their experience and expertise into the Alliance, which is helping partners to understand the potential benefits of working in this way.

4.1.2. The Institute of Healthcare Improvement (IHI) are working in partnership with the Alliance, specifically looking at data and opportunities for improving patient outcomes within our system. Working with the QI team they ran a 3-day event in early October which brought senior leaders together to discuss how as a system we can address some of the key issues around health inequalities in our system, backed up by the information that they had gathered through a number of discussions with Alliance partners. The four populations that they have suggested where there are opportunities to improve outcomes in West Suffolk are:

- people with mental health issues
- people who are obese
- homelessnes
- socially isolated over 65s.

4.1.2.1. Recommendations will be taken forward through the Alliance Qualtiy Group and the System Executive Group.

4.1.2.2. The IHI bring expertise from collaborative working in Scotland as well as international comparison.

4.2. **Alliance governance – System Executive Group** - In September, Sarah Howard started as the new Independent Chair for the Alliance. Sarah is well known in West Suffolk,

particularly for her role in the One Haverhill initiative. Sarah will chair the System Executive Group and will provide focus and challenge for the Alliance. The recruitment process involved a number of Alliance partners as well as the CCG Lay member for corporate governance and the Lay member for patient and public involvement.

4.2.1. At the System Executive Group meeting on the 2nd September a decision was taken to review the principles the Alliance is working to, to ensure they are fit for purpose. This follows on from some work done in North East Essex and in Ipswich and East where the Alliance is exploring the implications of becoming a subgroup to the CCG, which would enable it to take on more accountability. The CCG Executive Group and Governing Body will be involved in this work as it progresses.

4.2.2. This work will also ensure that the Alliance is well positioned to provide system leadership in the discussions around the Future System programme and the initiatives to enhance care and support in the community.

4.2.3. For the past six months the Alliance Steering Group has been meeting regularly as a more tactical West Alliance Cell. The monthly Steering Group will be reinstated from mid-September. However, the Cell meetings will be used for one off discussion where a workshop style of discussion is needed – for example around winter planning. Alliance members have been keen to maintain the opportunity for problem solving and information sharing which the Cell meetings have provided.

4.3. **#WhatAreWeMissing - West Suffolk -** The event was held on 29th September 2020 via MS Teams with over 80 attendees from across alliance partners and local community representatives.

4.3.1. During the session, two questions were asked. The first question was: ***What stops people in your community from accessing health and care services? E.g. Going to the doctor. What will help your community stay safe from Covid-19?*** Below is a word cloud of the key themes:

4.3.2. The second question asked was: ***How can we work together now and, in the future, to support local communities?*** Below is a word cloud of the key themes:

4.3.3. A small team are working on the actions from the event. This will include immediate actions and longer-term ones. Links have been made between the clinical leaders from the system and the internal WSFT BAME network and agreement to explore more join up going forward.

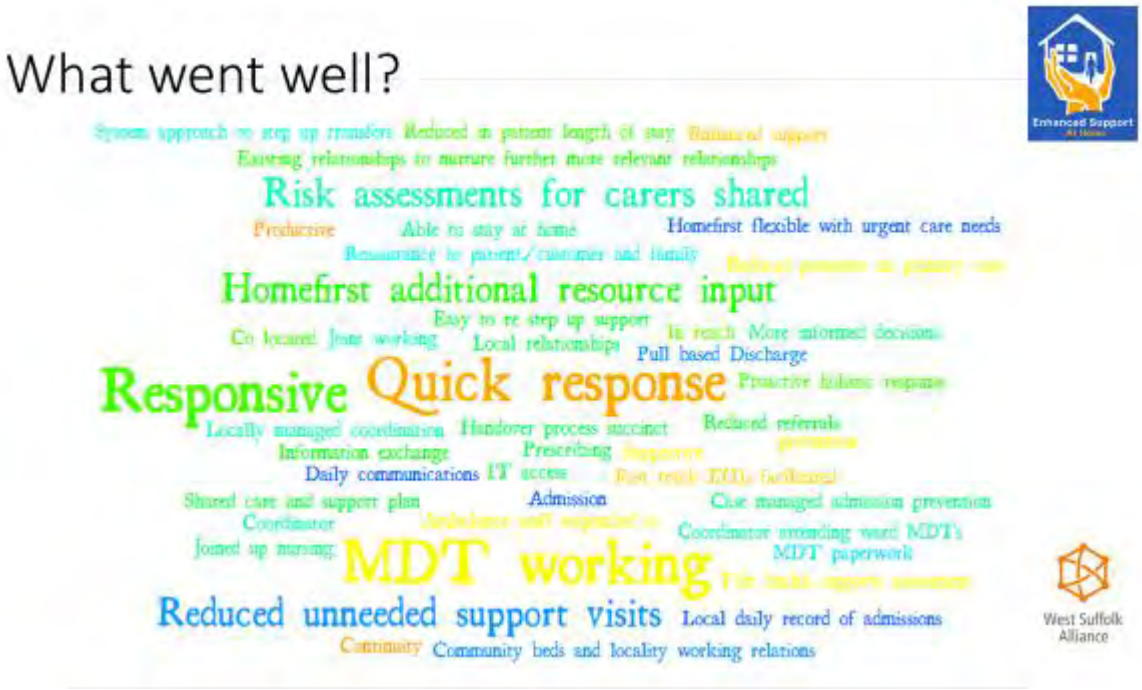
4.3.4. This is the start of the conversation and there are still voices within our communities that we have not heard from that we need to engage with. We are working to set up a community champions group to engage with these voices. The aim of the group will be to explore the key themes from the event so responses will be co-produced from the grass roots and have the lived experience influencing outputs.

4.3.5. Work has started on the NHS Charities Together funding, which ESNEFT are hosting the money for the ICS. The programme is aimed at reducing health inequalities in ethnically diverse and deprived communities disproportionately affected by COVID-19. The West Suffolk Alliance will be working with the community to finalise the form before going to a funding panel.

5.0 Recommendation

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

Appendix 1 - Word cloud from virtual ward evaluation



11:20 GOVERNANCE

16. Governance report

To APPROVE the report, including subcommittee activities

For Approval

Presented by Richard Jones

Board of Directors – 6 November 2020

Agenda item:	16			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	30 October 2020			
Subject:	Governance report			
Purpose:		For information	X	For approval

This report pulls together a number of governance items for consideration and approval:

1. **Agenda items for next meeting** (for information)
   Annex A 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.

2. **The pathology partnership limited (for approval)**
   When TPP was established the Trust acquired this limited company which could have been used to support future development. This was never enacted and with the new pathology service arrangements in place the company and its name are no longer required.

   Board approval is therefore sought to dissolved the company through Companies House. This will also support agreement with Cambridge University NHS Foundation Trust to set aside the legacy TPP Consortium Agreement.

3. **Use of Trust seal** (for information)
   To note use of the Trust Seal, pursuant to Standing Order section 8. The Trust Seal was used on the following occasions:

   3.1 Seal No. 144 - Deed of Variation to give effect to the East Trusts intention to leave the Consortium Agreement for TPP - Sealed by Craig Black & Stephen Dunn, witnessed by Ruth Williamson Mandal (19 October 2020)

   3.2 Seal No. 145 - Renewal of lease by reference to an existing lease of property at West Suffolk Hospital, with West Suffolk NHS Foundation trust and WH Smith Hospitals Ltd - Sealed by Craig Black & Stephen Dunn, witnessed by Ruth Williamson (19 October 2020)

4. **Quality and risk committee report (for approval)**
   At the meeting held on 2 October 2020 a presentation was received on the proposed stra6tegy review. This included as part of the strategy review and development capture of the views of members of the Board, Governors and partners on the relevant priorities within the strategy.

   Reports from the latest meetings of subcommittees of the Quality and Risk Committee were received, including approval of their annual reports and updated terms of reference. The committee's updated terms of reference were accepted as an interim measure by the Committee due to the forthcoming structure review.

   A risk appetite statement (Annex B) received by the Corporate Risk Committee is provided for approval by the Board and incorporation into the Trust's risk management strategy to ensure appropriate review and approval.

5. **Trust Executive Group report** (for information)
TEG continued with a different structure and approach to its meetings, focusing the agenda on key strategic issues. The meeting on 7 October considered:

- WSFT people plan, incorporating the what matters to you feedback
- Trust strategy update, using a similar approach to the Q&R committee to gain people view of the priorities going forward
- Future system programme, outlining the structure and focus of the programme in the short and medium term

The meeting on the 19 October delivered the first of a three stage training programme for senior leaders on human factors. The programme is complementary to the specialist training being delivered to members of the Trust's human factors leads.

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 noted the report and approve the following items:

- Item 2 – dissolution of The pathology partnership limited
- Item 4 – approve update of the Q&R committee's terms of reference pending implementation of the new committee structure
- Item 4 - adoption of the proposed risk appetite statement (Annex B) for inclusion in the risk management strategy

Annex A: Scheduled draft agenda items for next meeting – 4 December 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
Operational report, including 7-day services update	✓		Written	Action	HB
Integrated quality & performance report	✓		Written	Matrix	HB/SW
Finance & workforce performance report	✓		Written	Matrix	CB
Risk and governance report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
Invest in quality, staff and clinical leadership					
People plan, including: - People plan - staff recommender scores (if published) - Consultant appointment report - "Putting you first award"	✓		Written	Matrix	JO
Quality, safety and improvement report - Maternity services quality and performance report - Quality improvement programme board report - Quality and learning report, including learning from deaths - Nurse staffing report - National patient survey report	✓		Written	Matrix	SW / NJ
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	SW
Build a joined-up future					
Digital board report	✓		Written	Matrix	CB
Future system board report	✓	✓	Written	Matrix	CB
Strategic update, including Alliance, System Executive Group and Integrated Care System (ICS). Including timetable for strategy review.	✓	✓	Written	Matrix	SD
Governance					
Governance report, including - TEG report - Audit Committee report - Planning for annual governance review - Use of Trust's seal - Agenda items for next meeting	✓		Written	Matrix	SD
Scrutiny Committee report		✓	Written	Matrix	LP

Board assurance framework		✓	Written	Matrix	GN
Confidential staffing matters		✓	Written	Matrix – by exception	JO
Future Board meeting dates	✓		Written	Matrix	SC
Reflections on the meetings (open and closed meetings)		✓	Verbal	Matrix	SC

Annex B

Risk Appetite Statement 2020/21

Financial
The Trust has a flexible view of financial risk when making medium to long-term business decisions with transformative potential and is prepared to make bold, but not reckless, decisions, minimising the potential for financial loss by managing risks to a tolerable level. For other financial decisions, the Trust takes a cautious position, with VFM as the primary concern. However, the Trust is willing to consider other benefits or constraints and will consider value and benefits, not just the cheapest price. Resources are allocated in order to capitalise on opportunities.

Compliance/Regulatory
The Board has a minimal to cautious risk appetite when it comes to compliance and regulatory issues. Where the laws, regulations and standards are about the delivery of safe, high quality care, or the health and safety of the staff and public, it will make every effort to meet regulator expectations and comply with them and will only challenge them if there is strong evidence or argument to do so and the gain will outweigh the adverse consequences.

Innovation
The Board has a flexible view of innovation that supports quality, patient safety and operational effectiveness. Its strategic objective to embrace new ideas to deliver new, technology enabled, financial viable ways of working leads it to pursue innovation and challenge current working practices. It is willing to devolve responsibility for non-critical decisions on the basis of earned autonomy.

Quality
The Board has a cautious view of risk when it comes to patient safety, patient experience or clinical outcomes and places the principle of “no harm” at the heart of every decision it takes. It is prepared to accept some risk if, on balance, the benefits are justifiable and the potential for mitigation is strong. When taking decisions involving choices between a wide range of outcomes, it will prioritise the option resulting in the greatest benefit for the most patients.

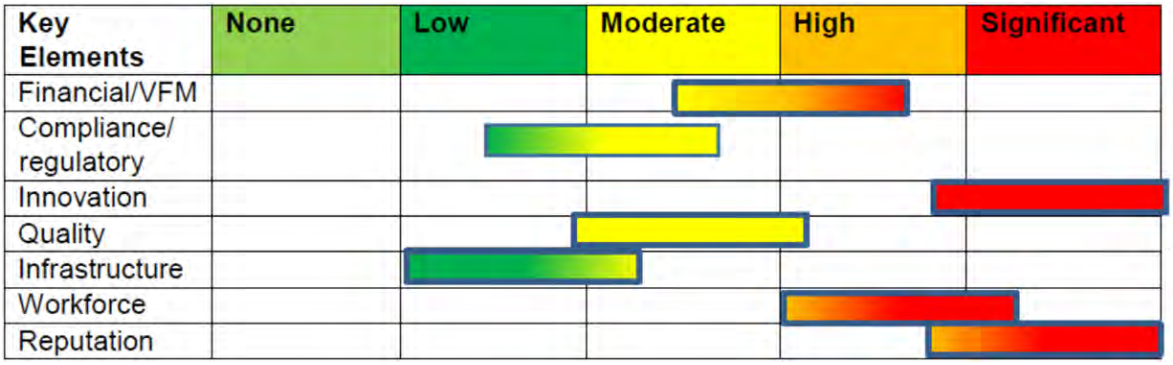
Infrastructure
The board will take a measured approach when investing in building and equipment maintenance and replacement, based on informed analysis and assessment of risk but may take informed risks if there are identifiable mitigations that can provide reasonable alternative protection.

Workforce
The board is prepared to take decisions that would have an effect on staff morale if there are compelling arguments supporting change, including some decisions with a high inherent risk if there is a potential higher reward.

Reputation
The Board’s view over the management of the Trust’s reputation is that it is willing to take high to significant risks and is willing to take decisions that are likely to bring scrutiny to the organisation where the potential benefits outweigh the risks and sees new ideas as potentially enhancing the reputation of the organization.

Commercial

The Board has a flexible view of commercial risk. It is willing to pursue business opportunities with the potential for high returns alongside commercial activities of a more established nature, taking a balanced view of risk and reward and on the basis of earned autonomy.



11:25 ITEMS FOR INFORMATION

17. 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

18. Date of next meeting

To NOTE that the next meeting will be held on Friday, 4 December 2020 at 9:15am in West Suffolk Hospital

For Reference

Presented by Sheila Childerhouse

18.1. Future Board meeting dates

For Approval

Presented by Sheila Childerhouse

NHS
West Suffolk
NHS Foundation Trust

TRUST BOARD MEETING DATES

2021/22

Open (Public) Session commences 9.15am – 11.15am
Closed (Private) Session commences 11.30am – 1.00pm

Friday 29 January

Friday 26 February

Friday 26 March

Friday 30 April

Friday 28 May

Friday 25 June

Friday 30 July

No meeting in August

AMM - .. September

Friday 5 November

Friday 3 December

Friday 28 January 2022

Friday 4 March 2022

Board meetings are held via Teams.

RESOLUTION TO MOVE TO CLOSED SESSION

19. 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