Board of Directors (In Public)

Schedule	Friday 2 October 2020, 9:15 AM — 11:30 AM BST
Venue	Via video conferencing
Description	A meeting of the Board of Directors will take place on Friday, 2 October 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 10 02 Oct.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: Richard Davies
   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 31 July 2020
   For Approval - Presented by Sheila Childerhouse
   - Item 6 - Open Board Minutes 2020 07 31 July Draft.docx

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

8. Chief Executive's report
   To RECEIVE a report on current issues
   For Report - Presented by Stephen Dunn
   - Item 8 - Chief Exec Report Sept '20.doc
   - Item 8 - CEO report Annex WSFT Flu Checklist 2020-21.docx

9:40 DELIVER FOR TODAY

9. COVID-19 report
   To RECEIVE a briefing
   For Report - Presented by Helen Beck
   - Item 9 - COVID 19 report Sept 2020.doc

10. Integrated quality and performance report
    To APPROVE a report
    For Approval - Presented by Helen Beck and Susan Wilkinson
    - Item 10 - Integrated Quality and Performance Report - Sept 2020.pdf

11. Maternity services quality and performance report
    To APPROVE a report
    For Approval - Presented by Karen Newbury

    Item 11 - Maternity quality and performance report Sep 2020.docx

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12. Infection prevention and control assurance framework
    To RECEIVE a report
    For Report - Presented by Susan Wilkinson

    Item 12 - 20-10-03 COVID IPC assurance framework.docx
    Item 12 Appendix 1 - WSFT Ass framework.pdf
    Item 12 Appendix 2 - CQC Assessment for WSFT on 04_08_20.pdf
    Item 12 Appendix 3 - Patient and Visitor Test and Trace SOP Aug 2020.pdf
    Item 12 Appendix 4 - Rapid review of current COVID practice.pptx
    Item 12 Appendix 5 - Infection Control Annual Report 2019-20.pdf

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

    Item 13 - Board report Cover sheet - M05.docx
    Item 13 - Finance Report- August 20 FINAL.docx

10:30 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

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

    Item 14 - People & OD highlight report.docx.doc

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15. Education report, including undergraduate training
    To ACCEPT the report
    For Report - Presented by Jeremy Over

    Item 15 - Education & Trust paper for Board September 2020.docx

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16. Equality, diversity and inclusion annual report

To APPROVE the report
For Approval - Presented by Jeremy Over and Ayusha Sinha

Item 16 - Trust Board Annual EDI 2020 report v2.docx

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

Item 17 - Nurse staffing report - Sept 2020.docx

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18. Quality and learning report – Q1
To ACCEPT the report
For Report - Presented by Susan Wilkinson

Item 18 - Quality and Learning report - Sept 2020.docx

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19. Improvement programme board report
To RECEIVE the report, including the Trust improvement plan
For Report - Presented by Susan Wilkinson and Stephen Dunn

Item 19 - Improvement programme board report Sep 2020.docx

Item 19 - Improvement Plan IPB Outputs.pdf

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

Item 20 - Consultant appointment report - Sept 2020.doc

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

11:00 BUILD A JOINED-UP FUTURE

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22. Pathology services report
To ACCEPT the report
For Report - Presented by Nick Jenkins

- Item 22 - WSFT Pathology Services Strategy - September 2020.doc
- Item 22 Appendix 1.1 - Pathology Services.xlsx
- Item 22 Appendix 1.2 - Pathology Services.xlsx

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23. WSFT digital board report
    To APPROVE a report
    For Approval - Presented by Craig Black
    - Item 23 - Digital Board Trust board - Sept 2020.doc

11:10 GOVERNANCE

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24. Trust Executive Group report
    To ACCEPT the report
    For Report - Presented by Stephen Dunn
    - Item 24 - TEG report.doc
    - Item 24 Annex A - Draft committee structure.docx
    - Item 24 Annex B - WMTU themes and commitment.docx

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25. Audit committee report
    To ACCEPT the report
    For Report - Presented by Angus Eaton
    - Item 25 - Audit Committee Report Sept 20.doc
    - Item 25 - Audit Committee Annual Report 1920.doc

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26. Council of Governors report
    To ACCEPT the report
    For Report - Presented by Sheila Childerhouse
    - Item 26 - CoG Report to Board October 2020.doc

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27. Review of COVID governance arrangements
    To ACCEPT the report
    For Report - Presented by Richard Jones
    - Item 27 - COVID governance arrangements.docx

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28. Use of Trust's seal
To APPROVE the report
For Approval - Presented by Richard Jones

Item 28 - Use of Trust Seal Report 2 October 2020.docx

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29. Agenda items for next meeting
To APPROVE the scheduled items for the next meeting
For Approval - Presented by Sheila Childerhouse

Item 29 - Items for next Board meeting.doc

11:20 ITEMS FOR INFORMATION

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30. Any other business
To consider any matters which, in the opinion of the Chair, should be considered as a matter of urgency
For Reference - Presented by Sheila Childerhouse

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31. Date of next meeting
To NOTE that the next meeting will be held on Friday, 6 November 2020 at 9:15am in West Suffolk Hospital
For Reference - Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

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32. The Trust Board is invited to adopt the following resolution:
“That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest” Section 1 (2), Public Bodies (Admission to Meetings) Act 1960
For Reference - Presented by Sheila Childerhouse

9:15 GENERAL BUSINESS

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DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 31 JULY 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	•	
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			
Nick Macdonald	Deputy Finance Director		
Daniel Spooner	Deputy Chief Nurse		
Kate Vaughton	Director of Integration and Partnerships		
Governors in attendance (observation only)			
Peter Alder, Florence Bevan, Judy Cory, Jayne Gilbert, Gordon McKay, Adrian Osborne, Liz Steele			

Action

GENERAL BUSINESS

20/157 RESOLUTION

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

20/158 APOLOGIES FOR ABSENCE

Apologies were received from Craig Black; Nick Macdonald attended in his absence. Richard Jones and Georgina Holmes had also sent their apologies.

- It was explained that the meeting was being recorded today in the absence of the Georgina Holmes.

- The Chair welcomed everyone to the meeting and introduced David Wilkes who was attending his first board meeting as a Non-Executive Director (NED). He gave a short summary of his background and career.

20/159 DECLARATION OF INTERESTS FOR ITEMS ON THE AGENDA

David Wilkes declared an interest as a trustee of St Nicholas Hospice.

20/160 QUESTIONS FROM THE PUBLIC RELATING TO MATTERS ON THE AGENDA

Q Could we have an update on testing and if this had progressed since the last boars meeting; was the track and trace system in the hospital the same as outside the hospital?

A Testing had not really progressed, despite continued efforts, although turnaround times from the outsourced company had improved. As from today this company were no longer being commissioned by the NHS to provide testing and trusts would be required to use NHS facilities. As WSFT had not utilised all the capacity it had commissioned from this company it would continue to use them for a further ten days. Following this the intention had been to use the ESNEFT testing facility, but as this was not yet ready a contingency had been identified. WSFT was still working to set-up on site testing but there had been issues with obtaining an affordable solution and efforts continued on this.

The Trust was responsible for staff Track and Trace but for patients and visitors it was the same as outside the hospital. Visitors were required to register their details with the ward reception staff.

Q Was there anything that governors could do to put pressure on about testing as the Trust appeared to be at a disadvantage?

A This was the case and there had been an issue with delays in receiving test results for patients. However, due to for example the lack of reagent. It had been decided that there would be one testing centre for each ICS and this was not at WSFT. However, in the future it would be possible for WSFT to undertake a small number of point of care tests to enable a rapid clinical decision.

If governors were able to help to influence this in any way they were free to do so. A number of the Trust's consultants, including microbiologists, had written to their local MPs to highlight the detrimental effect that this had on patient care and this had resulted in a positive reaction, although to date the issue had not been solved. The Chief Executive and Nick Jenkins had also raised this with the regional and national teams, as well as with the local MP.

20/161 REVIEW OF AGENDA

The agenda was reviewed and there were no issues.

20/162 MINUTES OF MEETING HELD ON 26 JUNE 2020

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

20/163 MATTERS ARISING ACTION SHEET

The ongoing actions were reviewed and the following issues raised:

Item 1751; continue to improve the narrative in the IQPR to ensure consistency and clarity in terms of 'When' field; also review the SPC metrics. The date for this had been amended several times due to the information team being required to focus on Covid. The team were now returning to their normal roles and a plan would be provided to the board meeting on 2 October.

Item 1828; maintain Board oversight of non-urgent patient transport performance, with formal review report to Board in May. Due to the reduced level of outpatient activity the level of issues was not being seen and this would continue to be monitored.

Item 1830; review and consider Board agenda and report structure. Provide greater focus on staffing/people over transactional issues. It was agreed that with the focus on cultural issues and feedback from workforce there should be a more structured opportunity/agenda item for the director of workforce and communications to provide regular updates at board meetings.

ACTION: director of workforce and communications to provide feedback to public board meetings on workforce and cultural issues. **J Over**

The completed actions were reviewed and there were no issues.

20/164 CHIEF EXECUTIVE'S REPORT

- Urgent and clinical services were now increasing within the hospital but there was still a significant backlog. This was a concern and it was important that the Trust continued to provide a service to the local population despite the changes as a result of Covid.
- A major piece of work had been undertaken with staff in response to the CQC report on culture. Nearly 1,400 staff had completed a survey and 50 workshops had taken place to try to understand what mattered to them. The themes that were coming out of this were detailed in the report.
- The executive team and senior leaders had been looking at how the Trust's governance could be redesigned to address some of the issues from the CQC report, working with key senior clinicians and medics; this would be fed into the Trust improvement plan.
- The external review team had been on site and the Chief Executive thanked colleagues for their time and commitment to this review. It was anticipated that the outcome of this would be available sometime in the autumn.
- The previous freedom to speak up guardian had stepped down and a recruitment process was being undertaken. Francesca Crawley had stepped into this role until a new guardian was appointed.
- Covid had had a significant effect on a number of staff, in particular those from Black, Asian and Minority Ethnic (BAME) groups. The Trust worked to ensure that risk assessments were undertaken for all staff and a BAME network had been set up to understand their concerns and experiences and what worked for them.
- There continued to be challenges with the structure of the building and remedial action was being taken to try to mitigate this. The regional and national teams were being kept updated on how the Trust was managing this risk.
- Work was progressing on the development of the new healthcare campus and the board and governors would be updated on this.
- The Trust's five-year strategy was in the process of being updated and would link with the development of the new healthcare campus, as well as taking into account feedback from the CQC and the culture of the Trust.

DELIVER FOR TODAY

20/165 COVID-19 REPORT

- During the last month WSFT had recommenced weekly winter planning meetings and the clinical commissioning group (CCG) was co-ordinating the work on this for the system.

- WSFT's plans to use critical care regional surge centres were now unlikely to be possible. This meant that if there was a significant spike in Covid cases the second critical care unit would be reopened which would need to be staffed by anaesthetists. This would have a significant impact on the Trust's elective recovery programme which was a concern.
- Critical care activity had been busy with the unit being at or almost at capacity for most of July, however none of this was Covid related.
- General and acute capacity was similar to last month. Activity within the emergency department continued to increase but was still below pre-Covid levels. The organisation was managing this level of demand, although it was challenging.
- RTT performance was a major concern; this would continue to deteriorate before it improved as the capacity to clear backlogs was outstripped by the increased level of demand that the Trust was experiencing. The majority of the backlog was patients waiting for diagnostics and procedures.
- Cancer backlogs were expected to improve. Although the number of patients waiting for over 62 days had significantly increased the majority were waiting for endoscopy procedures which were now taking place again. The majority of these patients did not yet have a diagnosis.
- Work was still required on recording virtual outpatients as distinct from face to face.
- The day surgery unit (DSU) was now operational again and the Trust also continued use capacity at the BMI. There had recently been a change to the national guidance which had reduced the requirement to self-isolate before coming in for a procedure from 14 to three days, and patents to have a swab three days in advance of their procedure.
- As part of phase 3 recovery across Suffolk and North East Essex a regional elective recovery board was being set up; Nick Jenkins and Helen Beck would attend the first meeting. This would look across the three acute trusts at anything that could be done differently and opportunities to support each other as well as the independent sector across the area. The board would be updated on progress.
- The report included information on community services and positive examples of the use of digital technology within this service. However, there were serious concerns within the paediatric team about the ADS diagnostic pathway as it was extremely difficult to undertake assessments with PPE etc. Work was being undertaken to address this.
- An update was provided on the Trust's focus and actions with BAME staff; this was also a national area of focus and it was a requirement that boards were updated on this. The chair of the BAME staff network and Jeremy Over would provide more detail at the next board meeting. The report detailed the completion of staff risk assessments, including those who were known to be at risk and BAME staff. Those staff who had not yet completed a risk assessment had been identified and followed up. Feedback from BAME staff obtained through 'What Matters to You' would also be reported to the next board meeting.

ACTION: provide report to next board meeting on feedback from BAME staff. **J Over**

Q Was it possible to increase theatre capacity both at the BMI and internally, as there is a lot of pressure on Trusts to resolve the backlog issue?

A The local BMI was a small facility with limited capacity and it would be very difficult to use their outpatient facility with social distancing. The Trust was using their endoscopy facility and had also been undertaking orthopaedic, skin and breast cancer procedures. Covid increased theatre staffing requirement for each session and the local BMI had indicated that they could not staff all this capacity.

However, it was expected that this would be resolved coming weeks. As from next week they had also agreed to add an additional procedure to each list which would mean that the number of patients per list were at pre-Covid levels.

The Trust's internal capacity was constrained by a number of issues, including structural repair work and staffing.

Q There was some concern from patients and the public about waiting times. Had there been any progress since the board meeting last month in providing information to patients through primary care about waiting list times for specialties?

A Patients on waiting lists for longer periods of time for surgical procedures had all been written to in order to advise them of the waiting time and what to do if their condition or symptoms worsened. It was hoped that that this could be progressed through the regional elective recovery board.

Q With the Trust's current endoscopy capacity, how long would it be before it was back to more realistic cancer endoscopy waiting times and did this take into account the backlog that was likely to be in the community that the Trust was not aware of?

A Capacity was less than before and it was very difficult to know what demand would look like, therefore a level of assumption was involved. Cancer referrals generally were now at about 90% of pre-Covid levels so were getting back to a normal level of activity.

There was a regional endoscopy group which WSFT was linking into so that it could learn from others across the system. It was expected that the cancer diagnostic backlogs would be cleared within a few months, however this had not taken into account the resumption of surveillance endoscopy; national guidance was awaited on this. Endoscopy teams were running additional evening and weekend lists and there was also the additional capacity at the BMI.

Q Would theatre 1 be ready for use during the winter pressures, or would it not be available until next year?

A It would not be available until next year as the contractors were unable to work in this area during lockdown. Even if it was available there would not be the bed capacity in the winter to utilise this.

20/166 INFECTION PREVENTION AND CONTROL ASSURANCE FRAMEWORK

- The CQC had developed an emergency support framework which included a set of questions all trusts were required to complete. These had been worked through together with stakeholder colleagues and would be updated on a monthly basis.
- The CQC recognised that it was not possible for trusts to be compliant in all areas and the purpose of this was to provide assurance that there were robust systems in place to mitigate against this non-compliance and demonstrate that these were effective.
- In addition to the three areas that were reported as being non-compliant last month (ventilation, timely receipt of testing results and isolation), three further areas had been identified which required further evidence to provide assurance that the Trust was compliant - patient moves, contact tracing, and timely taking of swabs. Work was being undertaken to address this assurance gap.

ACTION: Address assurance gap in the infection prevention and control assurance framework. **S Wilkinson**

20/167 INTEGRATED QUALITY AND PERFORMANCE REPORT

- Emergency department (ED) attendances continued to increase but were still not at pre-Covid levels. The Trust was looking at how it could respond to the proposal that patients/public should pre-book via 111 before they arrived at ED, with the exception of those arriving by ambulance. The guidance around this was not yet clear and the board would be updated once this had been confirmed.
- In response to a request at the last board meeting a chart had been included in this report to show how RTT performance had changed over the Covid period. There was a concern over the number of patients over 52 weeks and this would continue to increase; this was an issue being seen nationally.
- Further detail had been included on performance in the community, including how it had moved to telephone and video contact with patients. Information also showed the number of contacts made by all services across the community remained at a reasonably high level during this period, although it was acknowledged that there was an issue in paediatrics which would need to be addressed. The board considered this information to be very helpful.

Q Could the IQPR identify which performance indicators were national standards so that it could be evidenced that the board was focussing on these issues?

A These had been identified in the IQPR prior to Covid. This report would be developed further by the next board meeting and would include this information, as well as which indicators were local standards.

ACTION: develop the IQPR to indicate which indicators were national or local standards. **C Black**

Q Looked after children performance had previously been a concern and a focus of the board and this would also be an increasing national concern as a result of Covid. Which data in this report included looked after children?

A This was included under contacts but could not be specifically identified in this report. The team was very aware that this would be an increasing issue; the service had performed well in meeting the local standard of contacting families within 14 days of notification. Although it was recognised that in some cases there was a need for face to face contact, in a lot of cases it had been possible to speed up contact with the use of video appointments.

Q As so much of the Trust's performance going forward would depend on how well it planned for the future, would it be possible to include in the report a projection of the anticipated position versus the actual position? This would be for the board's information only, not to hold people to account.

A There would be a requirement for trajectories and this information could be included in this report, as long as the board was aware that this involved a considerable amount of educated guesswork and should not be used to hold people to account.

ACTION: develop the IQPR to provide anticipated recovery trajectories. **C Black**

- Duty of candour compliance had reduced slightly, but should improve by next month. All except one verbal duty of candour had been completed for the hospital acquired Covid cases and follow-up letters were now being sent out. The one that was outstanding was due to not being able to contact the family of a deceased patient but additional contact details had now been obtained. The communications team had prepared a response to any media interest that could result from this.

- The Trust had had a recent near-miss never event. This was not reported as a never event, in consultation with CCG, as no "life-changing" harm was caused to the patient. However, the incident would be fully investigated and learned from.
- The number of acute falls per 1000 bed days had increased; 89% of these patients had a falls care plan and this would continue to be worked on and improved. Falls with harm continued to be an ongoing focus and new falls mats were being trialled but the effectiveness of these depended on the staff monitoring them.
- The increase in community acquired acute pressure ulcers was a concern. However, a recent root cause analysis into a category 4 pressure ulcer showed that the patient had received excellent care and the issue this was about concordance with the family. A piece of work was being undertaken Trust-wide to build concordance.
- Compliance with completion of nutrition assessments had improved. This was an ongoing focus of the nursing team and it was expected that this would continue to improve.
- As anticipated, complaints had started to increase again but the team was now fully established and should be able to respond to these within the timeframe. Learning from complaints would continue to be focussed on; a recent theme that had been identified was around communication and further work would be undertaken on this. Further detail would be provided next month.

ACTION: provide update on themes and the learning from complaints. **S Wilkinson**

Q Could assurance be provided that the Trust was committed to continuing the operation of the clinical helpline which had been so successful in the future?

A This had been operated by members of staff who were now returning from shielding to their normal jobs, which meant that the team had reduced. The service had been a great benefit to patients and their relatives and the Trust needed to consider how this could continue to be staffed, particularly during the winter period.

20/168 MATERNITY SERVICES QUALITY AND PERFORMANCE REPORT

- This report would be produced on a monthly basis to provide visibility to the board of actions and progress in maternity services. Feedback was requested from board members on the future format and content.

Q In the light of the issues in the maternity department at Shrewsbury hospital, were the indicators in this report sufficient to provide assurance that the same issues were not occurring at WSFT?

A This should be the case, however there was also additional data and a number of other indicators and information that were triangulated to provide this assurance. This also included feedback from staff and patients and walkabouts by the Medical Director and Executive Chief Nurse. A quality assurance framework was also being put together in conjunction with external partners.

Q How concerned should the board be about the maternity safety highlight report and the indicators that were red and amber, e.g. ten steps to safety?

A One of the reasons for this was around the Trust's ability to evidence the actions that were being taken. There were some areas that may not move to green but other trusts would be in the same situation. The ten steps for safety on page 2 of the report was where the Trust was at this moment in time; the report would be finally submitted in March next year. Each year additional elements were added to this.

The Trust continued to review this and ensure that it was aware of the additional elements and that it was compliant with these and was able to evidence this.

- It was agreed that the information provided in this report was very useful and consideration should be given to adopting a similar format for other areas to provide similar assurance and additional visibility, some of which could be provided to the board.

Q Should there be an exception report for the 85 indicators on the maternity dashboard which would provide the board with visibility of areas of concern?

A In future the maternity safety highlight report would show the position for the previous month which would provide the board with information on the progress that was being made or where further rapid improvement was required.

ACTION: maternity safety highlight report to show position for previous month to provide further visibility on progress or where further action was required. **S Wilkinson**

- It was noted that the midwifery led birthing unit (MLBU) had not been used during Covid and this should improve as normal practice had now been resumed.
- The increase in the number of caesarean sections had been reviewed but there was no obvious reason for this; this would continue to be monitored.
- The total number of grade 2 caesarean sections (decision to delivery time) was due to a mixture of issues, mainly around the additional PPE required; it was confirmed that no harm had resulted.
- An action plan had been completed for the maternity incentive scheme year two submission, following the CQC visit and the Trust's non-compliance with this. This was about improvement and quality and the CNST had indicated that there could be funding to support the Trust to become compliant in those areas.

  This had been discussed in detail by the executive team who had been assured by the level of rigour applied to this process. The board confirmed that they were assured that there had been sufficient oversight of this and sufficient evidence that actions had been embedded.

  The board received and approved the action plan for the CNST maternity incentive scheme for submission to NHS resolutions.
- The board noted and received the Perinatal Mortality Tool report.

20/69 FINANCE AND WORKFORCE REPORT

- Trusts continued to be funded to a breakeven position and this was expected to continue until the end of September, after which this income stream would be devolved to the CCG. This was not expected to materially affect WSFT's income, therefore it continued to forecast income on the basis that it should continue to breakeven. However, it was not known what additional expenditure would be incurred in the second half of the financial year and this would be dependent on the Covid situation and activity levels.
- The main concern was that the situation for next year was also unknown, therefore the focus was on staffing and the cost improvement plan (CIP). The CIP was below plan but this was currently being offset by the funding that was being received. However, if recurring CIPs were not been achieved by the end of the year this would cause a problem moving into 2021-22. Therefore, the divisions had been asked to review their recurring CIPs and the trajectory for achieving them by the year-end.

- Another area of focus was total substantive staffing to ensure that this was not above the level budgeted for. Currently this was below budget with 157 vacancies which were being filled with temporary staff. Temporary staffing levels were over-establishment, mainly as a result of Covid and also failure to achieve CIPs.

Q 13 out of 17 CIPs were behind plan; is the programme management office (PMO) fully staffed and available to support the divisions in achieving their CIPs for this year?

A Vacancies in the PMO were being covered by temporary staff and a piece of work was being undertaken with the divisions to look at what support they needed both from a quality improvement and cost improvement point of view. The staffing of the PMO would be reviewed when this work had been completed.

It was acknowledged that the focus had not been on CIPs during the Covid period, however the teams were aware of the need re-focus on this as the Trust moved into the recovery period and looking forward to next year.

Q Did the executive team need any support from the board to stress to the organisation that funding to enable the Trust to breakeven during Covid was not going to continue indefinitely and CIPs would need to be achieved?

A The board could be assured that this has been area of focus at the review meetings this week. As result of the changes and also opportunities due to Covid it was suggested that the CIP may need to be reviewed, particularly the changes that had been made which were previously considered to be unachievable. Feedback from 'What Matters to You' could also provide additional opportunities/areas for cost improvement.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

20/170 NURSE STAFFING REPORT

- This report continued to be developed and the new deputy chief nurse, Daniel Spooner, had provided considerable input this month.
- The shortfall in fill rates had been mitigated to ensure that all areas were safely staffed.
- This report now included sickness levels and self-isolation and in future would also include information on patient flow and escalation areas to provide greater context around staffing levels, staffing requirements and quality indicators.
- Work had been undertaken to review actual nurse staffing vacancy levels across all areas of the organisation. The only area apart from theatres and critical care with significant vacancies was F3. All other areas were almost, or had plans to be, fully recruited to.
- Assurance was provided that the Trust had safe-staffing levels and did not appear to have an excess of number of nurses. However, a full establishment review would be undertaken over the next few months to ensure that this was fit for purpose, taking into account acuity of patients etc.

ACTION: outcome of nursing staff establishment review to be presented to the board when available in December. **S Wilkinson**

- The Trust continued to pro-actively recruit nurses taking into account the likely opening of additional capacity during the winter period.

- Information on the cost and use of temporary staff would be presented to the board in September.
- Quality indicators on falls, pressure ulcers and complaints were included in the report, as well as information on maternity services staffing.

Q When would the first phase of the development of this report be completed?

A If the board was in agreement with this format/content the report would remain the same but further information would be provided on staffing levels and risks.

Q Would the establishment review include the community?

A It was confirmed that this was the case.

20/171 SAFE STAFFING GUARDIAN REPORT

- During the Covid response there were significantly fewer exception reports which demonstrated the flexibility of the junior doctors during this period as well as the close attention of the medical staffing team.
- There were no exception reports about pattern of hours, the availability of support provided or the lack of educational opportunities. This was a significant achievement during this challenging period.
- The board recorded its thanks to Dr Francesca Crawley for taking on the interim role of Freedom to Speak Up Guardian until a new appointment was made.

20/172 IMPROVEMENT PROGRAMME BOARD REPORT

- There had been a very good level of engagement across the organisation and this was an opportunity to provide the board with the additional assurance it required. Richard Davies had agreed to be the additional NED on this board.
- There would be a deep dive on maternity at the next meeting.
- The board approved the updated improvement plan and terms of reference.

Q Could the next report provide clarification on the five clusters and responsibilities for these?

A This information would be provided in the next report.

ACTION: Improvement report to include information on the five clusters and responsibilities. **S Wilkinson**

Q Should there be greater emphasis on consultation and engagement with staff in the terms of reference, or in terms of the improvements, so that the Trust could demonstrate this?

A It was agreed that this was very important. The feedback from 'What Matters to You' and also the survey that Paul Molyneux has been undertaking with doctors was likely to be the subject of a deep dive by the improvement board. It was also recognised that it was very important to have the right people on the improvement board and also in each of the clusters, including good medical and clinical representation and further work would be undertaken to ensure that this was the case.

The outcome of discussions at the clusters would be fed through the improvement board and then the board. It was important that there was full ownership of the

improvement plan and there should be co-production with staff and a different way of driving-up the quality of the Trust's services.

- It was important that the board maintained overall responsibility for this but the improvement board would provide additional assurance.

20/173 MANDATORY TRAINING AND APPRAISAL REPORT

- During the Covid period training and appraisals had not completely stopped, however it had been recognised that the opportunity for staff to partake in these had been more difficult.
- The GMC had suspended the requirement for appraisals for medical staff until April 2021.
- There had a been a reduction in compliance with appraisals and mandatory training over the last quarter. However, the reduction in compliance with mandatory training was not as large as could have been expected, ie 86%.
- Plans were in place to address this as the Trust moved into the recovery period. However, there were challenges with training capacity in some rooms due to the requirements to maintain social distancing. Ways in which to mitigate this were being looked at, including external facilities.

Q Despite the current challenges around appraisals, should the organisation reflect on the importance of appraisals as a way of supporting staff and giving them the opportunity to discuss their concerns etc?

A This was a very important function of appraisals but there were other opportunities for staff to have this sort of conversation with their manager and this continued to be the case. The Trust had not put a stop on appraisals during Covid and for some areas it had been easier due to a reduction in activity.

As the Trust moved forward there would be a real opportunity to promote the staff wellbeing and staff support components of appraisal conversations. The feedback from 'What Matters to You' would help to refine this process.

20/174 CONSULTANT APPOINTMENT REPORT

The board noted the following appointments:

Miss Sonal Grover; Acute Consultant in Obstetrics and Gynaecology - Maternal Medicine

Miss Rukhsana Mohammad; Acute Consultant in Obstetrics and Gynaecology - Urogynaecology

20/175 PUTTING YOU FIRST AWARD

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

Stefan Currington, lymphoedema assistant practitioner:
Stefan has thrived since working within the lymphoedema service, particularly taking pride in the group workshops he has developed, which support lymphoedema patients with further education, emotional support and allow them to meet other patients with similar conditions.

Stefan researched the condition to develop a better understanding of how to support patients and now holds bi-monthly workshops. Feedback has been extremely positive, with patients feeling empowered. Stefan keeps the sessions upbeat and positive, despite considerable emotion from some of the attendees, and his enthusiasm to improve care for our patients is evident.

Lucy McDonald, speech and language therapist:
Lucy has shown exemplary leaderships skills. The SALT clinical lead for stroke commenced maternity leave in October 2019 and it took four months to recruit to this role. In the interim, Lucy supported the stroke SALTs and tirelessly managed an extremely busy caseload.

She supervised and supported junior members of staff through a challenging winter period, as well as flying the flag for SALT and continuing with service improvements to benefit the patients she works with.

The board congratulated Stefan and Lucy and commended them for going the extra mile.

BUILD A JOINED-UP FUTURE

20/176 INTEGRATION REPORT

- This report included information on work and developments with partner organisations during Covid which would continue as part of winter planning, e.g. working with the hospice and voluntary sector and the additional capacity which would underpin primary care networks and the locality teams.
- The main focus was now on flu and understanding how to meet the challenge of this from the point of view of primary care. community pharmacies and wider services and further guidance was awaited. Everyone was very engaged and ready to work differently and together to meet the requirements.
- Sarah Howard had been appointed as independent chair for the West Suffolk Alliance as from September. A number of partners and stakeholders had taken part the appointment process.
- The initiatives on end of life care were noted and considered to be a very positive step.

GOVERNANCE

20/177 TRUST EXECUTIVE GROUP REPORT

- Covid recovery and winter planning continued to be a key focus together with the improvement plan and pathology disaggregation.

20/178 EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE STRATEGY

- This was the Trust's strategy and policy document which was being presented to the board retrospectively.
- This document was likely to be updated post Covid, audit and new national guidance and would be brought back to the board for review.
- The board approved the current version of the strategy.

20/179 AGENDA ITEMS FOR NEXT MEETING

The board received and noted the content of this report.

ITEMS FOR INFORMATION

20/180 ANY OTHER BUSINESS

There was no further business.

20/181 DATE OF NEXT MEETING

Friday 2 October, 9.15am

RESOLUTION TO MOVE TO CLOSED SESSION

20/182 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 – 2 October 2020

Agenda item:	7			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	23 September 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
1823	Open	28/2/20	Item 8	Sepsis – assess impact of establishing super-RAT within ED	RAT area in ED is now the COVID area so will be revisited as part of COVID recovery when workflow re-established. **Capital bid submitted to increase the footprint of the current ED to recreate the RAT area. Currently awaiting clarity for external process and timeline for approval. Verbal update on position in meeting**	HB	~~27/03/2020~~ Review 2/10/20	Red
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		SW	29/01/21	Green

Closed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1751	Open	27/9/19	Item 8	Continue to improve the narrative in the IQPR to ensure consistency and clarity in terms of 'When' field for timing of improvements e.g. pressure ulcers. Also agreed as art of next phase of IQPR development to review the SPC metrics which are indicators as future performance	1/11/19 - agreed to provide more granular responses, if unable to state a timescale for improvement then indicate the blockers to doing this. An individual response has been sent to highlight the areas which require stronger narrative. There is a need to review the IQPR and its scope - this will be followed up at future Scrutiny Committee 31/1/20 agreed to bring back plan on how IQPR will provide clarity on timescale for delivery 27/3/20 reviewed at Scrutiny Committee and noted that plan for launch of interactive IQPR is Autumn 20. Agreed to develop options for interim arrangements. Reporting of quality and performance during COVID considered at Board and Audit Committee. The IQPR continues to evolve to provide a wider focus and quality and performance charts and supporting narrative. The 'interim' COVID IQPR will form the building block for the new reporting with the aim of providing an outline plan to the Board by September. **2/10/20 Proposal for 'watch list' review at Scrutiny Committee and forms part of the IQPR report to Board. This will be kept under review**	CB	~~31/01/2020~~ ~~24/4/20~~ 2/10/20	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1863	Open	26/6/20	Item 14	Provide an update on recruitment of the replacement FTSU guardian	Expressions of interest have been received from three individuals. Interviews will take place in August - the interview panel will consist of Sheila Childerhouse, Jeremy Over, Martin Wood and Fran Dawson (lead speak-up guardian at Norfolk and Norwich FT). Pending appointment Francesca Crawley has agreed to take up the FTSU guardian role on an interim basis. As the current Guardian of Safe Working Francesca is well placed to undertake the role and responsibilities. **AGENDA ITEM - Following a recruitment process over the summer, where expressions of interest were sought internally and from our West Suffolk Alliance partners, I am pleased to confirm the appointments of Amanda Bennett and James Barrett at our new Freedom to Speak Up (FTSU) Guardians. James, a consultant radiologist at WSFT and Amanda, Student Nurse Placement Facilitator with HEE/Suffolk and North East Essex ICS, will commence in their roles from 1 November and 1 October respectively. Further detail in the People and OD report on open Board agenda**	JO	31/07/20	Complete
1870	Open	31/7/20	20/165	Receive a feedback report from the chair of the BAME staff network	**AGENDA ITEM**	JO	02/10/20	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1871	Open	31/7/20	20/166	Address assurance gap in the infection prevention and control assurance framework relating to - patient moves, contact tracing, and timely taking of swabs	**AGENDA ITEM**	SW	02/10/20	Complete
1872	Open	31/7/20	20/167	Develop the IQPR to indicate: - which indicators were national or local standards - anticipated recovery trajectories.	**UPDATED IQPR**	CB	02/10/20	Complete
1873	Open	31/7/20	20/167	Provide update on themes and the learning from complaints	**AGENDA ITEM - Quarterly learning report**	SW	02/10/20	Complete
1874	Open	31/7/20	20/168	Maternity safety highlight report to show position for previous month to provide further visibility on progress or where further action was required	**AGENDA ITEM**	SW	02/10/20	Complete
1876	Open	31/7/20	20/172	Improvement programme board report to include additional information on the five clusters and their responsibilities.	**AGENDA ITEM**	SW	02/10/20	Complete

8. Chief Executive’s report

To RECEIVE a report on current issues

For Report

Presented by Stephen Dunn

Board of Directors – 2 October 2020

Agenda item:	8			
Presented by:	Steve Dunn, Chief Executive Officer			
Prepared by:	Steve Dunn, Chief Executive Officer			
Date prepared:	25 September 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

Putting you first

Chief Executive's Report

As we have seen on local and national news positive **cases of COVID-19 are continuing to rise** and while this is not at this stage translating into a significant increase in hospital admissions we need to be prepared. A significant focus of our virtual annual members meeting on 22 September was reflecting on what we have done in response to the pandemic and looking forward how patients and the public can protect themselves and those around them. I just want to repeat my thanks, and those of many others, to respiratory medicine consultant Dr Thomas Pulimood and public health consultant Dr Helena Jopling. Their interactive Q&A session was amazing and as requested is now available on our website for anyone who missed it or like me just wanted to watch again! The messages were clear keep following national guidance:

- ***Hands*** - wash your hands – it really does work
- ***Face*** - wear a face covering
- ***Space*** - follow the Social distancing rules

And if you are eligible protect yourself with the flu vaccine. COVID-19 has not gone away and we must do all we can to protect ourselves and others to help avoid a really bad second wave.

It is more important than ever to ensure our workforce is protected against seasonal flu. The Trust is required to provide public assurance, via the Board, at the start of the 2020 flu season about plans to promote and provide vaccination against flu to staff. All NHS trusts have been instructed by the Department of Health and Social Care and Public Health England to complete a self-assessment against a best practice checklist which has been developed based on five key components of developing an effective flu vaccination programme. The completed checklist must be published in public board papers at the start of the flu season. The WSFT staff flu vaccination programme starts on 1st October 2020 and the vaccine is being offered to all trust staff. A robust plan is in place to promote and provide vaccination against the flu to all WSFT staff. Our self-assessment against the national best practice checklist is appended to this report.

There is a report on the agenda of the Board which describes the huge amount of work we are doing to plan and prepare for winter, COVID-19 and recovery. But we do need to talk about the realities of where we are with recovery, and how this is impacting on our patients e.g. waiting lists. Before COVID-19 85% of patients on the waiting list were waiting less than 18 weeks. Now about half of the patients on the waiting list are waiting more than 18 weeks. I sorry about this but we are doing all we can to treat people as quickly as possible and mitigate harm while they wait for care. We are trying to restore as many services to 90% of their pre-COVID-19 levels but another wave of the virus might impact on this. We have been communicating with the public on this with myself, Helen Beck, chief operating officer and Nick Jenkins, medical director appearing on BBC Suffolk over the last three weeks explaining the honest realities of what we are facing.

Through the media we are trying to connect with the thousands of women missing potentially life-saving breast cancer checks after a 50% fall in the numbers attending appointments. The routine health screening, which is offered to women aged 50 to 71, was put on hold due to COVID-19 but restarted in July. Since then the numbers attending have dropped dramatically, with two thirds of women in west Suffolk and south west Norfolk not responding to letters offering them an appointment. The fall comes despite extended operating hours, and women now being offered the chance to choose their own appointment time rather than being automatically assigned a time slot. Before COVID-19, we saw around 13,000 women a year for potentially life-saving health checks but we have seen a worrying fall in appointments. We know people may be worried about COVID-19 but we have careful procedures in place to ensure the screening is as safe as possible, and it is really important that we continue to detect early breast cancer.

Another important factor which is impacting on our COVID-19 recovery is the planned work that we are undertaking to mitigate the structural risk caused by reinforced autoclaved aerated concrete (RAAC) planks. This reinforces the need for a new hospital.

We are currently putting together a design team for a new health and care facility in west Suffolk that is fit for the 21st century, this includes recruiting co-production leads to join the **Future System programme** team. This programme will support the major re-build of West Suffolk Hospital as part of the wider Suffolk and North East Essex Integrated Care System (ICS). The design will be based on a new co-produced clinical model. We will be working together with staff, families, patients, members of the public and other organisations in the ICS.

Linked to this future system work our strategy: Our patients, Our hospital, Our future, together is at the end of its life and we are starting process to **review and update our strategy**. The title alone shows how much the trust has changed since the document was written five years ago. Between us all we now work across two hospital sites, countywide community services, a GP practice and a reablement unit in a care home. Therefore, we need a new strategy to reflect how things have changed, and to describe everything we plan to achieve over the coming five years. At its highest level, the new strategy will enable us to:

- make the quality and safety improvements
- create a culture of empowerment that prioritises staff wellbeing
- adapt to COVID-19 and help us to recover from the impacts of the pandemic's first wave
- continue to digitise services
- look after our current estates and inform the design of the new facility that will replace the main hospital
- promote further integration with our local councils, primary care colleagues, the voluntary sector and other partner organisations
- educate and train the workforce of the future, and
- increase our contribution to research and development.

There is much more to be done beyond this and. like the future systems programme, we are using a new approach to this development in terms of listening and coproduction. For example, we are engaging with our teams and departments to consider the following questions:

1. What are you proud of achieving over the last five years and what would you like showcased?
2. What are your plans for the next five years and what are you hoping to improve?
3. Do the vision, priorities and ambitions we adopted in the last strategy still feel relevant and right, and is anything missing, or anything that you think is out of date?

Periodically the Trust puts on a 5 O'clock club meeting, these are a series of one hour long interactive leadership sessions with insightful speakers from outside the trust. They are open to all staff and everyone is welcome. We used to meet in the education centre but since Coronavirus hit we have moved online. Hopefully this is making it accessible and we are recording the sessions so people can watch them online. A couple of weeks ago we had a five o'clock club virtual session on creating a Just Culture with Amanda Oates, the Director of Workforce at **Mersey Care**. Over 80 people attended the virtual session, including many governors and nearly all the members of the board. And there was lots of food for thought in the session about how we can change our approach in the trust and build a new more compassionate and kinder culture. According to Amanda it was about changing the way you look at things that go well and things that do not go as expected, deliberately trying to reframe this from the traditional way of saying things that go wrong. It was about trying to be more curious about what happens in the workplace and about seeking to understand the human factors and other things that contribute to things going well or not going as planned, rather than solely focusing on mistakes and trying to apportion blame. Amanda also highlighted that we should be equally as curious when things go right. Do we really understand

why success is the rule and not the exception? And do we share and encourage that best practice? And are we civil, respectful and compassionate with each other?

Our Board and Human Resource and patient safety teams are going to look at the practical steps that Mersey Care have taken and see if we can make our trust an even more kinder, civil and compassionate place to work. But we can all start now by being more kind, ask each other if you are ok, and listen, really listen, don't jump in to respond, if we listen up more, I really believe people will speak up more and of course if they speak up, we need to listen, learn and plan how together we make things the best they can be, for all our people. Let's assume the best in people. And let's try to all live and work together for our patients and our community.

Following a recruitment process over the summer, where expressions of interest were sought internally and from our West Suffolk Alliance partners, I am pleased to confirm the appointments of Amanda Bennett and James Barrett at our new **Freedom to Speak Up (FTSU) Guardians**. James, a consultant radiologist at WSFT and Amanda, Student Nurse Placement Facilitator with HEE/Suffolk and North East Essex ICS, will commence in their roles from 1 November and 1 October respectively. There is more on this and other developments with our staff in the people and organisational development report on the main agenda.

As a Foundation Trust, we have a Council of Governors which ensures that our key stakeholders – patients, members of the public, staff and partner organisations – have a say in shaping their local health service. We are in the process of undertaking **elections for our public and staff governors** who are the voice of the public, patients as well as partners and colleagues and share their ideas, concerns and suggestions on a wider platform. They work with the board to ensure staff and community needs are taken into account in the planning of services. We want our Council of Governors to be inclusive and representative of the diversity of the Trust's workforce and the population we serve. To that end, we welcome nominations from anyone, no matter who you are or your background. It's a partnership, and it's one you can be a part of.

I am looking forward to welcoming our **pathology staff** back to the Trust and the West Suffolk family. We are continuing to work with East Suffolk & North East Essex NHS Foundation Trust (ESNEFT) to ensure the safe transition of services on 31 October. We know its been a difficult period with many changes and many different owners. Going forward we really do want to make changes for the better and improve the lab environment and ways of working.

Through the Trust Executive Group (TEG) we have engaged senior leaders and specialist to review how we oversee and deliver **quality, safety and improvement**. Through this work TEG with other specialists has coproduced a structure, informed by the national patient safety strategy, to drive an integrated approach to quality through three new groups focused on insight, involvement and improvement. The TEG report on the main agenda provides more detail of proposal and a recommendation to the Board.

I was delighted to Chair our new improvement programme board in September which includes representatives from the clinical commissioning group (CCG) and the regional office. A report from the meeting and a copy of the **Trust improvement plan** are included in the open Board agenda which will also provide the opportunity to feedback on some of the assurance work that has been undertaken in maternity services. I'd like to thank all the teams involved for their hard work in taking forward many of the improvement actions. There is lots of good progress but still work to be done.

Prior to COVID-19 the structure of the **integrated quality and performance report (IQPR)** was under review and a plan had been adopted to deliver a more targeted performance report to the Board. Early in our COVID-19 response an interim IQPR was developed which was well received. The previous plan to upgrade the IQPR has been updated taking into account these developments as part of the COVID-19 response. It has been decided that we will not use statistical process

control (SPC) charts as the filter for areas of performance that need greater focus but the metrics will be escalated to the Board based on a physical review. To enable this task to be manageable and meaningful, a 'watch list' of at-risk metrics will be developed from the full the IQPR. This list will exclude metrics that always perform well and require little attention – these will remain in the full list.

Each month, the watch list will be reviewed by the Head of Performance and Efficiency and the information team and any indicators that are under/over performing will be escalated into the Board report. A longer list will be maintained of all the metrics which will continue to be monitored. The watch list and the full longer list of KPIs will be reviewed quarterly and metrics moved between lists as appropriate. For example, if a metric on the watch list has had sustained performance improvement over the previous quarter, it may be moved into the longer list and not reviewed until the next quarter. In the same way, if a metric on the long list has deteriorated in the last quarter this would move to the monthly watch list and it could be subject to Board reporting. More detail is presented in the performance report as part of the main agenda.

This month we celebrated **25 years of My WiSH Charity**. In recent years, the charity has raised over one million pounds annually for our trust to improve patient care and support our staff. Having helped fund major projects such as the development of the Rainbow Ward and the new cardiac centre, My WiSH Charity has been an incredible part of our trust for a quarter of a century and I'm sure I speak for us all when I say a huge thank you to those who help and support this work that plays such an important part in support the care and services we provide.

Wellbeing Suffolk, the service that offers help and support to anyone experiencing stress, low mood and anxiety, has continued to provide a full range of interventions throughout the pandemic. Its community-based services are of course available to colleagues to recommend and refer to patients and their families, but are also open to our staff. Meanwhile WSFT is boosting its own staff support psychology service in the coming months. The team was initially set up to support people during the early phase of the pandemic and those who had been redeployed, exposed to traumatic situations or were struggling with the impact of working in healthcare during a pandemic. But we have funded additional posts and the service can now provide support for the next two years, and increased access for staff not based on the hospital site. The new team members are due to start in the next two months. so the service should be more widely accessible as we go into winter. The support is available for any issues impacting on staff wellbeing at work, not just for COVID-related problems. This is part of an additional package of support that we are putting in place in response to the *What Matters to You* feedback.

Trust self-assessment against the national best practice checklist

A	Committed leadership	Trust self-assessment
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers	Trust Board Meeting 2nd October 2020. WSFT ambition is to vaccinate all Trust staff, including all frontline healthcare workers
A2	Trust has ordered and provided a quadrivalent (QIV) flu vaccine for healthcare workers	5500 vaccines ordered – sufficient for all Trust staff
A3	Board receive an evaluation of the flu programme 2019/20, including data, successes, challenges and lessons learnt	Appended below
A4	Agree on a board champion for flu campaign	Dr Nick Jenkins, Medical Director
A5	All board members receive flu vaccination and publicise this	All board members will receive vaccination
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	Flu team in place since April 2020. Team includes Trust convenor
A7	Flu team to meet regularly from September 2020	Team has been meeting since April 2020 and will continue to meet regularly throughout 2020 campaign
B	**Communications plan**	**Trust self-assessment**
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	Communications plan in place. Launched at core brief on 7th September 2020
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Staff intranet, trust social media accounts, ward information packs and posters throughout Trust
B3	Board and senior managers having their vaccinations to be publicised	In communications plan
B4	Flu vaccination programme and access to vaccination on induction programmes	Arrangements in place
B5	Programme to be publicised on screensavers, posters and social media	In communications plan
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	Arrangements in place
C	**Flexible accessibility**	**Trust self-assessment**
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	Peer vaccinators in place
C2	Schedule for easy access drop in clinics agreed	In place
C3	Schedule for 24 hour mobile vaccinations to be agreed	Through peer vaccinators

D	Incentives	Trust self-assessment
D1	Board to agree on incentives and how to publicise this	Incentives e.g. pens and sweets, will not be available at vaccination in 2020 as an IPC measure. An evidence search by the Trust librarian demonstrated that incentives e.g. prize draws, are not effective in encouraging individuals to have their vaccination. Incentives/rewards will be available to peer vaccinators.
D2	Success to be celebrated weekly	In communications plan

Flu Campaign 2019/20 summary evaluation	
Total frontline staff vaccinated	80.03% (2481)
Successes and lessons learnt from 2019/20 campaign	• Need to be able to target areas of low take up quickly to identify options for support/opportunities to improve • Concentrating effort at the start of the campaign and building up momentum, including using internal flu fighters • Vouchers for staff who cannot easily access vaccinations from Trust locations worked well, particularly for community based staff • Literature search demonstrated no evidence for value as incentives e.g. pens. Use of materials for promotional purposes only • Peer vaccination is particularly valuable in outlying areas in the community
Developments for 2020/21 campaign	• Sufficient vaccine for every member of the workforce has been ordered in 2020 • New process for recording data vaccinations given that will allow for more targeted, timely and frequent updates for managers • Aim to catch staff at the start/end of shifts and make vaccination more accessible by setting up new vaccination stations at AAU and back (Rainbow) entrances in addition to availability in Time Out over key periods and in the OH department. • Vaccination processes reviewed to address the need for social distancing and additional IPC requirements in the light of COVID-19 pandemic • Audit of vaccine fridges in community settings completed.

9:40 DELIVER FOR TODAY

9. COVID-19 report

To RECEIVE a briefing

For Report

Presented by Helen Beck

Trust Board – 2nd October 2020

Agenda item:	9			
Presented by:	Helen Beck, Executive Chief Operating Officer			
Prepared by:	Helen Beck, Executive Chief Operating Officer Alex Baldwin, deputy chief operating officer Hannah Knights, head of elective access			
Date prepared:	28 September 2020			
Subject:	Operational Update Including: Phase 3 Recovery, Winter and Covid Planning, NHS111 first,Brexit and Community Engagement			
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, an update on progress to implement NHS111 first at the front door, EU exit planning and finally community engagement in response to the What Matters To You Feedback.

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

In their letter of 31st July 2020 Simon Stevens and Amanda Pritchard laid out ambitious targets for the resumption of elective activity which was put on hold during the phase one response to Covid. The well documented structural issues at WSFT have added an additional complexity and challenge to the planning required to meet the requirements set out in the letter.

Early submissions of the WSFT activity plans attempted to take the structural issues into account in a way which made it impossible to separate the residual Covid related constraints from the ongoing structural issues.

The most recent activity submissions have removed the structural issues from the planning assumptions and outline the plans to return to the required levels of elective and diagnostic activity assuming no compromise to theatres or beds as a result of structural damage requiring urgent remedial repairs.

Revised trajectories

The initial trajectory for inpatient treatment is provided in table 1 below. This assessment was made due to concerns around the impact of the ongoing structural issue and specifically the impact this would have on elective bed capacity.

		Sept-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
	Electives							
E.M.10a	Day Case spells	1,505	2,216	2,346	2,062	2,439	2,258	2,354
	Day Case spells - of which commissioned by Specialised Commissioning	9	14	14	6	9	10	7
	Percentage compared to same month previous year	65.0%	90.0%	95.0%	100.0%	100.0%	100.0%	100.0%
E.M.10b	Ordinary spells	135	242	258	234	251	318	291
	Ordinary spells - of which commissioned by Specialised Commissioning	0	1	1	1	1	2	1
	Percentage compared to same month previous year	50.0%	75.0%	80.0%	85.0%	90.0%	95.0%	100.0%
E.M.10	Total Elective spells	1,640	2,458	2,604	2,296	2,690	2,576	2,645
	Total Elective spells - of which commissioned by Specialised Commissioning	9	15	15	7	10	12	8

Table 1: initial inpatient trajectory.

It was felt (and still is) that a higher level of activity is achievable for day cases as the majority of this activity is undertaken away from the main theatre suite.
For reference the NHS England / Improvement (E/I) target is 90% of pre Covid activity to be delivered in October.

Following dialogue with system partners and NHS E/I the trust has committed to delivering a revised recovery trajectory (table 2). This updated trajectory excludes any additional impact of ongoing structural works and assumes positive progress with a variety of options to create additional capacity. Improvements in bed availability are also being explored via reduction in stranded and super stranded patients and length of stay reductions.

	Electives	Sept-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
E.M.10a	Day Case spells	1,505	2,216	2,346	2,062	2,439	2,258	2,354
	Day Case spells - of which commissioned by Specialised Commissioning	9	14	14	6	9	10	7
	Percentage compared to same month previous year	80.0%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%
E.M.10b	Ordinary spells	135	291	291	248	251	318	291
	Ordinary spells - of which commissioned by Specialised Commissioning	0	1	1	1	1	2	1
	Percentage compared to same month previous year	80.0%	90.0%	90.0%	90.0%	90.0%	95.0%	100.0%
E.M.10	Total Elective spells	1,640	2,507	2,637	2,310	2,690	2,576	2,645
	Total Elective spells - of which commissioned by Specialised Commissioning	9	15	15	7	10	12	8

Table 2: revised inpatient trajectory (010920)

It should be noted that F4 remains in out of use and is currently undergoing structural repairs and will now not be released for elective care until 04 November. In the meantime, F2 is in use (7 beds) as a temporary elective ward and plans are in development to release 2 bays in medicine to deliver surgical activity during October.
Return to full use of theatres is planned from 27th September and whilst every effort will be made to enable this there is considerable risk to delivery due to lack of bed capacity.

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 25/09/20.

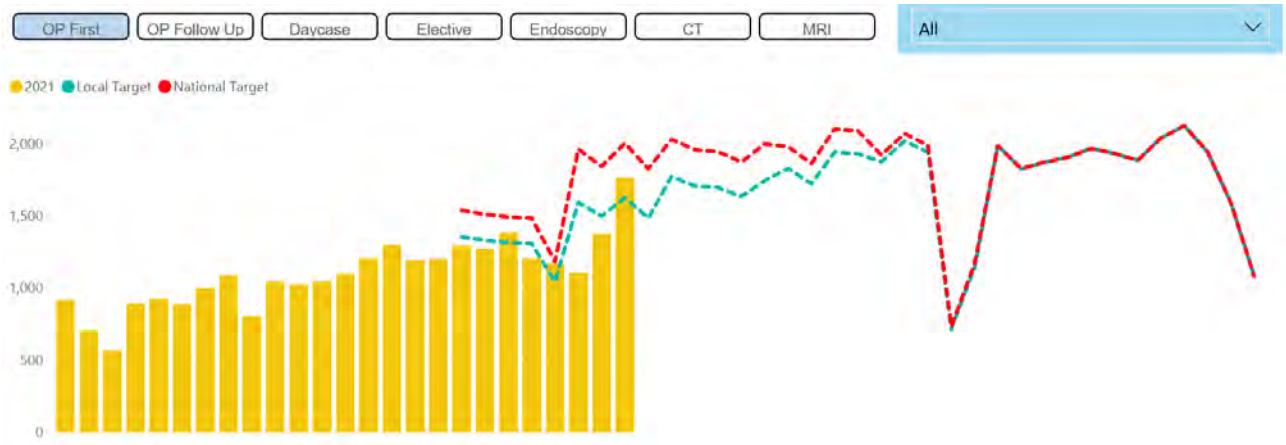


Chart 1: OP First

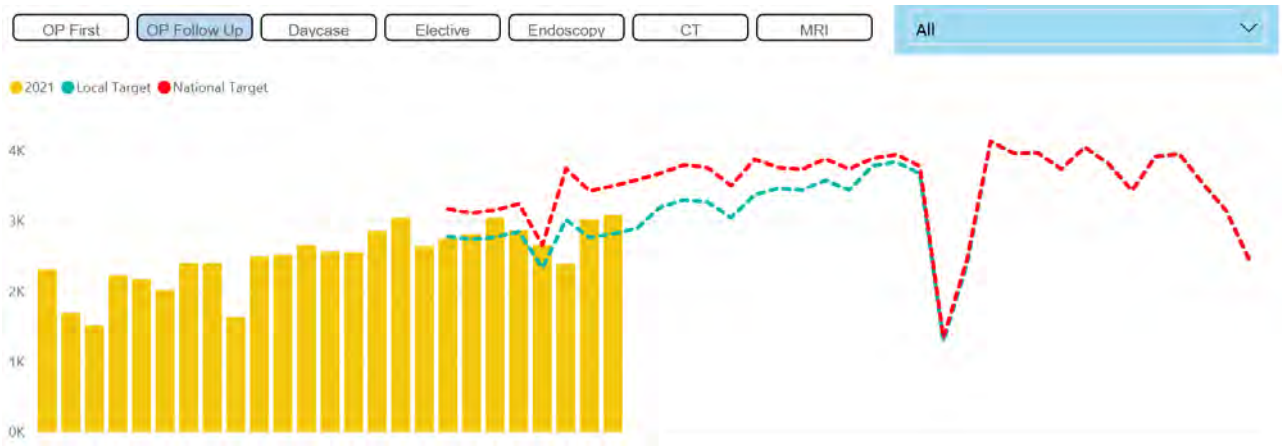


Chart 2: OP follow-up

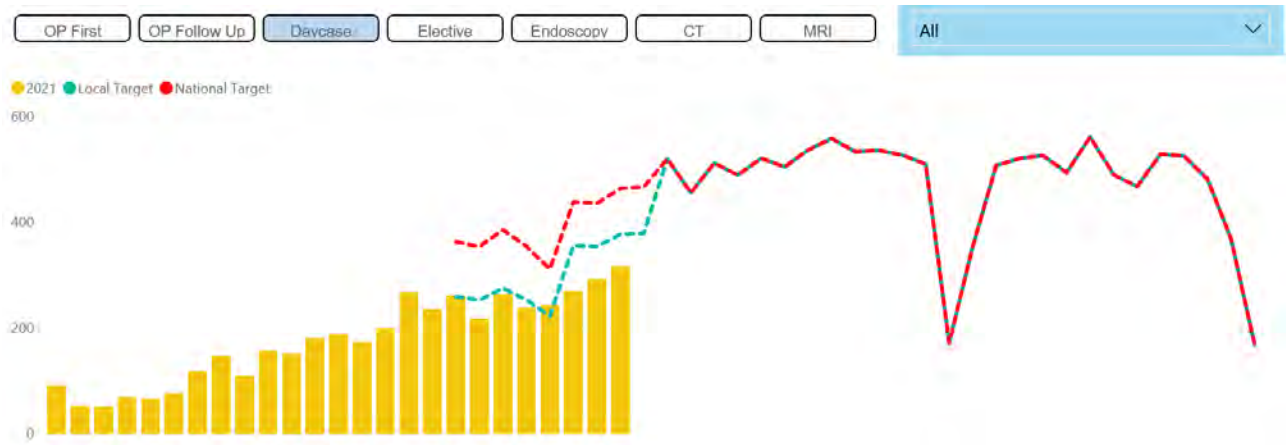


Chart 3: Daycase

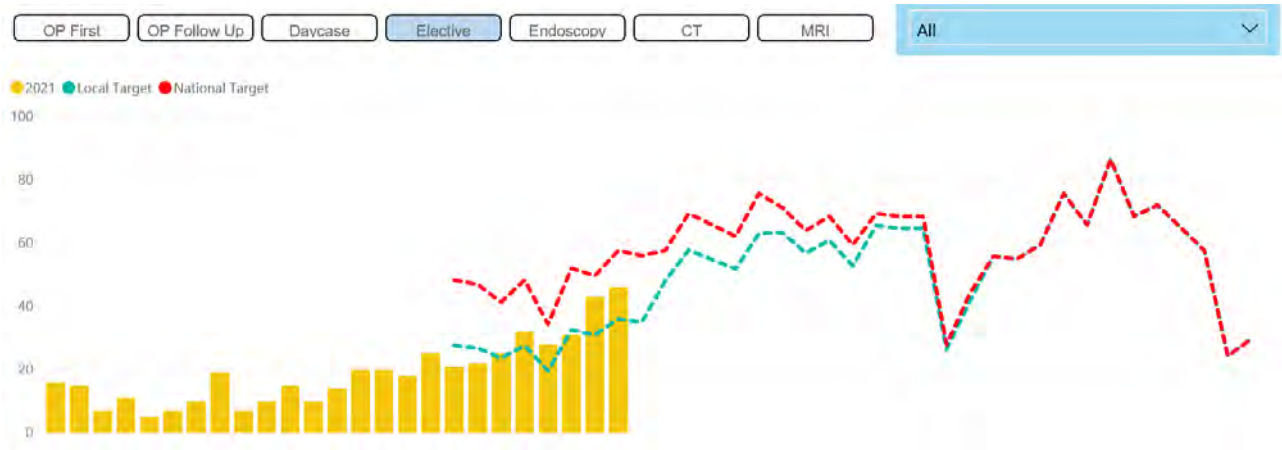


Chart 4: Elective

Chart 5: Endoscopy

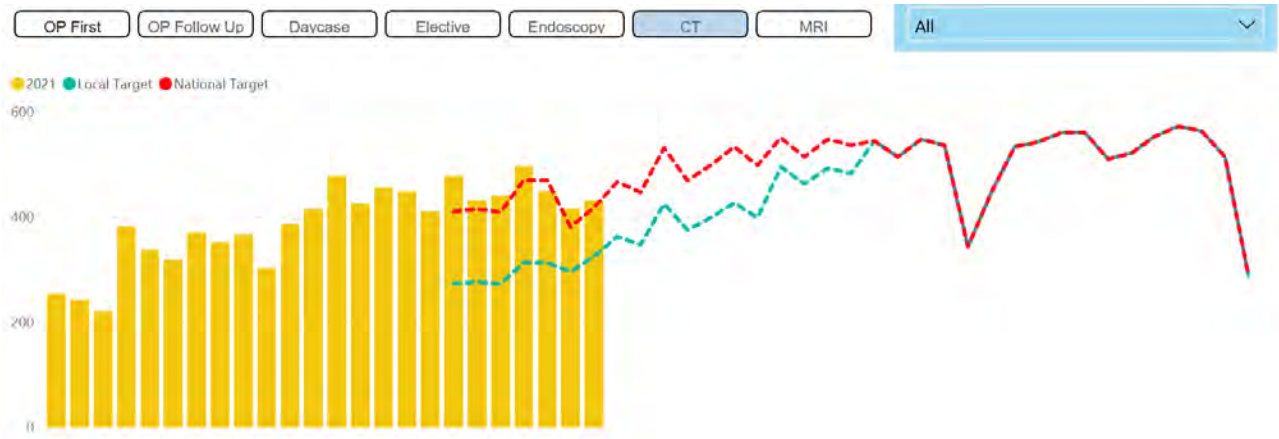


Chart 6: CT

Chart 7: MRI

Progress against these trajectories is managed via the divisional teams and monitored through detailed specialty action plans which are reviewed on a weekly basis. These plans include trajectories for managing the 52 week back log and completion of patient harm reviews.

The need to maintain social distancing in waiting rooms is now the most significant challenge to delivery of outpatient activity. Video consultations and telephone appointments are being used where possible but there are still a significant number of cases where a face to face appointment is required.

Additional endoscopy capacity is now being delivered through an insourcing list planned to take place every Sunday in addition to extended days and Saturday lists from our own teams.

Whilst MRI and CT activity is preforming well against the trajectories there is still a need to deliver more activity to clear backlogs created during Covid. We have secured use of mobile CT and MRI Units to assist with this and the teams are currently working with estates colleagues to identify suitable, locations either on the main site or at Newmarket or Sudbury.

Winter planning including Covid activity

The trust's winter planning activity is ongoing and reflects local knowledge and national best practice. The planning activity is split in to four key work streams; physical capacity, out of hospital care, workforce and patient flow. Our work plan is supported by and informs our future planning activity.

We are currently assuming return to full ward occupation from 14 December. This includes occupation of G9, resumption of elective activity on F4 and additional capacity at Newmarket and Marham Park, spot purchased beds and a reduction in length of stay. A full summary of the (current) bed model is provided in table 3.

Our work is supported by revised discharge planning guidance which was issued by the Government on 21 August. The guidance provides an enhanced framework for managing discharges and a series of additional asks for us as providers. We are currently working through the detail and will include relevant elements in our work plan.

Mitigated demand and capacity										
	POD	Group	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Bed Demand	Emergency - General and Acute	General and Acute Beds	345	386	423	452	462	487	471	483
	Elective inpatients	General and Acute Beds	10	30	30	18	23	34	24	23
	Non Covid patients	General and Acute Beds	355	415	453	471	485	520	495	506
	Covid (inludes 20% contingency)	General and Acute Beds	70	95	95	95	95	95	70	70
	Total Demand	General and Acute Beds	425	510	548	566	580	615	565	576
Bed Capacity	Baseline	General and Acute Beds	392	392	392	392	392	392	392	392
	Baseline	Contingency	71	71	71	71	71	71	71	71
	Additional	Newmarket Community	15	15	15	15	15	15	15	15
	Additional	Marham Park	25	25	25	25	25	25	25	25
	Additional	Care Home tbd		20	20	20	20	20	20	20
	Additional	LOS reduction	24	24	24	24	24	24	24	24
	Additional	BMI	12	12	12	12	12	12	12	12
	Additional	Contingency (Hospice)	16	16	16	16	16	16	16	16
	Social Distancing Impact	General and Acute Beds	0	0	0	0	0	0	0	0
	Baseline Capacity	General and Acute Beds	555	575	575	575	575	575	575	575
	Baseline Bed Gap		130	65	27	9	-5	-40	10	-1
	Elective Work Capacity (on site inpatient)		All	All	All	All	All	None	All	All
	Insufficient beds for NEL+Covid		SUFFICIENT	SUFFICIENT	SUFFICIENT	SUFFICIENT	SUFFICIENT	INSUFFICIENT	SUFFICIENT	SUFFICIENT
		Assumptions	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
		NEL demand	88%	92%	96%	100%	100%	100%	100%	100%
		EL (IP) throughput	35%	90%	90%	90%	90%	90%	90%	90%
		Social distancing workaround	0%	0%	0%	0%	0%	0%	0%	0%
		LOS reduction	6%	6%	6%	6%	6%	6%	6%	6%

Table 3: current bed modelling (subject to change)

The above plan assumes normal levels of NEL admissions plus an additional 70-95 beds for Covid related activity. Further work is being undertaken across the ICS and regionally to refine these assumptions based on the experiences from other parts of the UK. Latest projections indicate the possibility of a second spike in Covid related hospital admissions in Suffolk by the end of October. There is a clear expectation that Trusts will continue to deliver elective activity for as long as possible during any second spike in Covid cases. The need to deliver additional critical care capacity is a key factor in this as it would require increased levels of anaesthetic cover which would reduce those available for the elective programme. Negotiations are ongoing to resolve this with the regional critical care network and the regional recovery lead.

NHS 111 First

There is a national drive to capitalise on the reduction in ED attendances at the peak of the first wave of the COVID 19 pandemic by encouraging patients to think differently before attending. The aim is to encourage all patients to contact 111 before attendance in order to reduce the number of 'unheralded' patients attending ED.

111 aim to increase their clinical capacity to ensure that all patients sent to ED are triaged by a clinician (currently around 80% are reviewed by a clinician.)

The expectation is that by the end of November 2020, all hospitals will

- Provide enhanced steaming service at the front door
- Provide some form of 'booked slots' for 111 to book patients in to, in order to stagger arrival times and reduce over crowding

It is important to understand that these are not 'new' patients – they are patients that we would be seeing any way – we are simply aiming to better manage their arrival times.

WSH are more advanced that many sites on this as we already have an email referral system in place for 111 to send details of patients. Numbers are sporadic and can range from 10 – 45 per day so assessing required capacity to accommodate this fluctuating demand may be difficult. Our current plans are to provide slots between 10:00 and 14:00 in the first instance.

We are working through some issues such as appropriate space within department for timed appointments, reporting and coding of activity, IT interface between 111 and WSH and our communication strategy to encourage behavioural change and manage patient expectation.

EU Exit Planning

It is well documented that the UK exited the EU on 31 January 2020 and is now in a transition period until 31 December 2020.

Preparatory activity for this event took up most of the operational bandwidth through the summer and autumn of 2019 but for obvious reasons it has been a reduced priority since the first half of 2020. This will change as we head towards the last days of the year and the end of the transition period.

To date we have received limited direction from the national team on revised or amended plans. We have been informed that the transition period will cease as planned on 31 December and there will be no extension. We also know that Keith Willett will resume his role as EU Exit senior responsible officer. This will be in addition to his role as strategic incident director for Covid-19. To this end it is likely that preparatory activity will be routed through the established national and regional incident coordination centres which should ensure single, shared operational readiness and response. Furthermore, we know that the overarching planning assumption will mirror the governments planning assumptions which are unchanged since 2019.

Preparatory activity

In order to assess the trusts readiness for the end of the transition period we are following the preparatory framework established towards the end of last year. This is as follows,

Operational communications

1. Via the Core Resilience Team (CRT) the trust board will be sighted on all published operational guidance for EU Exit and specifically any additional guidance relating to the end of the transition period.
2. Following receipt of said guidance we will communicate all additional activity to staff as required.
3. We will also ensure any EU Exit impact is shared across the local health system via the ICS and LHRP.

Operational readiness

1. The EU Exit team has been established via the CRT and has capacity, through our tactical command structure, to respond out of hours and over a sustained period of time. This includes established operational leads for workforce, supply, data and medicines.

Supply

1. National contingency arrangements for supply are fully understood. This includes a local assessment of EU dependent supply issues which may not have been identified nationally.
2. To this end we have undertaken to repeat our local preparatory assessment with all suppliers and will escalate potential areas of risk to the national team.

Workforce

1. Systems are in place to monitor the workforce impact as we come to the end of the transition period.
2. The workforce risk assessments are being reviewed and will be considered alongside the Covid risk assessments.
3. We have also committed to proactively contact all EU national staff members to offer support and assistance with any outstanding EU settlement scheme applications.

Data

1. We will undertake to re-review all clinical data flows which could be affected by the end of the transition period

As it stands there are no additional or new risks to trust activity as a result of the end of the EU Exit transition period.

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

Community Engagement Plans

In response to the community feedback received as part of the What Matters To You Survey we have embarked on a dedicated programme of work to support our community teams.

A triumvirate of senior leaders from the Trust and the System have been brought together to lead this work and provide additional senior leadership to support the teams on the ground and enable this work to be undertaken at pace. The team consists of Lesley Standring from WSFT, Sandie Robinson from the CCG and Bernadette Lawrence from adult social care.

To underpin the programme, we have commissioned Rethink Partners to undertake a focussed piece of work to engage our community teams and help us to gain a better understanding of their perspective. The work will ask teams “What do your patients need ?” and “What do you need to deliver that ?”

The board will be updated on progress in future reports.

10. Integrated quality and performance report

To APPROVE a report

For Approval

Presented by Helen Beck and Susan Wilkinson

Trust Board Report

Agenda Item:	10			
Presented By:	Helen Beck & Sue Wilkinson			
Prepared By:	Information Team			
Date Prepared:				
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.

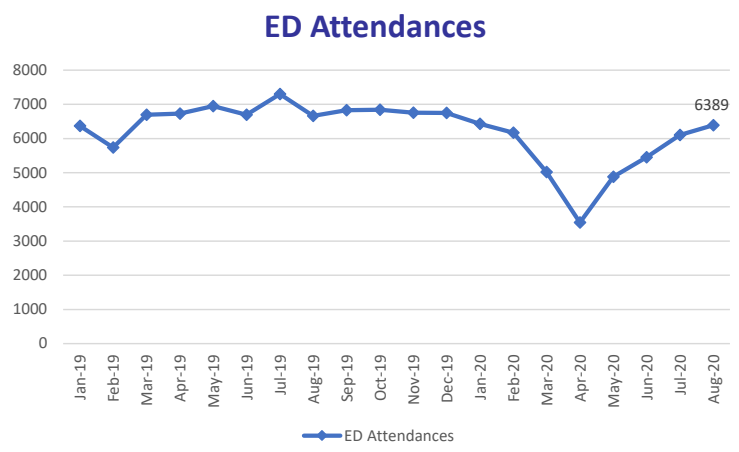
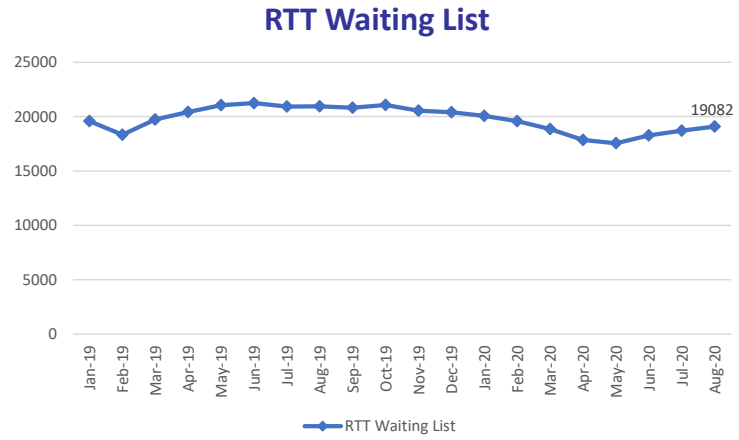
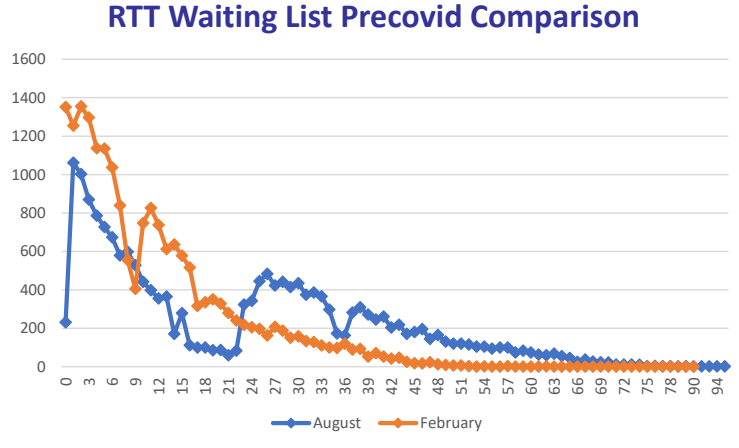
Trust Priorities [Please indicate Trust priorities relevant to the subject of the report]	**Delivery for Today**	**Invest in Quality, Staff and Clinical Leadership**	**Build a Joined-up Future**
	X		

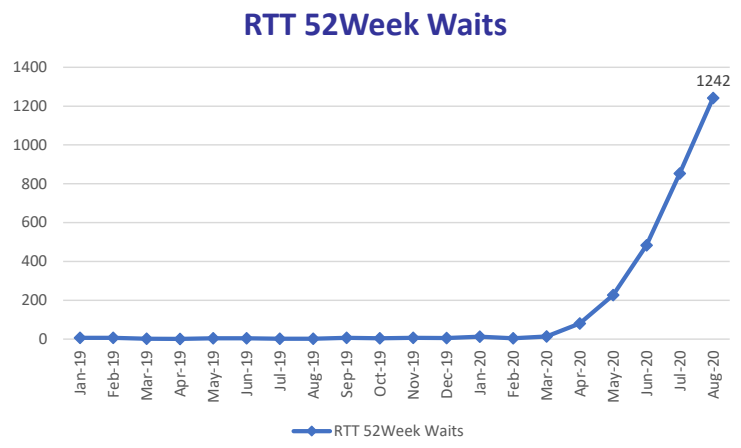
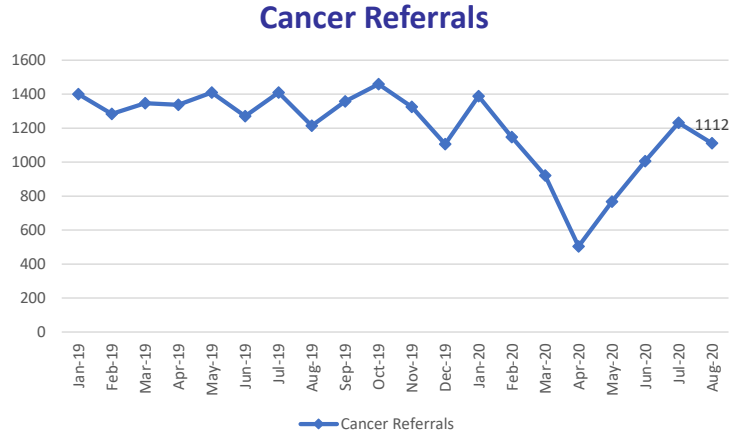
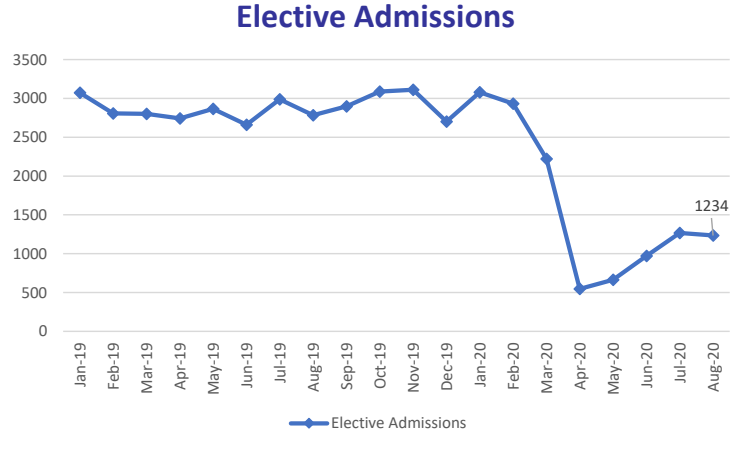
Trust Ambitions [Please indicate ambitions relevant to the subject of the report]	Deliver personal care	Deliver safe care	Deliver joined-up care	Support a healthy start	Support a healthy life	Support ageing well	Support all our staff
		X	**X**				**X**

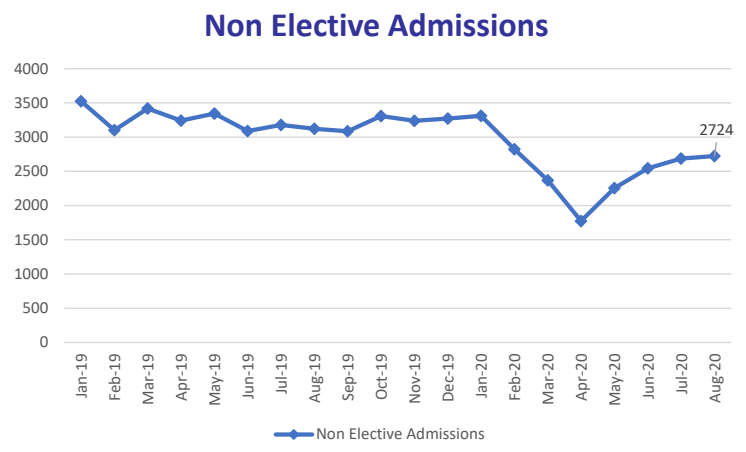
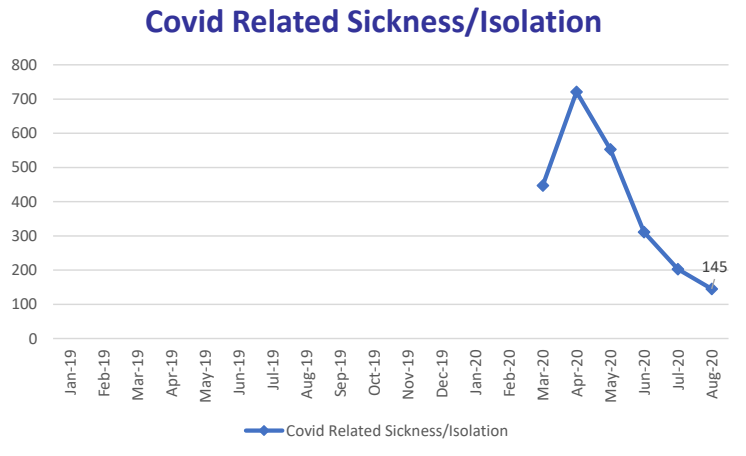
Previously Considered by:	
Risk and Assurance:	
Legislation, Regulatory, Equality, Diversity and Dignity Implications	

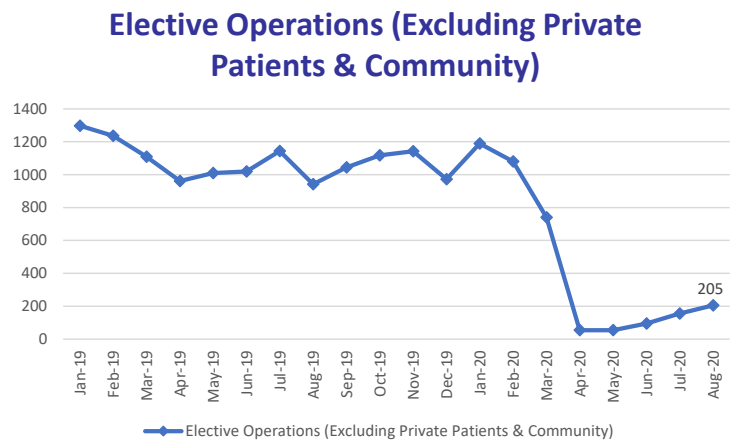
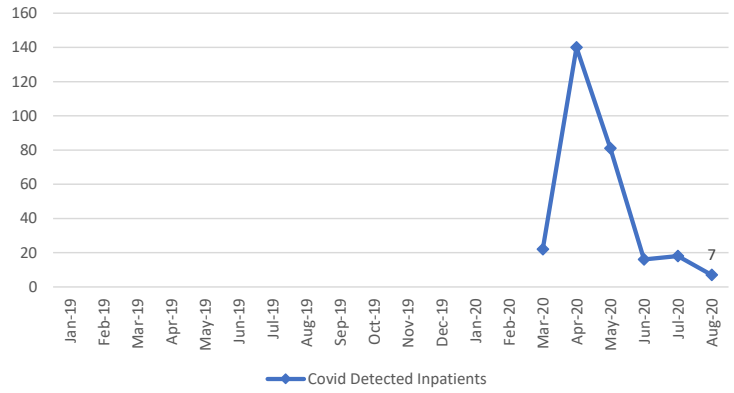
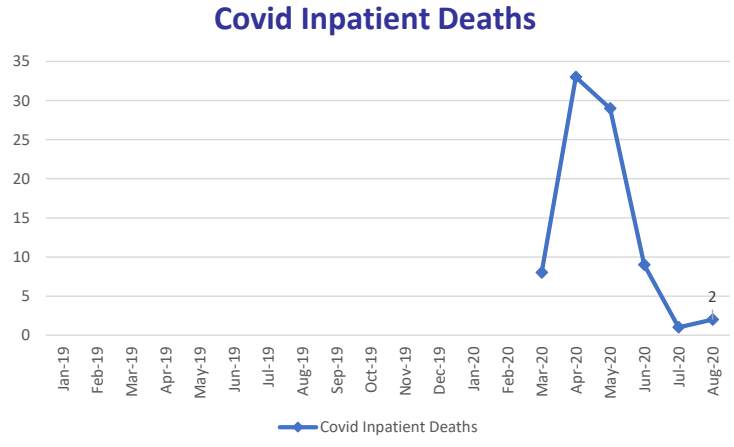
Recommendation:

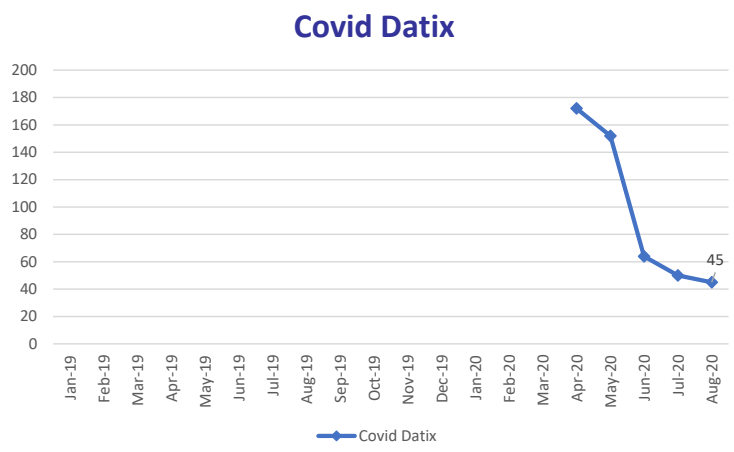
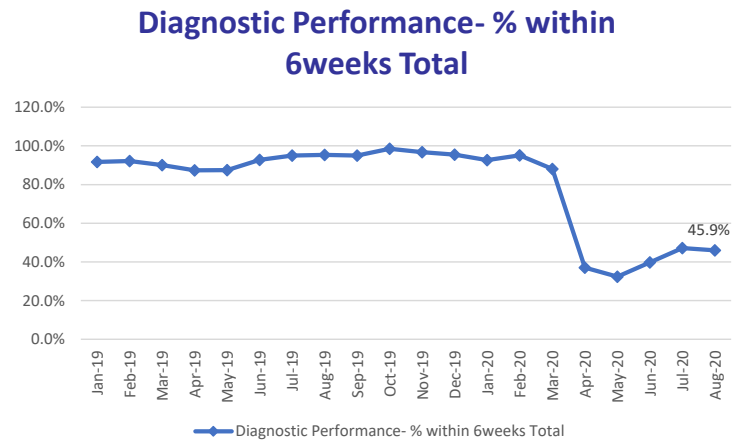
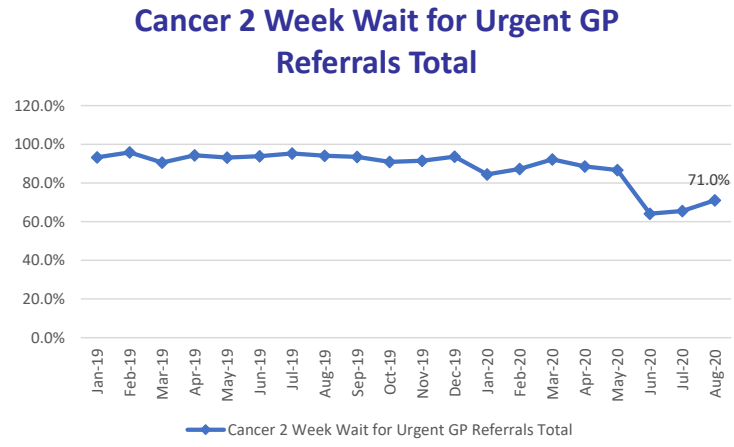
That Board note the report.

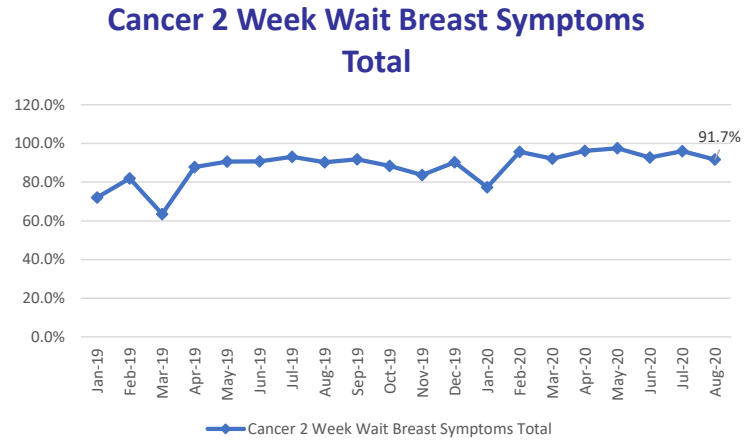
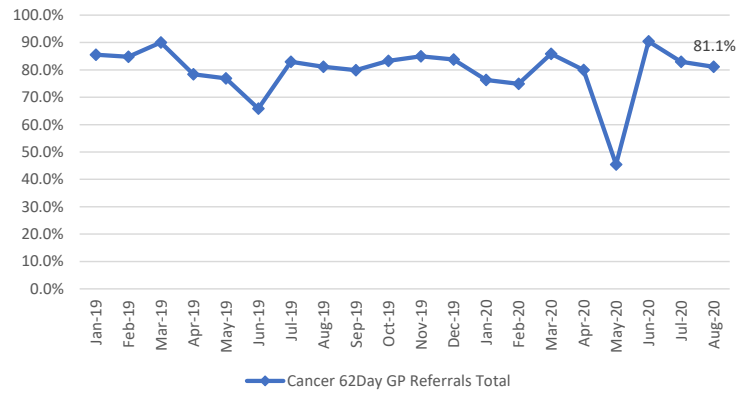
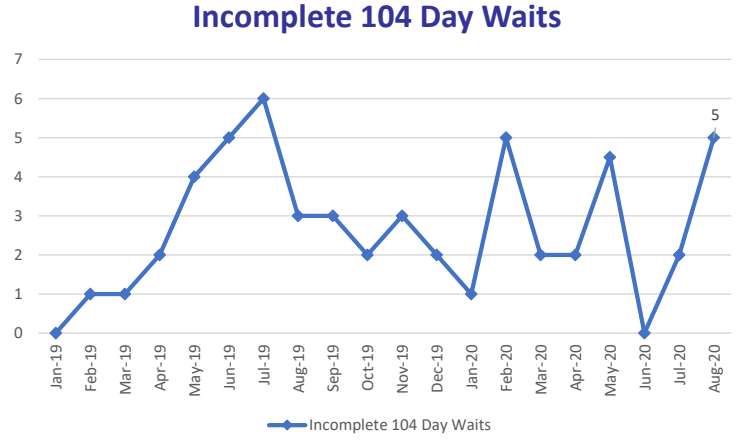
Board Report KPIs	Narratives
	There were 6389 attendances in ED in August compared to 6105 in July (an increase of 284 patients 4.44%.) Although this is still lower that our pre-covid attendances, attendances are increasing to a more normal level. 1732 patients were admitted in July compared to 1638 in July (increase of 94 patients 5.42%.)
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 overall waiting list continues to increase as we see referrals increasing at a faster rate than we are able to treat patients. The overall waiting list size is returning to pre-covid levels.
A count of the patients on the waiting list for treatment.	
	The waiting list shape continues to change as anticipated with long waiting patients moving along their pathway without treatment.
A year on year comparison of the number of patients waiting for treatment.	

Board Report KPIs	Narratives
	The number of 52 week waits is still increasing at a rapid rate. The majority of these patients are waiting for routine surgery whilst theatre capacity and bed capacity begin to increase. It will take some time to begin to clear these patients and currently they are tipping over the 52 week wait mark at a greater rate than they are able to be removed.
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.	
	There was a very slight reduction in referrals in August for Cancer, this is in line with the normal pattern for August. It would be anticipated that this will continue an increase again from September onwards.
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).	
	The rise in elective admission numbers has plateaued a little during August. The increases in Endoscopy capacity and the resumption of other day procedures has been offset by limitations on inpatient elective bed capacity.
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 2724 in August which is an increase from 2686 in July (1.39% increase) but still lower than pre COVID levels. In comparison to August 2019, this is a decrease in admissions by 12.7%.
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 August 2020 was 3.8%. This is a reduction as April through to July 2020 the rate was consistent at 3.9%. At the end of March 2020, prior to COVID-19, the Trust's 12 month cumulative run rate was 3.6%.
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 August 2020 there were 145 episodes compared to 203 in July and 311 in June. This is consistent with the decreasing trend in absence related to COVID-19 since the peak in April 2020.
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.	

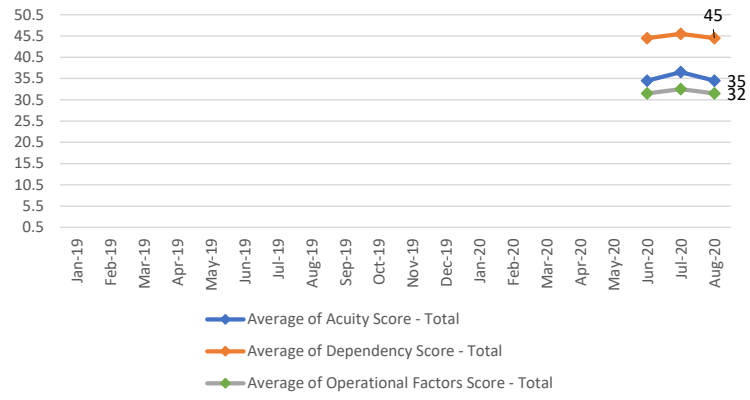
Board Report KPIs	Narratives
	Elective operations continue to rise in line with planned changes in capacity and transition of rotas. Limitations on elective bed capacity has impacted on the rate of recovery. Work continues to align theatre and anaesthetic staff rotas to enable enhanced throughput and increased future capacity.
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.	
	The number of COVID detected in-patients has decreased for the month of August from 18 to 7, reflective of the picture for the East of England which is continuous to be lower than the national average.
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.	
	The number of COVID inpatient deaths has continued to be lower than the national average with 2 deaths recorded, 1 death higher than the previous month. However one of this death occurred 25 days post positive result with multiple co-morbidities. This reflects the current national picture of reduction in deaths from COVID-19.
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.	

Board Report KPIs	Narratives
	Incident reporting rose again in August although it fell slightly when expressed as a percentage of occupied bed-days. The number of incidents related to COVID continues to be captured although the numbers were still low in August. Harm related incidents continue to rise, and a drill down into the data identifies that this is due to increases in reported pressure ulcers rather than any other incident categories
A count of the number of Datix recorded as a result of Covid. This is a local metric to monitor the local impact of Covid.	
	Radiology performance has improved during August in comparison to pre-covid activity in January activity (MRI 79%, CT 92%, USS 63% and plain film 90%). Further increases in performance are limited due to on-going covid restrictions. Business cases for additional CT/MRI capacity and additional staffing resource have been approved. Endoscopy performance has reduced this month due to annual leave of endoscopists. However, insourcing capacity has been commenced. In addition, recent changes to covid infection prevention procedures will enable an increase in the number of patients per list.
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.	
	Biggest constraint is within Colorectal, due to the reduction in endoscopy numbers. In total 202 straight to test patients were seen within Endoscopy and 155 of these were over 2 weeks. Additional capacity for Endoscopy is coming on line with insourcing company starting 27th September. Also constraints within Skin referrals, majority are booked over 2 weeks due to referral volumes and limitations on volumes. Additional clinics are taking place on a weekend to increase volume.
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.	

Board Report KPIs	Narratives
	Performance slightly dropped in August from July, predominantly due to patient choice, this is in line with normal patterns of performance during peak holiday periods. Engagement work with GP's to ensure patients are ready and available to come in within 2 weeks continues.
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.	
	limited endoscopic investigations resulting to delay in diagnosis and other capacity issues including patient safety concerns during COVID 19 contributed to 10 local and one shared breach - Various strands of work to enhance endoscopy capacity to reduce diagnostic wait, locum cons to reduce waiting times within dermatoplastic pathways - Improving operational engagement at the weekly cancer PTL meetings
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.	
	2 Colorectal and 2 Head and Neck and one Skin patients treated past 104 days wait. There was long diagnostic wait for all five patients and these breaches are being reviewed by the team and services to confirm any clinical/psychological harm to patients following Datix protocol in the Trust, In addition to those treated after 104 days there are currently 19 patients awaiting diagnosis or treatment who have waited over 104 days. OF these 7 are patient choice, 2 are awaiting treatment at CUH, 4 are awaiting the outcome of treatment or diagnostics and 5 have next steps planned.
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.	

Board Report KPIs

Acuity Measures



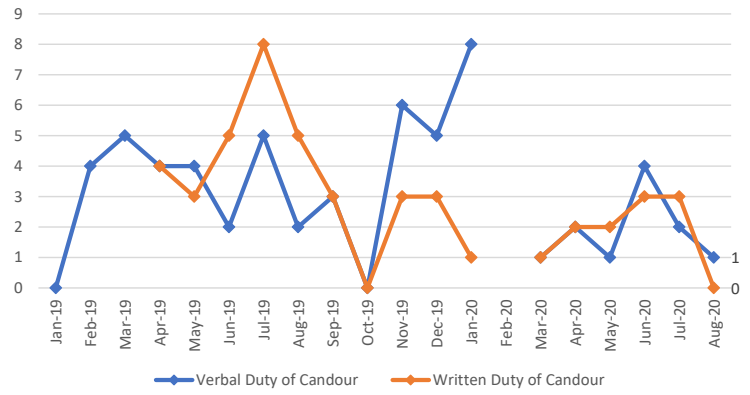
A range of measures have been identified which are analysed to provide an overall acuity score, as displayed in this chart. This provides an overview of the acuity of admitted patients.

Narratives

The organisation is experiencing a rise in acuity post pandemic surge and this can be validated by increasing metrics on the acuity dashboard. The data is extracted for each participating ward from eCare. Each metric is then compared and wards are then ranked accordingly and assigned a corresponding score. For example; the ward that has the highest percentage of patients with a EWS score >4 will be ranked highest and given the highest score possible for this metric. If there are 20 wards included then this score will be 20. This is repeated for each metric, the scores are then added together to provide an overall total and a sub-total for each domain. These scores are then reflected in the graphing on the report and the colour-coding is informed by comparing current scores against a rolling average. Over time, as the baseline is established, this will provide information on when the Trust is under increasing pressure and whether this is from an acuity, dependency or operational perspective.

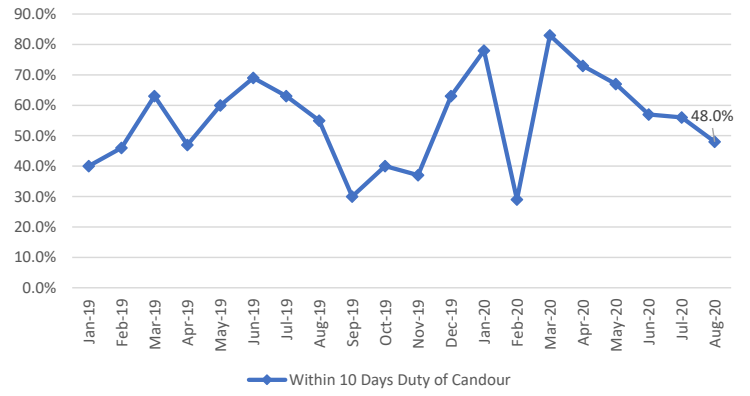
In conjunction with this report, Clinicians are reporting that they are experiencing a rise in the acuity due to late presentation either due to a reduction in services during the pandemic surge or a reluctance for individuals to seek help due to fear and anxiety of the risk of contracting Covid-19.

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

Within 10 Days Duty of Candour

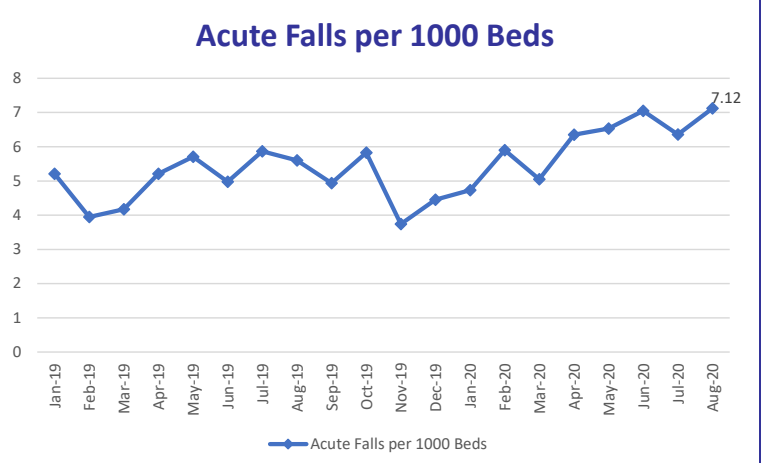
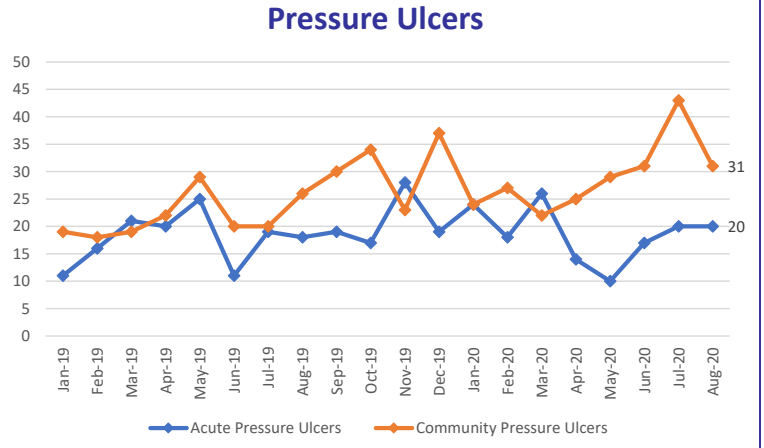
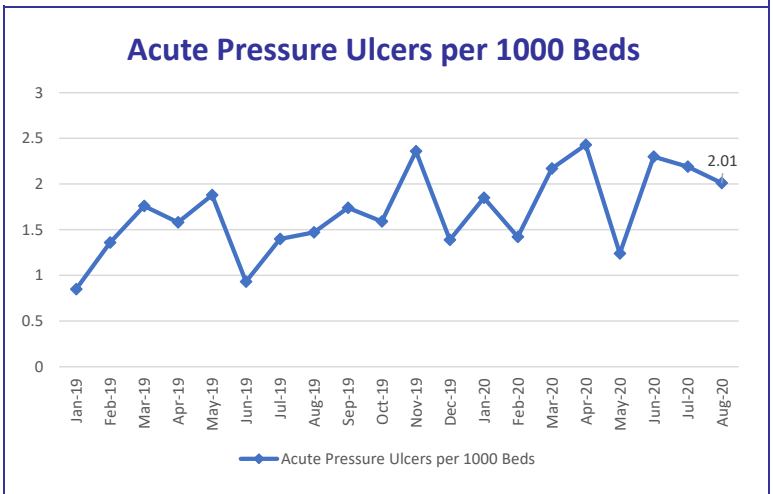


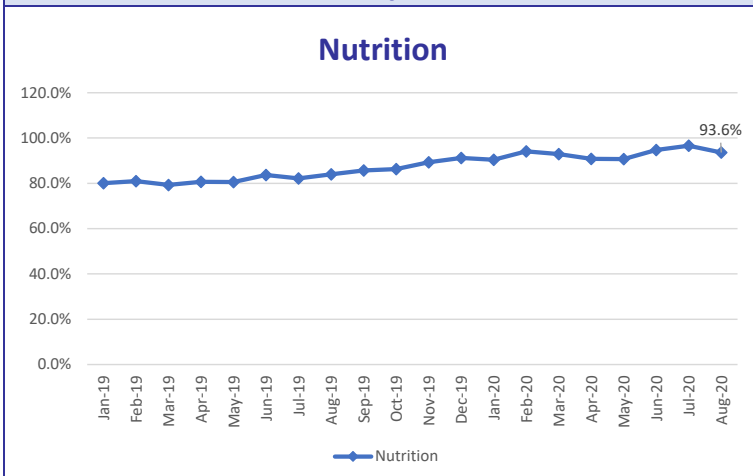
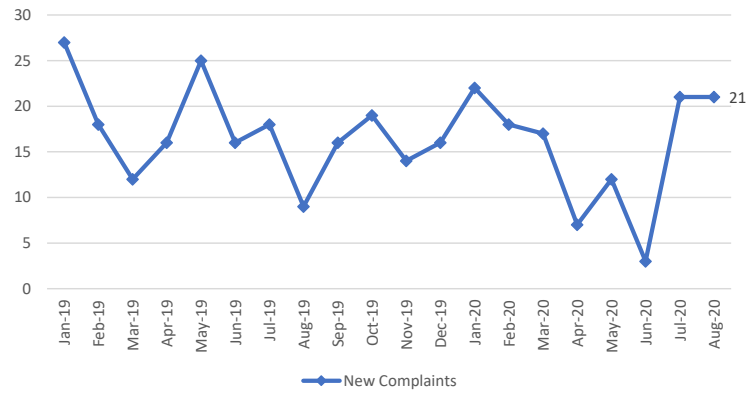
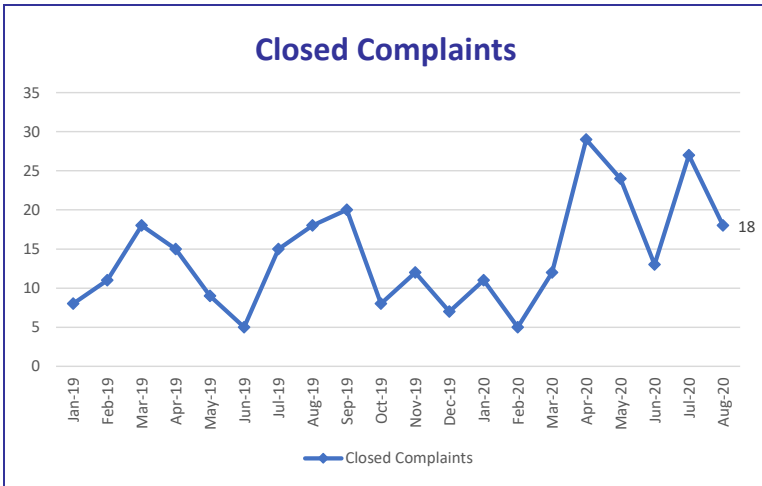
The percentage of cases reported in that month where verbal duty of candour was completed within the nationally required 10 working day timeframe.

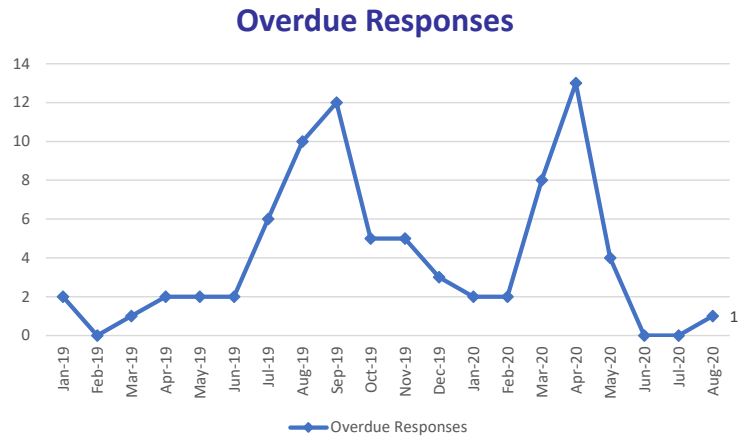
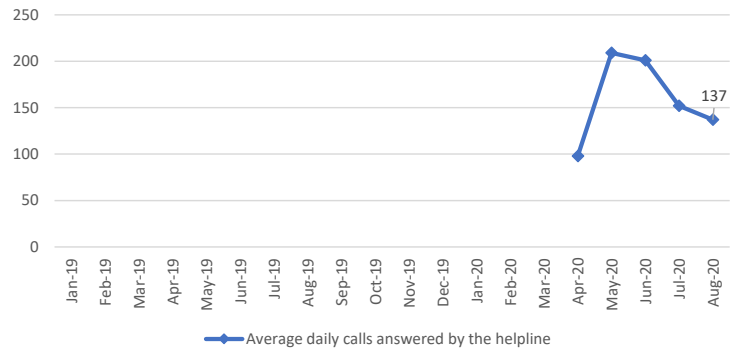
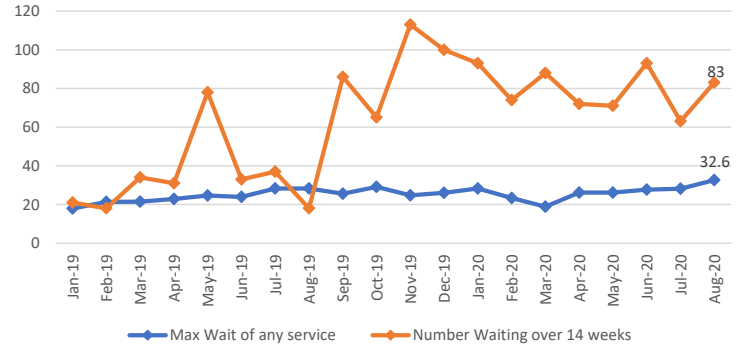
Two charts are provided which measure 1). a count of how many cases are still overdue (both verbal and written) at the end of the reporting month and 2). timely completion of verbal Duty of Candour against the national requirement of 10 working days reported using an SPC chart). Whilst there is only one Duty of Candour verbal still outstanding that was due in August, the timely completion within the 10 working day requirement is still only achieved around half of the time with 52% of the 21 cases achieved within 10 working days of reporting in August.

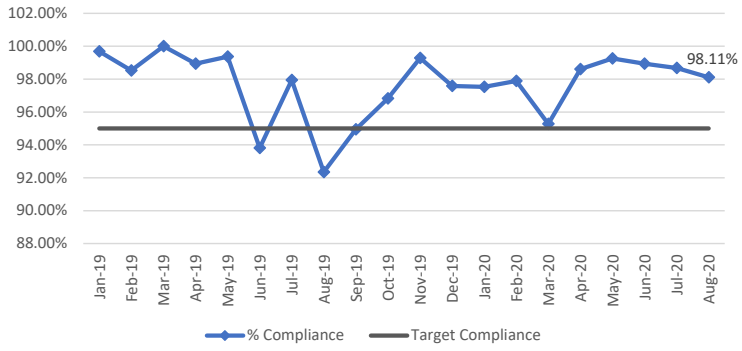
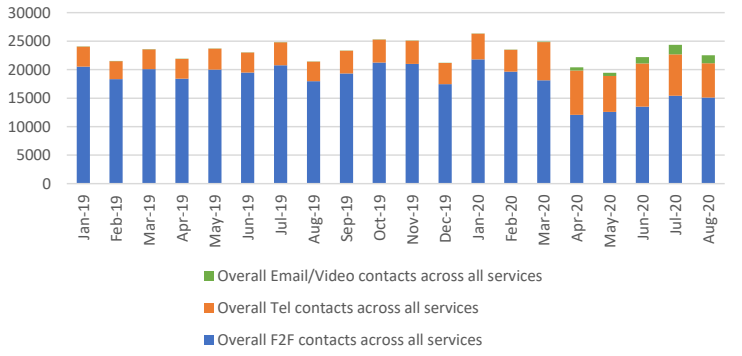
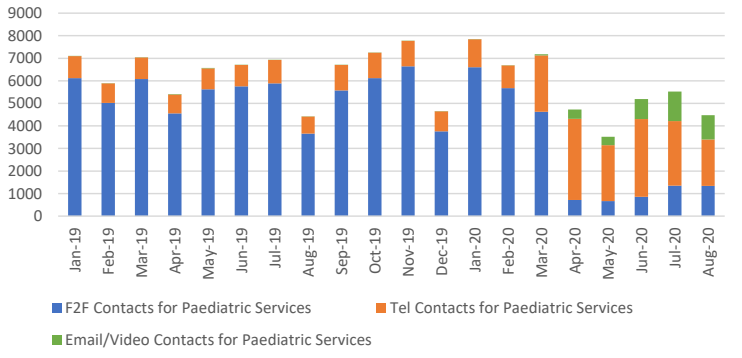
At the time of submission of this report there was one Duty of Candour conversation that had not taken place in August; a delayed fracture diagnosis in ED. There were no Duty of Candour notification letters outstanding where verbal Duty of Candour had previously been undertaken.

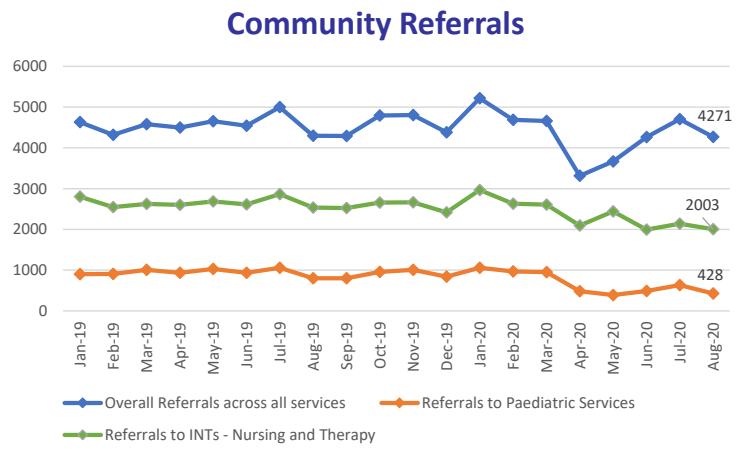
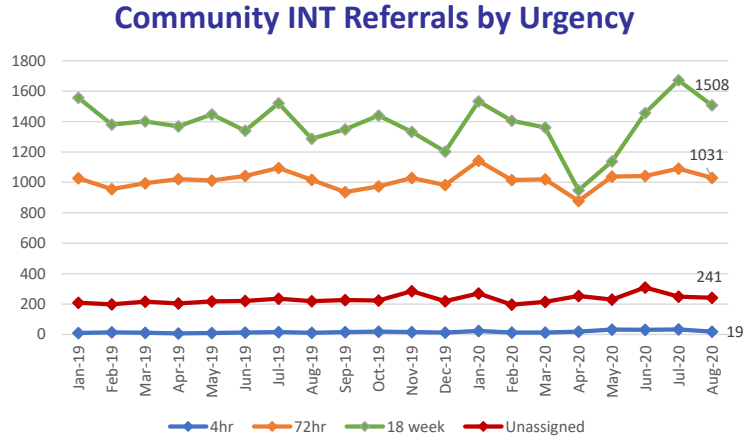
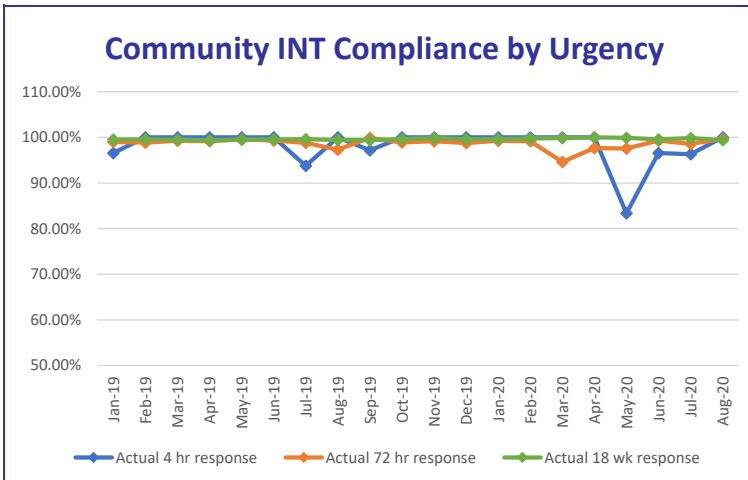
There is a CQC improvement plan for Duty of Candour which sets out opportunities to improve timely completion and how to support staff in undertaking these conversations.

Board Report KPIs	Narratives
 A measure of the number of falls in the acute hospital measured per 1000 bed days. Community falls are excluded from this metric.	The total number of falls in August increased from 58 in July to 69 in August. Falls per 1000 bed days =7.12. Within August 53 falls resulted in no harm, 2 negligible and 14 minor harm. There were no moderate or severe/major harm. There remains a high prevalence of cognitively impaired patients. Staff continue to effectively report all falls on datix. Request for extra staff to support the provision of one to one care continue, though in many cases could not be fulfilled by West Suffolk Professionals. Senior nursing teams assess and re-deploy staff where appropriate. A 'Falls' lead was appointed but unfortunately this has fallen through so recruitment process has been recommenced. The trial on the falls equipment is now completed with a successful evaluation favouring the Stanley M200 monitor. All ward areas have identified falls champions with a champions day arranged for 11th November 2020.
 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.	A decrease has been noted during August in terms of reported pressure ulcers. Incidence of Cat 2 and Cat 3 PU's has reduced, though a slight increase in unstageable PU's is noted and unfortunately a further Cat 4 PU is also reported in the community. Again, incidence in the Community is greater than the Acute, as we would expect for those not receiving 24 hour care. Community: The theme of patient non-concordance is being addressed with a review of our Patient Information Leaflet; with messages which will remain respectful but more assertive around the impact of declining clinical advice. In order to equip staff to have more confidence in these situations we are continue to work on developing our webinar for staff. Some patients in their own homes remain reluctant to allow access to clinicians due to the risk of infection; this is particularly the case with Care Homes, where relationship building has been key; we are hopeful that this month's reduction is an indication that the results of necessary delegation of pressure are care to family members/non- professionals, has now been revealed; we are grateful for the care they have given and the support to our services. Themes for learning are to be identified more easily we hope, by piloting a Patient Safety Audit approach to investigating fewer incidents, but more meaningfully; we also hope this will motivate our staff to engage more fully in the process of incident investigation and learning. Acute: Opportunistic learning continues, with the Tissue Viability Team consistently engaging staff during interventions on wards/departments. Digital platforms have been developed in response to particular themes identified and staff directed to national digital resources. Successes have been demonstrated following support to Ward F7 particularly, resulting in a decrease in incidence. NMCC will receive a presentation from F7 Matron and the TVNs in October to share this learning wider. Senior Matrons have engaged with the production of resources for use in clinical areas, to support staff education/knowledge.
 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.	

Board Report KPIs	Narratives
	There has been a slight decrease in compliance with nutrition risk assessments in August due to a decline in PYMS assessments on inpatient children. This continues to be an area of focus for the Paediatric team, with the objective to embed these assessments into practice within the first 24hrs of admission. Overall, compliance within the adult inpatient wards remains excellent, with only a couple of areas demonstrating a slight decline. The Senior Nursing team will focus on compliance in these areas, specifically. In general, the focus is now on the quality of these assessments and ensuring an appropriate plan of care is in place and being implemented. Assurance is being gained via Perfect Ward reviews and a quarterly audit conducted by the Dieticians. The Nutrition group are exploring ways to promote these improvements in care delivery. There are plans to recommence auditing Protected mealtimes following a change in times of meal delivery on the wards. The audit tool will be reviewed to gain appropriate data prior to the reviews, working in conjunction with the nursing teams, catering staff and dieticians.
% of patients with a Malnutrition Universal Screening Tool (Adults)/Paediatric Yorkhill Malnutrition Score (Children) assessment completed within 24 hours of admission	
	Consistent volume of complaints received in August which put additional pressure on the complaints department which means at least 1 complaint response needs to be completed and finalised each day in order to maintain acceptable overall complaint figures. Trends - 4 complaints related to ED with the trend continuing that the complainant felt there was a delay or failure to diagnose. This is however a 50% reduction on complaints received for ED compared to July. Other trends show that listening to patients view of their condition is going unnoticed and patients feel like clinical staff are not listening to them which may help with their treatment.
New formal complaints received and accepted, this counts both West Suffolk Hospital and Community	
	Decrease in overall complaints resolved in August compared to July due to holiday within the team. We typically found that a lot more clinical staff were also on holiday throughout July and August which meant there were delays with responses. From 1st August 2020, we went back to “BAU” meaning that we put a timescale for clinical staff to respond to complaints and provided expected timescales for complaints to received their finalised report.
Formal complaints signed off by the CEO, this counts both West Suffolk Hospital and Community	

Board Report KPIs	Narratives
	We are finalising the last of the complaints received during the height of the covid period where we placed a pause on the complaints process to allow clinical staff to focus on covid planning and covid patients as a priority. We have 4 of these remaining. We left these complaints open ended and did not specify a timescale as to when they would receive a response however all complaints remained updated with regular communication throughout the length of their complaint.
Any complaints which were sent outside of the given timeframe and no extension was agreed, this counts both West Suffolk Hospital and Community	
	A reduction in inbound calls received on the helpline service for August. We put a hold on the helpline service due to clinical staff returning back to their normal roles and we were not able to provide the staffing levels as we would have liked. We felt this was the right decision to take as we didn't want to damage the reputation of the fantastic service that the clinical and non-clinical staff have provided.
All answered calls from the clinical and non-clinical team, excluding any abandoned calls, this counts both West Suffolk Hospital and Community	
	In August 3 services have patients waiting over 18weeks at the end of June: Paed SLT, Heart Failure and Wheelchairs. The maximum wait for each of these services are 32.57weeks, 22.57 weeks and 23.00 weeks 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 14weeks across ALL services has increased from 63 in July to 83 in August.
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 August was 98.11% with the lowest individual service being Paed SLT at 93.10%.
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.
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 August
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 		Category	Score this month	Score last 12
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1	Confirmed or Suspected Cases	100% (30)	100% (70)
2	Hand Hygiene	100% (100)	96% (169)
3	PPE	99% (148)	98% (255)
4	Patient Safety	0% (0)	0% (0)
5	Signage	100% (35)	93% (60)
6	Staff Awareness	99% (138)	99% (236)		This table is not available for September as this was from Covid PW audit – and was informed by Sue that not needed to be done in September due to very low Covid numbers. Will be reintroduced again if we start to see increases in cases. Update on rest of PW is: • Observation and Documentation Audit has been altered for adult wards and do be moved to weekly in near future • IPC audits have been made accessible to all matrons to help the IPC team with no Lead. Still quarterly audit • Perfect Ward presented to the HoN's and Matrons around a new version of Perfect Ward that will include action plan setting on 9th September. Went well – likely to do slow roll out of it when ready, possibly IPC audit first • Staff Audit to be removed and switch for Medicine Optimisation one run by Pharmacy
Perfect Ward Assessment Audits	

11. Maternity services quality and performance report

To APPROVE a report

For Approval

Presented by Karen Newbury

Trust Open Board – 2nd October 2020

Agenda item:	11			
Presented by:	Karen Newbury – Head of Midwifery			
Prepared by:	Karen Newbury – Head of Midwifery/Rebecca Gibson Compliance Manager			
Date prepared:	23rd September 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. As a second edition, it may be subject to changes in future iterations. It is proposed initially to present monthly but move to quarterly in future.

This report contains:

- Maternity dashboard (Annex A)
- Maternity Safety Highlight Report incorporating CNST Maternity incentive scheme (Annex B)
- Local audit / monitoring of compliance with Section 29A letter indicators (Annex C)
- Other Maternity indicators including those incorporated elsewhere in board reporting schedule

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 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 (frequency of reporting tbc but no less than quarterly).

In July there were six indicators categorised as Red and four as Amber. In August there were four indicators categorised as Red and four 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 Total Number of Babies born at WSH Midwifery Led Birthing Unit (MLBU) Births	The number of births this month is lower than anticipated, however this is variable month by month. With the increased number of induction of labours this is affecting the number of women eligible to birth in the birthing unit
Total Caesarean Sections Total Elective Caesarean Sections Total Emergency Caesarean Sections	This is an isolated variance from previous months. This remained high in July but within green parameters in August
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 2 Caesarean Section (Decision to delivery time met)	All non-compliant cases reviewed. Varying reasons for the timeframe not being met. The majority over by a few minutes. No adverse outcomes from the delay.
Shoulder dystocia	Variance to be monitored if continues to be raised
Breastfeed within the first 48 hours	Maternal choice. Due to COVID antenatal education significantly reduced. Action plan in place to address this
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.

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). https://resolution.nhs.uk/wp-content/uploads/2019/12/Maternity-Incentive-Scheme-Year-three.pdf

10 Steps-to-safety		
1	Perinatal tool	
2	MSDS	
3	ATAIN	
4	Medical Workforce	
5	Midwifery Workforce	
6	SBLCBv2	
7	Patient Feedback	
8	Multi-professional training	
9	Safety Champions	
10	Early notification scheme	

The Trust is now collating data for the Year three submission and reporting progress through the Maternity highlight report (full document in Annex B). This contains the current performance against the 10 indicators. Two are graded as green (on track)

Indicators 2, 4 and 8 rated as red and ,3,5,6 and 9 as amber indicating risks to their delivery and support required.

MSDS – Awaiting Euroking to update software to meet the requirements

ATAIN – Awaiting confirmation that audits continue.

Medical workforce – Obstetric medical workforce action plan re GMC National Training Survey not provided & inaccurate data re neonatal nursing staffing,

Midwifery workforce – paper to go to governance Oct and Board Nov.

SBLCBv2 – awaiting increased compliance with GAP and CTG training.

Patient Feedback – awaiting CQC quality survey action plan

Multi-professional training – 90% attendance of each staff group not achieved.

Maternity Safety Champions meet bi-monthly, in addition to this the Executive Safety Champion also undertakes a bi-monthly 'walk-about' to enable staff to raise any safety concerns. Maternity Safety Champions email address enables any maternity or neonatal staff member to raise a safety concern at any time. To date only one e-mail has been received and this has been reviewed, actioned and resolved.

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. (See Annex C)

Other Maternity indicators including those incorporated elsewhere in board reporting schedule

- Maternity safe staffing reporting

This is currently under development, to be presented next month in line with CNST timeframe. It is incorporated into the trust-wide staffing report in future months.

- Maternity serious incidents

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 July and one in August 2020. A woman sadly miscarried at 32 weeks gestation. This does not meet the criteria for HSIB.

- HSIB

The trust participates in HSIB reviews of care according to the national definitions. There are currently two WSFT HSIB Maternity investigations. One draft report has been received by the trust an MDT meeting is planned to discuss any safety actions and findings. The remaining one is within the initial investigation stages. 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).

- Participation in national clinical audits

The Maternity service participate in the national MMBRACE and NNAP, National Maternity Perinatal Audit, Each Baby Counts, ATTAIN, Saving Babies Lives Care Bundle v2, HSIB National Reports and the self-assessment process is used to identify areas for improvement.

- User Group Participation

Maternity Voice Partnership. Bi-monthly meetings occur to provide a forum for the service to share information and listen to user group feedback. Annual '15 Steps' took place in February 2020. Action plan is complete. The MVP have been vital in assisting with communication to our women during COVID, assisting with development of our service, Facebook page and sharing positive feedback from women and families who have used our service in this extraordinary time.

- 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.

In August consultant K Croissant presented the investigations findings regarding maternal deaths to the Learning from Deaths group.

- Basildon Maternity CQC report

We are aware of this recent report. We have reviewed the report and any potential learning will be incorporated into the maternity improvement plan.

- CCG/NHSE/I Assurance Visit

Assurance visit planned for the 25/09/2020. Report of findings to be presented in next month's report.

Trust priorities	Deliver for today		Invest in quality, staff and clinical leadership			Build a joined-up future	
	X		X			X	
Trust ambitions	 *Deliver personal care*	 *Deliver safe care*	 *Deliver joined-up care*	 *Support a healthy start*	 *Support a healthy life*	 *Support ageing well*	 *Support all our staff*
		X	X	X			
Previously considered by:			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
Total Women Delivered	>208 or <216	>216 or <208	> 224 or <2 00	178	180	187	174	183
Total Number of Babies born at WSH	>208 or <216	>216 or <208	> 224 or <2 00	179	182	190	175	187
Twins		No target		1	2	3	1	4
Homebirths	2.5%	2% or less	Less than 1%	5 2.8%	7 3.9%	5 2.7%	3 1.7%	2 1.1%
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%
Labour Suite Births	77.5%	69% - 74%	68% or less	170 95.5%	161 89.5%	154 82.4%	149 85.6%	161 88%
BBAs		No target		4 2.3%	5 2.8%	4 2.2%	0	0
Non operative vaginal deliveries	>59%	58% -59%	<58%	144 80.9%	144 80%	131 70.1%	128 73.6%	144 78.7%
Normal Vaginal deliveries				127	125	118	112	122
Vaginal Breech deliveries				1	1	0	1	1
Waterbirths		No target		3 1.7%	12 6.7%	17 9.1%	7 4%	13 7.1%
Total Caesarean Sections	<26.%		> 22.6%	34 19.1%	36 20%	56 29.9%	46 26.4%	43 23.5%
Total Elective Caesarean Sections	11%	>11% -13%	13% or more	14 7.9%	14 7.8%	23 12.3%	14 8%	20 10.9%
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%
Total Instrumental deliveries	12% - 14%	>14% - 15%	> 15%	9.6%	10.6%	7.0%	8.6%	11.5%
Inductions of Labour (ex pre labour & twins)	<31%	>31% -32.9%	>33%	39.9%	35%	32.6%	36.2%	39.3%
Inductions of labour <37 weeks (% of total inductions)				2.5%	1.30%	6.8%	2.9%	2.5%
Grade 1 Caesarean Section (Decision to Delivery Time met)	100%	96 - 99%	95% or less	100%	100%	100%	100%	100%
Grade 2 Caesarean Section (Decision to delivery time met)	80%	76 - 79%	75% or less	57%	81%	67%	95.4%	78%
Postpartum Haemorrhage 1500 mls or more	<3.5%	3.5% - 3.8%	> 3.8%	1.7%	1.1%	8%	4.0%	2.7%
Shoulder Dystocia	2	3-4	5 or more	3	7	4	4	5
Total women delivered who breastfed babies with first 48 hours	>80%	75-80%	<75%	76.7%	72.8%	78.4%	71.4%	79.2%
1 to 1 Care in labour	100%	96-99%	95% or less	99.4%	100%	100%	100%	100%
Supernumerary Labour suite co-ordinator	100%			100%	100%	No data	84%	74%
Midwife to birth ratio	1:30		1:32 or more	1:26	1:26	1:27	1:30	1:27
Completion of WHO checklists	100%	90%	80%	No data	No data	93%	96%	96%

Annex B – Maternity Safety Highlight Report for August & September 2020 (July & August data)

Maternity Safety Highlight Report

Trust: West Suffolk NHS Foundation Trust	July data	Date: 07/08/2020

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	0
DATIX	Outstanding DATIX
	0
Out of date guidelines	
3	

Maternity Safety Highlight Report

Trust: West Suffolk NHS Foundation Trust	August data	Date: 18/09/2020

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
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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
1	0
DATIX	Outstanding DATIX
61	0
Out of date guidelines	
1	

ANNEX C – CQC Section 29A monthly compliance monitoring

Observation recording and MEOWS Scoring (Issues 1 and 2)

In July's audit 464 MEOWS were undertaken, the overall compliance rate for MEOWS was 99.5%

In August 264 MEOWS were audited in 90 women's care, the overall compliance rate for MEOWS was 99.1%. The missed elements have been reviewed and will be shared with all staff, via clinical governance and 'Take 5'. Compliance will continue to be audited.

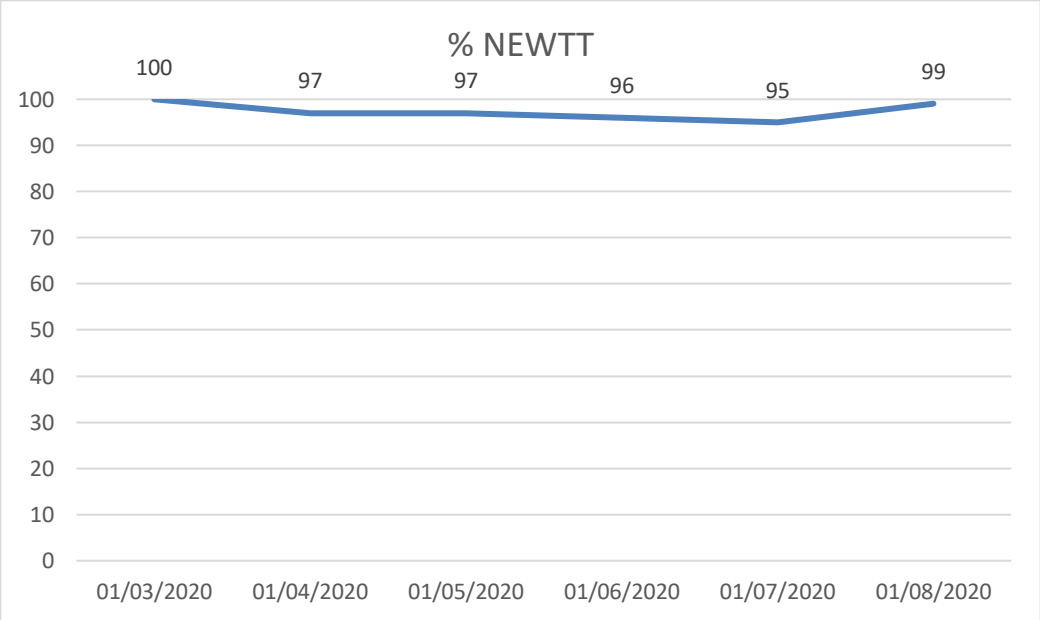
Pain Scores

Recording of non-labouring women's pain score has been added to the new MEOWS chart and audit results below.

In July 90 sets of records were reviewed for this audit. Labour Suite Triage, Birthing Unit and MDAU were 100% compliant. Labour Suite and F11 were 99% compliant.

In August 90 sets of records were reviewed for this audit. Labour Suite Triage, Birthing Unit and MDAU were 100% compliant. Labour Suite and F11 were 99% compliant.

NEWTT



In July it was noted that there is a gradual reduction in compliance over 4 weeks from 100% to 95% in NEWTTS. This equated to 7 incomplete observations out of the 141 undertaken. Reminders to be sent out to key lead Midwives across inpatient areas.

In August there was a significant improvement and compliance was 99%.

Domestic Violence questioning (Issue 4) and CO Monitoring (Issue 5)

We have adapted an audit tool to capture if we are able to ask women twice in the antenatal period and once in the postnatal period regarding domestic abuse. In April due to COVID-19 we were unable to complete this audit

CO monitoring has been suspended on the recommendation of The National Centre for Smoking Cessation and Training (NCSCT) due to the risk of coronavirus transmission. Smoking cessation continues to take place via our Smoking Cessation Midwife (telephone contact) and One Life Suffolk (telephone contact).

In July 40 notes were audited from community teams there was 100% compliance of women being asked twice about DV in the antenatal period and 95% (2 out of 40) compliance of women being asked once about DV in the postnatal period. Clinicians not meeting the required standard are identified and reminded of the expectation of 100% compliance

In August 40 notes were audited from community teams there was 95% compliance of women being asked twice about DV in the antenatal period and 97.5% (1 out of 40) compliance of women being asked once about DV in the postnatal period. Clinicians not meeting the required standard are identified and reminded of the expectation of 100% compliance.

12. Infection prevention and control assurance framework

To RECEIVE a report

For Report

Presented by Susan Wilkinson

Board of Directors – 2 October 2020

Item no.	12			
Presented by:	Sue Wilkinson Exec Chief nurse			
Prepared by:	Rebecca Gibson – Compliance Manager			
Date prepared:	September 2020			
Subject:	NHSE ICT assurance framework			
Purpose:	x	For information		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 August meeting including:

- COVID testing facilities
- CQC oversight
- Key actions to improve compliance and gather robust assurance

The Infection prevention & control annual report is also provided for information

Appendix 1 - NHSE IPC BAF (Sept20 update)

Appendix 2 – CQC Assessment for WSFT on 04_08_20

Appendix 3 - Patient and Visitor Test and Trace SOP Aug 2020 (Draft)

Appendix 4 - Rapid review of current COVID practice

Appendix 5 - Infection Control Annual Report 2019-20

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 (last met 18th September 20)
Risk and assurance:	As per attached assurance framework
Legislation, regulatory, equality, diversity and dignity implications	NHSE
Recommendation: Receive this report for information	

Background

The NHSE ICT COVID-19 board assurance framework (BAF) sets out how trusts can assess measures taken in line with current guidance to provide a level of board assurance including to provide evidence and as an improvement tool to optimise actions and interventions and thus support organisations to maintain ten quality standards underpinned by 63 of key lines of enquiry (See Appendix 1).

As previously reported; an initial self-assessment highlighted three areas of partial / non-compliance: Ventilation, Isolation and timely receipt of testing results.

- Isolation – This is a consequence of the hospital building structure / layout and the CQC/CCG have acknowledged that these are outside the control of the organisation and are appropriately recorded as such on our risk register (RR15) with all relevant mitigations in place and documented.
- Ventilation – A recent trial was undertaken of installing bars on the windows of F7 (to enable restrictors to be removed and windows opened wider). Initial feedback received was that it allowed increased airflow however didn't improve temperature. This has been fed back but currently there has been no decision as to whether it should be rolled out across the trust. This is also incorporated in RR15.
- Test results - The NHS funded contract ended with Source Bioscience on August. However, as ESNEFT were not in a position to take over the PCR testing, WSFT made a decision to continue using SBS but funding directly and are expecting this to be recovered as part of our COVID funding. We now have an NPEx link with the Ipswich lab and Covid testing moved to ESNEFT from last Monday 21st September.

  On-site point of care testing (POCT) for Covid-19 is now available using the SAMBA II analysers, although this is currently limited. However, testing provision will increase if additional personnel resource recruited. In addition, an Influenza A/B and Covid-19 kit is also to be released (approx. Nov 2020) by Roche for the LIAT POCT analyser, WSFT has requested all of their allocation (1000 kits) to be this kit type.

External scrutiny

As part of the CQC Emergency support framework (ESF) all trusts underwent an assessment by their local CQC partners. This was undertaken by WSFT in the format of an Exec to CQC conference call on the 21st July and submission of the July IPC Board paper. The trust has received the product of this review (see Appendix 2 for Summary record) which gave full assurance of the trust's arrangements in place to address the requirements of COVID including identification of areas of partial compliance and board assurance and oversight.

In addition, from a staff perspective the reported noted:

"*The trust continues to ensure that the health needs of staff are met. This is a supportive and holistic approach which considers both the physical and psychological needs of staff. All care workers are given sufficient information to ensure that they are aware of, and discharge their responsibilities in preventing and controlling infection.*"

NHSE and the CCG are being sent a copy of each month's IPC to enable oversight. The CQC summary report was also provided in September.

How we undertook this review

- Self-assessment against BAF including review of estates and isolation facilities overseen by Lead Infection prevention & control nurse (AH) and Compliance manager (RG). Responses at specialist level including: IPC, housekeeping, estates, occupational health, antimicrobial pharmacy, trust clinical psychologist, patient flow and purchasing.
- DIPC/Exec-led task & finish group established to oversee self-assessment and action point arising
- Structured response provided to board and external stakeholders (CQC/NHSE/CCG)

Previously highlighted actions not already recorded as complete

Issue 1: Consider eCare audit for three further areas where we have declared compliance but cannot confidently evidence this without an audit or deep dive review. Patient moves / Contact tracing / Timely taking of swabs

Patient moves Draft patient flow policy encompassing issues of movement throughout the Trust. Will include a flow chart with movement standards to enable an audit pathway for > 3 moves or out of hours transfers. Policy is due to be submitted for issue before the end of September.

Contact tracing See Appendix 3 for the current draft trust SoP 'Test and Trace' for visitors and patients (inpatients and discharged patients)

Timely taking of swabs 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.

Issue 2: Gaps in assurance and mitigation for all items need to be described within risk assessments. Current risk register entries clearly describe isolation facilities are within but there is not an obvious record for some other aspects. Need to complete a BAF risk assessment for the full document and link to current risk register entries where they already describe elements of the document.

Update - The Trust BAF entry 3.2 (RR:3651) *Failure to deliver the national access standards* is being expanded to incorporate the impact of COVID on recovery and this is therefore the most appropriate place for this wider assurance review to be captured. This is being overseen by Richard Jones, Trust Secretary & Head of Governance.

Evidencing compliance and monitoring

In line with further information, a rapid review of current practice with suggestions for improvement was undertaken in September by Sam Crouch, Service Manager – Tactical and Grace Norman, Public Health Registrar. The full review is enclosed in Appendix 4. In summary:

Contact tracing is working within the hospital and there have been examples through <2m contact within office environments in the hospital resulting clinical staff needing to self-isolate when a colleague is diagnosed as covid positive. This poses risks to the staff, who have been exposed to covid, and risks to patients through avoidable staff absence.

A walkabout audit within the hospital and surrounding buildings found good compliance within Time-Out (except sometimes in the queues) and corridors but offices in the main building were not meeting the minimum requirements (hence the impact of contact tracing). Offices in the Oak/Cedar buildings had better compliance and there was seen to be spare office space provision as the opportunities for working from home were being well used. It was also noted that in some areas there was insufficient space for clinical staff to take breaks.

Key messages were therefore a need to focus on space utilisation (office use optimisation and home working), signage and staff information / communication and clear guidelines on mask usage.

Infection Prevention and Control annual report

The Health and Social Care Act (2008 – amended in 2015) Code of Practice on the Prevention and Control of Infections and Related Guidance requires the Director of Infection Prevention and Control (DIPC) to produce an annual report on the Trust's performance in respect of healthcare associated infections (HCAIs). The report for the period April 2018-March 2019 was presented to CSEC on the 14th September (enclosed in Appendix 5).

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	Previously reported as partially compliant now moved to full. Whiteboard amendment made to enable tracking and exception reporting for out-of-hours moves or >3 moves. Patient flow policy describes process.		
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		

Ref	Quality standard	Key lines of enquiry	Compliance	How would we evidence this?	Gaps in assurance	Mitigating actions
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		
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 areas of non-compliance are fully described in risk assessments (e.g. ventilation and contact tracing)	Undertake a full risk assessment of the BAF and link to current risk assessments. This is currently (September) 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		

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

Ref	Quality standard	Key lines of enquiry	Compliance	How would we evidence this?	Gaps in assurance	Mitigating actions
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.		
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 predominantly in place as per Patient safety risk assessment	No fans in use in any waiting areas. Windows open where possible Testing options of bars (allowing wider window opening) vs window restrictors

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 or nursing/medical care in a timely fashion	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		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 specific training in the period Mar-June did not have records maintained though attendance numbers were good in all cases	All future training sessions will have attendance records taken Where and who keeps these records will be confirmed
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		
6.5		any incidents relating to the re-use of PPE are monitored and appropriate action taken	Compliant	Datix incident reporting system		

Ref	Quality standard	Key lines of enquiry	Compliance	How would we evidence this?	Gaps in assurance	Mitigating actions
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 are prioritized according to the risk of the infection; this forms the main element of the duty IPN workload. Side room lists occupancy lists are completed daily and circulated Sheeting has been installed to provide a 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	Previously reported as partially compliant now moved to full. 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		

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		

Infection Prevention and Control Assessment

Engagement call

Summary Record

West Suffolk NHS Foundation Trust

Provider address	Date
Hardwick Lane Bury St Edmunds IP33 2QZ	04/08/2020

Dear West Suffolk NHS Foundation Trust

The Care Quality Commission is not routinely inspecting services during the pandemic period and recovery phase, although we will be carrying out some focused inspections. We are maintaining contact with providers through our usual engagement calls and by monitoring arrangements such as those for infection prevention and control.

This Summary Record outlines what we found during an engagement call to discuss infection prevention and control arrangements, using standard sentences and explanatory paragraphs.

We have found that the board is assured that the trust has effective infection prevention and control measures in place. The overall summary outlines key findings from our assessment, including any innovative practice or areas for improvement.

This assessment and other monitoring activity are not inspections. Summary Records are not inspection reports. Summary Records are not published on our website.

Infection Prevention and Control – Assessment areas

1. *Has the trust board received / undertaken an assessment of infection prevention and control procedures and measures in place across all services since the pandemic of COVID 19 was declared. Does this include an assessment of the estate / isolation facilities?*	
Yes	The Board had received/undertaken a clear and comprehensive assessment of Infection Prevention and Control across all services including an assessment of the estate and isolation facilities.

2. *Are there systems in place to manage and monitor the prevention and control of infection? Do these systems use risk assessments and consider the susceptibility of service users, and any risks that their environment and other users may pose to them?*	
Yes	There are systems in place in manage and monitor the prevention and control of infection.

3. *Are there systems in place to provide and maintain a clean and appropriate environment in managed premises, facilitating the prevention and control of infections?*	
Yes	There are systems in place to provide and maintain a clean and appropriate environment in managed premises, facilitating the prevention and control of infections.

4. *Is there appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance?*	
Yes	There is appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

5. *Does the trust provide suitable accurate information on infections, in a timely fashion, to service users, their visitors and any person concerned with providing further support or nursing/ medical care?*	
Yes	The trust provides suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.

6. *Is there a system in place that ensures 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?*	
Yes	The trust has systems to identify promptly people who have an infection, or who are at risk of developing an infection so that they receive timely and appropriate treatment.

7. *Are there systems in place 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?*	
Yes	There are systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process or preventing and controlling infection.

8. *Are there secure or adequate isolation facilities?*	
Yes	The trust has effective process in place to manage the isolation of patients appropriately.

9. Is there adequate access to laboratory support?	
Yes	There is adequate and responsive access to laboratory support.

10. *Is there evidence that the trust has policies designed for the individual's care which will help prevent and control infections?*	
Yes	The trust has effective policies designed for the individual's care which will help prevent and control infections.

11. ***Does the trust have a system to manage the occupational health needs of staff, regarding infection?***	
Yes	The trust has a system to manage the occupational health needs of staff regarding infection.

Overall summary record

We had a meeting with the trust on 21/07/2020. During this meeting, different areas of the board assurance framework were discussed in relation to infection prevention and control. The board assurance framework overview was presented to the trust board at the end of June 2020, and an updated version with all the relevant assurances went to the trust board a second time in July 2020. The trust has undertaken a thorough assessment of infection prevention and control, across all services, since the pandemic of Covid 19 was declared. Appropriate systems in place include having prompt identification of people within the organisation who have, or are at risk of developing an infection. Cohorting areas have been established for patients across the trust. Staff have received, and continue to receive necessary training, in line with national guidance and are updated accordingly. The trust continues to provide information for carers and the wider public through their website and regular outward communications. The trust continues to ensure that the health needs of staff are met. This is a supportive and holistic approach which considers both the physical and psychological needs of staff. All care workers are given sufficient information to ensure that they are aware of, and discharge their responsibilities in preventing and controlling infection. The trust has a robust culture of risk assessing areas of concern such as isolation capacity and lack of positive / negative pressure areas, and undertaking appropriate mitigations.

DRAFT - Standard Operating Procedure

'Test and Trace' for Visitors and Patients (In-patients and Discharged Patients)

As part of the NHS response to COVID-19 it is essential that we are able to provide a 'Test and Trace' process to both patients and visitors who have been affected following the identification of a COVID-19 positive patient.

We have experienced an increase in positive patient numbers due to a rise in swabbing in line with the mandatory 7 day retest, but also due to some episodes of unnecessary re-swabbing of patients. To ensure that we are accurately identifying the relevant patients a standardised flow chart 'COVID-19 Swabbing of In-patients' has been developed to provide staff with clear guidance of the schedule for and necessity of swabbing and re-swabbing of patients **(see Appendix A).**

For the purposes of 'Test and Trace' the following process should be followed to ensure that the correct individuals (patients and Visitors) are firstly identified and then subsequently notified of their exposure to a COVID-19 positive patient and the necessary actions they should take in response to this.

Test and Trace Process

- A daily list of COVID-19 positive patients will provided to the Infection Prevention Team (Monday to Friday) Patient Flow Team (Saturday and Sunday)
- Positive patient list to be 'data cleansed' by the Infection Prevention Team (Monday to Friday) Patient Flow Team (Saturday and Sunday)
- A list of confirmed COVID-19 positive patients to be provided to the 12:15 Capacity Meeting (Monday to Friday) 10:00 Capacity Meeting (Saturday and Sunday)
- Divisional representative (Monday to Friday) Patient Flow Manager /Matron of the Day (Saturday and Sunday) to take this information to the in-patient area/s where the positive patient/s have been identified and then initiate the 'Test and Trace' process

  For in-patients and discharged patients follow the process outlined below in **Appendix B** - In-patient and Discharged Patient Test and Trace Process

  To identify those 'contact' patients that have been discharged home from the affected area please follow the process contained within **Appendix C** – PAS Search Location History

  For visitors follow the process outlined in **Appendix F** – Visitor Test and Trace Process

- Divisional representative (Monday to Friday) Patient Flow Manager /Matron of the Day (Saturday and Sunday) to update the Tactical Commander of progress with the 'Test and Trace' process at the 15:15 Capacity Meeting (Monday to Friday) and 15:00 Capacity Meeting (Saturday and Sunday)
- Any issues in regards to 'Test and Trace' must be escalated to the Tactical Commander and appropriate other departments for prompt resolution
- Divisional representative (Monday to Friday) Patient Flow Manager /Matron of the Day (Saturday and Sunday) to update the Tactical Commander of completion with the 'Test and Trace' process at the following day Capacity Meeting
- The standardised processes, audit tools and scripts must be used **(see Appendices B/C/D/E/F/G/H)**
- Records of completed audit tools must be held by the clinical area/s

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COVID-19 Swabbing of In-patients

All patients to be swabbed on admission

NB: patients who have been swabbed within the last 72 hours as part of their pre-admission screen, will not require re-swabbing on admission

Contact patients should be swabbed on identification and then repeated after 5 days

Contact patients are those exposed to a positive patient (from 48 hrs prior to the positive swab being taken)

If this coincides with the day 7 admission re-swab only 1 test will be required

All negative patients must be re-swabbed at day 7, an automatic task will be generated by ECare

Elective surgical patients swabbed prior to admission should be re-swabbed 7 days after their pre-admission swab

Further swabs are not required after the 7 day post admission repeat swab

Patients to be re-swabbed for discharge purposes if going to a

- **Nursing Home**
- **Residential Home**
- **CAB**

Patient to be re-swabbed if they develop new COVID symptoms

Patients who have tested as positive within the last 6 weeks should not be routinely re-swabbed

- **Any other requests for COVID-19 swabbing outside of the guidance above should be discussed with the Matron of the Day or the Clinical Site Manager (out of hours)**
- **Swabbing for discharge purposes should be undertaken to coincide with the planned discharge date (48 hours prior to discharge)**
- **Rapid swabbing (Cepheid) must be authorised by Tactical Command, this is a limited resource that must be used appropriately based on clinical and operational needs**
- **Patients must not be restrained for the purposes of swabbing**
- **Any patient refusal in regards to swabbing must be documented and escalated**

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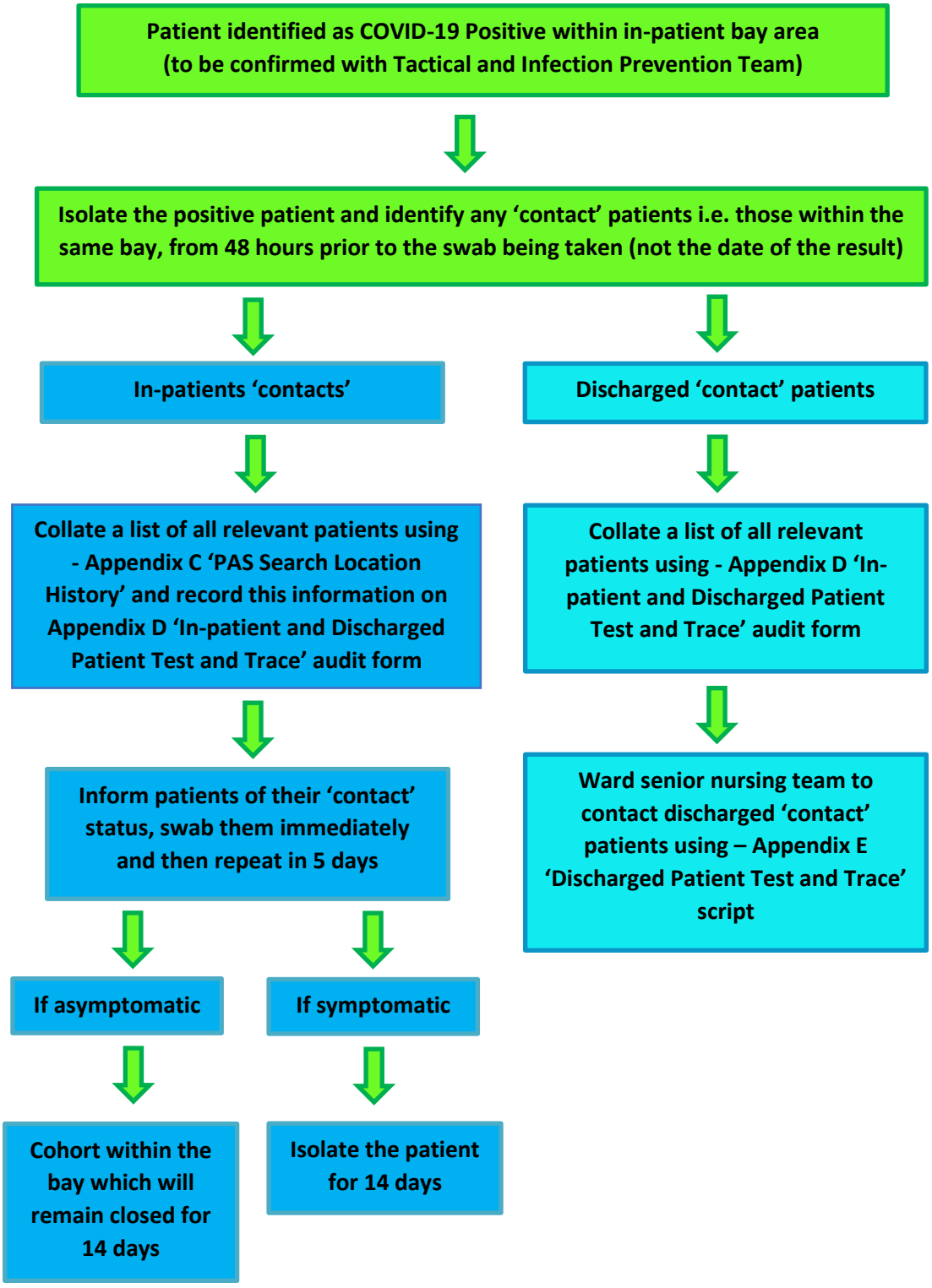
In-patient and Discharged Patient Test and Trace Process

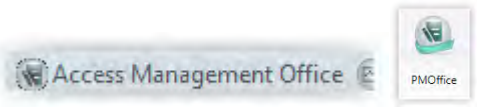
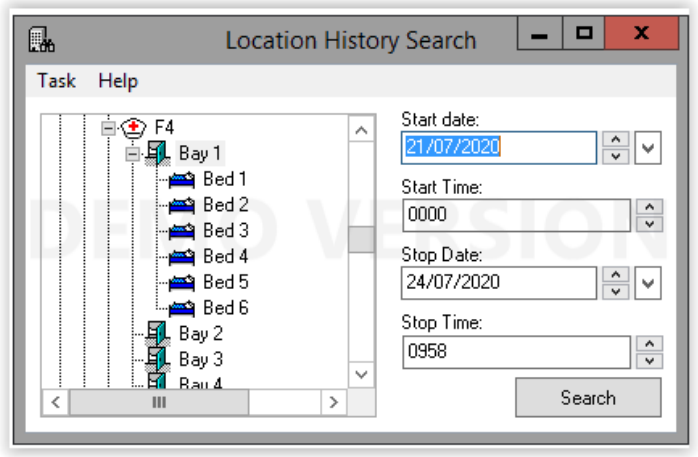


- **Any communication with discharged patients must be undertaken by a member of the Ward Senior Nursing Team (Sister / Charge Nurse / Matron)**
- **If contacting discharged patients do not leave an answerphone or voice mail message, please make a note of any attempts to call and escalate to the Tactical Command if contact cannot be made within 24 hours.**

PAS – Search Location History

Searching for a list of patients that have shared the same location over a set period of time

Overview
Searching the location history will reveal a list of patients that have shared the same location of a pre-determined period of time. This can be set to the ward, bay or bed level

Step	Instructions
1.	Open the Access Management Office application: 
2.	Select the “Search Location History” icon at the top of the screen 
3.	Using the Location History Search tool, select the precisie location and date/time range parameters for the search: 
4.	When “Search” is selected, a list of patients meeting the criterion will be presented.

Appendix D

In-patient and Discharged Patient Test and Trace

NB: Do not leave an answerphone or voice mail message, please make a note of any attempts to call and escalate to Tactical if contact cannot be made within 24 hours.

Date of Test and Trace ……. MRN of Index Case ……. Staff Completing – Name / Position ……

Name	MRN	Contact Number	Comments

Appendix E

Discharged Patient Test and Trace Script

NB: This must be undertaken by a member of the Ward Senior Nursing Team (Sister / Charge Nurse / Matron)

Hello Mr / Mrs ....

I am calling you from ward …. , please do not worry. The reason for my call is that whilst you were an in-patient on ward …. , another patient within the same bay where you were cared for has subsequently tested positive for COVID-19.

I would like to re-assure you that my contacting you is part of the standard NHS process that we follow when a case of COVID-19 is identified.

As per NHS guidance you should now isolate for 14 days, this would be from ….

(Date to be calculated from 48 hours prior to the taking of the positive swab, not the result date)

If you were to develop any symptoms suggestive of COVID-19 please follow guidance on the NHS website which will include information on arranging a swab test:

Apply online at GOV.UK.

Or

Call 119 if you do not have access to the internet.

Appendix F

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Visitor Test and Trace Process

Patient identified as COVID-19 Positive within in-patient area (to be confirmed with Tactical and Infection Prevention Team)

Isolate the positive patient and identify any 'contact' visitors i.e. those within the same bay, from 48 hours prior to the swab being taken (not the date of the result)

Discharged 'contact' patients

Collate a list of all relevant visitors using - Appendix G 'Visitor Test and Trace' audit form

Ward senior nursing team to contact visitors using – Appendix H 'Visitor Patient Test and Trace' script

- **Any communication with visitors must be undertaken by a member of the Ward Senior Nursing Team (Sister / Charge Nurse / Matron)**
- **If contacting visitors do not leave an answerphone or voice mail message, please make a note of any attempts to call and escalate to the Tactical Command if contact cannot be made within 24 hours.**

Appendix G

Visitor Test and Trace

NB: Do not leave an answerphone or voice mail message, please make a note of any attempts to call and escalate to Tactical if contact cannot be made within 24 hours.

Date of Test and Trace ……. MRN of Index Case ……. Staff Completing – Name / Position ……

Name	Contact No.	Face Covering Yes / No	Hand Sanitizing Yes / No	Comments

Visitor Test and Trace Script

NB: This must be undertaken by a member of the Ward Senior Nursing Team (Sister / Charge Nurse / Matron)

Hello Mr / Mrs ....

I am calling you from ward …. , please do not worry. The reason for my call is that whilst you were visiting your relative / friend on ward …. , a patient within the same bay area has subsequently tested positive for COVID-19.

I would like to re-assure you that the visiting guidance and processes we have put in place should provide sufficient protection to you.

Can I confirm if you wore a face covering whilst you visited ward …. ?

Can I confirm if you sanitized your hands on arrival and again when leaving?

If you were to develop any symptoms suggestive of COVID-19 please self-isolate and follow guidance on the NHS website in regards to arranging a swab test.

If you have no symptoms there is no need to take any further action at this time.

To re-assure you we will test and closely monitor the individual you had visited and take any necessary actions if it were to be indicated. If they are or have been discharged they will be advised to self-isolate for 14 day.

Enhancing COVID Security: A rapid review of current practice & suggestions for improvement

Sam Crouch, Service Manager - Tactical

Grace Norman, Public Health Registrar

9th September 2020

Current issue

- The number of cases of covid are rising locally and nationally and we have a duty to protect all of our staff and patients as much as possible from contracting covid
- Recently, contact tracing within the hospital has identified examples where a staff member with covid has been in close contact (<2m distance) with other staff members in offices. This has resulted in a number of clinical staff needing to self-isolate for 2 weeks.
- This poses risks to the staff, who have been exposed to covid, and risks to patients through avoidable staff absence.
- New guidance has been released which means that in the main hospital building, when staff are not doing patient facing work they should be maintaining 2m distancing and wearing a face mask

Understanding the issue

- Asked DOCC's about current areas & whether they are 'covid secure'
- Undertook a small scale audit of a range of areas:
  - Time Out
  - F5/F6 corridor offices
  - Ward G3
  - Quince House
  - Oak House & Cedar House
- Based on the following criteria:
  - Distancing of 2m when not undertaking patient contact
  - Mask wearing unless working alone in an office
  - Adequate ventilation, but not use of fans
  - Frequent cleaning
  - One way movement where possible

Key findings: Good practice

- Time Out:
  - Most people wearing masks appropriately
  - Good one way system & everyone was following it
  - People were distanced at the tables
- One way system in the main building is working
- Lots of working from home within teams & teams have developed rotas to maintain distance & also let people come to work
- Everyone walking around the hospital are wearing masks and they are over both their mouth and nose
- Some desks have got ‘do not use’ markings on them to remove them from use

Key findings: Quantitative

- In the main hospital building:
  - Surveyed 7 offices on the F5/F6 corridor
  - 5 / 7 did not meet the 2m requirement
  - Most staff were not wearing masks when in offices
  - All had fans available, although none were on *(fans are bad)*
  - All had open windows (but the weather is still mild) *(windows are good)*

- In the offices away from the main building:
  - Surveyed 12 offices in Oak House & Cedar House
  - 2 / 12 did not meet the 2m requirement
  - 6 / 12 could have accommodated more staff than were regularly using them

Key findings: Qualitative

- There is inadequate social distancing in key areas in main hospital:
  - Doctors working in very close proximity in small areas on the ward and off the ward
- There is insufficient space for staff to take breaks
  - Clinical staff have been using small offices – doctors and nurses
  - Catering staff also very cramped
- There is under-utilisation of space in some office space away from the main building
- There is a lack of understanding of what 2 metres is and how many people can be in a space
- There is a lack of signage in many parts of the hospital about how many people can be in a certain room
- There is concern from staff about implications of higher covid secure standards while maintaining hospital services
- Time Out: Overall very good although there was limited social distancing in the serving queue

Recommendations

- Suggested mitigations could include:
  - Encouraging more working from home for those who can. In the main hospital this could free up some space in the main hospital for those who need to be in the main building and work in offices, and those who need to be on site but could be further away from clinical areas could utilise some space which is currently under-utilised elsewhere
  - Identify an additional area for clinical staff to take breaks which allows adequate distancing
  - Greater signage about the number of staff who can be in a space
  - Time out: red or blue coloured tape on the floor may help people maintain 2m distance in the queue (which would help protect the catering staff)
- More work to be done to further investigate specifically who could be working elsewhere and how the offices should be optimised, and to propose and implement other mitigations, while being mindful of the need to maintain services.
- Communications and education plan, to focus on what 2m really is, when staff should be wearing masks & that covid hasn't gone away & we need to reduce our risk as much as possible (especially with regards to staff on breaks)

Thank you

Any questions?

Agenda item:	6.6			
Presented by:	Sue Wilkinson, Interim Executive Chief Nurse			
Prepared by:	Sue Partridge, Consultant Microbiologist and Anne How, Lead Infection Prevention Nurse			
Date prepared:	July 2020			
Subject:	Infection Prevention and Control Annual Report, 2019-20			
Purpose:	x	For information		For approval

Executive summary:

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

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

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

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

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

Recommendation:
For information.
The Board is asked to note that the longstanding issue of lack of isolation facilities, while an accepted risk, has become even more important because of Covid 19. The support of the Board will be required for any remedial works in terms of adding doors to bays, because of the operational and financial impact of this work.
The management of Covid-19 and its impact on all areas of activity are likely to dominate the Infection Prevention agenda during the coming year.

Executive Summary

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Introduction

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

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

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

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

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

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

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

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

The Infection Prevention and Control Arrangements

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

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

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

The IPN team comprises:
Lead IPN WTE 0.8, Band 8a
Two Infection Prevention nurses 1 WTE Band 6 & 1 0.8 WTE Band 6
Limited clerical support is provided by the Pathology Admin and Clerical staff
The Infection Prevention and Antibiotic audit nurses work closely with the IPNs. They are professionally accountable to the lead IPN, although they are managed within the Pharmacy Department, Clinical Support Services Division.
Band 7 WTE 0.8 (0.26 dedicated to Community IPN role). Michelle Smith left this post in November 2019. Amanda Devereux was appointed to the post in April 2020 and recruitment to the vacant IPN post (below) is in progress.
Band 6 WTE 0.9 (increased from 0.8 to support service and practice development in the IPN role)

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

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

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

Assurance Framework

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

ANNUAL PLAN

In addition to the regular activities described in subsequent sections, variable progress was made against the 2019-2020 Annual Plan in the following areas:

- It was not possible to undertake a formal programme of deep cleaning during 2019-20 because of the lack of a decant facility. Ad hoc deep cleans were undertaken when G9 was available
- The Antimicrobial Management Team worked with other Trust staff with a view to meeting the requirements of National CQUIN target (see below).The IPT has been involved in planning for all major estates projects including finalisation of the AAU project and the Theatre project (ongoing).

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

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

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

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

The programme of testing for pseudomonas in augmented care areas continues. A major programme of work to improve the water circulation is still underway and it is hoped that this will overcome some of the issues. In the meantime, however, there are some outlets where the continued use of point of use filters is required.

Regular testing for Legionella is also undertaken
The IPT participated in an external Water Safety Audit performed by the Trust's specialist adviser in March 2020, and undertook necessary training.

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

The IPT reports cases of Clostridium difficile, Gram negative bacteraemia (E. coli, Klebsiella and Pseudomonas) and Staphylococcus aureus bacteraemia (both meticillin-sensitive and meticillin-resistant) to the mandatory National Surveillance Scheme. Note that no reporting under this scheme was undertaken from February-March 2020 for Gram negative bacteraemias because of the pressures associated with Covid-19. Reporting of the other DCS organisms is complete for the year.

1. C. difficile infection (CDI) 25 Hospital onset cases. 10 Community Onset Healthcare associated cases (COHA) This is the first year we have been required to report COHA's

The Trust objective for 'trajectory' Hospital/Healthcare attributable (by time-frame) cases of CDI for 2019-20 was 20. A total of 25 Hospital cases plus 10 COHA cases were reported, of which 3 counted against the trajectory.
The remaining 22 were non-trajectory as were all of the COHA's. Cases are now deemed to fall into one of the following categories

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

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

April 2019 the attribution of CDI cases is as follows. Cases are counted against the Trust objective if they meet any of the following definitions:

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

The Trust objective for CDI cases has been increased to 20 in the light of these revised definitions
Of the 10 Community-Onset Healthcare-Associated cases none were Trajectory. 1 case was escalated for Post Infection review and remained non-trajectory.

2. Meticillin-resistant Staph. aureus (MRSA) bacteraemia (all 4 Quarters are complete)

Two episodes of hospital-acquired MRSA bacteraemia were reported. One was a patient with deep-seated infection as the source; this case was deemed 'unavoidable' by the external review panel which included the Regional IPN lead. In the second case no source of the bacteraemia was ever identified, and again this was deemed 'unavoidable' by the panel and the Regional IPN Lead. WSFT and the CCG are still required to conduct a PIR for all cases (this is no longer a national requirement for all trusts).
The nationally-set objective for these cases remains zero.

3. Meticillin-sensitive Staph aureus bacteraemia (All 4 Quarters are complete)

Five cases were identified. None of the cases were linked and no themes relating to the Trust provision of healthcare were identified. Two patients had pre-existing wounds and two of the other cases had a diagnosis of osteomyelitis made.

The presence of a senior clinician at PIR meetings is very helpful in understanding the course of events, and the support of clinical colleagues is gratefully acknowledged. Senior medical trainees also sometimes attend the meetings; this allows them to understand the wider context of their patient's infection: mandatory review of HCAIs and the trajectories which a given to Trusts.

4. Gram negative bacteraemia (GNB) – E. coli, Klebsiella sp. and pseudomonas aeruginosa. The recording of GNB's is complete until the end of January 2020; we do not have the figures for February & March 2020.

Reporting of E. coli bacteraemias was mandatory from April 2019, although no objective for the number of cases has been set. There were 21 cases which were attributable to the Trust by time-frame (a total of 169 cases were attributable to the CCG). It was noted that many of these patients

had significant comorbidities. Root Cause Analyses were performed for all cases, and reviewed by the CCG.
There were 15 Klebsiella and 3 Pseudomonas bacteraemias attributable to the Trust. There is no requirement to conduct an RCA for these cases; they are assessed when entered onto the data capture system to establish if there are any themes.
The Gram negative bacteraemias are reviewed monthly and reported to the Trust Board.
The Trust has been participating in the catheter passport scheme in Suffolk in tandem with community services. The Trust completed a QI project on the timeliness of nurse led urinary catheter removal. A poster outlining the project and the findings demonstrating minimal additional catheter days was presented at the QI exhibition.

5. Surgical Site Infection Surveillance.

The Trust is participating in a Getting it Right First Time (GIRFT) initiative with respect to surgical site infection. As part of this process, an audit of infections was undertaken.

Results of audit 1st May to 31st October 2019:

	Total number of operation	Total number of SSI cases	%
Orthopaedic (elective)	336	0	0
Breast surgery (elective)	16	1	6.2
General surgery (elective and emergency)	260	23	8.8

We await the publication of national data for comparison.

A number of actions have been taken as part of the Quality Improvement Programme

- Successful WSH electronic SSI surveillance data report submission to PHE (elective orthopaedic cases)
- West Suffolk Hospital Surgical Site Infection Surveillance Integrated Service (WISE) project
- Proposed change to clinical guidelines of surgical antibiotic prophylaxis for groin hernia surgery.
- The Trust is part of the National SSI Orthopaedic giving prophylactic Octenidine: all elective orthopaedics patients are given Octenidine at pre-op to start before coming in for surgery.
- A process for undertaking SSSI surveillance post-discharge is under consideration

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

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

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

With the advent of the Covid 19 pandemic the focus of the Infection Prevention team and Consultant Microbiologists alongside our Tactical colleagues from January to March 2020 has been to ensure all of the guidance issued by PHE has been implemented as and when published to ensure that our staff and patients have the most up to date information. This is extremely challenging, as guidance appears via different routes and often outside normal working hours.

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

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

- Assessment and proactive response to the risk of infection
- Ensuring effective working practices that avoid the risk of transmission
- Universal application of fundamental infection prevention and control techniques and practices
- Managing specific infectious agents (including Covid 19) in line with best practice

The key objectives for 2019-20 were

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

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

Ensure effective risk assessment and risk management strategies are employed whenever and wherever a risk is identified, including out of hours. The team work closely with the bed flow team to ensure that the single rooms and the admissions to F12 are optimised. The team have been working closely with the eCare team to optimise the information staff can access in respect of Isolation both within the Capacity Management module. It did not prove possible to implement the Cerner Infection Prevention Module; however an alternative system has been identified and procured for implementation in 2020-21. Potential benefits are anticipated for recognising infection and triggering required actions.

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

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

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

- Non-clinical staff undertake e-learning every three years. A minimum of 90% were up to date (against a Trust target of 90%) prior to February 2020.

- Frontline Clinical staff (predominantly but not exclusively Nursing staff) receive annual classroom training. A minimum 90% were up to date (against a Trust target of 90%) prior to February 2020).
- Consultants undertake annual e-learning; 95% are compliant (target 80%)

IP is a core element in Trust mandatory training.

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

As part of IPC audit, if poor practice is noted than it is escalated to the service manager for resolution.

Most clinical areas (Trust and Community) have an IP Link Practitioner who acts as a source of information and advice regarding appropriate practice. The Link Practitioners are supported by the IPT and there are usually four training days a year, unfortunately in 2019 we could only hold two. The most recent meetings have covered:

Antimicrobial Resistance

Microbiology and Winter Infections (including Routes of Transmission)

Criterion 7
Provide or secure adequate isolation facilities

In January, because of concerns regarding Covid-19 the risk noted on the Trust Risk Register regarding the low number of single rooms (Risk 15) was regraded to RED (circa 10% of available beds are single rooms) which is recognised as being the lowest in the region.
The IPT continued to liaise closely with the Estates and Facilities department regarding any development proposals.
The IPT attend as a minimum the morning Safety Huddle and the Midday patient flow meeting, as well as other patient flow meetings as required. This is to ensure that staff managing this key function can access accurate information on available isolation facilities.

The IPN's visit the acute wards daily (Monday to Friday) in order to assess patients requiring isolation and those for whom monitoring is required, to ensure all measures to reduce onward transmission are in place. Up to date information on the status of patients who are isolated, or who should be isolated when there is capacity to do so, is recorded every weekday by the IPT. This information is supplied to the patient flow bed team on a daily basis.
A review was undertaken, with the IP lead for our Commissioners, of the feasibility of accurately reporting on our ability to isolate patients, it was agreed that this would no longer from part of the monthly reporting schedule. **Risk 15** remains as a red risk for the Trust and is captured in the Annual Plan which is reviewed quarterly.

Criterion 8
Secure adequate access to laboratory support as appropriate

During 2019-20, it was agreed that (from a date yet to be determined) Public Health England would cease to provide Microbiology for the North East Essex and Suffolk Pathology Services network.
On 28th April 2020 WSFT were informed by ESNEFT that they had decided to dissolve the NEESPS partnership, by the end of October 2020.
The repatriation of Pathology services to WSFT will require a huge amount of work by colleagues in many areas including Laboratory staff, Managers, Human Resources, contracting and Procurement

Detailed investigation of the feasibility of implementing the eCare Infection Prevention module demonstrated that this would not provide the necessary functionality, so this option will not be pursued. A feasibility assessment of another commercial system is being undertaken.

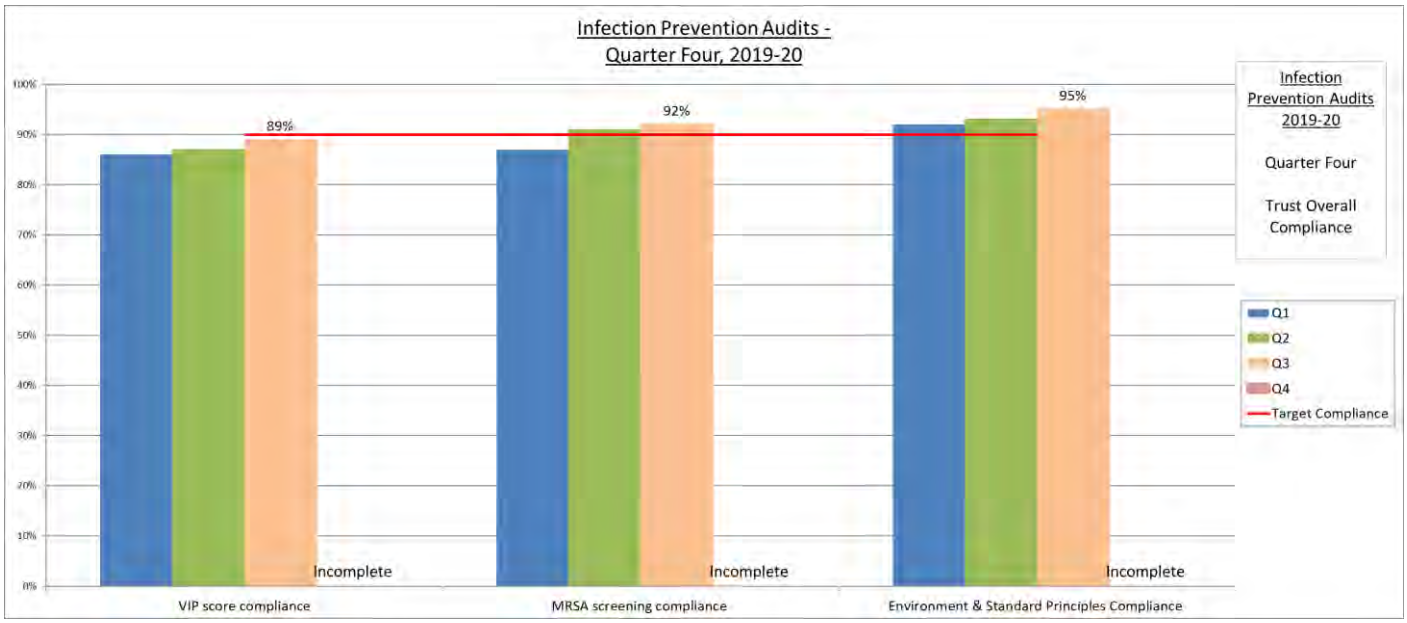
Criterion 9
Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections

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

HIIs and Hand Hygiene Audits

Indicator	Target	Red	Amber	Green	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
HII compliance 1a: Central venous catheter insertion	= 100%	<85	85-99	= 100	100	100	100	100	100	100	100	100	100	100	94	
HII compliance 1b: Central venous catheter ongoing care	= 100%	<85	85-99	= 100	89	100	100	100	100	100	100	97	100	100	97	100
HII compliance 2a: Peripheral cannula insertion	= 100%	<85	85-99	= 100	100	98	100	100	91	90	98	98	100	95	100	100
HII compliance 2b: Peripheral cannula ongoing	= 100%	<85	85-99	= 100	100	99	100	99	100	100	99	97	99	99	99	100
HII compliance 4a: Preventing surgical site infection preoperative	= 100%	<85	85-99	= 100	100	100	100	100	100	100	100	100	100	100	100	100
HII compliance 4b: Preventing surgical site infection perioperative	= 100%	<85	85-99	= 100	100	100	100	100	100	100	100	90	100	100	50	100
HII compliance 6a: Urinary catheter insertion	= 100%	<85	85-99	= 100		100	100	100	100	100	100	100	100	94	100	
HII compliance 6b: Urinary catheter on-going care	= 100%	<85	85-99	= 100	96	94	96	100	100	99	95	98	100	97	99	98
Hand hygiene compliance	= 95%	<85	85-99	= 100	100	100	99	100	97	99	100	100	100	100	100	96

Additional Infection Prevention Audits



Compliance with Visual Infusion Phlebitis scores have been below target since the launch of e-Care in May 2016, however since the launch there has been both ad-hoc and formal training on how and why to complete this with more focus of late on the timely removal of cannulas, there has subsequently been a steady improvement in compliance rates.

We continue to report non-compliances to the Ward manager and Matron and the findings discussed. If there are on-going issues identified in previous audits a formal meeting is held with the Ward Manager and Matron. Audit results and issues identified during the audits are discussed at the IPT/DIPC meeting.

The results of the audits are formally reviewed by the Lead IPN and Audit Nurse. If concerns are raised then additional review of practice on the ward is undertaken and support given as necessary to improve practice. This process has continued in 2019/20, allowing any themes to be identified and appropriate actions taken.

For 2019/20 the community in-patient beds at Newmarket Hospital and King Suite, Glastonbury Court, were included in the Trust IP audit programme. In October 2018 the Community Nursing teams began an audit programme of High Impact Interventions which continues and is under review whilst still in the early bedding in phase.

The Quarter Four audit programme is incomplete due to planning for the Covid-19 Pandemic.

Aseptic Non-Touch Technique (ANTT)

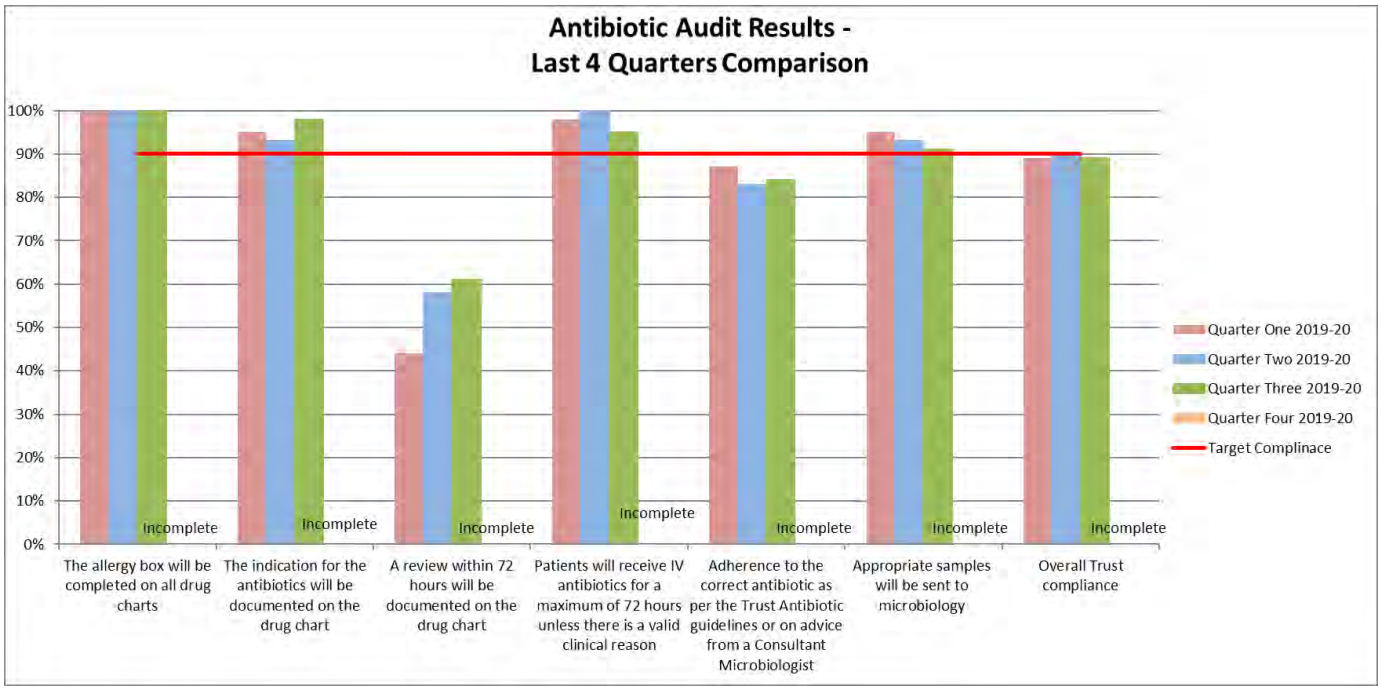
It is now 10 years since the ANTT training and assessment programme was introduced. Mid 2019/20 the Trust compliance with ANTT assessments stands at 64.95%, with the standard being that all relevant staff are assessed every 3 years. Inconsistencies have been identified within the report; this has been reviewed by the Education and Training team but have yet to be resolved.

Community ANTT training session was held in September as planned with staff from each Community Team present. Each attendee received the session followed by an assessment and can go on to assess colleagues/other members of staff.

Work continues to be on-going to apply for ANTT accreditation to demonstrate the work that has been done over the past 10 years. This should be possible when issues with the compliance report are resolved.

ANTIMICROBIAL STEWARDSHIP

The rolling programme of audit has continued.



Overall results

In January 2020 it was agreed that the Trust would be aligned with the rest of the STP in having a compliance target of 90%

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

Dr Jonathan Kerr (who held the Antimicrobial Lead role) left the Trust in November 2019. His replacement, Dr Albert Lessing, joined the Trust in May 2020.

The AMS strategy written in December 2019 is as follows:

Antibiotic strategy version - draft.pdf

Achieving best prescribing practice:

- The availability of IV antibiotics within the global antibiotic market has continued to fluctuate over 2019-20; Trust guidelines were updated in a timely manner to reflect availability.

- The Antibiotic Audit Nurses and Antibiotic Pharmacist have continued to attend individual Ward Governance meetings to discuss with the Doctors, Ward Pharmacists and Ward staff to discuss non-compliances with a view to promoting best practice prescribing alongside Antimicrobial Stewardship.

- The introduction of a 72 hour review alert in e-Care awaits an e-Care update. The ##antibioticreview auto-text on ward rounds to support the 72 hour review was not widely used. Instead the Lead Antibiotic Audit and IPC Nurse and the Lead Antimicrobial Pharmacist undertake audits together and provide real-time feedback to staff, together with email feedback. Proactive AMS interventions are made during the audits; the results are being collated.Pharmacists incorporate antibiotic prescribing practice within the medical and surgical induction training sessions and Pharmacy alongside the Antibiotic Audit Nurses provide annual training on Antibiotic Stewardship to the Registered Nurses via the Mandatory Training platform.

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

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

2019-20 AMR CQUINs

a) Lower Urinary Tract Infections in Older People

b) Antibiotic Prophylaxis in Colorectal Surgery

Both CQUINs were accepted by the CCG as being fully met

The AMR CQUIN for 2020-21 is as follows:

1) Appropriate antibiotic prescribing for UTI in adults aged 16+	60% of all antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment. ED & Inpatient. Number of cases all following actions applied: 1. Documented diagnosis of specific UTI based on clinical signs & symptoms; 2. Diagnosis excludes use of urine dipstick in people aged 65+ years and in all Catheter Associated UTI (CAUTI); 3.Empirical antibiotic regimen prescribed following NICE / local guidelines; 4.Urine sample sent to microbiology as per NICE requirement; and, 5. For diagnosis of CAUTI, documented review of urinary catheter use is made in clinical record.

Surgical prophylaxis audit

This audit was not undertaken during 2019-20 due to Covid pressures. A repeat of the prophylaxis for Total Hip Replacement and Total Knee Replacement surgery is planned for late 2020. This will help to determine the impact of increasing the Teicoplanin dose to 10 mg/kg. Results of this audit will be reviewed alongside the results of SSI surveillance, and results from the QUIST pre-operative skin decolonisation project in which the Trust is participating (see below).

The Trust was one of 30 Trusts which participated in a Quality Improvement for Surgical teams (QUIST) project to reduce MSSA infections in joint replacement surgery. This was focussed on preoperative skin and nasal decolonization prior to planned joint replacement surgery. It was anticipated that this would result in a 60% reduction in joint infections; in fact the Trust has seen no deep wound infections since commencing the study.

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

Please see criterion 6 with respect to staff training.
Staff vaccination against influenza remained a national CQUIN target for 2019-20. The Trust achieved a vaccination rate in excess of 80% against a target of 80%. The IPT were involved in the Trust's planning for the vaccination programme, which this year included community staff. Two of the IPT were peer vaccinators.

INCIDENTS

Norovirus
There was one outbreak in January 2020 on F9, involving 8 patients. This coincided with an outbreak of Influenza affecting 6 patients. Learning from the Influenza outbreak has been implemented by the Trust. This included: a data collection sheet, a resource box and allocation of a dedicated member of the IPT, thereby harmonising the management of both Norovirus and Influenza outbreaks.

The outbreak was reported as a Serious Incident Requiring Investigation and appropriately investigated

It did not prove possible, despite protracted negotiations with Public Health England (as providers of the Microbiology Laboratory service) and NEESPS, to introduce in-house testing for all WSFT patients during the 2019/20 influenza season. Use of the limited laboratory capacity was extended to Maternity. Addenbrooke's Hospital withdrew Respiratory Viral testing during the Covid pandemic.
Plans to introduce Point of Care testing for Influenza and Respiratory Syncytial Virus were well advanced, but this could not be implemented because of restrictions on POC testing and also lack of availability of suitable swabs, due to of Covid-19. It is hoped to introduce this service in time for the 2020-21 influenza season.

Measles
A case of measles was admitted in July 2019. The patient had had a protracted stay of 13 hours in ED (not isolated); the clinical diagnosis was not made until the patient had a consultant review following admission to a single room on F7. This resulted in:
148 patient contacts
114 staff contacts
All contacts had to be reviewed to determine their immunity and potential vulnerability and to be notified of the exposure.
The SIRI investigation generated significant opportunities for learning and an action plan has been completed.

SARS Coronavirus (Covid-19)
From January 2020 the IPT were significantly involved in planning for and managing this pandemic infection. The impact on other activities has been described above.

SUMMARY

The Covid-19 pandemic has been the main focus of Infection-Prevention related activity. It has highlighted previously-known issues regarding the lack of isolation facilities in the Trust. The need to improve provision has been acknowledged in plans for the refurbishment of G9, and for the new

modular wards. In addition the Chief Operating Officer has requested a review, by the Estates Department, of options for adding doors to the bays of existing wards.
The requirement for Personal Protective Equipment, together with training and support in its use, has been very significant.
The opportunity for the IPT to work collaboratively with colleagues in the Trust and with external agencies has been very positive and fruitful, with many improvements made. These include high compliance with Hand Hygiene, the development of the PPE safety officer role, maintenance of high cleaning standards by the Housekeeping team, a comprehensive PPE training and fit testing programme and… The need for improvement of the Trust infrastructure from an IP perspective has also been supported by clinical engagement and the availability of central funding. We are hopeful that this will leave a legacy of an improved infrastructure including door on bays.
The demands on the IPT, and on the Trust in general, have meant that the routine audit programme and other activities such as Mandatory Reporting of specific infections have been modified or suspended. These changes were agreed by the DIPC and were reported to CSEC in June 2020.

Changes to the ownership and provision of Laboratory Services provide an opportunity to the Trust to develop a modern, robust and sustainable service in all disciplines. The model for networking has yet to be agreed, but it is hoped that this will be a flexible model which maps with the clinical pathways followed by our patients, rather than being a rigid ‘one size fits all’ approach.

From a Microbiology perspective, this needs to incorporate molecular diagnostic techniques which give rapid results (for example for respiratory tract and gastrointestinal infection) thereby supporting effective infection prevention management and patient. Without these developments it will not be possible to provide the best care for our patients, and optimal infection prevention and control measures.

13. Finance and workforce report

To ACCEPT the report

For Report

Presented by Craig Black

Board of Directors – 2 October 2020

Agenda item:	13			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	28th September 2020			
Subject:	Finance and Workforce Board Report – August 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)

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

We have submitted a revised activity plan which requires a reforecast of associated income and expenditure.

Given the unusual nature of the current financial year our focus is on our underlying income and expenditure position in readiness for 2021-22. We continue to analyse our recurring expenditure in order identify and to take action to improve any pressures that would otherwise arise in 2021-22.

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
August 2020 (Month 5)

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	£18.5m	adverse
EBITDA margin YTD	18%	adverse
Total PSF Received	£18.5m	accrued
Cash at bank	£23.7m	

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)
- The Trust has been reimbursed with all costs relating to COVID 19
- We have submitted a revised activity plan which requires a reforecast of associated income and expenditure.
- Given the unusual nature of the current financial year 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
- Delivery of £8.7m CIP programme
- Being fully reimbursed for all COVID related costs

SUMMARY INCOME AND EXPENDITURE ACCOUNT - August 2020	August 2020			Year to date			Year end forecast		
	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)
	£m	£m	£m	£m	£m	£m	£m	£m	£m
NHS Contract Income	18.1	18.0	(0.1)	93.9	90.2	(3.7)	228.1	228.4	0.3
Other Income	3.0	2.3	(0.7)	14.8	14.5	(0.3)	36.2	35.9	(0.3)
Total Income	**21.1**	**20.3**	**(0.8)**	**108.8**	**104.7**	**(4.0)**	**264.3**	**264.3**	**(0.1)**
Pay Costs	16.0	18.6	(2.6)	80.1	84.4	(4.3)	202.3	206.1	(3.9)
Non-pay Costs	8.1	5.0	3.0	40.0	34.2	5.8	92.0	88.1	3.9
Operating Expenditure	**24.1**	**23.6**	**0.5**	**120.1**	**118.6**	**1.5**	**294.3**	**294.2**	**0.0**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA excl STF	**(3.0)**	**(3.3)**	**(0.3)**	**(11.4)**	**(13.9)**	**(2.5)**	**(30.0)**	**(30.0)**	**(0.0)**
Depreciation	0.7	0.6	0.1	3.4	3.0	0.3	8.1	8.0	0.0
Finance costs	0.3	0.3	0.1	1.6	1.6	0.1	3.9	3.8	0.2
SURPLUS/(DEFICIT)	**(4.0)**	**(4.1)**	**(0.2)**	**(16.4)**	**(18.5)**	**(2.1)**	**(42.0)**	**(41.8)**	**0.2**
Provider Sustainability Funding (PSF)									
PSF / FRF/ MRET/ Top Up	4.0	4.1	0.2	16.4	18.5	2.1	42.0	41.8	(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 – August 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 – August 2020

Income and Expenditure Summary as at August 2020

The reported I&E for August is break even, in line with NHSI guidance. Due to COVID-19 we are receiving a top up payment that includes MRET and FRF and ensures we break even. The value of this for August was £4.1m (£18.5m YTD).

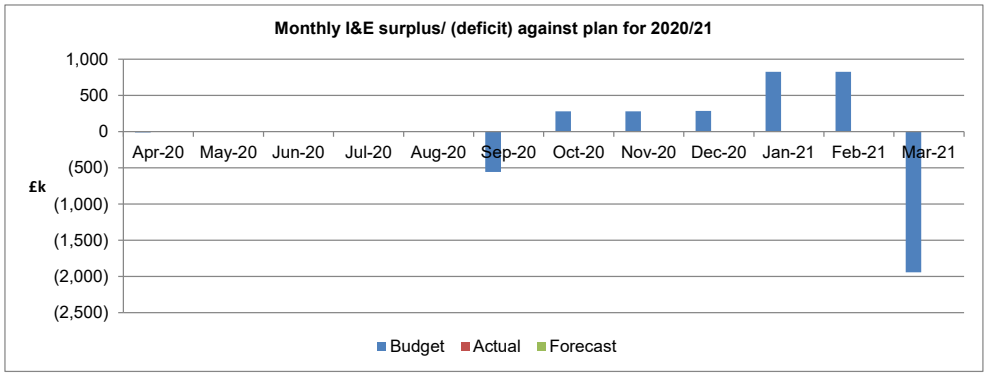
This funding arrangement will continue until the end of September and as a result we forecast to break even, in line with our Financial Improvement Trajectory (FIT).

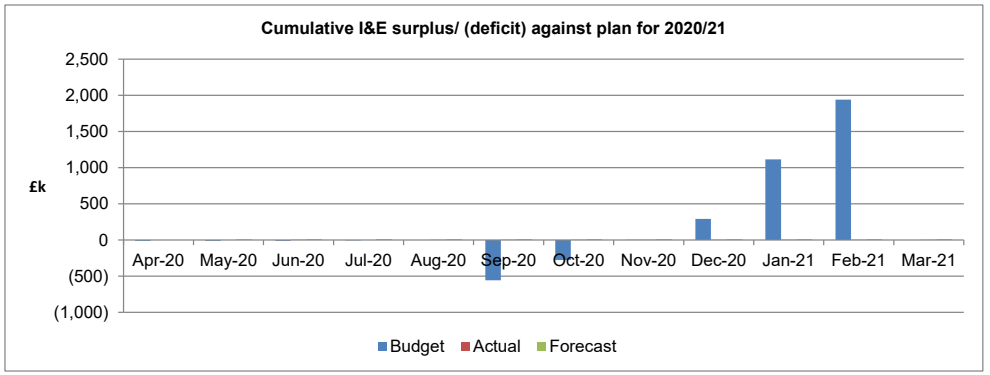
However, during September we submitted a revised activity plan (referred to as Phase 3) and are now calculating the costs of delivering this plan, including costs associated with inefficiencies caused by COVID and building constraints. We have also recently received guidance around funding for the remainder of 2020-21.

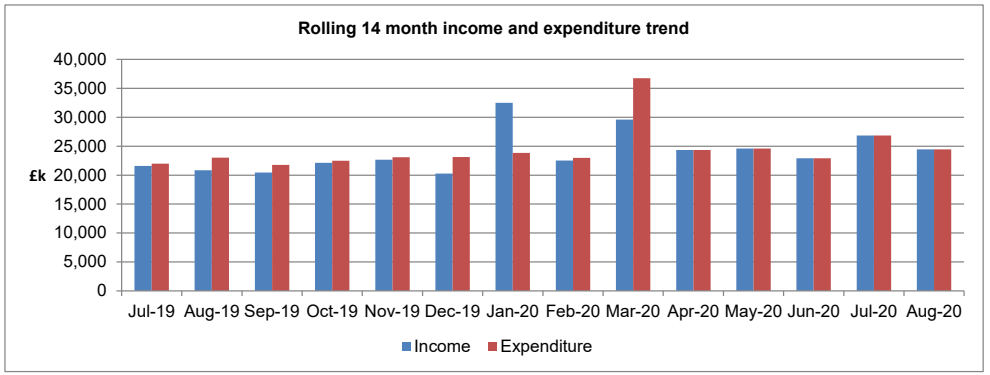
This revised income and expenditure plan, will result in a re-forecast that will be presented in the September Board papers. There is a considerable amount of uncertainty surrounding this position which will hopefully be resolved within the next month

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)	4	⟺	Green
YTD surplus/ (deficit)	0	(1)	(1)	⟺	Amber
Forecast surplus/ (deficit)	(0)	4	4	⟺	Green
EBITDA (excl top-up) YTD	(3,960)	(4,131)	(172)	↓	Amber
EBITDA %	(18.8%)	(20.3%)	(1.6%)	↓	Red
Clinical Income YTD	(196,535)	(188,792)	(7,743)	↑	Red
Non-Clinical Income YTD	(26,265)	(28,381)	2,116	↓	Green
Pay YTD	80,119	84,402	(4,284)	↑	Red
Non-Pay YTD	45,016	38,816	6,200	↑	Green
CIP Target YTD	3,667	1,861	(1,806)	↓	Red







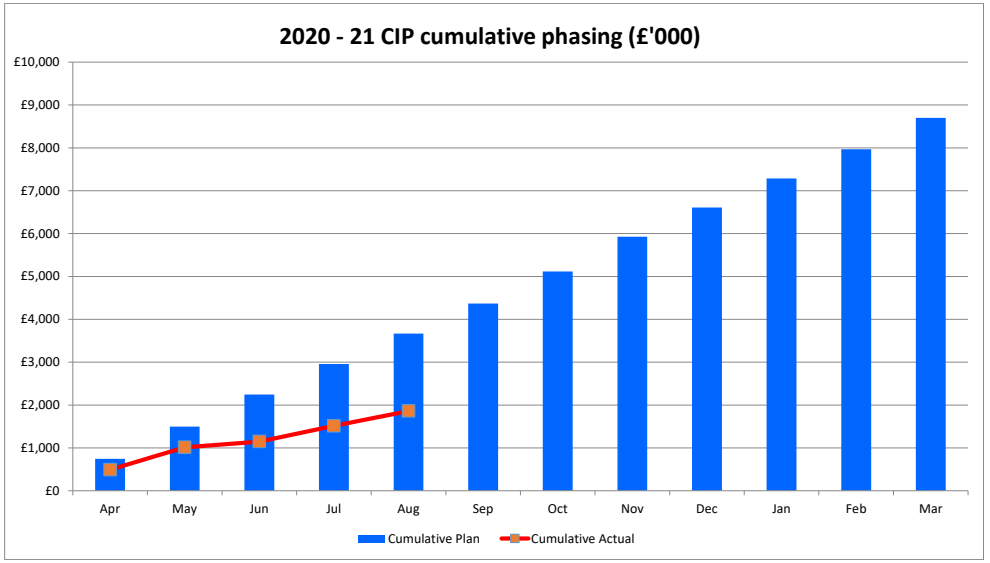
Page 3

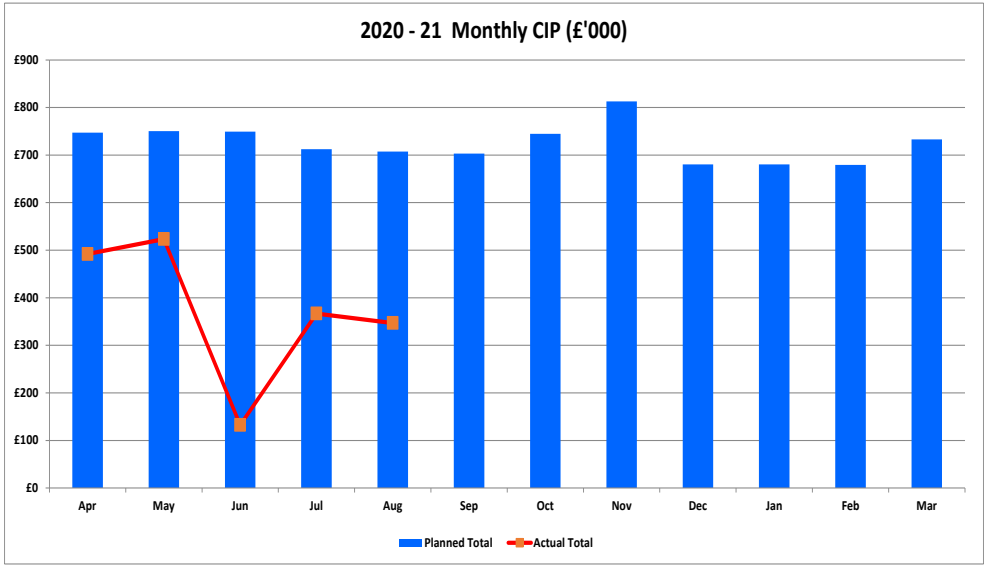
Cost Improvement Programme (CIP) 2020-21

In order to deliver the Trust's control target in 2020-21 we needed to deliver a CIP of £8.7m (3.4%). The plan for the year to August was £3.667m (42.1% of the annual plan) and we achieved £1.14m (21.4%). This represents a shortfall of £1,806k.

Recurring/Non Recurring	2020-21 Annual Plan	Plan YTD	Actual YTD
	£'000	£'000	£'000
Recurring			
Outpatients	254	69	23
Procurement	492	205	207
Activity growth	200	83	83
Additional sessions	363	151	-
Community Equipment Service	510	213	211
Drugs	367	153	104
Estates and Facilities	114	60	47
Other	954	348	334
Other Income	493	205	25
Pay controls	260	108	79
Service Review	16	13	13
Staffing Review	819	297	257
Theatre Efficiency	302	126	-
Contract Review	50	21	4
Workforce	-	-	-
Consultant staffing	-	-	-
Agency	-	-	-
Unidentified CIP	1,049	426	-
Recurring Total	**6,242**	**2,478**	**1,387**
Non-Recurring			
Pay controls	647	305	281
Other	1,805	879	189
Estates and Facilities	6	5	5
Non-Recurring Total	**2,458**	**1,188**	**475**
Total CIP	**8,700**	**3,667**	**1,861**

Division	Divisional Target £'000	YTD Var £'000	Unidentified plan £ YTD	Unidentified plan £ year
Medicine	2,555	(977)	106	255
Surgery	2,029	(341)	85	203
W&C/CSS	1,847	(68)	0	0
Community	1,422	(172)	52	125
E&F	516	(161)	104	276
Corporates	331	(87)	79	191
Stretch	0	0	0	0
Total	**8,700**	**(1,806)**	**426**	**1,049**

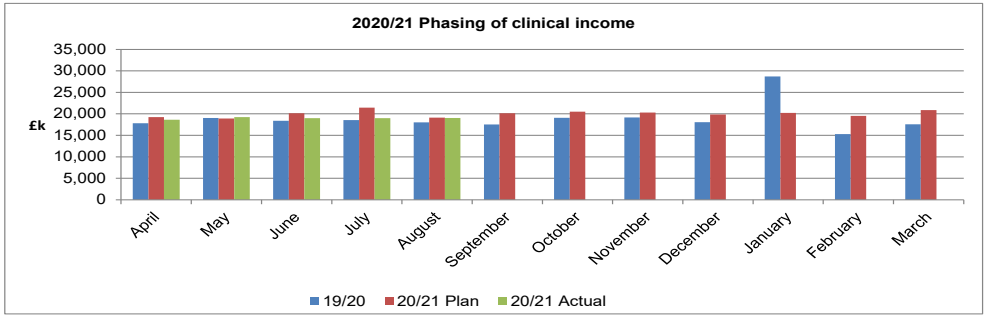




FINANCE AND WORKFORCE REPORT – August 2020

Income Analysis

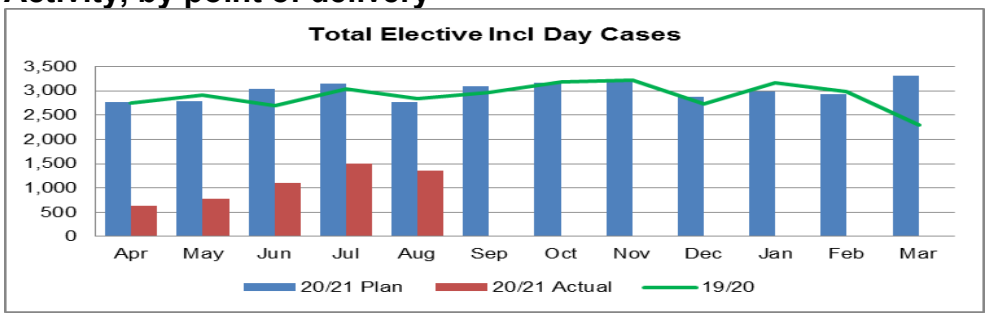
The chart below demonstrates the phasing of all clinical income plan for 2020-21, including Community Services. This phasing is in line with phasing of activity.

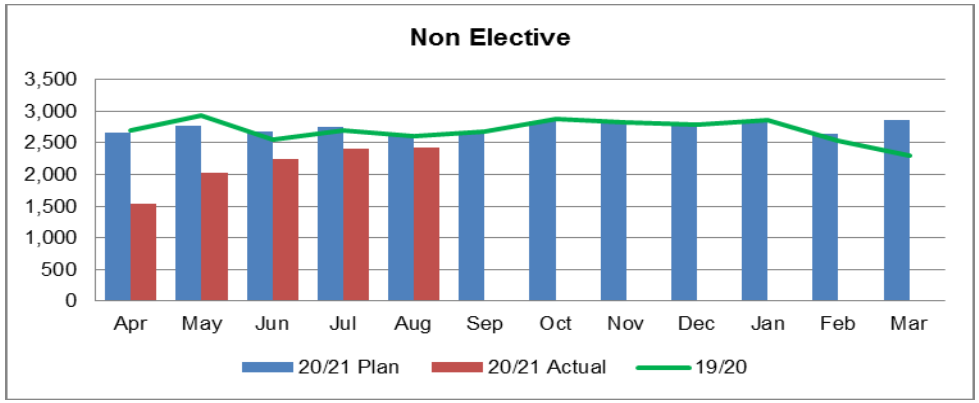


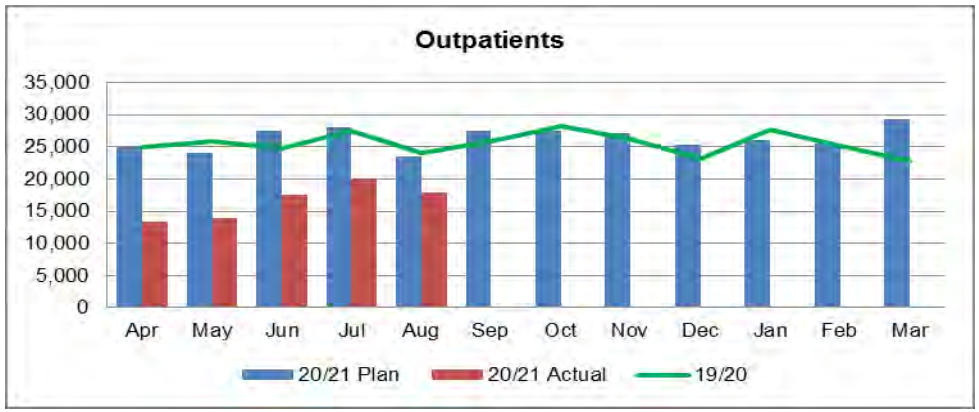
The income position was behind plan for August. The income was based on the national agreed block payments as set out by NHS England, these were put in place to give Providers assured income during the coronavirus period.

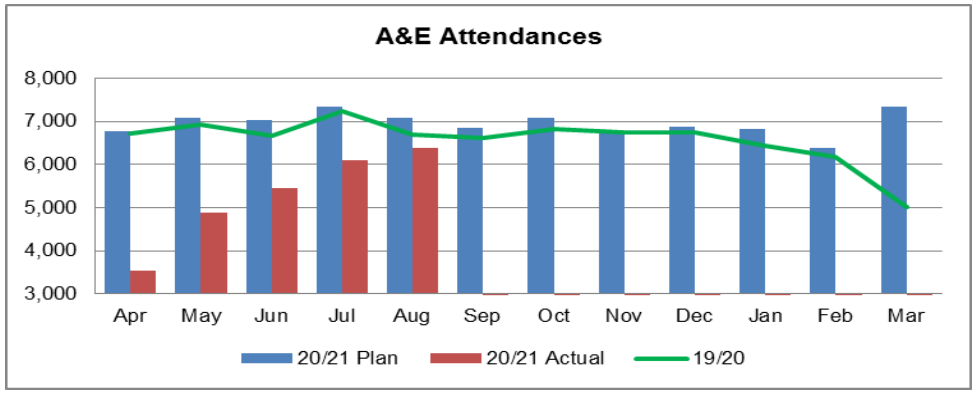
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	1,037	969	(69)	5,169	4,078	(1,091)
Other Services	3,084	5,612	2,527	16,449	32,541	16,092
CQUIN	173	139	(34)	891	640	(251)
Elective	2,749	1,122	(1,628)	14,061	3,918	(10,143)
Non Elective	6,332	6,307	(25)	32,291	31,392	(899)
Emergency Threshold Adjustment	(331)	(331)	0	(1,699)	(1,699)	0
Outpatients	2,852	1,986	(866)	15,561	8,144	(7,417)
Community	2,988	2,988	0	14,940	14,940	0
Total	**18,885**	**18,791**	**(94)**	**97,664**	**93,955**	**(3,709)**

Activity, by point of delivery



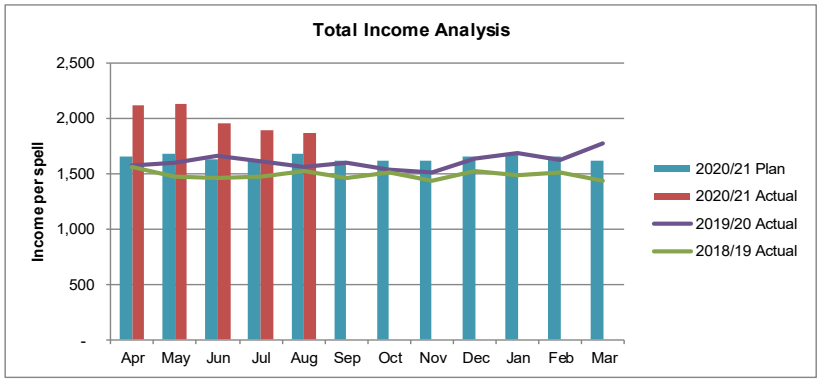


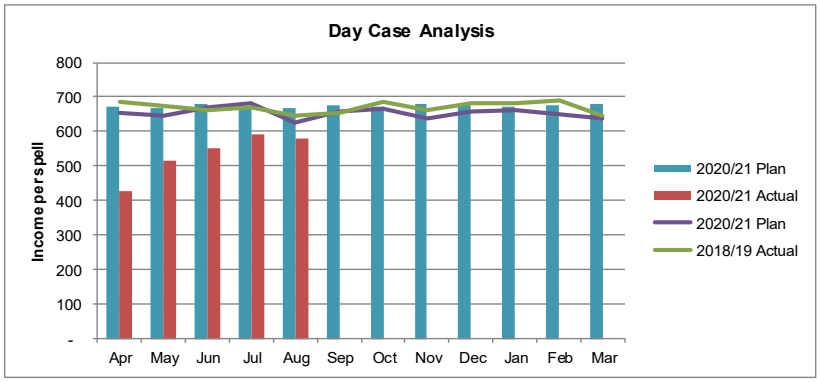


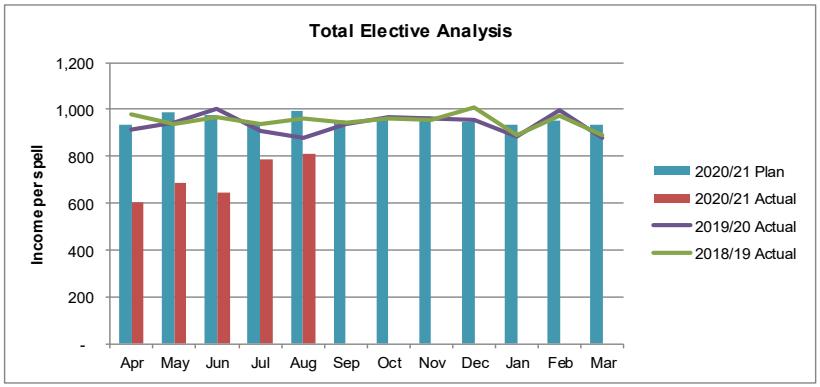


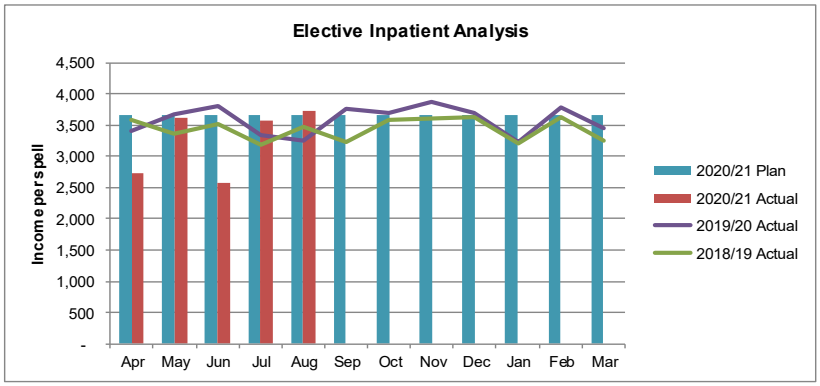
FINANCE AND WORKFORCE REPORT – August 2020

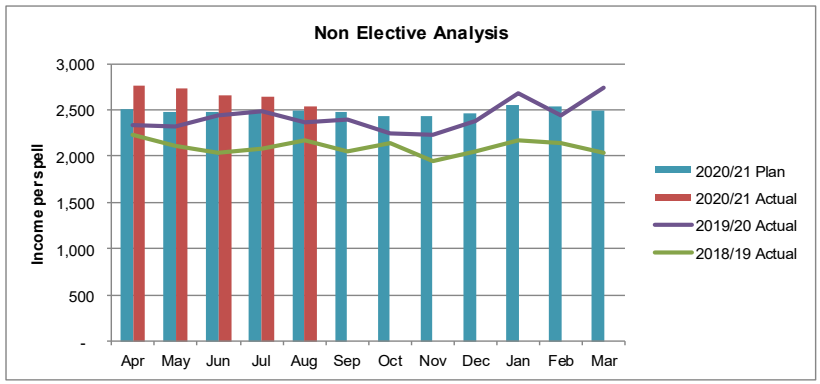
Trends and Analysis

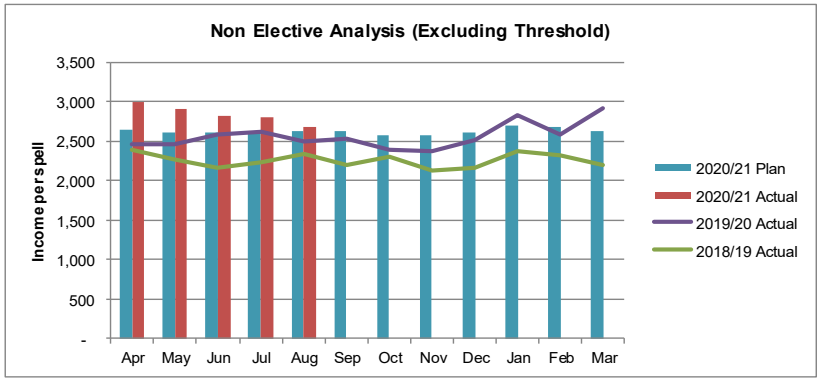










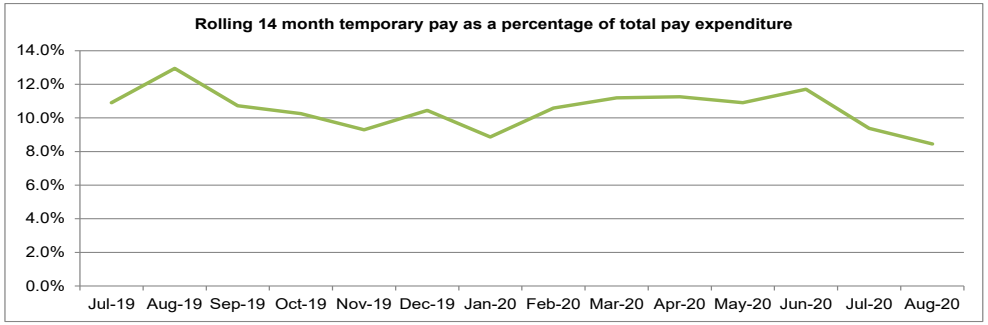


FINANCE AND WORKFORCE REPORT – August 2020

Workforce

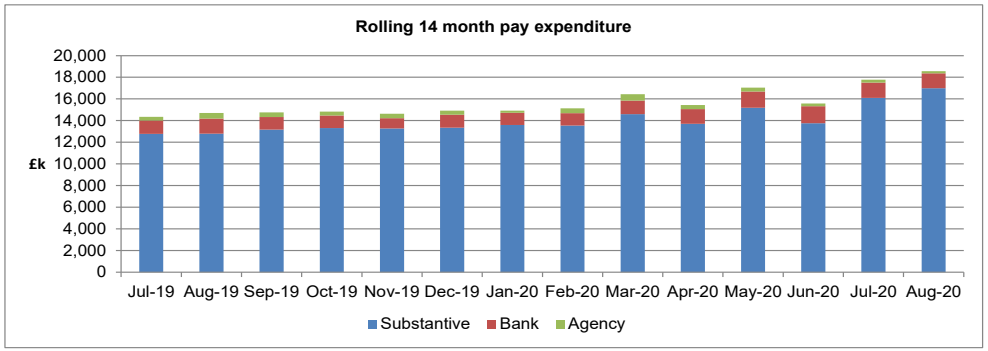
Monthly Expenditure (£)				
As at August 2020	Aug-20	Jul-20	Aug-19	YTD
	£000's	£000's	£000's	£000's
Budgeted Costs in-month	15,985	15,535	14,118	80,119
Substantive Staff	16,993	16,102	12,792	75,749
Medical Agency Staff	194	194	213	906
Medical Locum Staff	342	346	402	1,560
Additional Medical Sessions	263	272	286	1,536
Nursing Agency Staff	20	18	203	367
Nursing Bank Staff	400	391	310	2,085
Other Agency Staff	(10)	42	91	186
Other Bank Staff	201	219	171	1,010
Overtime	76	96	152	617
On Call	82	86	73	386
Total Temporary Expenditure	1,568	1,665	1,902	8,654
Total Expenditure on Pay	18,561	17,768	14,693	84,402
Variance (F/(A))	(2,576)	(2,233)	(575)	(4,284)
Temp. Staff Costs as % of Total Pay	8.4%	9.4%	12.9%	10.3%
memo: Total Agency Spend in-month	204	253	507	1,460

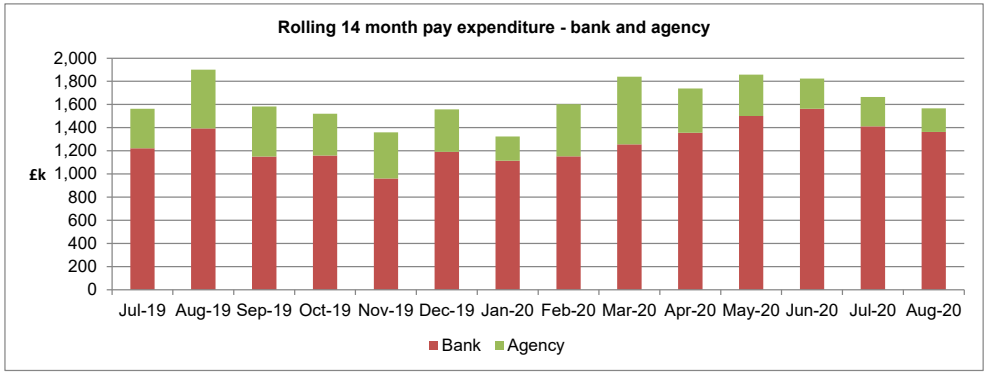
Monthly WTE				
As at August 2020	Aug-20	Jul-20	Aug-19	YTD
	£000's	£000's	£000's	£000's
Budgeted WTE in-month	4,069.6	4,043.5	3,852.1	20,943.6
Substantive Staff	3,781.3	3,791.9	3,512.9	18,848.5
Medical Agency Staff	15.2	18.1	12.7	90.4
Medical Locum Staff	33.7	33.2	35.4	139.4
Additional Medical Sessions	7.7	8.8	12.0	25.2
Nursing Agency Staff	7.2	21.3	28.6	74.5
Nursing Bank Staff	121.1	127.4	96.9	630.8
Other Agency Staff	8.8	5.1	24.4	46.2
Other Bank Staff	82.9	83.6	75.1	396.6
Overtime	21.6	28.2	40.6	167.6
On Call	7.3	7.6	6.9	34.0
Total Temporary WTE	305.7	333.3	332.6	1,604.6
Total WTE	4,087.0	4,125.2	3,845.5	20,453.2
Variance (F/(A))	(17.4)	(81.7)	6.6	490.4

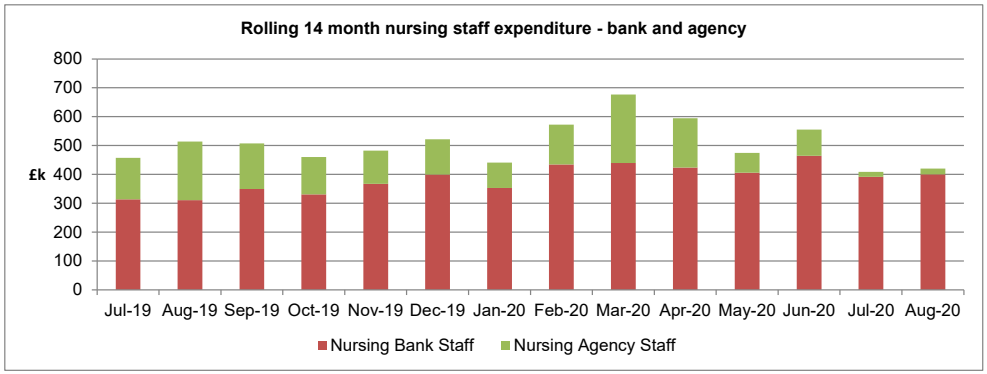


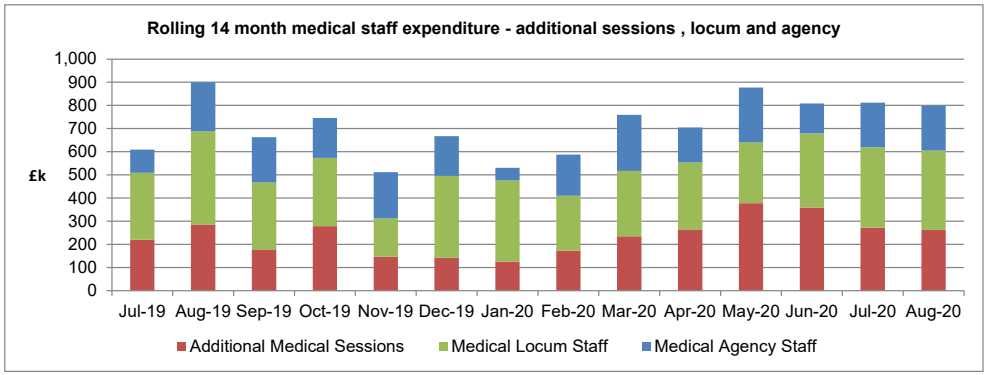
Pay Trends and Analysis

During August the Trust overspent by £2.6m on pay as all year to date Covid related pay costs were recognised (£4.3m overspent YTD).

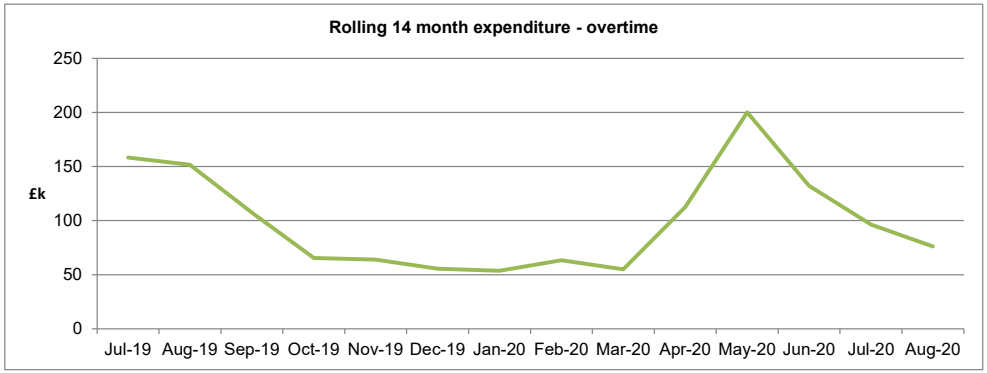








Expenditure on Additional Sessions was £263k in August (£272k in July)



FINANCE AND WORKFORCE REPORT – August 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	(7,136)	(6,066)	(1,070)	(36,825)	(28,107)	(8,717)
Pay Costs	4,355	5,093	(738)	21,171	24,553	(3,382)
Non-pay Costs	1,522	1,565	(42)	7,619	7,709	(90)
Operating Expenditure	**5,877**	**6,658**	**(781)**	**28,790**	**32,262**	**(3,471)**
SURPLUS / (DEFICIT)	**1,259**	**(592)**	**(1,851)**	**8,034**	**(4,155)**	**(12,189)**
SURGERY						
Total Income	(5,198)	(3,869)	(1,329)	(26,845)	(13,445)	(13,400)
Pay Costs	3,512	4,044	(532)	16,931	18,942	(2,010)
Non-pay Costs	1,117	932	185	5,523	3,822	1,701
Operating Expenditure	**4,628**	**4,976**	**(348)**	**22,454**	**22,763**	**(309)**
SURPLUS / (DEFICIT)	**570**	**(1,107)**	**(1,677)**	**4,391**	**(9,319)**	**(13,709)**
WOMENS AND CHILDRENS						
Total Income	(1,923)	(1,646)	(278)	(9,724)	(7,709)	(2,015)
Pay Costs	1,481	1,539	(58)	7,127	7,296	(169)
Non-pay Costs	166	194	(28)	860	856	4
Operating Expenditure	**1,647**	**1,733**	**(86)**	**7,987**	**8,152**	**(165)**
SURPLUS / (DEFICIT)	**277**	**(87)**	**(364)**	**1,737**	**(443)**	**(2,180)**
CLINICAL SUPPORT						
Total Income	(810)	(645)	(165)	(4,197)	(2,753)	(1,444)
Pay Costs	1,665	1,694	(30)	8,181	7,951	231
Non-pay Costs	1,113	1,086	27	5,525	5,519	6
Operating Expenditure	**2,777**	**2,780**	**(2)**	**13,707**	**13,470**	**237**
SURPLUS / (DEFICIT)	**(1,967)**	**(2,135)**	**(168)**	**(9,510)**	**(10,717)**	**(1,207)**
COMMUNITY SERVICES						
Total Income	(3,513)	(3,481)	(32)	(17,565)	(17,564)	(1)
Pay Costs	2,557	2,675	(118)	12,643	13,176	(533)
Non-pay Costs	951	1,305	(355)	4,819	6,238	(1,419)
Operating Expenditure	**3,508**	**3,980**	**(473)**	**17,462**	**19,414**	**(1,952)**
SURPLUS / (DEFICIT)	**5**	**(499)**	**(504)**	**103**	**(1,850)**	**(1,953)**
ESTATES AND FACILITIES						
Total Income	(420)	(106)	(315)	(2,102)	(896)	(1,206)
Pay Costs	901	968	(68)	4,503	4,780	(277)
Non-pay Costs	612	724	(111)	3,061	3,168	(107)
Operating Expenditure	**1,513**	**1,692**	**(179)**	**7,565**	**7,948**	**(383)**
SURPLUS / (DEFICIT)	**(1,093)**	**(1,586)**	**(494)**	**(5,463)**	**(7,052)**	**(1,589)**
CORPORATE						
Total Income	(6,053)	(8,644)	2,591	(27,835)	(52,669)	24,834
Pay Costs	1,515	2,547	(1,032)	9,562	7,705	1,856
Non-pay Costs	2,601	(767)	3,368	12,602	6,897	5,704
Capital Charges and Financing Costs	993	858	135	4,964	4,531	432
Operating Expenditure	**5,108**	**1,780**	**3,328**	**27,127**	**14,603**	**12,524**
SURPLUS / (DEFICIT)	**945**	**6,864**	**5,919**	**709**	**38,067**	**37,358**
TOTAL						
Total Income	(25,054)	(24,456)	(598)	(125,092)	(123,143)	(1,949)
Pay Costs	15,985	18,561	(2,576)	80,119	84,402	(4,284)
Non-pay Costs	8,081	5,039	3,043	40,009	34,209	5,800
Capital Charges and Financing Costs	993	858	135	4,964	4,531	432
Operating Expenditure	**25,059**	**24,457**	**602**	**125,091**	**123,143**	**1,948**
SURPLUS / (DEFICIT)	**(5)**	**(1)**	**4**	**0**	**0**	**(0)**

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Medicine (Sarah Watson)

The division is behind plan in month by £1.9m and £12.2m YTD.

Clinical income is behind plan in month by £1.1m and £8.7m 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 £1.0m gap in August compared to a £1.9m gap in June). This decrease is most notable within non-elective activity which was only 3% behind plan (10% behind in July). The gaps for elective & outpatient activity only reduced by 1% in August to 37% and 15% respectively. 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 a negative variance against budget of £788k in month and £3.6m YTD. This variance continues to be driven by the additional costs of COVID (£587k) and unmet CIP schemes (£186k). With these removed the division is at breakeven for August.

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, £2.7m is using existing resources (e.g. medical wards) solely towards COVID. The remaining £0.9m 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 £1.7m in month and £13.7m year to date.

COVID has had a major effect on Surgery's elective activity. Surgery is working to reopen all theatres by the end of September and maximise the use of outpatients within social distancing requirements. However, there are challenges in delivering pre-COVID levels of efficiency.

Surgery is £1.3m underachieved against income plan in month (£13.4m YTD).

Pay overspent by £532k in month (£2,010k YTD) due to COVID related costs.

Non-pay has underspent by £185k in month (£1,701k YTD) due to fewer patients being in surgical beds or being treated in theatres and clinics.

Surgery missed its CIP plan in month and has not identified a full plan due to COVID planning taking precedence. Further to this due to the effect COVID is anticipated to have in theatres and clinics some CIP schemes will not be achievable, until normal service is possible. Surgery is working up a process to see which CIP's can revived later this year, and is aiming to reduce the deficit by £300k.

Women and Children's (Darin Geary)
In July, the Division reported an adverse variance of £364k (£2,180k 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 £278k in-month and behind plan by £1,835k YTD.

Pay reported a £58k overspend in-month and an overspend of £169k YTD. In-month, the additional COVID nursing support in F1 and the COVID related double running of antenatal clinics continued. The Division has a favourable underlying pay spend without the COVID costs.

Non-pay reported a £28k overspend in-month and an underspend of £4k YTD. Non-pay costs have started to increase as the impact of COVID on activity has lessened.

Clinical Support (Darin Geary)
In July, the Division reported an adverse variance of £168k (£1,207k YTD).

Income for Clinical Support reported £165k behind plan in-month and £1,444k behind plan YTD. This is because Radiology outpatient, direct access and breast screening activity has reduced as COVID has limited the number of patients that can be seen.

Pay reported a £30k overspend in-month and an underspend of £231k YTD. It has been difficult to fill vacancies in Radiology, Outpatients and Pharmacy.

Non-pay reported a £27k underspend in-month and an underspend of £6k YTD. COVID has limited the Division's activity which has reduced its non-pay spend.

Community Services (Michelle Glass)
The division reports an adverse variance of £504k in month (£1,953k YTD). Of the in-month overspend, £393k was directly COVID related.

Income reported a £31k under recovery in month (£1k adverse 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 over spend on pay of £118k (£533k YTD). £517k YTD has been incurred to support the division's response to COVID. The division is utilising agency staff to cover some vacant roles in order to ensure service resilience, support patient flow and manage demand across the services. Through the use of bank and some staff redeployment, the division is managing the impact of vacancies at this time and is actively recruiting.

Non-pay reported an adverse variance of £355k in August (£1,419k YTD). £705k 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. We have put in place a number of initiatives, such as providing clinical advisor capacity to ensure utilisation of recycled special equipment and undertake frequent core stock product reviews to ensure the most effective products are available to prescribers and relaunched the 'return, recycle, reuse' campaign. Other one-off costs were incurred to further support home and mobile working across our teams and community property costs. The division's estate costs are expected to exceed budget too.

Phase 3 COVID recovery planning will be 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 improve the division's position in the second half of the financial year.

FINANCE AND WORKFORCE REPORT – August 2020

Statement of Financial Position at 31 August 2020

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2020	Plan 31 March 2021	Plan YTD 31 August 2020	Actual at 31 August 2020	Variance YTD 31 August 2020
	£000	£000	£000	£000	£000
Intangible assets	40,972	48,993	41,380	42,301	921
Property, plant and equipment	110,593	148,457	120,695	116,189	(4,506)
Trade and other receivables	5,707	5,707	5,707	5,707	0
Total non-current assets	**157,272**	**203,157**	**167,782**	**164,197**	**(3,585)**
Inventories	2,872	3,000	3,000	3,072	72
Trade and other receivables	32,342	20,666	20,666	23,116	2,450
Cash and cash equivalents	2,441	1,510	16,010	23,657	7,647
Total current assets	**37,655**	**25,176**	**39,676**	**49,845**	**10,169**
Trade and other payables	(33,692)	(23,000)	(29,641)	(31,373)	(1,732)
Borrowing repayable within 1 year	(58,529)	(2,000)	(58,185)	(58,284)	(99)
Current Provisions	(67)	(67)	(67)	(60)	7
Other liabilities	(1,933)	(25,000)	(20,000)	(22,694)	(2,694)
Total current liabilities	**(94,221)**	**(50,067)**	**(107,893)**	**(112,411)**	**(4,518)**
Total assets less current liabilities	**100,706**	**178,266**	**99,565**	**101,631**	**2,066**
Borrowings	(52,538)	(45,000)	(54,090)	(52,396)	1,694
Provisions	(744)	(744)	(744)	(744)	0
Total non-current liabilities	**(53,282)**	**(45,744)**	**(54,834)**	**(53,140)**	**1,694**
Total assets employed	**47,424**	**132,522**	**44,731**	**48,491**	**3,760**
Financed by					
Public dividend capital	74,065	161,856	74,065	75,102	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**	**44,731**	**48,491**	**3,760**

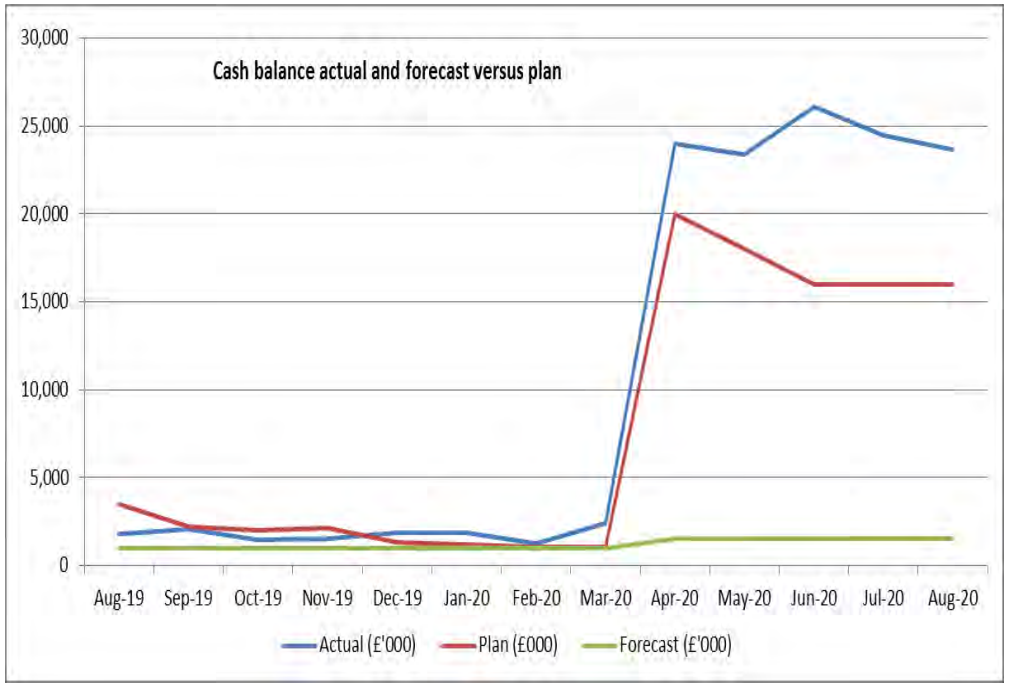
There has been little movement in the balance sheet since the year end.

Other liabilities

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

Cash Balance Forecast for the year

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



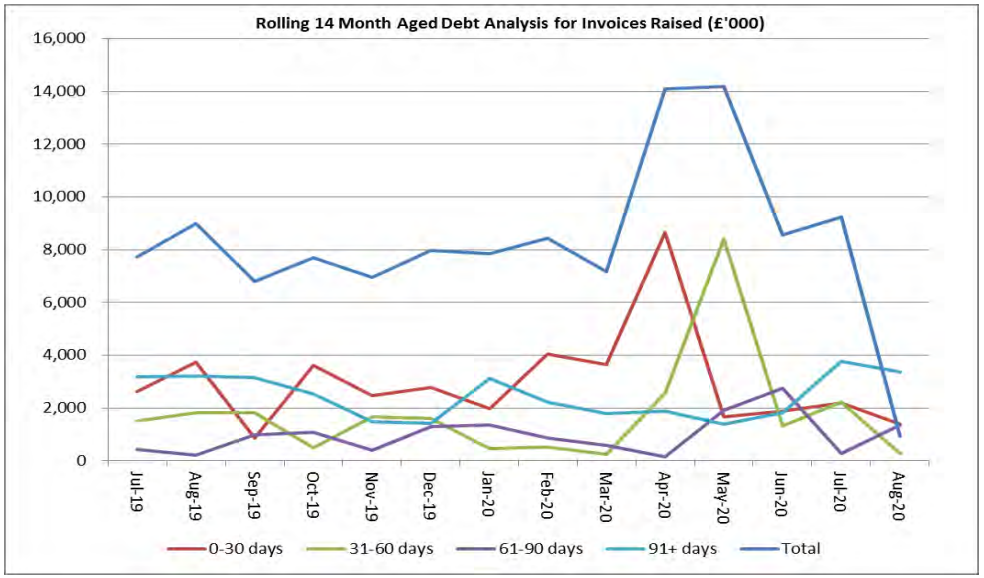
The cash balance has increased significantly and this is due to the current cash regime within the NHS. Contract payments have been paid in advance to ensure that there are adequate cash balances across the NHS and to ensure that payments to suppliers can be made quickly to keep the supply chain in full 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 – August 2020

Debt Management

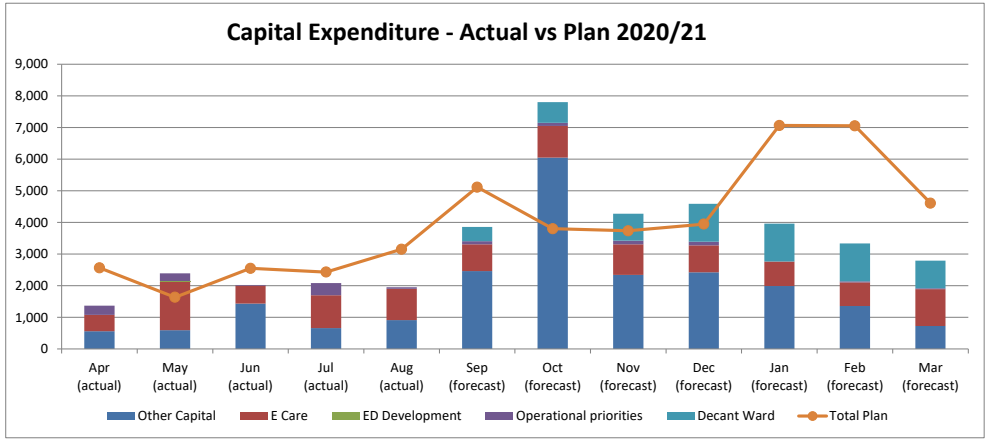
The graph below shows the level of invoiced debt based on age of debt.



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

The overall level of sales invoices raised but not paid has remained stable. The majority of the debts outstanding are historic debts. Over 77% of these outstanding debts relate to NHS Organisations, with 64% of these NHS debts being greater than 90 days old. Over £2m is owed from ESNEFT, which has since been settled in September. We are actively trying to agree a position with the remaining corresponding NHS Organisations for these debtor balances.

Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Actual £'000	Aug Actual £'000	Sep Forecast £'000	Oct Forecast £'000	Nov Forecast £'000	Dec Forecast £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	Total 2020-21 £'000
E Care	520	1,541	568	1,037	988	845	1,003	968	851	773	745	1,163	11,002
ED Development	0	16	0	0	0	0	0	0	0	0	0	0	16
Operational priorities	289	243	24	382	52	100	100	115	115	0	35	30	1,485
Decant ward	0	0	0	0	0	450	650	850	1,200	1,200	1,197	871	6,418
Other Schemes	558	590	1,431	661	911	2,462	6,046	2,338	2,421	1,989	1,357	726	21,490
Total / Forecast	1,367	2,390	2,023	2,080	1,951	3,857	7,799	4,271	4,587	3,962	3,334	2,790	40,411
Total Plan	2,562	1,632	2,546	2,430	3,151	5,113	3,799	3,734	3,945	7,063	7,053	4,608	47,636

The initial capital budget for the year was approved at the Trust Board Meeting in January as part of the operational plan process. 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 is the main reason for the reduction in the forecast capital expenditure figure. 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.

10:30 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

14. People and organisational development (OD) highlight report

To APPROVE a report

For Approval

Presented by Jeremy Over

Board of Directors – Friday 2 October 2020

Agenda item:	14			
Presented by:	Jeremy Over, Executive Director of Workforce and Communications			
Prepared by:	Jeremy Over, Executive Director of Workforce and Communications			
Date prepared:	24 September 2020			
Subject:	People & OD Highlight Report			
Purpose:	✓	For information		For approval

To strengthen the Board's focus on how we support our people, grow our culture and develop leadership at all levels, this month's meeting of the Board includes a People & OD Highlight Report. This provides an update on recent and current work, and how future plans are being developed and taken forward.

This month this includes an update on our Freedom to Speak Up Guardian recruitment, and our plans to develop our culture building on What Matters to You, the national NHS People Plan and the learning from elsewhere in the NHS around a developing a Just and Learning Culture. The report also provides an update on our staff Flu vaccination campaign for 2020.

In addition to discussing the content of the report, and related issues, 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 like to receive this report.

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.

Freedom to Speak Up

Following a recruitment process over the summer, where expressions of interest were sought internally and from our West Suffolk Alliance partners, I am pleased to **confirm the appointments of Amanda Bennett and James Barrett at our new Freedom to Speak Up (FTSU) Guardians.**

James, a consultant radiologist at WSFT and Amanda, Student Nurse Placement Facilitator with HEE/Suffolk and North East Essex ICS, will commence in their roles from 1 November and 1 October respectively.

In support of the Board's commitment to growing and embedding a FTSU culture, and reflecting on the recommendations of our most recent CQC report, we recognised and agreed that the role of FTSU Guardian needed a dedicated time allocation to support the Guardian to be proactive in promoting the role as well as reacting to concerns raised with them. As such when we invited expressions of interest in the summer we changed it from an 'as and when' role to a substantive part-time post. We also recognised the importance of the FTSU guardian being able to bring a clinical perspective.

I would formally like to record my thanks and appreciation to Nick Finch, who stepped down as our FTSU Guardian at the end of his three year term on 31st May 2020. I am also indebted to Dr Francesca Crawley, Consultant Neurologist and Guardian of Safe Working, who has been acting as our interim Guardian.

Whilst at an organisational level, our relative scores in the staff survey for this theme are encouraging, we know that there are pockets within our Trust where this is not the experience for staff. There is a dedicated action plan overseen by the Improvement Programme Board that is addressing this. We have also been working to implement the recommendations of our internal audit in the Spring, overseen by Audit Committee. The Trust Freedom to Speak Up policy has been updated and will be reviewed again with Amanda and James. A central database of concerns raised formally though all available channels has been created and the first summary report from this is included within the Governance Quality and Learning Report to the October Trust Board.

The appointment of two new Guardians will significantly strengthen our approach and I look forward to introducing them in person to the Board in due course.

Developing our Culture

(i) What Matters to You

The Board received feedback from the team of facilitators that engaged with staff across our Trust during July and August at the development session on 26 August, however this is the first public Board meeting since then and thus I have included the **top 5 themes and our response to these, which was communicated to all staff in early September**:

What Matters to You: five key themes

The importance of great line managers

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

Our commitment to you is to invest in development for new and existing managers so that this is the experience for every one of you. You have lots of ideas on how we could do this including development ideas and mentoring schemes etc.

Creating an empowered culture

You have told us that it can feel like there is 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.

Our commitment to you is to change our behaviours as a leadership team – and to encourage others to do the same. We want the organisation to be one where our staff are working together to maximise new opportunities and to develop solutions to problems. And where we as an exec team are supporting and empowering you to do this.

Building relationships

What Matters to You has shown 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.

Our commitment to you is to introduce a dedicated programme of work to bridge this gap, bringing staff together to start to build relationships and ensuring that leaders are much more visible to community staff. This is one we cannot do alone however – we need your help in order to succeed.

Appreciating all of our staff

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, who often feel that their contribution is not understood or recognised. You told us how much you appreciated the extra things we did to look after you during COVID. Things such as the well-being service, free tea and coffee and on-site parking for acute staff. However not everyone was aware that they could access these things – and some staff felt that they were excluded from these. We also need to do more to help our colleagues that are and have been shielding at home.

Our commitment to you is to take the time to understand how all of us contribute to patient care and ensure that we recognise and appreciate the things that all teams achieve. Through the ongoing engagement work we will ensure that all parts of the trust are included. We want to hear your stories.

We also commit to continuing with as many of the additional well-being extras as possible. We won't be able to keep everything for very practical reasons! Car parking is an example of this. We have already agreed that the well-being service will become business as usual and invested in additional posts to support this. We also commit to making sure there is equity across the organisation in how people can access these, particularly for community and shielding staff.

The future and recovery

You have told us that you are fearful of recovery and how we will be able to 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 that you would like to keep home working (for those that are able to do so).

Our commitment is to work with you to understand how we will collectively reintroduce services. You will have the ideas on how this could work and we will listen to these. We also commit to making sure that home working becomes part of our culture where it is possible for staff. This includes ensuring that you have what you need to work effectively from home and helping managers to understand how to support their teams to work in this way.

(ii) A Just and Learning Culture

At our 5 o'clock club session on 7 September, we heard Amanda Oates, HR Director at Merseycare 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.

Further to the 5 o'clock club session, and the positive response from delegates, Steve Dunn and Jeremy Over have spent further time with Amanda, and their academic partners at Northumbria University, to understand how we could practically take forward the learning from their experience, underpinned by the evidence base they have developed.

We already have plans to review and update relevant HR policies. The plan now is to engage the whole organisation in this work and integrate the ethos into our leadership and management practices. This includes consideration of this approach on any current HR cases that are active.

Merseycare and Northumbria University have developed a training package to support organisations as they seek to adopt and develop a just culture. The training supports participants to learn how to manage these issues in a restorative way that minimises negative impacts, maximises learning and develops an organisational culture where people feel safe and one they can trust.

It is proposed that we form a team of ten individuals who will benefit from this training and then lead and guide our work to take it forwards. The training will take place in November.

(iii)NHS People Plan

The "**We are the NHS: People Plan 2020/21**" was published in late July. It sets out actions to support transformation across the whole NHS, focusing on how we must all continue to look after each other and foster a culture of inclusion and belonging, as well as action to grow our workforce, train our people, and work together differently to deliver patient care.

The plan sets out practical actions that employers and systems should take, as well as the actions that NHS England and NHS Improvement and Health Education England will take over the remainder of 2020/21. It focuses on the following four themes:

- Looking after our people
- Belonging in the NHS
- New ways of working and delivering care
- Growing for the future

It is incredibly positive to have a national framework for how the NHS will work together to support and develop its people and, coupled with the local approaches we are taking here at West Suffolk, will help to form a comprehensive People and OD Plan for our organisation.

(iv) The WSFT People and OD Plan

We will bring all of these plans, idea and feedback – from WMTY, Just and Learning Culture, and priorities from the NHS People Plan - into one overarching **People and OD Plan for our organisation**. This is currently in development and, prior to the next meeting of the Board, will be shared with staff in draft form to incorporate their feedback. It will also

be shared with the team of WMTY facilitators, who gained such a depth of understanding and appreciation of staff's views from the time they spent leading this engagement work.

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.

A comprehensive flu vaccination programme has been developed for WSFT, to enable all members of staff to benefit from the vaccine and protect themselves, their loved ones, their colleagues and their patients. This includes drop-in clinics, 'vaccination stations' and a team of trained 'peer vaccinators', which commence from 01 October.

I am grateful to colleagues across a number of our teams including Workforce, Occupational Health, Public Health, Pharmacy and Communications who have worked together to ensure we are ready to launch this year's flu programme.

15. Education report, including undergraduate training

To ACCEPT the report

For Report

Presented by Jeremy Over

Board of Directors – 2 October 2020

NHS West Suffolk NHS Foundation Trust

Agenda item:	15
Presented by:	Jeremy Over, Executive Director of Human Resources & Communications
Prepared by:	Mr Peter Harris, Director of Medical Education, Lorna Lambert, Medical Education Manager, Diane Last, Non-Medical Clinical Tutor, Dr Jessica White, Associate Clinical Dean & Denise Pora, Deputy Director of Workforce (Organisation Development).
Date prepared:	25th September 2020
Subject:	Education Report

Purpose:	☑	For information		For approval

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

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

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

Previously considered by:	March 2020 Education and Training Trust Board paper
Risk and assurance:	Risk to patient safety due to lack of staff training and education, patient safety, correct staffing levels, staff morale, turnover etc. internal and external reputation. Staff perception of Education, Training & Development opportunities through the annual NHS Staff Survey. Medical Education - Royal College and HEEoE visits and assessments Results of annual GMC annual survey of training grade doctors
Legislation, regulatory, equality, diversity and dignity implications	Legislation & regulatory implications, linked to professional body requirements. Equality and health and safety legislation regarding skills, equipment and behaviours of all staff.

Recommendation: For information

Education and Training – Report for Trust Board Members 2 October 2020

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

Priority 1: Deliver for today

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

Undergraduate Medical Education

- As a result of COVID-19 undergraduate medical students did not attend medical placements at the West Suffolk Hospital between March and the end of July. During this time remote learning was undertaken and a large number of WSH medical staff provided these remote learning sessions. The teaching has been very well received by the students and we would like to thank all staff involved for helping with this delivery. We were particularly impressed at how readily people embraced the new technologies involved in on-line teaching and made the sessions so interactive and helpful for the students.

  At the start of August, the students returned on placement to the Hospital. Again, with help from Trust staff this has gone extremely well. In particular, feedback from students highlights how warmly they have been welcomed. The next few months will see more undergraduate students return to their medical placements at the Hospital.

Postgraduate Medical Education

- Reporting to HEEoE
  No incidents reported on up to April 2020.
  The Trust reports to HEEoE on any fitness to practice concerns about doctors in training.
  Reports are required for:
  1. Serious incidents where the trainee has been named and investigated
  2. Complaints naming the doctor
  3. Concern about probity or conduct

- Foundation Training Programme Director
  Dr Kaushik Bhowmick (Consultant Intensivist) returned to this role from July 2020. A very big thank you to Dr Francesca Crawley (Consultant Neurologist) who temporarily took on this role during early COVID-19.

Nursing, Midwifery and Allied Health Professionals

- Quality Performance Review (QPR) and student feedback
  HEE undertook a virtual inspection on the 20th July to speak to medical and non-medical students and educators. The organisation has received a draft copy of the report and following comment are waiting for the finalised report. Non-medical feedback included:

- There was a focus on learning and education as part of the trust's culture
- The education team had organised training in advance of the new NMC standards and educators felt prepared
- Midwifery learners expressed concerns about induction and equipment training – Actions taken: all current learners have been given a newly designed equipment competency form and passport and are being supported to achieve these
- Midwifery learners did not realise improvements were needed until the CQC report – Action taken: All managers/educators reminded to include learners in improvement and quality meetings, team meetings and Datix reviews
- Learners did not always know who they supervisor/assessor was and struggled to find time for meetings – Action taken: supervisors/assessors to be highlighted on roster and meetings planned at beginning of placement

- Learners felt they were sometimes used in staffing numbers – Action taken: Supernumerary status promoted and review of staffing numbers being undertaken by Executive Chief Nurse and Deputy Chief Nurse

HEE have requested a development plan in light of their findings which was returned on the 11th September.

- Pre-registration Numbers
  Pre-registration numbers for nursing are higher for September 2020 than in previous years. In September 2019 we welcomed 19 adult nursing first year students and in 2020 we will be welcoming approximately 50. A capacity review has taken place to ensure that the organisation is able to host the increase in learners whilst still maintaining a safe and effective learning environment and has been successful in obtaining some funds from HEE to support this. Within midwifery, universities over-recruited earlier this year so the WSFT is increasing places for first-year student numbers from 8 to 18. An additional midwifery clinical practice facilitator will be employed to support the increase in numbers. Pre-registration numbers for AHP, ODP and radiography programmes remain static.

- International Registered Nurses
  Our overseas nurses, who had not undertaken their OSCE programme before the OSCE centres closed, all applied for temporary access to the NMC register and have been working as registered nurses (under supervision) during Covid. The OSCE centres have now re-opened and 11 have successfully passed their exam to gain permanent entry to the NMC register. 3 will take the exam (second attempt) in October. The success of the overseas nursing program will continue to ensure consistent flow into the registered nursing workforce. The organisation welcomed 3 new Filipino nurses to the country on the 17th September and is currently recruiting nurses from Nigeria. All will undertake the OSCE programme and additional pastoral program of support has been produced to support the new intake as they self-isolate on entry into the country. This includes regular virtual check ins, grocery provisions and local community involvement:

Induction month (cohort)	Number of staff	Number who have passed OSCE
November 2019 (13)	12	12
December 2019 (14)	13	13
January 2020 (15)	12	11 – 1 to retake
March 2020 (16)	10	8 – 2 to retake
October 2020 (17)	3	0

- Student Nursing Associate Programme
  The organisation has 8 nursing assistants who are undertaking the student nursing associate programme with UoS. Following successful completion of the 2-year programme, the nursing associates will be registered with the NMC and employed as band 4 staff. A second cohort of students will start at the end of 2020.

- Student apprentice nurses (4 year)
  Our cohort of 11 student apprentice nurses undertaking the 4-year programme have now completed 50% of their programme. They are all enjoying the programme and have been well supported by the clinical areas. HEE is investing money into the 4-year programme and the organisation are scoping interest in supporting further cohorts

Support Workforce/Other Staff Groups

- Apprenticeship levy:

The Trust is now able to commission apprenticeship training, which allows the education provider the opportunity to draw down the cost of the training from the Levy. For apprenticeships we now have 95 live learners on the on the Digital Apprenticeship Service (DAS) account, with 27 learners having completed their apprenticeships. This number may have been higher as we have several members of staff who are waiting to complete their end point assessment which have not taken place due to COVID 19. Our current funds are £1,497,858 the trust has spent £342,933 since September 2019 and estimated plan spend for the next 12 months is £865,289.

We have apprenticeships across the following subjects;

- Business Administration Level 2
- Business Administrator Level 3
- Health Pharmacy Science Level 3
- Operations/Departmental Manager Level 5
- Engineering Manufacture Level 3
- Senior Health Care Support Worker Level 3
- Healthcare Assistant Practitioner Level 5
- Registered Nurse Level 6
- Team Leader/Supervisor Level 3
- Senior Leaders Master's Degree Level 7
- Infrastructure Technician – Level 3
- Building Surveying BSc
- Level 6 Management
- Advanced Clinical Practitioner Level 7
- Nursing Associate Level 5
- Pharmacy Services Assistant Level 2
- HR Support Level 3
- HR Consultant Level 5
- Chartered Surveyor Level 6
- Mammography Associate Level 4
- Commercial Procurement and Supply Level 4

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

Priority 2: Invest in quality, staff and clinical leadership

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

Postgraduate Medical Education

- Career Advice
  A Medical Careers Fair was scheduled for 17th September was cancelled due to room cancellations and COVID. Alternatives methods were investigated as a way of delivering this ie, alternative location or virtually but neither were feasible. We hope to resume this next year.

- Education/Clinical Supervisors Training
  Face to face training provided at WSH was cancelled and resources adapted due to COVID. HEE EoE converted the content of our Clinical (HEE) Contact Days into a 'Video Pack', using Panopto (online learning platform).
  There are Nine videos to watch covering the following areas:
  - Induction and Educational Contract
  - Study Leave Refresher Training
  - Professional Support and Well-being Service

- Trainees in Difficulty
- Supported Return to Training
- Clinical and Educational Supervision
- Educational Supervisor Reports (3 videos)

Other elements of Educator Training are still required for completion of training such as E-learning and University (HEI) Days via 'online webinars'. Certificates for completion are provided by HEE.
Foundation Trainers are being shown how to use this software on 30th September 2020.

- FiY1 Dr's
  On Monday 27 April 2020, 22 Foundation Interim Year 1's (FiY1) graduated early joining the trust to help during the pandemic (many remained from 4th Aug for their FY1 year). Extensive supervision was provided for each FiY1 including working alongside a current foundation doctor, having an assigned Mentor, Named Educational Supervisor (pastoral role) and named Clinical Supervisor. This worked very well providing them with a unique opportunity to contribute to healthcare and the CS report used as evidence for the Foundation Professional Capabilities.
  The Fiy1s were formally thanked by Nick Jenkins via email letter.

- Preparing for Professional Practice Week
  19 newly graduated FY1 doctors joined us for a week-long induction before starting at the trust. This was aimed at preparing them for their new role by gaining practical experience of clinical care on the wards. A mixture of face-face, trainee lead and interactive sessions were provided throughout the week plus shadowing along with presentations of 'Trainee of the Year award' for our current FY1/FY2 doctors.

- HEE Virtual Exploratory visit
  HEE virtual Exploratory Meeting with HEE panel and foundation/core medical/IMT trainees/trainers/educators was held on Monday 20th June 2020 via Teams. Aimed as a feedback session with Health Education England about trainee's experience in the Trust and how they escalate concerns. Overall the visiting team was impressed. We have submitted our intended action plan for 4 requirements and 1 recommendation.

- Junior Drs Induction, August 2020
  This 2-day induction was overhauled due to COVID. All doctors were emailed an IT E-learning package & Induction DVD to complete and watch prior to arrival. Face to face sessions were conducted in the Education Centre covering HR/IT (registering/log in) & welcome from DME/GOSW. A 'Welcome from Chief Executive & Medical Director' and talk from Consultant Radiologist were delivered via TEAMS. The A&E Dr's attended Raven Wood Hall for their induction. They are to be surveyed for their opinions how this can be improved.

Nursing, Midwifery and Allied Health Professionals

- COVID
  The arrival of Covid 19 has meant that the education team have had to respond quickly and innovatively to upskill a large number of staff to provide a flexible and mobile staff group during the global pandemic. While some traditional training has been cancelled due to rapid service redesign and social distancing, the education team has provided a number of training days and courses to provide various skills to enable staff who have been redeployed to confidently work in new areas of practice. The following table demonstrates what has been provided during this challenging period.

Upskilling programme	Number of events	Number of attendees	Comment
Community upskilling	12	90	Mixture of nursing and AHPs

Ward assistant training	6	40	Non-clinical staff to assist on wards
RN refresher day 1	9	64	Medications, drug round, IVs, pumps
RN refresher day 2	6	46	Moving and handling, vital signs, glucometer
RN refresher day 3	7	45	Cannulation, venepuncture, ECG, deteriorating patient
Blood transfusion refresher	2	9	
Critical Care upskilling	Various sessions	120 nursing 40 medical	
Royal Papworth Hospital surge training	2	8 ready to assist if required	13 attended the shadow day but 8 completed the 2-day training programme
BMI hospital training	5	31	
Extra days for RtP	7	16	Provided after induction for those returning to the register or moving to the acute sector from a completely different setting
TOTAL	**56**	**509**	

- CPD funding
  Following the announcement of £1,000 per nurse/midwife/AHP over a period of 3 years, the organisation has received a significant increase in CPD funding this year. Following relaxation of the funding rules, we have greater flexibility in how this money can be used to provide education and training. As well as funding individuals to undertake study, the funding will be used to support:
  - a Band 5 development programme
  - support a level 1 maths & English course in partnership with West Suffolk College for those who require this qualification and for our overseas staff who wish to progress
  - an increase in the number of deteriorating patients courses in partnership with the resus and outreach team
  - a programme for those caring for bariatric patients (particularly AHPs)
  - the development of a virtual learning platform.

  An electronic CPD application programme has been developed with IT which will streamline the application process and allow individuals to see funds that have been invested in their education over the course of their employment with the organisation. Unfortunately, this is not available to those in the community but this will change as systems are updated.

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

- Bespoke courses
  A number of courses were cancelled during the acute Covid period. The education team are looking to reinstate these over the next few months although in some cases the deliver method may change to a virtual environment whilst other courses may look to external training rooms if the education centre is not available.

Support Workforce/Other Staff Groups

- Mandatory training
  In March 2020 significant elements of mandatory training were paused due to the COVID-19 crisis. Trust overall compliance for mandatory training was 89% in March 2020 this has dropped to 85% in September. The Trust reinstated single session mandatory training in August for manual handling, basic life support and conflict resolution. All other mandatory training subjects can be completed via eLearning. Managers are being supported to manage their staff's mandatory training compliance through notification reminders via ESR informing them when their staff's mandatory training is due to expire and has expired. This new process was introduced in September.

- Staff, management and leadership development and talent management
  Local and national leadership development programmes were paused in March 2020 due to the COVID-19 pandemic. On-line development workshops will be available later in the autumn through NHS Elect who have previously provided face-to-face workshops as part of our staff, management and leadership development programme. When it is restarted in full the programme will reflect the feedback from the What Matters To You staff engagement process around the importance of supporting all managers, particularly those who are new to the role.

  Development support has been available to individuals and teams and this includes provision of 1:1 coaching and 360 degree feedback for a number of staff and a programme of development commissioned for the Catering Team.

  The Trust continues to support the Graduate Management Training Scheme as an element of our talent management strategy. We currently have one Management Trainee from the March 2020 intake on placement in Medicine and the Surgical Division were successful in recruiting two previous WSFT Graduate Management Trainees to Assistant Service Manager roles over the summer. We will be bidding for a trainee for the March 2021 intake (there was no September 2020 intake due to COVID-19)

  The 5 O'clock club has met twice since May using Microsoft teams, which is proving to be popular with staff. In June, the LGB&T+ network hosted the meeting as part of our Suffolk Pride 2020 celebrations. Amanda Oates, Executive Director of Workforce at Mersey Care NHS Foundation Trust spoke about their approach to a just and learning culture and around 60 people participated in the meeting.

- Library Services
  The Trust library has remained open throughout the COVID-19 pandemic and provided a modified service for users, for example supporting journal clubs and providing database search training via MS Teams rather than face-to-face. Additionally, it has acted as a wellbeing hub for staff with access to free hot drinks and snacks. Training courses provided by the library are being modified to be delivered online. Additionally, use of MS Teams in the past six months has highlighted the issues facing community staff and ways to better engage with community teams online that will continue beyond the end of the pandemic.

Priority 3: Build a joined up future

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

Nursing, Midwifery and Allied Health Professionals

- Health and Care Academy
  The launch of the WSFT Health and Care Academy has been delayed due to Covid however, the first cohort will start on the 19th September. This is a 6-week programme of half days (Saturdays) for students, aged 17 and 18, who were booked to undertake the student volunteer programme but were unable to do so due to Covid. The programme will provide both theoretical and practical elements and also an introduction to the careers available across the health and care sectors. Further academy programmes will be planned following the evaluation of this course.
  The education team's ambition is to host a health and care academy webpage. Communications are assisting with the development of the webpage which will provide a platform for schools, colleges and students to access information and discover the range of opportunities provided by the WSFT to introduce them to a career in healthcare. Current programmes supported by the WSFT include:
  - student volunteering
  - insight events
  - 6th form healthcare careers conference
  - Clinical shadowing
  - Work experience
  - Health and care academies
  - Attendance at careers events held in schools and colleges
  - Career specific information and support
  - Mock interviews

- Next steps
  - Continue to implement improvement plan and review at pre-registration meeting in October
  - Scope all areas regarding possibility of further student nurse apprenticeship (4 year) cohorts
  - Continue to review student placement capacity on a three-monthly basis especially areas that may be closed or reopened due to Covid
  - Continue to support overseas OSCE programme and consider how this could be delivered virtually if Covid pandemic continues to rise
  - Facilitate further back to the ward training during the winter months
  - Consider how development programmes can be delivered virtually

16. Equality, diversity and inclusion annual report

To APPROVE the report

For Approval

Presented by Jeremy Over and Ayusha Sinha

Trust Board Meeting – 2 October 2020

Agenda item:	16			
Presented by:	Jeremy Over, Executive Director of Workforce and Communications			
Prepared by:	Denise Pora, Deputy Director of Workforce (Learning and Organisation Development) and Ian Beck, Workforce Information Analyst			
Date prepared:	23rd September 2020			
Subject:	Equality, Diversity and Inclusion Annual Report			
Purpose:	X	For information		For approval

Executive summary

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

The Equality and Human Rights Commission suspended PSED reporting obligations in England for 2020 but the Trust is still choosing to report fully this year. The Government Equalities Office and the Equality and Human Rights Commission suspended enforcement of the gender pay gap deadlines for the reporting year 2019/20. The Trust chose to publish its report in May 2020.

Inclusion Strategy

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

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

Inclusion objectives and action plan 2019 – 2021

Nine inclusion objectives were agreed by the Board in September 2019 to further progress our Inclusion Strategy over the two years to August 2021. These objectives were developed following a process of consultation with staff, patient representatives and the wider community, as well as a review of our performance against NHS standards and legal requirements.

We aim to have inclusive approach to all people at all times and, in addition, our inclusion objectives around specific protected characteristics provide an additional focus for two years. Our equality, diversity and inclusion plan (**Appendix 1**) sets out the action needed and taken in the past 12 months to make progress towards our objectives.

The inclusion action plan includes action to address the issues arising from the Trust's performance against the NHS Workforce Race Equality Standard (WRES) and the NHS Workforce Disability Equality Standard (WDES) and the Trust's Equality Delivery System (EDS2). The plan has developed in 2020 and also includes updates reflecting our experience of and learning from the COVID-19 pandemic and the NHS People Plan published in July 2020.

Progress made since September 2019

Despite facing the challenge of COVID-19, progress towards our objectives has been made since September 2019. The Trust has demonstrated its commitment to creating a culture of inclusion in its approach to the COVID-19 pandemic most notably in the action taken to support the mental health and wellbeing of staff and supporting staff from BAME backgrounds.

As evidence emerged around the heightened risks around COVID-19 faced by people from BAME backgrounds representatives were involved in discussions and decisions around provision of PPE; ethnicity has been recognised as an independent risk factor in our individual staff risk assessment for COVID-19 and Dr Emily Baker who leads our Staff Support Psychology team was successful in a bid for charitable funding to recruit a psychologist to her team to support staff from BAME backgrounds.

Examples of action taken to make progress towards our inclusion objectives are (full details in **Appendix 1)**:

Improve the experience and care of people who are lesbian, gay, bisexual, trans and all other sexualities and gender identities e.g.

- The Trust LGB&T+ network helped improve understanding and awareness of different gender identities by hosting a virtual 5 O'clock club meeting as part of Suffolk Pride 2020 celebrations. The presenter was Ali Hannon a non-binary senior communications professional and comedy improviser and the title of their session was Accept and Build: How to survive ambiguity and find out you actually enjoy it.

Ensure that the recruitment and selection processes are bias free and inclusive e.g.

- The Staff Disability Network contributed to the development of an annex to the trust recruitment and selection policy giving examples of reasonable adjustments within the selection process. This helps ensure every candidate is given the opportunity to fully present their abilities and their best self to the panel.

Facilitate the voices of all staff, providing forums for individuals to come together, to share ideas, raise awareness of challenges, provide support to each other and feedback to the trust of issues of equality, diversity and inclusion e.g.

- A BAME staff network was established under the leadership of Dr Ayush Sinha, Consultant Anaesthetist. The network was launched with an open forum session for network members with the Chief Executive and Executive Directors on 16th June.

Take action to support the mental health wellbeing of all staff e.g.

- The business case for a WSFT staff support psychology service was fast-tracked and implemented in response to COVID-19. A team of psychologists are providing on-going support and training for staff and mangers.

Promote a culture of inclusion in the delivery of care to all patients and staff e.g.

- The Chaplaincy team led by Reverend Rufin Emmanuel, hosted celebrations of Eid at the end of Ramadan on 26 May and Eid al-Adha, the festival of sacrifice, on 4 August.

- Head of Patient Experience, Cassia Nice and her team have improved accessibility of the Trust website by arranging for 'Browsealoud' to be installed. It allows the website to be converted into many different accessible formats, as well as translation into other languages. The software can also convert the format of PDF documents and fully translate them into other languages.

- The Library team led by Laura Wilkes invited users to read beyond their experience and broaden their understanding through 'Books Beyond Borders' which ran from October 2019 (Black History Month) to February 2020 (LGBT+ History Month). Staff were invited to read 2 or more books from the newly established equalities collection of books celebrating diversity in our society.

Developments since the 2019 annual report

- The importance of our action to facilitate the voices of all staff was highlighted by the disproportionate impact of COVID-19 on BAME staff and the Black Lives Matter movement and the emergence of the WSFT BAME staff network is a significant step forward. We will focus on the best ways of supporting all our staff networks and ensuring they can contribute to decision-making process in the Trust, whilst respecting their independence and desire to set their own agendas.

- A workforce that represents the population we serve at every level continues to be a challenge and has become a national priority in 2020. Proportionate representation of women, staff with disabilities and people from BAME backgrounds at senior leadership levels of WSFT, including the Trust Board is a priority. A review of recruitment and promotion practices in partnership with staff representatives will support this process.

External assurance and standards

The Trust has complied with external requirements to report on standards linked to some of the characteristics protected by the Equality Act 2010. Specifically the Workforce Race Equality Standard (**Appendix 2**), Workforce Disability Equality Standard (Appendix 3), Gender Pay Gap reporting (available on the Trust website in the corporate information, information we publish section) and our Public Sector Equality Duty (PSED).

The Equality and Human Rights Commission suspended PSED reporting obligations in England for 2020 but the Trust is still choosing to report this year. The Government Equalities Office and the Equality and Human Rights Commission suspended enforcement of the gender pay gap deadlines for the reporting year 2019/20. The Trust chose to publish its report in May 2020.

Internal assurance – performance management

We have identified that staff from the Philippines are disproportionately represented in HR cases -15% of cases involved staff from the Philippines whilst they represent only 3% of our workforce. As a result we will be undertaking a review of previous disciplinary, grievance, capability and bullying and harassment cases, involving Filipino colleagues, including outcomes. Going forward we are exploring how we can look at potential formal HR processes involving staff from the Philippines through a cultural lens. This process will involve discussion with our Filipino workforce.

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

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

Previously considered by:	n/a
Risk and assurance:	Equality monitoring processes within Workforce and Communications Directorate

Legislation, regulatory, equality, diversity and dignity implications	• Compliance with the 2010 Equality Act and Public Sector Equality Duty • Workforce Race Equality Standard and Workforce Disability Equality Standard included in NHS standard contract and CQC well-led domain • Annual Gender Pay Gap reporting is a legal requirement
Recommendation: Trust Board Members are invited to approve this report, including the Workforce Race Equality Scheme report and the Workforce Disability Scheme report before they are published on the Trust website.	

Annual equality, diversity and inclusion report 2020

Purpose of this report

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

Introduction - WSFT inclusion strategy

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

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

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

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

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

We aim to have inclusive approach to all people at all times and, in addition, our inclusion objectives around specific protected characteristics provide an additional focus for two years. Our inclusion objectives for 2019 - 2021 are:

For patients, service users and carers

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

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

For staff

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

For patients, service users, carers and staff

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

Our equality, diversity and inclusion plan sets out action against these objectives and progress made in the last 12 months. See **Appendix 1**

Significant progress has been made since September 2019 and the Trust has also demonstrated its commitment to creating a culture of inclusion in its approach to the COVID-19 pandemic most notably in the action taken to support the mental health and wellbeing of staff and supporting staff from BAME backgrounds.

As evidence emerged around the heightened risks around COVID-19 faced by people from BAME backgrounds representatives were involved in discussions and decisions around provision of PPE; ethnicity has been recognised as an independent risk factor in our individual staff risk assessment for COVID-19 and Dr Emily Baker who leads our Staff Support Psychology team was successful in a bid for charitable funding to recruit a psychologist to her team to support staff from BAME backgrounds.

Governance of equality, diversity and inclusion

Development and implementation of our inclusion strategy is overseen by the Equality, Diversity and Inclusion Steering Group and an update is provided to the Patient Experience Committee for patient issues every six months. Staff issues are escalated to the Trust Executive Group as required. A report is made to the Trust Board annually. The LGB&T+, Staff Disability and BAME staff networks are invited to contribute to the organisational inclusion agenda and decision making through representation on the Equality, Diversity and Inclusion Steering Group.

Developments since the 2019 annual report

The importance of our action to facilitate the voices of all staff was highlighted by the disproportionate impact of COVID-19 on BAME staff and the Black Lives Matter movement and the emergence of the WSFT BAME staff network is a significant step forward. We will focus on the best ways of supporting all our staff networks and ensuring they can contribute to decision-making process in the Trust, whilst respecting their independence and desire to set their own agendas.

A workforce that represents the population we serve at every level continues to be a challenge and has become a national priority in 2020. Proportionate representation of women, staff with disabilities and people from BAME backgrounds at senior leadership levels of WSFT, including the Trust Board is a priority. A review of recruitment and promotion practices in partnership with staff representatives will support this process.

The Inclusion Action Plan has developed in 2020 and includes updates reflecting our experience of and learning from the COVID-19 pandemic and the NHS People Plan published in July 2020.

Standards and external assurance

Equality Delivery System 2 (EDS2)

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

The four goals are:

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

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

Workforce Race Equality Standard (WRES)

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

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

One issue of particular concern in the NHS currently is that BAME staff are relatively more likely than white staff to enter the formal disciplinary process. This was highlighted in the **NHS England and NHS Improvement report '*A fair experience for all'*.** The goal set for the NHS is to ensure that the relative likelihood for BAME staff entering the formal disciplinary process compared to white staff are within the non-adverse range of 0.8 – 1.25 (measured by WRES indicator 3). WSFT performance is as follows:

Year	**2020**	**2019**	**2018**
WSFT Indicator 3 score	0.15	0.62	0.29
No. BAME staff entering the disciplinary process	1	3	1

The WSFT score in this indicator has been outside the non-adverse range in the last three years and suggests that BAME staff are less likely than white staff to enter the formal disciplinary process.

Another issue of national concern is the difference in the likelihood of BAME and white candidates being appointed from a shortlist. WSFT performance is as follows:

Year	**2020**	**2019**	**2018**
Score above 1 indicates white candidates are more likely to be appointed than those from BAME backgrounds, below 1 indicates candidates from BAME backgrounds are more likely to be appointed than white.	0.90	1.43	1.60

In 2020 this indicator suggests BAME candidates are slightly more likely than white staff to be appointed from a shortlist. It is important to note that this may represent the impact of significant recruitment from overseas in 2019/20. These were nursing staff from the Philippines and the appointment to a number of trust grade doctor posts which tend to attract applicants from overseas. It is, therefore, too early to conclude that our efforts around ensuring fair recruitment and selection are achieving the desired results.

WRES indicators based on NHS staff survey results demonstrate BAME staff continue to experience greater bullying and harassment from both patients and colleagues and experience more discrimination at work. BAME staff also report a lower level of belief than white staff in equality of opportunity for career progression or promotion.

BAME staff continue to be very under represented at senior management levels (band 8a+) and on the Trust Board.

A report showing WSFT performance against the WRES indicators is attached as **Appendix 2**. Action to address issues raised by the WRES is in the Inclusion Action Plan (**Appendix 1**).

Workforce Disability Equality Standard (WDES)

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

Full details of the Trust's performance against the WDES indicators are provided at **Appendix 4**. In summary:

- Overall disabled staff completing the National NHS Staff Survey in 2019 reported a less favourable experience at work than non-disabled colleagues in all indicators where comparison is possible.

- Disabled candidates appear less likely than non-disabled staff to be appointed from shortlisting and the trend in this indicator has deteriorated since the 2019 WDES. Non-disabled staff were 1.46 times more likely to be appointed from a shortlist than disabled staff in 2019/20, compared to 1.03 times more likely in 2018/19.

- Disabled staff are more likely to experience bullying and harassment from patients, their colleagues and their managers than non-disabled staff and are slightly less likely to report it.

- The overall staff engagement score for disabled staff is lower compared to non-disabled staff and the overall engagement score for the trust. However, it is worth noting that the staff engagement score for WSFT disabled staff is still higher than the national average score for comparable trusts.

Action to be taken can be found in **Appendix 1**.

All staff have been invited to contribute to the development of action to address issues raised by the WDES and WRES through the Green Sheet, Core Brief, and through the BAME and Staff Disability Networks.

Gender Pay Gap (GPG) reporting

All employers with 250 or more employees are required by law to publish their gender pay gap each year on their own and the Government's website. Due to the COVID-19 pandemic the Government Equalities Office and the Equality and Human Rights Commission suspended enforcement of the gender pay gap deadlines for the reporting year 2019/20. However, the Trust chose to publish its report in May 2020. This was our third GPG report.

The figures reported show West Suffolk NHS Foundation Trust's gender pay gap in two ways – as median and mean average hourly rates. Average hourly rates:

	Average hourly rate (mean) % pay gap	Median hourly rate % pay gap
31.3.17	24.2%	8.1%
31.3.18	23.5%	6.0%
31.3.19	22.8%	5.3%

As in previous years the gender pay gap is caused by the trust employing proportionately more men in more skilled, senior, higher paying jobs than we have women; in particular amongst senior management roles and medical staff. Detailed analysis of the data by pay band highlights that female pay is higher than male pay in 9 out of the 15 pay bands/groups. The average hourly rates of men are still higher than those of women at executive level and amongst medical staff.

The bonus pay gap was calculated differently following additional national guidance for the reporting year ending 31.3.19 which means this year's data is not comparable with previous years.

Bonus pay	2017		2018		2019	
	Female	Male	Female	Male	Female	Male
% staff receiving bonus pay	1.0%	4.5%	1.09%	5.14%	5.99%	10.97%
Mean average bonus pay	£8088	£12130	£7563	£9857	£2634	£5088
Mean average bonus GPG	33.10%		23.27%		48.23%	
Median average bonus pay	£5972	£8958	£6032	£6032	£1500	£3000
Median average bonus GPG	33.33%		0%		50%	

Proportionately more men than women receive the highest level of the highest paying bonuses (i.e. Clinical Excellence Awards (CEA) made to consultant medical staff). 56% of the 89 men receiving bonus payments were consultant medical staff in receipt of CEA, whilst only 19% of the 202 women receiving bonus payments were consultant medical staff in receipt of CEA.

Therefore, the inclusion for 2019 reporting of a large number of additional, lower, awards in addition to CEA, has exacerbated this situation. The impact has been to drive down both the mean and median bonus disproportionately for women and increased the bonus GPG.

A copy of the full report published in May 2020 can be found on the Trust website in the corporate information, information we publish section. Actions to address the issues raised are highlighted in the Inclusion Strategy Action Plan 2019 – 21 at **Appendix 1**.

National NHS Staff Survey 2019: Equality, diversity and inclusion theme

In addition to information from the NHS staff survey referenced in sections on WRES and WDES above, overall trust performance in the equality, diversity and inclusion theme placed WSFT well above the national average for similar trusts and close to the best in the country.

Trust performance in the equality, diversity and inclusion theme has remained consistently above the national average for the past five surveys.

	2015	2016	2017	2018	2019
Best	9.5	9.4	9.4	9.6	9.4
WSFT	9.3	9.3	9.2	9.3	9.3
Average	9.2	9.2	9.1	9.1	9.0
Worst	8.3	8.2	8.1	8.1	8.3

West Suffolk NHSFT equality and diversity profile 31 March 2020

The Trust workforce appears more diverse than immediate local areas, and less diverse than the whole of England with the exception of Asian groups. Ethnic groups account for approximately 13% of total workforce and 9.5% of total staff survey of respondents.

Whilst the White British group makes up around 80% of the workforce, this is not reflected across all staff groups:

- Estates and facilities, administrative and clerical, allied health professionals and ancillary staff groups have a greater proportion of white groups overall.
- There is a more even distribution of white and minority groups amongst medical staff.

79% of the Trust's workforce is female, with the majority in nursing, administrative and healthcare support posts. Male staff members represent 21% of the workforce with a slight majority in medical roles.

Female staff members work almost equally part-time and full-time, whilst almost 90% of male staff members work full-time. Overall, 58% of Trust staff work full-time, with 42% working part-time.

The majority of staff members are between the ages of 40-60, with a large number of staff having been with the trust between 1-10 years. Over a quarter of staff members have been with the Trust for more than 10 years.

- Approximately 48% of the workforce falls within the 36 – 55 age bracket.
- There are 341 employees over 60, 15 of these are over the age of 71.

3% of staff have declared a disability, 49% have said they do not have a disability, 12% stated they preferred not to answer and the status of the remaining 36% of staff is unknown.

There has been a slight increase (2%) in staff members choosing to disclose their sexual orientation.

- 0.72% bisexual
- 0.90% gay or lesbian
- 74.20 % heterosexual
- 24.13% not disclosed
- 0.02% other sexual orientation not listed
- 0.02% undecided

Trust staff have a diverse range of faiths and religions. For example, 50% report their religion as Christianity, 1% Buddhism, 1% Hinduism, 1% Islam, 13% Atheism and 17% chose not to disclose their faith or religion.

Performance Management

As part of the Trust's processes for equality monitoring the Workforce and Communications Directorate record all formal investigations for disciplinary, capability, grievance, bullying, harassment and recruitment complaints. The factors being monitored are age, ethnicity, gender and disability to identify any trends that may indicate discrimination.

We have identified that staff from the Philippines are disproportionately represented in HR cases -15% of cases involved staff from the Philippines whilst they represent only 3% of our workforce. As a result we will be undertaking a review of previous disciplinary, grievance, capability and bullying and harassment cases, involving Filipino colleagues, including outcomes. Going forward we are exploring how we can look at potential formal HR processes involving staff from the Philippines through a cultural lens. This process will involve discussion with our Filipino workforce.

A detailed breakdown of the Trust equality and diversity profile and performance management data is provided at **Appendix 4.**

Appendix 1

Inclusion Action Plan 2019 to 2021 – update September 2020

Objective	Action – by 31.8.21	Lead	Comments
Where actions are relevant to improving WSFT performance against the Workforce Race Equality Standard (WRES) or Workforce Disability Equality Standard (WDES) or Gender Pay Gap (GPG) reporting this is indicated against the objective.			
For patients, service users and carers			
1. Improve the experience and care of patients and service users experiencing mental distress those with learning disabilities and neurodiversity	Implement the Green Light Toolkit to better meet the needs of patients and service users who have learning disabilities and/or autism	Head of Patient Experience	• LD engagement event scheduled but paused due to COVID-19
2. Improve the experience and care of people who are lesbian, gay, bisexual, trans and all other sexualities and gender identities	Participate in the NHS Rainbow Badge Scheme to promote a message of inclusion to LGB&T+ patients, service users, and carers Improve understanding and awareness of different gender identities and the lived experience of those who are non-binary Promote the take up of screening by trans people	LGB&T+ network Superintendent Radiographer, Breast imaging team/LGB&T+ network	• WSFT joined scheme in June 2019 and around 500 staff signed the pledge by September 2020 • The Trust LGB&T+ network hosted a virtual 5 O'clock club meeting as part of Suffolk Pride 2020 celebrations. The presenter was a non-binary senior communications professional and comedy improviser and the title of their session was Accept and Build: How to survive ambiguity and find out you actually enjoy it.
For staff			
3. Promote and support inclusive leadership at all levels of the Trust.	Review and update Equality, Diversity and Inclusion Mandatory Training by 31.12.20, enhance disability awareness training. ***WDES*** Increase compliance with mandatory Equality, Diversity and Inclusion training from 90% to 95% by 31.12.20. ***WRES, WDES and GPG***	Deputy Director of Workforce (Learning and Organisation Development)	• Completion date put back due to COVID-19 impact on staff capacity. • Carried forward from 2017 – 19 plan: compliance in August 2020 = 93%

	Encourage Trust leaders throughout the organisation to develop awareness of their own unconscious bias and the potential it has to impact on their behaviour. Increase take up of unconscious bias e-learning. ***WRES, WDES and GPG***	Deputy Director of Workforce (Learning and Organisation Development)	• 101 staff undertook unconscious bias e-learning in the 12 month period
	Unconscious bias e-learning to be mandatory for case investigators.	Deputy Director of Workforce (HR and People Services)	
4. Ensure that the recruitment and selection processes are bias free and inclusive	Complete implementation of action plan resulting from audit recruitment of BAME staff. ***WRES***	Deputy Director of Workforce (Learning and OD), Senior HR Manager and, Medical Staffing Manager (Operational)	• All actions to be completed by 31.12.19. Carried forward from 2017-19 plan. Trend analysis of shortlisted candidates undertaken – report to EDI Steering Group 16.7.20 and annual monitoring agreed going forward. ***COMPLETE***
	Review recruitment and promotion practices in partnership with staff representatives to ensure staffing reflects the diversity of the community, regional and national labour markets ***NHS People Plan, WDES, WRES, GPG***	Deputy Director of Workforce (HR and People Services)	
	Review and update policies relevant to the recruitment and selection of people with disabilities. ***WDES***	Deputy Director of Workforce (Learning and OD) and Disabled Staff Network Members	• Staff disability network have developed an annex to trust recruitment and selection policy with examples of reasonable adjustments in the selection process.
	Achieve 'Disability Confident Employer' status and explore potential to become a 'Disability Confident Leader' ***WDES***	Deputy Director of Workforce (HR and People Services)	• Disability Confident Employer status achieved 30.9.19

5. Facilitate the voices of all staff, providing forums for individuals to come together, to share ideas, raise awareness of challenges, provide support to each other and feedback to the trust on issues of equality, diversity and inclusion.	Offer staff the opportunity and support to set up networks around Equality Act protected characteristics. ***WDES & WRES***	Deputy Director of Workforce (Learning and OD)	• Interested staff invited to form a vegan staff network via Greensheet article September 2019 and contact facilitated between interested staff
	Support the development of the Trust Disabled Staff Network. ***WDES***	Deputy Director of Workforce (Learning and OD)	• Network established and support ongoing. Open forum session on 2.9.20 to discuss WM2Y and WDES 2020.
	Feedback results of Workforce Race Equality Standard and explore opportunities for a BAME staff network. ***WRES***	Deputy Director of Workforce (Learning and OD)	• WRES results fed back at September 2019 core brief and via Greensheet. Staff invited to attend BAME open forum 9.10.19 but no interest from staff. Network set up in June 2020 WRES results fed back at September 2020 core brief and shared with BAME staff network.
	BAME Staff Network ***WRES***	BAME Staff Network Chair	• BAME staff network/committee established under leadership of Dr Ayush Sinha June 2020. Open forum session held with Chief Executive and Executive Directors 16.6.20
	International Medical Support Group ***WRES***	Medical Staffing Manager and Consultant in Obstetrics and Gynaecology	• Induction guidelines and familiarisation process piloted since September 2019. Proposal being developed for the Trust to formally adopt the guidelines and process.
	Review the governance arrangements of the LGB&T+, BAME and Staff Disability networks with members to ensure they are able to contribute to and inform decision-making processes in the Trust **NHS People Plan**	Executive Director of Workforce and Communications	• People plan deadline December 2021
6. Take action to support the mental health wellbeing of all staff	Provide access to training and awareness raising for managers and staff to support mental health wellbeing ***WDES & WRES***	Clinical Education Lead, Nursing Directorate	• 2020 staff mental health awareness training/emotional first aid workshops postponed due to COVID-19. Three workshops booked for November and December 2020.

		Clinical Psychologist a Lead for Staff Support Psychology Service, Deputy Director of Workforce (Learning and Organisation Development), Deputy Medical Director/ Lead Better Working Lives Group (BWLG) Deputy Medical Director/ Lead Better Working Lives Group (BWLG)	• Business case for WSFT Staff Support Psychology service fast-tracked and implemented in response to COVID-19. Team of psychologists providing on-going support and training for staff and managers. • Provision of support to staff from BAME backgrounds in response to heightened vulnerability to COVID-19. Included involving representatives in discussions and decisions around provision of PPE, including ethnicity as an independent risk factor in the Individual Staff Risk Assessment for COVID-19 v5 onwards and successful bid for funding to recruit a psychologist to the Staff Support Psychology team to support staff from BAME backgrounds. This action supported physical health and mental wellbeing. • Wellbeing workshops for medical staff held in September 2019 and February 2020 organised by BWLG. Included sessions on emotional and mental health wellbeing and stress management as well as burnout, resilience and mindfulness.
For patients, service users, carers and staff			
7. Promote a culture of inclusion in the delivery of care to all patients and staff	Engage with staff, patients and service users to explore potential of WSH chapel to ensure it is an inclusive space for all. Identify, share and celebrate existing good practice within the Trust.	Head of Patient Engagement Trust Librarian and Deputy Director of Workforce (Learning and OD)	• Group established and Chaplaincy and pastoral care services survey issued via Greensheet 6.12.19. Paused during COVID-19 work restarted in September 2020. • Plans being developed for 'EDI Awareness Week September 2020' cancelled due to COVID-19. To review for 2021 or 2022.

	Encourage staff to broaden their understanding of the lived experiences of others and celebrate all cultures represented at WSFT	Trust Librarian	• The WSFT library invited staff to read beyond their experience through 'Books Beyond Borders' between Black History Month (October 2019) and LGBT+ History Month (February 2020). Staff were invited to read two or more books from the newly established equalities collection of books celebrating diversity in our society
		Lead Chaplain	• The Chaplaincy team hosted celebrations of Eid at the end of Ramadan on 26 May and Eid al-Adha, the festival of sacrifice on 4 August in the Chapel garden. In August Muslim colleagues each bought a dish to share with others to celebrate the event.
	Improve accessibility for patients, carers and visitors	Head of Patient Engagement	• 'Browsealoud' was installed on the WSFT website in February 2020. It allows the website to be converted into different accessible formats as well as translating it into other languages. The software can also convert the format of PDF documents and fully translate them into other languages.
	Ensure every level of the workforce is representative of the overall BAME workforce. ***NHS People Plan***	Executive Director of Workforce and Communications	• Monitor WSFT progress against the 'Model Employer: increasing black and minority ethnic representation at senior levels across the NHS' goals and identify action to achieve them
	Improve the diversity of the Trust Board ***WDES & WRES***	Trust Board Chair	• Identify opportunities to increase diversity of executive and non-executive Trust Board membership
	Develop Board members' understanding of the lived experience of minority and marginalised groups	Trust Board Chair	• September 2020 patient story to be told by patient talking about his experience of care as a black man.

8. Tackle bullying and harassment of and by staff and support staff to respectfully and successfully challenge problem behaviours.	Implement the Trust 2019 Leadership Summit Action Plan to address poor behaviour and encourage staff to report it. ***WDES & WRES***	All Trust Leaders (monitoring through Directorate Performance Review process)	• Plan being implemented – reviewed at PRM meetings in September and due for second review March 2020. Postponed due to COVID-19. To be reviewed in light of findings of 'What matters to you' staff engagement exercise October 2020.

Workforce Race Equality Standard Report 2020

Name and title of board lead for WRES:	Jeremy Over, Executive Director of Workforce and Communications
Name, title and contact details of lead manager for compiling this report:	Denise Pora, Deputy Director of Workforce (Learning and Organisation Development) denise.pora@wsh.nhs.uk
Name of commissioner this report has been sent to:	Giles Turner, Human Resources Business Partner, West Suffolk CCG
This report was signed off by the Trust Board on:	2nd October 2020
Total Number of staff at 31.3.19 (permanent, fixed term and bank staff):	5271
Proportion of BME staff employed within the trust at 31.3.20:	12.8% (10.9% 2019)
Period this data refers to:	31 March 2020
Workforce Race Equality Standard Indicators	
Actions to address areas for improvement are included in the **Trust's Inclusion Action Plan 2019 – 21** as indicated below.	
Relative likelihood of staff being appointed from shortlisting across all posts	2018 = shortlisted white candidates 1.60 times more likely to be appointed than BME candidates 2019 = shortlisted white candidates 1.43 times more likely to be appointed than BME candidates 2020 = shortlisted white candidates 0.90 times more likely to be appointed than BME candidates (i.e. BME candidates **more likely** to be appointed than white candidates) **NB:** in 2019/20 there was significant recruitment from overseas. These were nursing staff from the Philippines and appointment to trust grade doctor posts which tend to attract applicants from overseas. **Inclusion Action Plan 2019 – 2021: action under objectives 2 and 3.**
Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator is based on data from a two year rolling average of the current year and the previous year	2018 = BME staff less likely than white staff to enter the formal disciplinary process (0.29) 2019 = BME staff less likely than white staff to enter the formal disciplinary process (0.62) 2020 = BME staff less likely than white staff to enter the formal disciplinary process (0.15) **NB:** the numbers involved are very small. The numbers of BME staff entering the formal disciplinary process were: 2018 – 1, 2019 – 3, 2020 - 1

<table>
<tr><td>Relative likelihood of staff accessing non-mandatory training and CPD</td><td>2018 = White staff less likely to access non-mandatory training and CPD compared to BME staff (0.63)

2019 = White staff less likely to access non-mandatory training and CPD compared to BME staff (0.57)

2020 = White staff less likely to access non-mandatory training and CPD compared to BME staff (0.91)

NB: The relatively high proportion of BME staff who are doctors may impact on this indicator i.e. medical staff generally have greater access to non-mandatory training and CPD than other staff groups.</td></tr>
<tr><td>National NHS Staff Survey 2019 Indicator
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months</td><td><table><tr><td></td><td>2017</td><td>2018</td><td>2019</td></tr><tr><td>White</td><td>26.5</td><td>26.7</td><td>25.1</td></tr><tr><td>BME</td><td>41.9</td><td>20.5</td><td>27.9</td></tr></table>Inclusion Action Plan 2019 – 2021: action under objectives 5 and 8</td></tr>
<tr><td>National NHS Staff Survey 2019 Indicator
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months</td><td><table><tr><td></td><td>2017</td><td>2018</td><td>2019</td></tr><tr><td>White</td><td>18.5</td><td>22.9</td><td>21.5</td></tr><tr><td>BME</td><td>29.5</td><td>34.1</td><td>21.9</td></tr></table>Inclusion Action Plan 2019 – 2021: action under objectives 5 and 8</td></tr>
<tr><td>National NHS Staff Survey 2019 Indicator
Percentage believing that the trust provides equal opportunities for career progression or promotion</td><td><table><tr><td></td><td>2017</td><td>2018</td><td>2019</td></tr><tr><td>White</td><td>88.8</td><td>90.0</td><td>89.6</td></tr><tr><td>BME</td><td>81.8</td><td>78.6</td><td>84.9</td></tr></table>Continue to work to ensure all staff receive at least annual appraisal and have access to information about career development opportunities and Inclusion Action Plan 2019 – 2021: action under objective 5</td></tr>
<tr><td>National NHS Staff Survey 2019 Indicator
Percentage staff personally experienced discrimination at work for manager/team leader or other colleague</td><td><table><tr><td></td><td>2017</td><td>2018</td><td>2019</td></tr><tr><td>White</td><td>5.5</td><td>6.6</td><td>5.7</td></tr><tr><td>BME</td><td>15.9</td><td>11.4</td><td>11.9</td></tr></table>Inclusion Action Plan 2019 – 2021: action under objectives 5 and 8</td></tr>
<tr><td>Percentage difference between the organisations' board voting membership and its overall workforce</td><td><table><tr><td>2018</td><td>2019</td><td>2020</td></tr><tr><td>White +16.7%</td><td>White +16.6%</td><td>White +11.00%</td></tr><tr><td>BME -10.2%</td><td>BME -10.9%</td><td>BME -12.8%</td></tr></table>The Trust board voting membership on 31.3.20 was 100% white. Recruitment consultants are instructed to actively seek candidates from all possible sources from within the constituency to provide a diverse range of candidates for all board appointments.</td></tr>
</table>

Appendix 3

Workforce Disability Equality Standard Report 2020

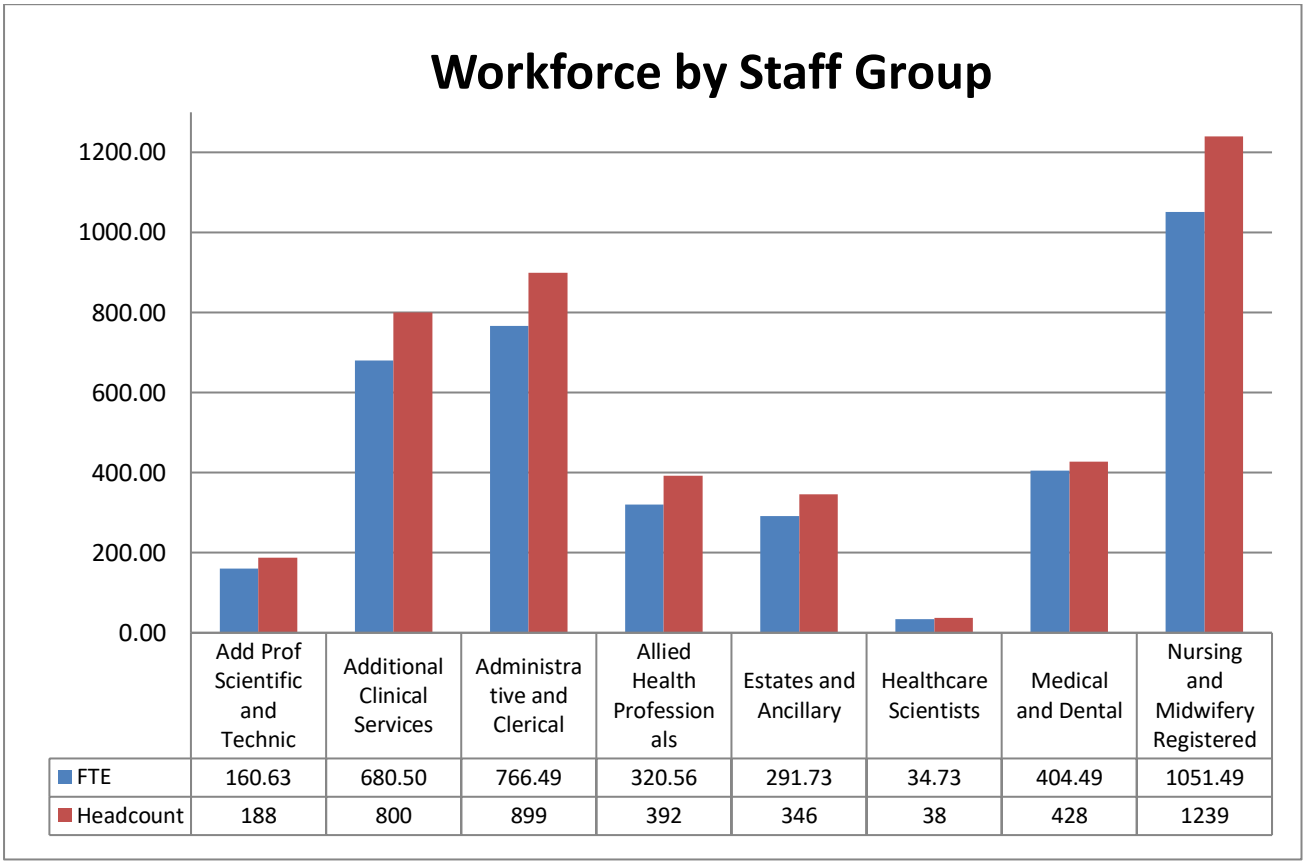
Name and title of board lead for WRES:	Jeremy Over, Executive Director of Workforce and Communications
Name, title and contact details of lead manager for compiling this report:	Denise Pora, Deputy Director of Workforce (Learning and Organisation Development) denise.pora@wsh.nhs.uk
Name of commissioner this report has been sent to:	Giles Turner, Human Resources Business Partner, West Suffolk CCG
This report was signed off by the Trust Board on:	2nd October 2020
Total Number of staff at 31.3.20 (permanent, fixed term and bank staff):	5271 (4936 2019)
Proportion of disabled staff employed within the trust at 31.3.20:	3% (3% 2019)
Period this data refers to:	31 March 2020
Workforce Disability Equality Standard Indicators	
Actions to address areas for improvement are included in the **Trust's Inclusion Action Plan 2019 to 21** as indicated below.	
Relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all post.	1.46 non-disabled staff are more likely to be appointed than disabled staff from shortlist. (1.03 2019) Inclusion Action Plan 2019 to 2021: action under objectives 3 and 4
Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.	0.32 disabled staff are less likely to enter the formal capability process than non-disabled staff. (no disabled staff entered the formal capability process in 2019) Inclusion Action Plan 2019 to 2021: action under objectives 5 and 6
National NHS Staff Survey 2019 Indicator Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	**Disabled** 30.7% (23.9% 2018) **Non-Disabled** 24.4% (26.7% 2018) Inclusion Action Plan 2019 to 2021: action under objectives 3 and 8
National NHS Staff Survey 2019 Indicator Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months	**Disabled** 16.8% (14.8% 2018) **Non-Disabled** 9% (10.4% 2018) Inclusion Action Plan 2019 to 2021: action under objectives 3 and 8
National NHS Staff Survey 2019 Indicator Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	**Disabled** 23.5% (20.4% 2018) **Non-Disabled** 15.8% (18.4% 2018) Inclusion Action Plan 2019 to 2021: action under objectives 3 and 8

National NHS Staff Survey 2018 indicator Percentage of disabled staff compared to non-disabled staff saying that last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	**Disabled** 44% (28.2% 2018) **Non-Disabled** 45.5% (42.4% 2018) Inclusion Action Plan 2019 to 2021: action under objective 8
National NHS Staff Survey 2018 Indicator Percentage believing that the trust provides equal opportunities for career progression or promotion	**Disabled** 84.3% (83.8% 2018) **Non-Disabled** 90.0% (90.2% 2018) Inclusion Action Plan 2019 to 2021: action under objective 3
National NHS Staff Survey 2018 Indicator Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	**Disabled** 25.1% (21.7% 2018) **Non-Disabled** 17.7% (18.0% 2018) Inclusion Action Plan 2019 to 2021: action under objective 3
National NHS Staff Survey 2018 Indicator Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	**Disabled** 51.8% (45.9% 2018) **Non-Disabled** 59.7% (55.8% 2018) Inclusion Action Plan 2019 to 2021: action under objectives 3 and 5
National NHS Staff Survey 2018 Indicator Percentage of disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work	82.1% (82.7% 2018) Inclusion Action Plan 2019 to 2021: action under objectives 4 and 6
National NHS Staff Survey 2018 Indicator The staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score of the organisation	**Disabled** 7.2 (7.1 2018) **Non-Disabled** 7.6 (7.5 2018) **Overall all staff Trust score** 7.5 **National average score for comparable Trusts** 7.1 Inclusion Action Plan 2019 to 2021: action under objective 3
Has your Trust taken action to facilitate the voices of disabled staff in your organisation to be heard?	Yes – staff disability network
Percentage difference between the organisation's Board voting membership and its organisation's overall workforce	No board members with a declared disability Inclusion Action Plan 2019 to 2021: action under objective 4

WSFT equality and diversity profile 31 March 2020

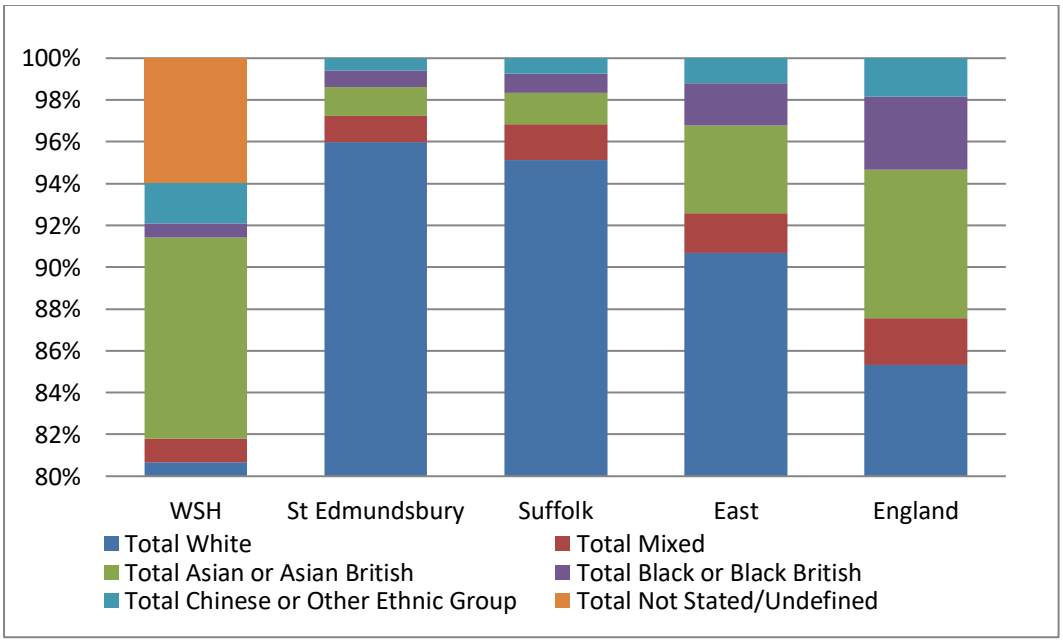
Workforce by staff group

The Trust's total headcount as of 31 March 2020 was approximately 4330. Nurses and midwives continue to be the largest single staff group, accounting for almost 30% of total staff in the Trust, followed closely by administrative and clerical and additional clinical services.



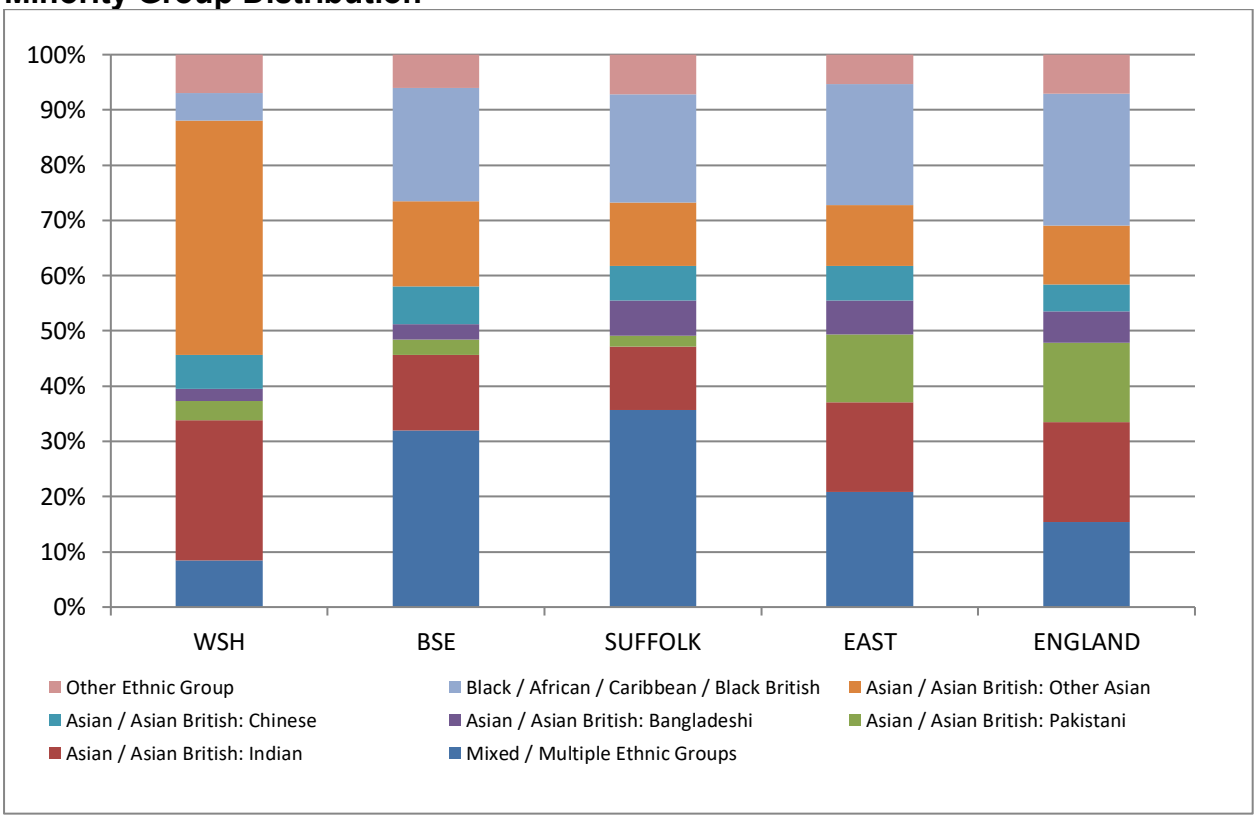
	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
FTE	160.63	680.50	766.49	320.56	291.73	34.73	404.49	1051.49
Headcount	188	800	899	392	346	38	428	1239

Population ethnicity



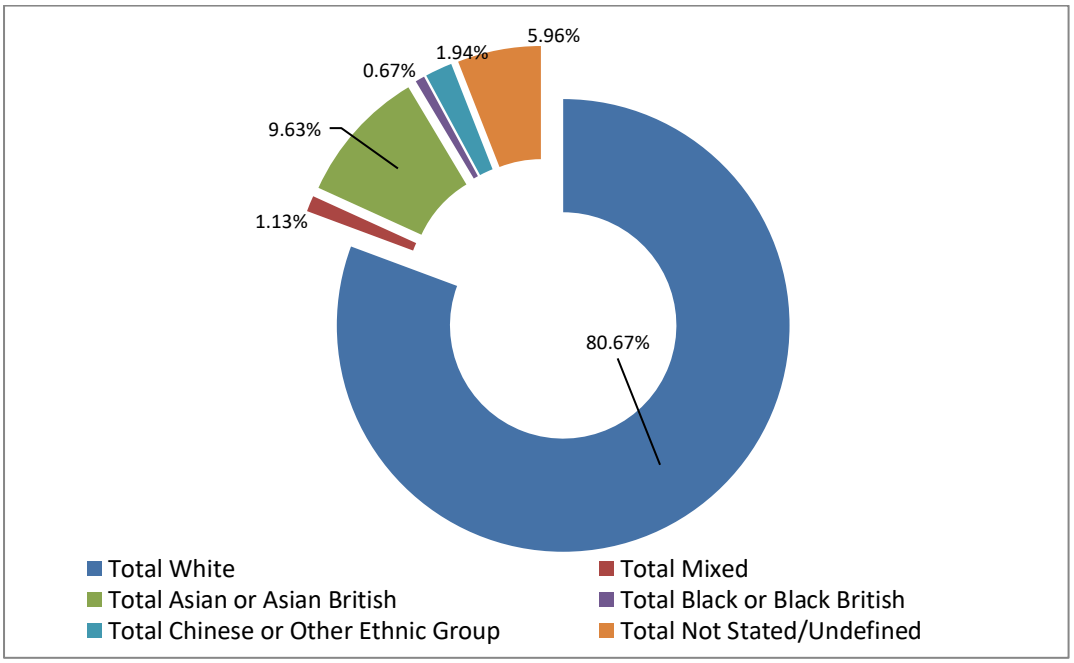
The chart above compares the overall ethnic profiles for the Trust, Bury St Edmunds, Suffolk, East of England and England as a whole. The Trust appears more diverse than the immediate local areas, however slightly less diverse when compared with England as a whole, with the exception of the Asian groups.

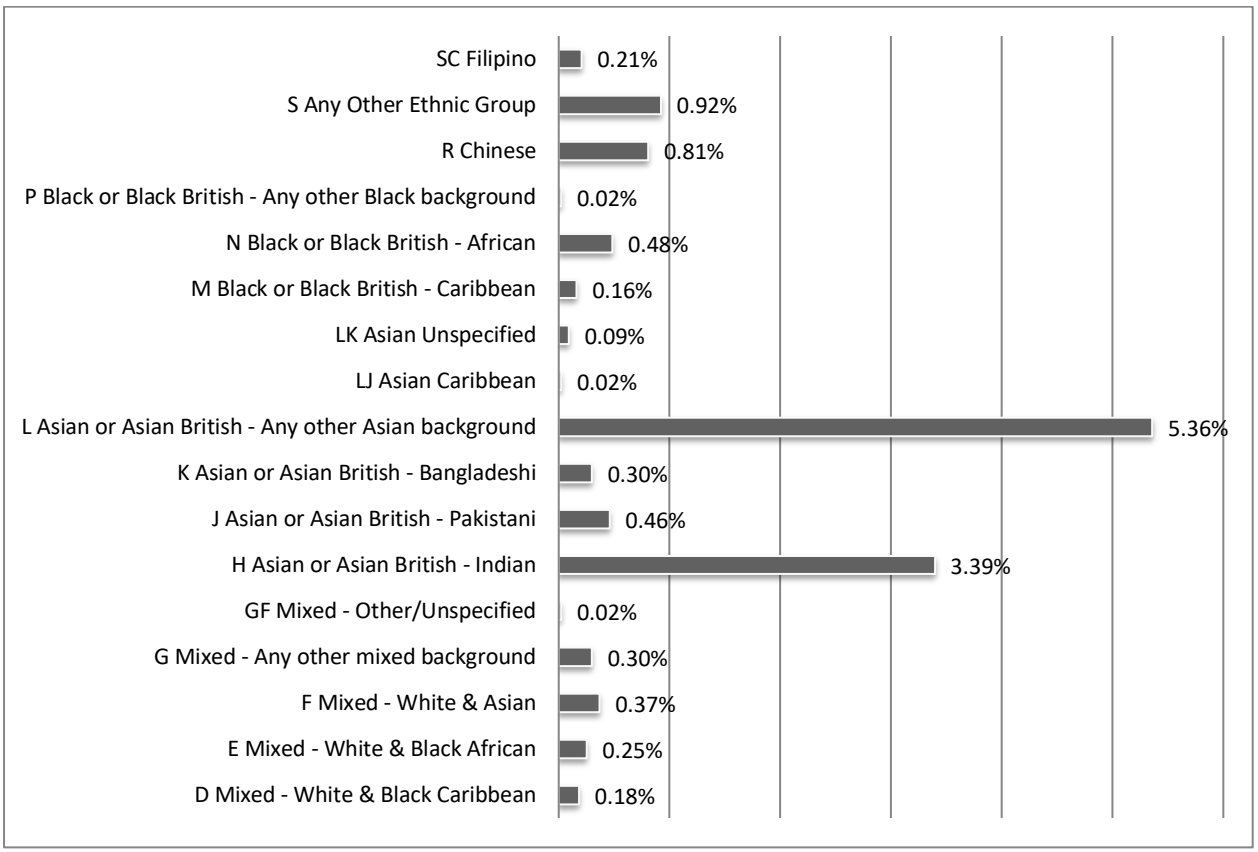
Minority Group Distribution



Workforce ethnicity breakdown

Overall, 13.3% of those staff choosing to disclose their ethnicity stated they were from a minority ethnic group. Currently 94% of the workforce has chosen to disclose their ethnicity.

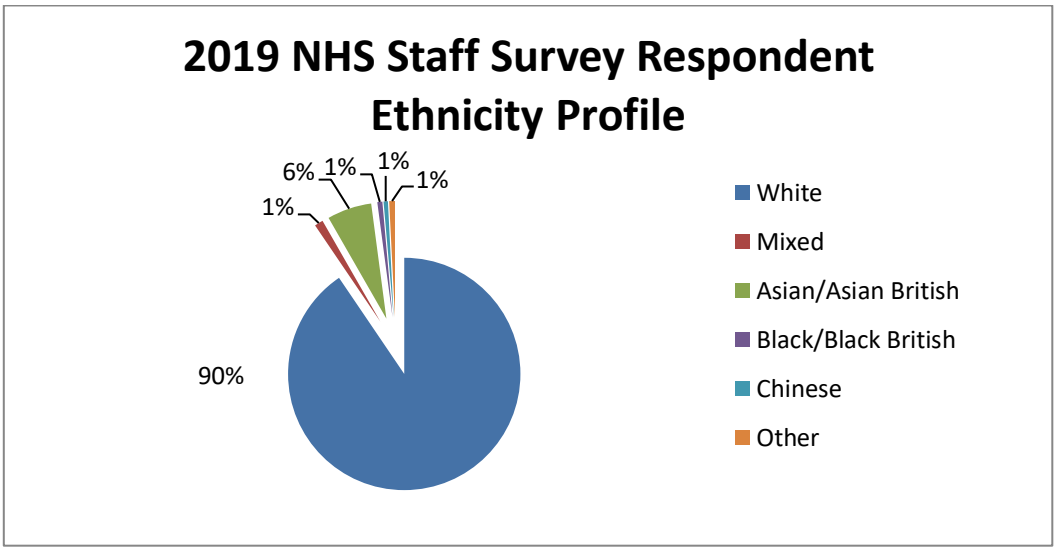




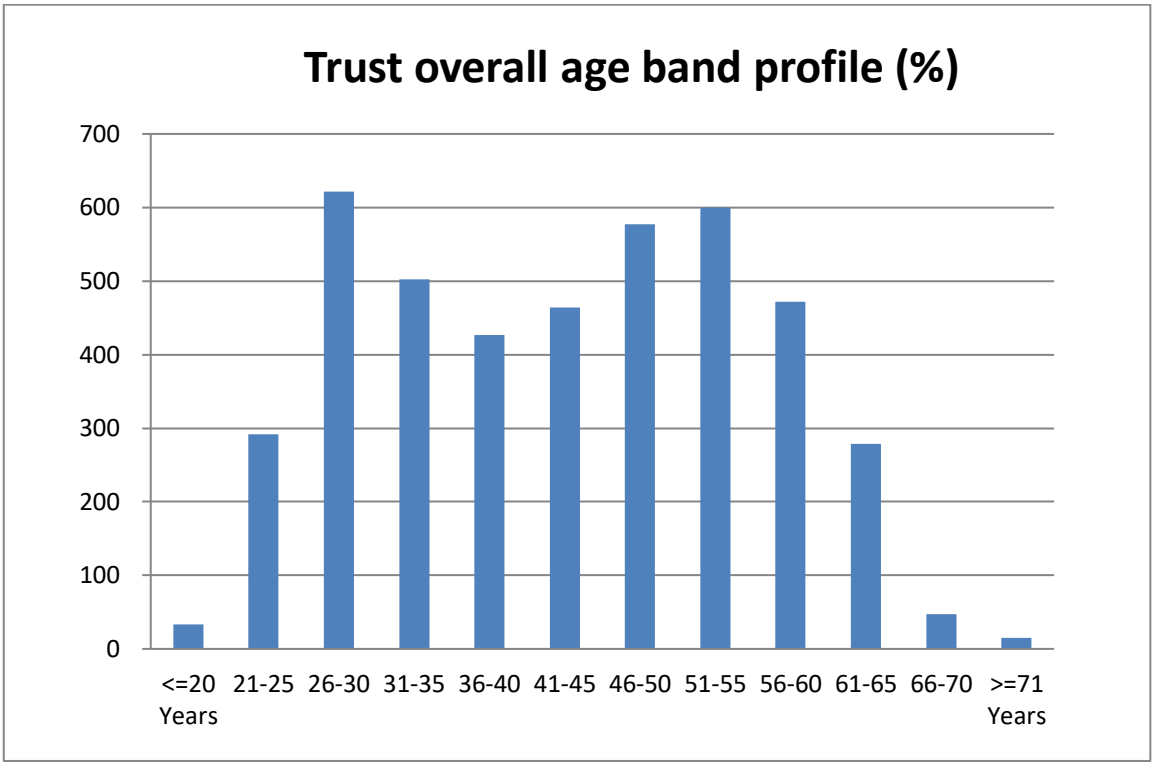
Staff Survey sample – ethnicity

From a census of all eligible staff, 2077 employees responded to the Trust Staff Survey in 2019, giving a total response rate of 51.8% - above the Picker Institute average for Acute Trusts of 47.5%.

The chart below shows how our staff respondents described their ethnic background when completing the survey. In total 90% were recorded as white groups and 9.5% recorded as minority groups.



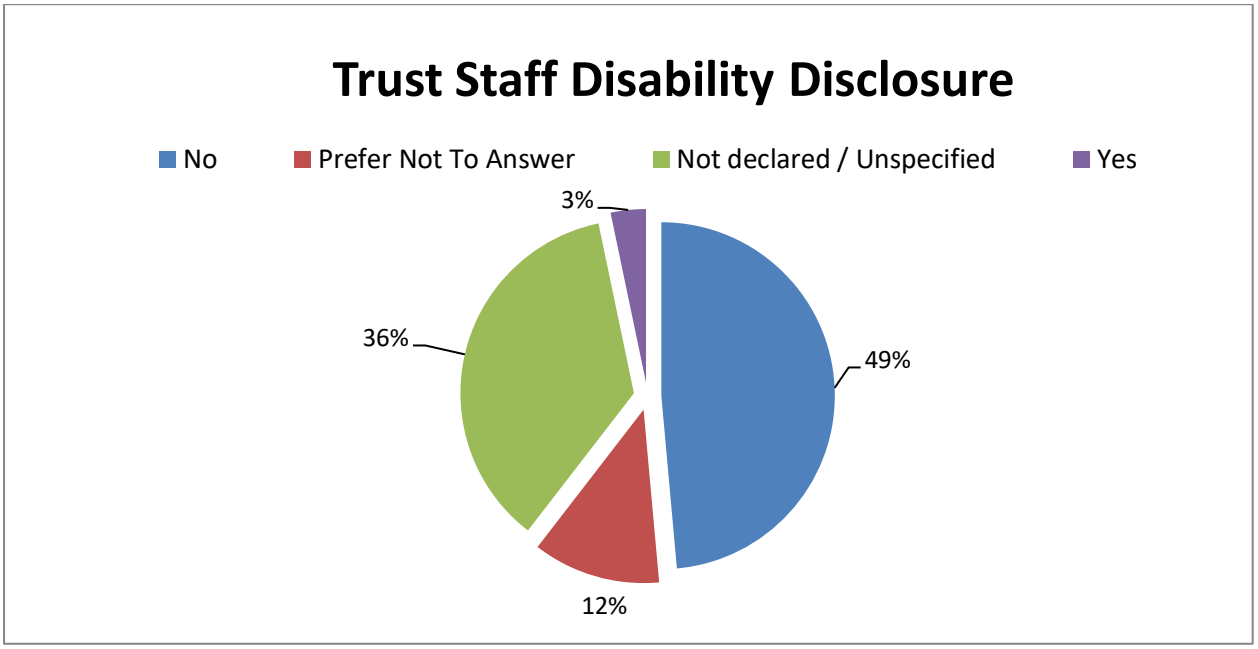
Age profile



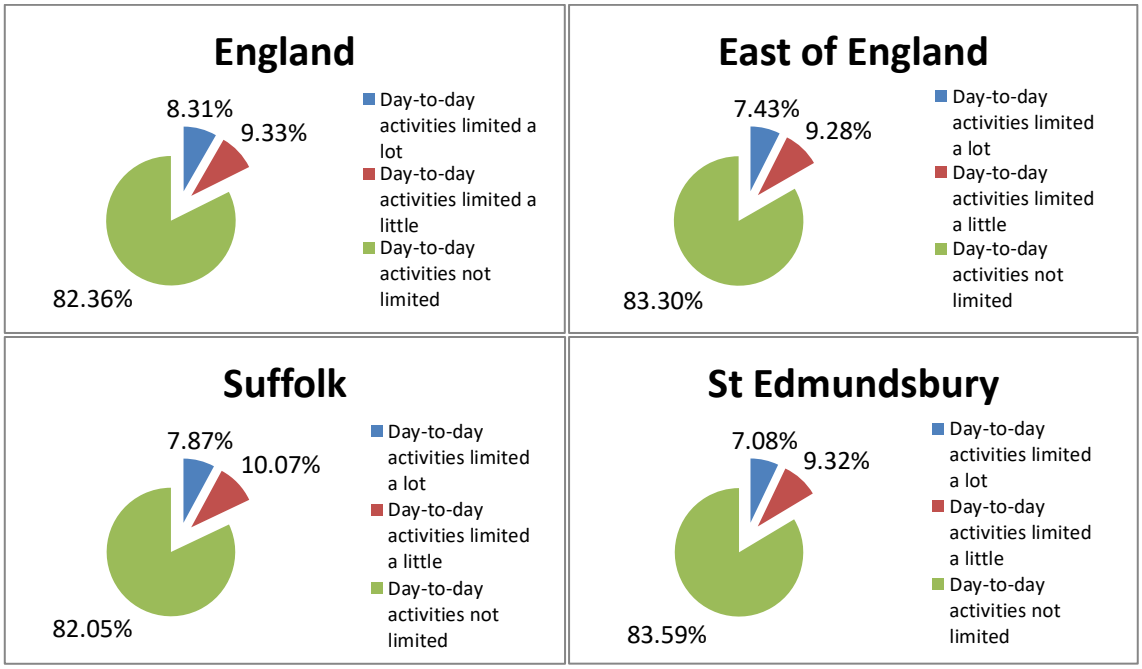
The average age for staff within the Trust is 44 years old. For female staff it is 44 and for male staff, 42.

Disability

Trust disability data quality has improved and shows that over half of all staff members have a recorded disability disclosure.

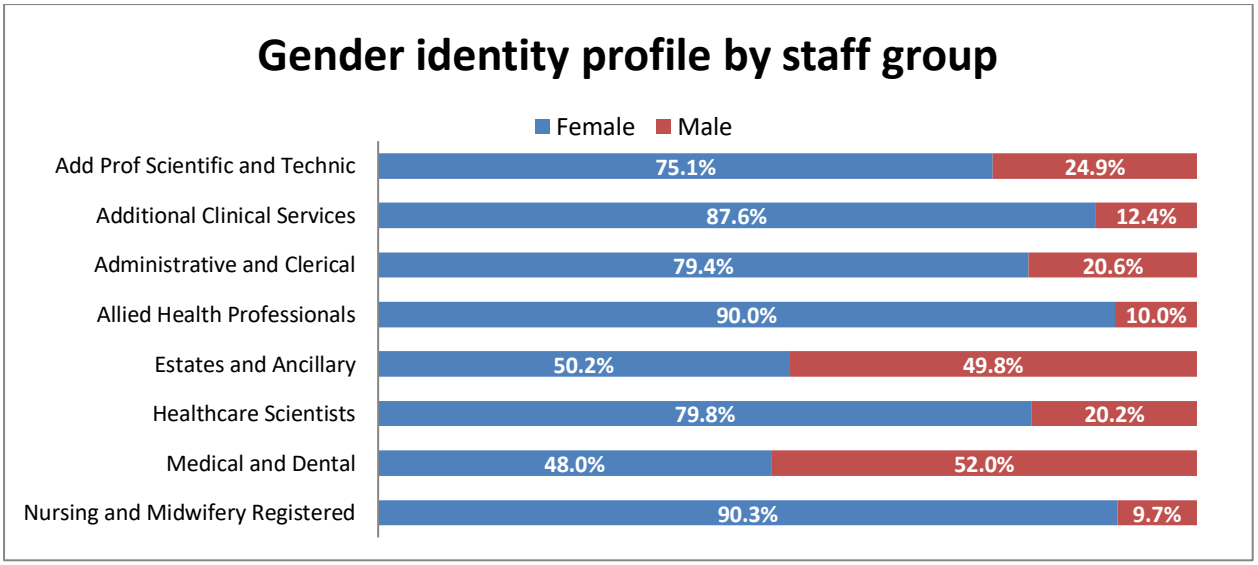


The data below shows the comparison between the locality, region and country as a whole in terms of the number of people who have either no disability/limitation with day-to-day activities, limited or more limited activity.



Gender identity

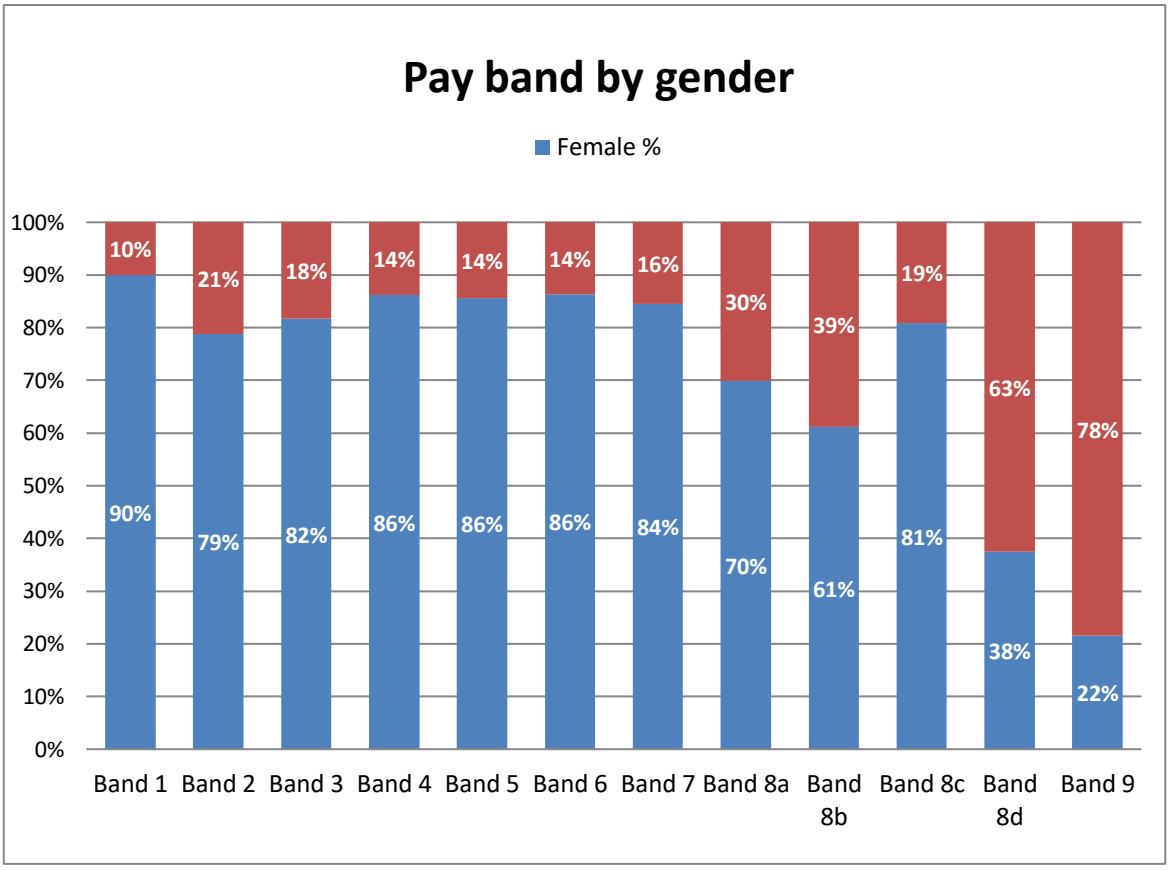
The gender split of the workforce remains reasonably constant; it comprises 79% female staff and 21% male staff. A similar distribution was seen amongst the respondents to the Trusts 2019 Staff Survey, with the inclusion of 0.1% of respondents preferring to self-describe and 2.3% of respondents preferring not to state.



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

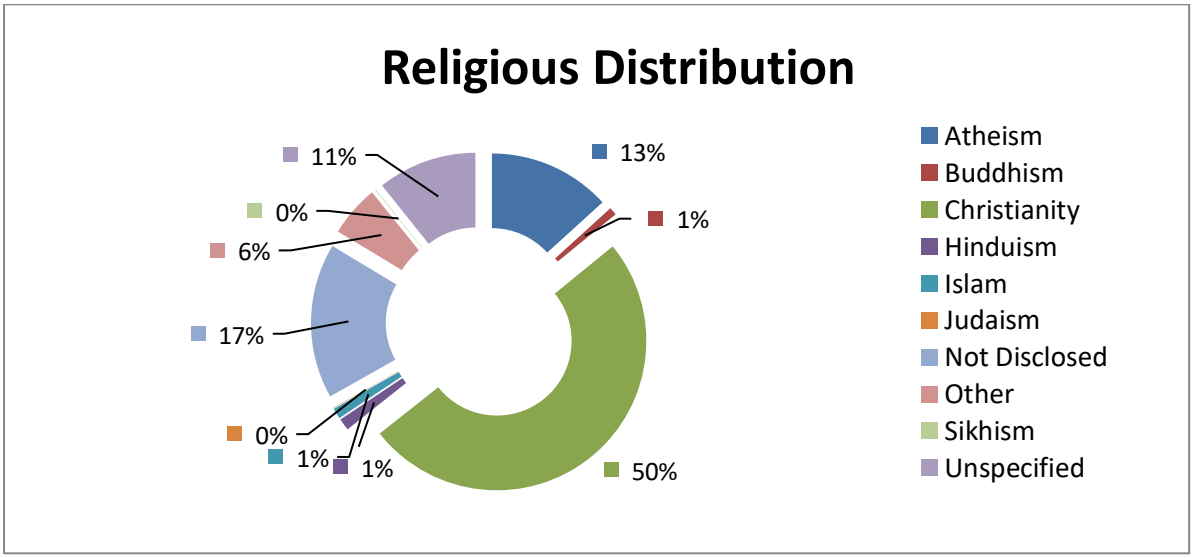
Pay

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



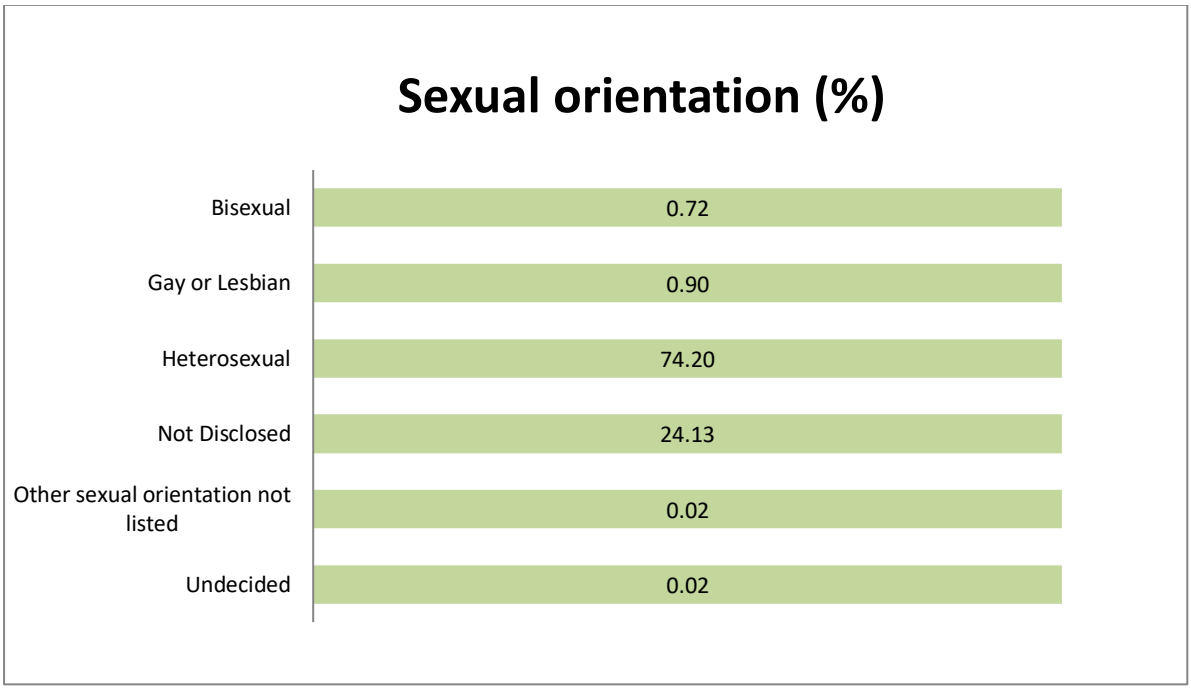
Religion and belief

The Trust workforce has a diverse range of faiths, with fewer staff choosing not to disclose their religion.



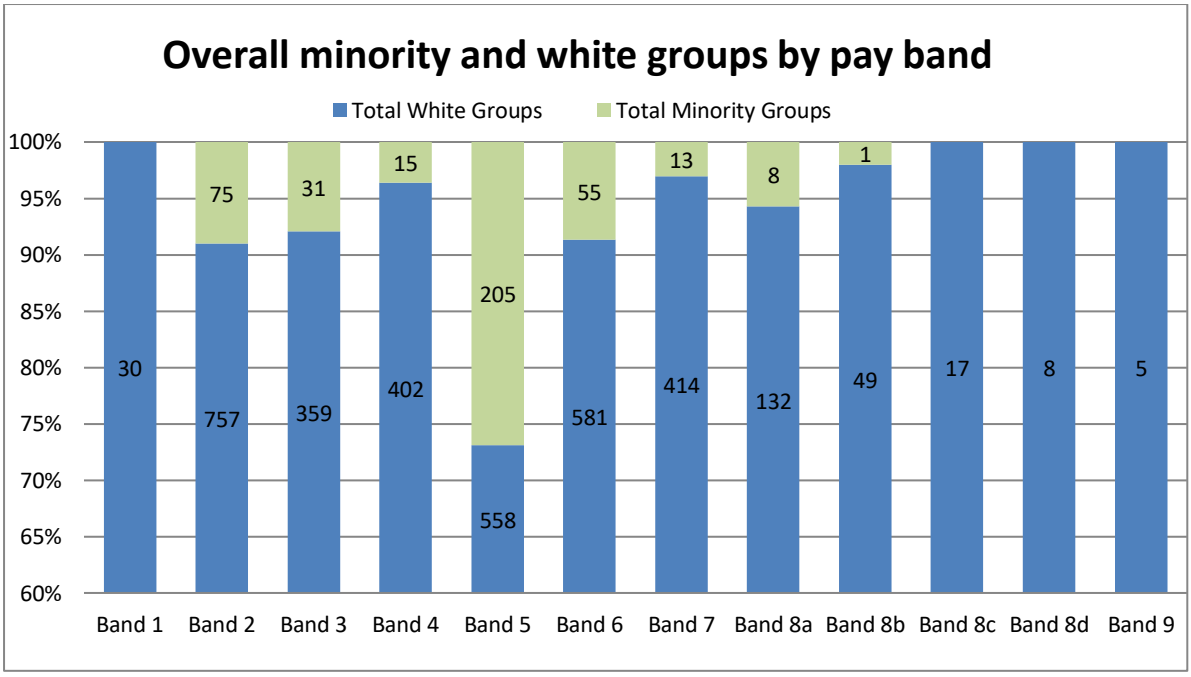
Sexual orientation

More staff members have chosen to disclose their sexual orientation since last year. The number of staff choosing not to disclose their sexual orientation has fallen by 2%



Pay band by ethnicity

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



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

Performance Management

As part of the Trust's processes for equality monitoring the Workforce and Communications Directorate record all formal investigations for disciplinary, capability, grievance, bullying, harassment and recruitment complaints.

The factors monitored are age, ethnicity, gender and disability to identify any trends that may indicate discrimination. Sickness absence is monitored separately.

In 2019/2020 the Trust conducted a total of 52 formal investigations split into the categories listed in the table below.

	2019/20	2018/19	2017/18
Disciplinary	27	37	29
Capability	7	2	5
Grievance	13	8	4
Bullying and harassment	5	1	2
TOTAL	52	48	40

Our analysis shows that 43 of the cases listed above involved people of White British or White European/White Other ethnicity. Eight members of staff were Filipino and one was of Black African ethnicity. One person had a disability and the age range of staff was from 23 years old to 63 years old.

Disciplinary Cases 27
Male = 6
Female = 20
One case that involved both male and female employees
Disability = None
Dismissed = 3 all-female, White British – one case was overturned on appeal
Resigned before hearing = 2
On hold due to Covid-19 = 2
Ethnicity = White British = 24 Filipino = 3
Age range = 30 years old to 63 years old

Capability Cases 7
Male = 2
Female = 5
Disability = 1
Dismissed = 1
Resigned before hearing = 3
On hold due to Covid-19 = 1
Ethnicity = White British = 5 Filipino = 2
Age range = 28 years old to 54 years old

Grievance Cases 13
Male = 7
Female = 6
Disability = None
Dismissed = None
Resigned before hearing = 2 and 1 left under a COT3 Agreement
On hold due to Covid-19 = None
Ethnicity: White British = 11, Filipino = 1 Black African = 1
Age range = 23 years old – 63 years old

Bullying & Harassment 5
Male = 1
Female = 4
Disability = None

Dismissed = None
Resigned before hearing = None
On hold due to Covid-19 = None
Ethnicity: White British = 3 Filipino = 2
Age range = 34 years old – 51 years old

We have identified that staff from the Philippines are disproportionately represented in HR cases -15% of cases involved staff from the Philippines whilst they represent only 3% of our workforce. As a result we will be undertaking a review of previous disciplinary, grievance, capability and bullying and harassment cases, involving Filipino colleagues, including outcomes. Going forward we are exploring how we can look at potential formal HR processes involving staff from the Philippines through a cultural lens. This process will involve discussion with our Filipino workforce.

Data sources for this report

Electronic staff record (ESR)/Oracle Business Intelligence (BI)
Standard workforce figures for staff groups as at 31-March-2020
Trust diversity statistics as at 31-March-2020, for protected characteristics

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

17. Nurse staffing report

To ACCEPT the report

For Report

Presented by Susan Wilkinson

Trust Board – 2 October 2020

NHS West Suffolk NHS Foundation Trust

Agenda item:	17			
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			
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 theposition 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 July and August. The paper presents both months in recognition that there was no board meeting in August.

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 July and August within the data submission deadline. Table 1 below shows the summary of overall fill % for these 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 July 2020	102%	101%	101%	117%
Average fill rate August 2020	103%	95%	98%	109%

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 in August reflecting the data cleansing that the Deputy Chief Nurse and matrons are completing is providing a more informed picture.

On interrogating 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. This action will form part of the 'utilising nursing resource' action plan that is being produced by the Deputy Chief Nurse to better illustrate use of nursing resource and risk management.

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. No significant increase in staff sickness occurred during this period and overall sickness was reduced in August (Table 2b).

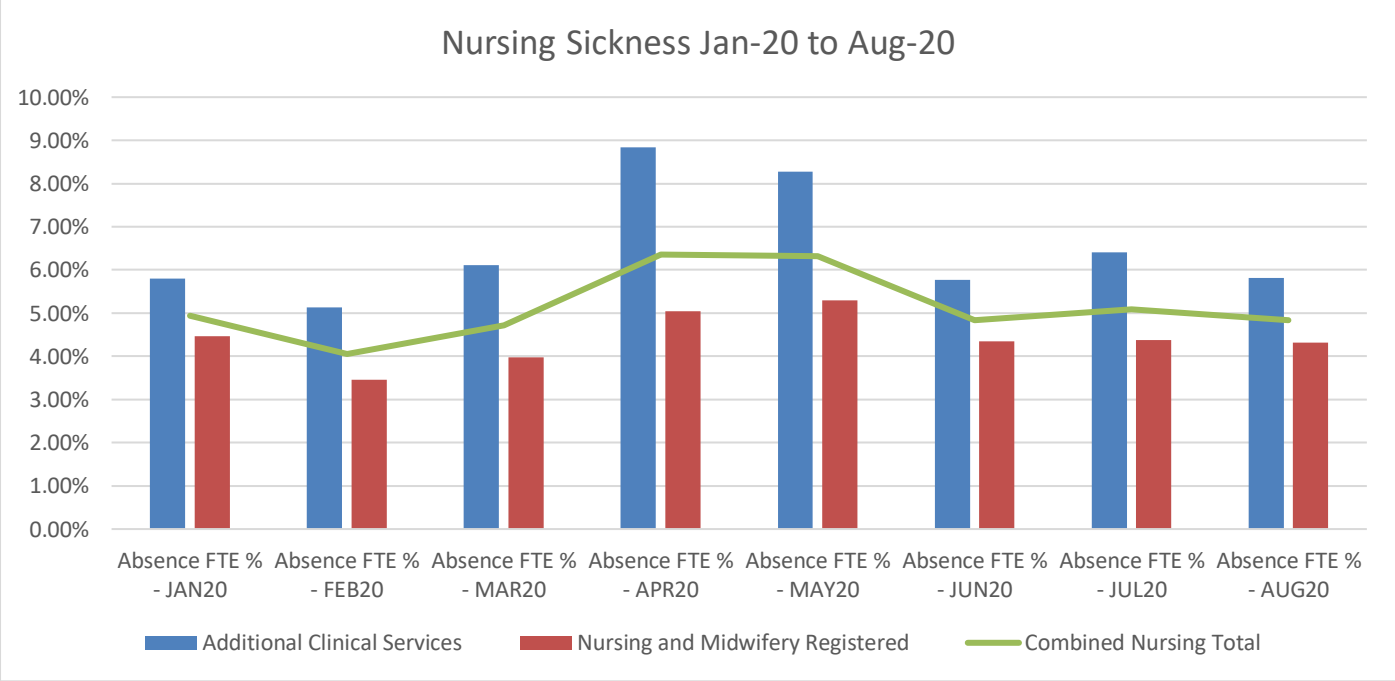


Chart 2.

	March	April	May	Jun	July	August
Unregistered staff (support workers)	6.18%	8.81%	8.34%	5.69%	6.41%	5.82%
Registered Nurse/Midwives	3.98&	5.14%	5.61%	4.78%	4.37%	4.31%
Combined Registered/Unregistered	4.76%	6.42%	6.55%	5.10%	5.90%	4.84%

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 continued to reduce in July and August. This is positive despite implementation of national test and trace where increasing incidence of self-isolation was anticipated. It is anticipated that this will be set to rise again in September as schools re-open.

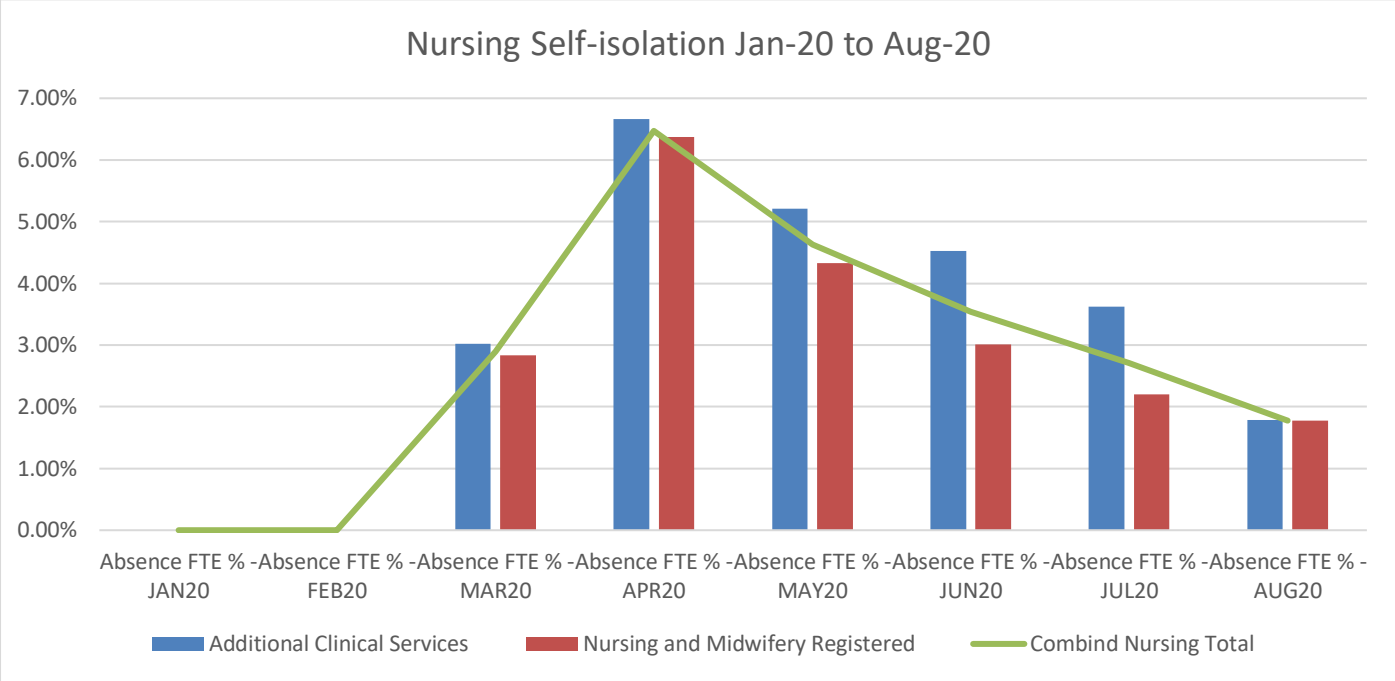


Chart 3

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: During June ward G9 was closed due to nosocomial covid 19 outbreak. This ward remains closed following concerns regarding the ability to safety isolate/segregate patients during the pandemic. Staff have been redeployed within the speciality.

During July, ward G5 moved to F4, and G4 moved into the vacant G5. This was to facilitate building works. Both wards had returned to their original footprint by early August.

During August F6 moved to F4 and F5 moved into the vacant F6 foot print to again accommodate building works

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

Using budgeted versus contracted staff there is a shortfall of 84.4 registered nurses however this is improved by substantive staff that have been reflected in the coronavirus support costs. The net vacancy rate is 20.4 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.

	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 CURRENT MONTH VARIANCE
RN Substantive	Ward	420.6	453.7	446.1	452.6	470.0	84.4
	CV19 Costs	99.9	82.8	141.3	111.7	64.0	(64.0)
Total: Nursing Registered Substantive		**520.5**	**536.4**	**587.4**	**564.3**	**534.0**	**20.4**

Table 4

The Nursing numbers in the table above include a number of non-Nursing WTEs that have been allocated to Covid related costs. This is causing fluctuations that are not entirely relating to Nursing numbers. We are adjusting our reporting to remove these staff from the Nursing WTEs and this change will be reflected on the September staffing report and subsequent board, back dated to 1st April". This will give a more accurate picture of total trust RN/RM vacancies. Using these figures, it would suggest that in July and August 53 RNs left substantive posts. Information from workforce and moment with ESR suggest that this figure is actually 12 RNs leaving in between 1st July and 30th August 2020.

On review of individual wards areas with a notable shortfall of staff would be maternity services, currently carrying a vacancy of 13.9 WTE (23.5%). 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. Section 9 describes specific maternity service activity and risk in further detail.

On review of the vacancy rate of unregistered support staff, this is also demonstrating an over establishment of 33.8 WTE (table 5). This will be driven by additional duties for 1:1 enhanced care and also reasons cited for registered staff when costed against covid 19 costs.

Expense Parent Description	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 CURRENT MONTH VARIANCE (against budget)
Nursing Unregistered Substantive	Ward	223.8	238.0	249.3	270.3	283.7	53
	CV19 Costs	130.4	103.6	121.2	113.4	84.7	(84.7)
Nursing Unregistered Substantive Total		**354.1**	**341.6**	**370.5**	**383.8**	**368.4**	**(31.7)**

Table 5

Overseas Nurse recruitment:
During the pandemic the NMC opened an emergency register in recognition of the value and contribution of staff established within organisations and working towards obtaining their NMC PIN. Of the remaining nurses that our Trust was employing, all joined the temporary register. This can be observed in the increase in substantive registered nurses in May. The NMC decreed that the staff joining the emergency register would still be required to complete the OSCE training program and exams. The remaining 22 nurses completed the exams in August and 19 passed successfully. 3 will retake as soon as possible.

No nurses from overseas joined the organisation in July and August due to travel restrictions. A further 3 OSN are scheduled to commence in the organisation in October following arrival in September and a period of isolation. Further interviews to maintain this pipeline are due to continue in September.

New starters

	July 2020	August 2020	Commencing from September onward
Registered Nurses	4	6	23
Non-Registered	5	6	16

Table 6: Data from HR inductions

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

While fall rates did decrease in July, with occupied bed day rates also reducing, they increased again in Augusts. This is potentially related to the high incidences of patients with cognitive impairment. Recruitment to the falls lead role has gone back out to advert which is disappointing. The education team are supporting the delivery of a falls conference day in November to spread awareness and learning.

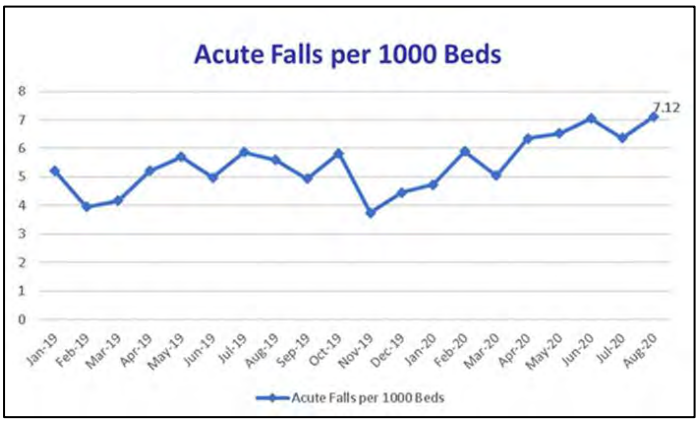


Chart 6

Pressure Ulcers

July saw an increase in hospital acquired pressure ulcers (HAPU) to 20 from 16 the previous month (chart 7). There was no further increase in August. Learning continues, with the Tissue Viability Team consistently engaging staff during interventions on wards/departments. Digital platforms have been developed in response to particular themes identified and staff directed to national digital resources. Successes have been demonstrated following support to Ward F7 particularly, resulting in a decrease in incidence. Learning from this level of intervention will be scoped to seek other opportunities for bespoke improvements

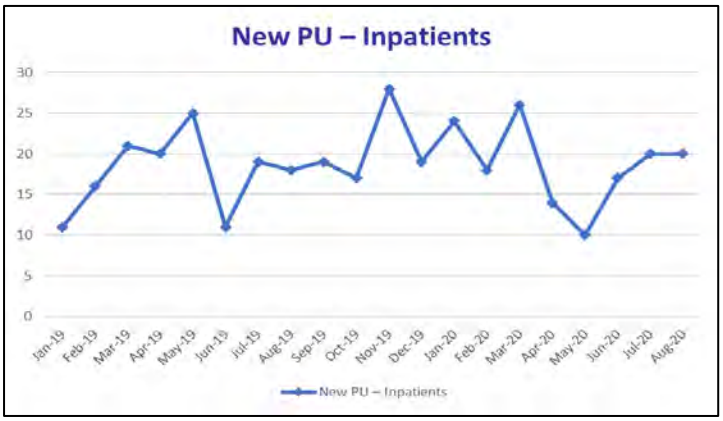


Chart 7

8. Compliments and Complaints

Table 8 demonstrates the incidence of complaints and compliments for this period. There has been an increase in complaints compared with the previous months. This reflects Pre-Covid levels and is likely due to a relaxing of visiting restrictions and to the return of many clinical services. The complaints team are reviewing the complaints investigation process to strengthen the identification of delays. Themes around the communications of new ways of working following covid have caused some concerns from patients and relatives. This has led to initiatives including improved patient information which articulates the reasons for changes in service provision to support infection control practices

	Compliments	Complaints
April 2020	14	8
May 2020	14	9
June 2020	8	3
July 2020	7	21
August 2020	18	21

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 were four red flag incidents reported in July – 3 delayed induction of labours and 1 delay in a 3rd degree tear repair. This is reflected in the Midwife to birth ratio for this month below.
- There were two red flag incidents reported in August – 2 delayed, grade 2 Caesarean Sections.

All have been investigated and no harm or adverse effect were found to be caused by the delay.

Midwife to Birth ratio

In July 2020 the Midwife to Birth ratio was 1:30 this is the upper limit of a safe ratio, Birthrate+ recommend a Midwife to Birth ratio of 1:27.7
In August 2020 the Midwife to Birth ratio was 1:27.

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 July 2020 we achieved 84% compliance and in August 2020 74% compliance. The status is currently being documented on the daily safety huddle sheet, however we have noted the limitations of this, for example in times of escalation the labour suite midwife may need to care for a woman whilst awaiting a community midwife to attend. This may only be for 5 minutes but on the daily Safety Huddle sheet the rationale, length of time etc. is not captured. Birthrate+ acuity tool has now been purchased and training commenced. The tool will capture the supernumerary status of the labour suite co-ordinator 4 hourly and if not compliant it will enable the data to have more narrative. This will inform workforce planning and establishment setting so that the service can provide informed assurance on supernumery status and senior oversight of the department.

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. During July and August audit training workshops were delivered to the senior nursing team to be able to roll out the acuity and dependency audit in September 2020. These workshops which were delivered virtually has provided robust audit training to 64 members of the senior nursing team. This will ensure that data collection reliable and informed by staff that are engaged with the audit program. 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)

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 and the senior nursing team will commence in October.

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
- National Quality Board red flags to be added to Datix to capture staffing incidents more accurately
- Monthly roster KPI meetings to be re-established to review retrospective roster control and prospective staffing plans and shortfalls
- Birth-rate+ tool to be used to review and provide recommendations on Midwifery establishment

Appendix 1a. Fill rates and CHPPD. July 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				
A&E	5,978.75	5,565.00	2,127.50	2,124.17	2,456.75	2,624.25	690.00	1,130.83	93%	100%	107%	107%	N/A	N/A	N/A	N/A
AAU	2,091.00	2,016.92	1,623.75	1,610.25	1,782.50	1,686.00	1,150.00	1,173.00	96%	99%	95%	102%	529	7	5.3	12.3
Cardiac Centre	2,688.00	2,748.50	1,247.33	1,234.08	1,782.50	1,736.50	706.50	621.00	102%	99%	97%	88%	626	7.2	3	10.1
Critical Care	3,270.00	3,384.00	473.00	495.25	2,862.00	2,896.50	121.00	121.00	103%	105%	101%	100%	193	32.5	3.2	35.7
Glastonbury Court (CAB)	714.50	742.50	1,074.25	1,049.75	713.00	702.00	542.50	598.00	104%	98%	98%	110%	617	2.3	2.7	5
Midwifery Services	3,782.50	3,902.75	1,436.00	1,613.75	2,968.50	2,784.08	1,064.50	968.00	103%	112%	94%	91%	N/S	N/S	N/S	N/S
Neonatal Unit	1,091.50	1,103.50	228.00	204.00	1,104.00	1,044.50	264.00	228.00	101%	89%	95%	86%	N/S	N/S	N/S	N/S
Rosemary Ward (CAB)	682.00	1,020.00	1,065.00	1,030.00	713.00	713.25	542.50	868.75	150%	97%	100%	160%	573	3	3.3	6.3
Ward F1	1,219.00	1,455.50	713.00	758.75	1,069.50	1,265.00	0.00	217.50	119%	106%	118%	100%	212	12.8	4.6	17.4
Ward F10	1,426.00	1,586.00	1,409.00	1,323.50	1,069.50	1,030.00	1,067.00	1,303.50	111%	94%	96%	122%	724	3.6	3.6	7.2
Ward F12	575.00	755.50	346.50	328.00	712.00	652.00	356.50	365.50	131%	95%	92%	103%	203	6.9	3.4	10.3
Ward F14	744.00	783.50	156.00	165.00	744.00	719.00	0.00	0.00	105%	106%	97%	100%	119	12.6	1.4	14
Ward F3	1,368.50	1,471.50	2,133.50	2,342.50	1,023.50	1,322.50	1,415.00	1,605.00	108%	110%	129%	113%	870	3.2	4.5	7.7
Ward F5	1,426.00	1,634.50	1,408.50	1,482.00	1,069.50	1,209.00	713.00	706.00	115%	105%	113%	99%	766	3.7	2.9	6.6
Ward F6	1,644.50	1,904.00	1,594.50	1,527.50	1,046.50	1,057.50	701.50	816.50	116%	96%	101%	116%	869	3.4	2.7	6.1
Ward F7	1,380.00	1,519.50	1,948.50	1,636.50	1,380.00	1,428.00	1,741.00	1,514.00	110%	84%	103%	87%	854	3.5	3.7	7.1
Ward F8	1,426.00	1,449.00	1,426.00	1,408.00	1,426.00	1,350.50	1,069.50	1,149.50	102%	99%	95%	107%	759	3.7	3.4	7.1
Ward F9	1,426.00	1,466.00	2,135.50	1,863.00	1,069.50	1,056.50	1,419.50	1,508.50	103%	87%	99%	106%	943	2.7	3.6	6.3
Ward G1	2,839.00	2,354.73	1,057.50	1,007.50	713.00	712.50	356.50	372.50	83%	95%	100%	104%	372	8.2	3.7	12
Ward G3	1,424.50	1,397.75	2,123.00	2,211.25	1,042.00	1,045.50	1,069.50	1,706.58	98%	104%	100%	160%	944	2.6	4.2	6.7
Ward G4	1,583.00	1,474.50	2,079.00	2,130.75	1,064.50	984	1,426.00	1,520.50	107%	96%	103%	118%	915	2.7	4	6.7
Ward G5	1,340.50	1,382.25	1,892.10	2,373.60	1,069.50	1,083.33	1,012.00	1,727.00	103%	125%	101%	171%	927	2.7	4.4	7.1
Ward G8	2,139.00	2,084.75	1,784.00	1,796.75	1,426.00	1,398.50	1,063.00	1,393.33	97%	101%	98%	131%	798	4.4	4	8.4

Appendix 1b Fill rates and CHPPD. August 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	679.00	1,012.75	1,034.50	1,052.50	713.00	746.50	542.5	752.25	149	102%	105%	139%	602	2.9	3	5.9
Glastonbury Cour	660.00	724.50	1,058.00	1,127.50	690.00	716.00	542.50	536.00	110	107%	104%	99%	620	2.3	2.7	5
AAU	2139	1996.25	2495.5	1781	1782.5	1622.5	1426	1183.5	93	71%	91%	83%	446	8.1	6.6	14.7
Cardiac Centre	2,713.00	2,590.00	1,223.00	1,151.50	1,782.50	1,689.00	713.00	644.00	95	94%	95%	90%	620	6.9	2.9	9.8
F10	1,426.00	1,397.00	1,406.50	1398.25	1069.5	1043.5	1069.5	1416.75	98	99%	98%	132%	768	3.2	3.7	6.9
F8	1,426.00	1,388.00	1,409.50	1,318.50	1426	1,345.50	1,069.50	1,193.50	97	94%	94%	112%	728	3.8	3.5	7.3
F12	552.00	694.50	356.50	356.50	713.00	701	356.50	368.00	126	100%	98%	103%	229	6.1	3.2	9.3
F7	1,426.00	1,403.00	1,958.50	1,708.50	1,391.50	1381	1,767.00	1,474.00	98	87%	99%	83%	463	6	6.9	12.9
F9	1,426.00	1,452.00	2,134.50	1,911.00	1,069.50	1,065.50	1,426.00	1,469.00	102	90%	100%	103%	942	2.7	3.6	6.3
G1	2,276.50	2,017.73	810.00	1,040.00	712.50	680.50	356.50	384.83	89	128%	96%	108%	319	8.5	4.5	13
G3	1,415.00	1,540.00	2,132.50	2,095.50	1,046.50	1,024.00	1,069.50	1,722.92	109	98%	98%	161%	962	2.7	4	6.7
G4	1434	1,290.50	2,095.50	2,029.50	1069.5	963.5	1420	1479.5	90	97%	90%	104%	913	2.5	3.8	6.3
G5	1420	1403	2,119.52	2,139.27	1069.5	1076.5	1066	1680	99	101%	101%	158%	952	2.6	4	6.6
G8	2076.5	2137.583	1784.5	1731.583	1426	1440.917	1066	1202.833	103	97%	101%	113%	753	4.8	3.9	8.7
Critical Care	2,766.25	2,973.25	341	385	2,518.50	2,597.00	110.00	118.75	107	113%	103%	108%	185	30.1	2.7	32.8
F3	943.00	1,473.50	2,075.00	2,212.00	989.00	1,311.00	1368.5	1413	156	107%	133%	103%	935	3	3.9	6.9
F5	1,426.00	1428	1,403.00	1328	1058	1139.5	701.5	697	100	95%	108%	99%	753	3.4	2.7	6.1
F6	1,656.00	1,645.00	1,634.00	1,371.00	1,069.50	1034.25	713	728.5	99	84%	97%	102%	832	3.2	2.5	5.7
F11	3,721.50	3,703.25	1422.5	1219.5	2,950.50	2,644.58	1109	839	100	86%	90%	76%	0	0	0	0
Neonatal Unit	1116	1209	240	214.5	1080	875.5	368	264	108	89%	81%	72%	91	22.9	5.3	28.2
F1	1,127.00	1,357.25	563.5	706	1,069.50	1,108.25	0	310.5	120	125%	104%	n/a	0	0	0	0
F14	744.00	751.50	144	132	744.00	742.50	0	0	101	92%	100%	n/a	95	15.7	1.4	17.1
Total	34,568.75	35,587.57	29,841.52	28,409.10	27,440.50	26,948.50	18,260.50	19,877.83	103	95%	98%	109%	12208	5.1	4	9.1

Appendix 3: Ward by Ward breakdown of Falls and Pressure ulcers July AND August

HAPU

	Cat 2	Cat 3	Unstageable	Cat 4	No value	Total
APS	1	0	0	0	0	1
G7	3	0	0	0	0	3
Critical Care Unit	2	0	0	0	0	2
F10	2	1	0	0	0	3
F12	1	0	0	0	0	1
F3	3	0	0	0	0	3
F5	1	0	0	0	0	1
F9	3	0	0	0	0	3
G1	2	0	1	0	0	3
G3	1	0	0	0	0	1
G4	6	0	0	0	0	6
G5	3	0	0	0	0	3
G8 - ward	2	0	1	0	0	3
Labour Suite (CDS)	0	0	0	0	1	1
F8	1	0	0	0	0	1
F7	3	0	1	0	0	4
AAU	0	0	0	0	1	1
Total	34	1	3	0	2	40

Falls

	Harm					
	None	Negligible	Minor	Moderate	Major	Total
G7	2	0	2	0	0	4
ED	1	0	1	0	0	2
F10	11	1	2	0	0	14
F12	0	0	1	0	0	1
F3	4	0	0	0	1	5
F5	2	0	0	0	0	2
F6	9	0	0	0	0	9
F9	7	2	2	0	0	11
G1	1	0	2	0	0	3
G3	10	0	0	0	0	10
G4	6	0	0	0	0	6
G5	5	0	7	0	0	12
G8	10	0	3	0	0	13
Glastonbury Court	5	0	0	0	0	5
F8	6	1	3	0	0	10
Rosemary Ward	4	0	1	1	0	6
F7	6	0	1	0	0	7
AAU	9	0	2	0	0	11
Total	98	4	27	1	1	131

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

18. Quality and learning report – Q1

To ACCEPT the report

For Report

Presented by Susan Wilkinson

Trust Open Board – 2nd October 2020

Agenda item:	18			
Presented by:	Sue Wilkinson – Executive Chief Nurse			
Prepared by:	Governance Department			
Date prepared:	September 2020			
Subject:	Quality and Learning report			
Purpose:	X	For information		For approval

Executive summary:

This report provides a summary of key learning points, trend analysis and opportunities for improvement that have arisen from in the quarter ending 30/06/20.

Information has been obtained from the following data sources:

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

Key highlights in this report are as follows:

- PSIRF update including **requirement for formal Board minute**
- HSIB reports
- Raising concerns: pathways for staff and learning examples

Please note:

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

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

Trust ambitions	Deliver personal care	Deliver safe care	Deliver joined-up care	Support a healthy start	Support a healthy life	Support ageing well	Support all our staff
		X	X				X
Previously considered by:							
Risk and assurance:							
Legislation, regulatory, equality, diversity and dignity implications							
Recommendation: 1. The board to **minute** wording as set out in PSIRF (section 2.)							

Activity within the quarter

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

1. Learning themes from investigations in the quarter

SI RCA reports submitted in Q1

There were 11 SI reports submitted in Q1. There were no reports which were collaborations with another organisation in the quarter. All cases which included a patient's death have the final report reviewed by the 'learning from death' group to determine preventability (there are no relevant cases for Q1).

NB: One incident investigation completed in Q1 fell within the wider 'loss to surveillance / loss to follow-up' pathway. It has been agreed that all actions from these individual SI reports and the mitigations / actions listed on the associate risk register entry RR 4002 will be incorporated into the wider trust wide CQC Improvement plan (ref. no. 6/30/62) to create one integrated action plan.

Incident details	Learning
WSH-IR-47782 Concerns raised by the surgical team that some patients are not receiving follow-up appointment after having an 'Aneurism' scan (AAA).	Root causes: It was acknowledged that the local AAA patient surveillance system stopped functioning and when results were received there was no evidence of action being taken for further follow-up. Patients missed their surveillance clinical reviews and the trigger to rebook their next scan. In some cases these patients were not followed up due to human error, because results were not actioned in a timely manner and the Trust did not have a policy in place covering the endorsement of results. In conjunction with this the introduction of the e-Care system purging process meant that result notifications messages in consultants' message centre in-boxes were purged after 45 days when showing a 90 days option without making clinicians aware. Lessons Learned: • Need to agree and implement a standardised system of endorsement for results across the Trust in order to be able to monitor performance.

Incident details	Learning
	• Need to ensure visiting consultants are linked in to their division's business meetings, clinical governance processes, training requirements, Trust communications and significant process changes. • Interaction between the clinical incident and clinical risk management processes could be improved. Actions: 1. Develop and introduce a Trust guideline for the management of surveillance including ongoing monitoring and audit. 2. Implement an internal professional standard for the endorsement process for results across the Trust. 3. Conduct a full review of all vascular surveillance pathways. 4. Implementation, review and monitoring of the new vascular virtual clinic pathway. 5. Review content of all clinicians e-Care training for inclusion of message centre functionality. 6. Ensure robust clinical risk assessment and communication is undertaken for all e-Care practice with implications of change to clinical practice. 7. Ensure all clinical staff receives mandated annual e-care training as per their job specific roles. 8. Ensure that visiting consultants are linked in to their division's business meetings, clinical governance processes, training requirements, Trust communications and significant process changes. 9. Further develop the common process areas in which clinical risk assessment and incident management to ensure a consistent and combined approach. 10. The Trust board should receive and review this report. Shared Learning: Share this report openly with all patients and families. Direct feedback to all clinicians involved in the investigation, discussion at Clinical Directors Meeting and feedback to other trusts that are part of the Vascular Network Learning bulletin and presentation to be developed summarising the outcome of the case and learning with the case presented at Trust shared learning events PGME education event and at each Divisional Governance Meeting Wider distribution of the report outcomes and learning to be sent to all clinical specialty teams including their administration and service management.
WSH-IR-55544 Patient not invited for follow up mammogram	Root causes: This was identified as a human error combined with documentation issue linked to e-Care limitations around transmission of MDT findings; requiring a manual process to update a database. This event occurred when a 'page 2' was not noted and three patients were missed off the database update (although only one was actually 'lost' from the system). A look back exercise found no other cases in a two year period. Actions: 1. Patient's details to be added to the symptomatic annual follow up database 2. All report boxes to have appropriate headings even with a continuation of category 3. Review of administration process 4. Review if electronic system can automatically update and add track and trigger tool to electronic records. 5. Radiology reports documentation to use 'Page X of Y' notation and 'please turn'

Incident details	Learning
	6. To be captured as a risk on the radiology risk register and the eCare risk register Shared Learning**:** Surgery and Clinical Support Governance meetings, Radiology and Breast Care Team meetings Shared Learning events, bulletin and at Divisional Governance Meetings. Incident to be added to wider multiple lost to surveillance case for learning.
WSH-IR-56246 Delay in clinical investigation with potential adverse effect on prognosis	Root causes**:** 1. Delay in escalation at point of failed intubation during first diagnostic procedure **2.** General anesthetic lists for diagnostic endoscopic procedures are not routinely scheduled and are organised on a needs basis. Lessons Learned**:** To ensure clear pathways of escalation at the time of failed procedures with clear channels of communications. Actions**:** **1.** Option appraisal for provision of regular list for diagnostic endoscopy procedures under general anesthetic. **2.** Explore process for communication channels and upward escalation. **3.** Formulate a SOP to capture this information. Shared Learning**:** Through a shared learning bulletin, at the patient experience committee meeting and through the clinical support governance steering group
WSH-IR-55255 Error in the type of food given to post-operative patient resulting in food bolus obstruction, pneumonia requiring tracheostomy, leading to treatment on ITU and urgent gastroscopy.	Root causes: Dietary status displayed above the bed space did not specify sloppy diet. Although the patient was on a normal diet in terms of the menu provided, they had been advised to choose sloppy items of food due to potential associated risk. Lessons Learned: To ensure accurate, up to date information is displayed above the patient's bed space. In future specific information around dietary advice will be documented clearly for all staff to view. Actions: 1. Each Registered Nurse will now incorporate several checks into their daily routine each morning, lunch and evening drug rounds. Regular checks on e-Care documentation will then be important in keeping up to date with all recent clinical decisions. This will ensure that accurate information around the patient's dietary status is clearly displayed throughout the day. 2. The Nurse in charge will communicate any highlighted points from the Board round to the relevant Nurse and Patient, ensuring communication is accurate and timely. Shared Learning: The incident has been shared with all ward staff through the ward bulletin, the ward Governance Meeting and in the 'Matrons message'. A surgical Consultant attended the ward Governance Meeting to ensure that the advice and learning would be shared to their peers and to their junior teams. It will be included in a future Shared Learning bulletin and as a case presentation at safer surgery
WSH-IR-56961 Occurrence and deterioration of Pressure Wound	Root causes: An air mattress should have been fitted to the patient's bed during their stay on F7 as the pressure ulcer continued to decline The patient was at increased risk of pressure damage due to their on-going complex clinical comorbidities in particular the bypassing urinal catheter causing moisture damage.

Incident details	Learning
	Unclear documentation regarding moving and handling methods has questioned whether there was a shearing injury which has impacted on the wound. Actions: 1. To ensure all wards have supply of slide sheets and hoist. 2. To consider capturing method of manual handling as part of nurse rounding. 3. Discuss at Governance meeting how best to embed flowchart guidance into SystemOne and policy. Shared Learning: Reflection of the incident to be shared with all Community Teams via CREWS newsletter and in the Medicine Division Governance meeting.
WSH-IR-56525 Inappropriate use of MCA / failure to complete Section 5:2. Patient held against wishes.	Root causes: There was unclear communication with patient regarding which assessments had been carried out and the implications they had for their freedom to leave the hospital. Lessons Learned: There was a lack of knowledge and understanding in the required process for a Section 5(2). Information about Section 5(2) was not on the staff intranet and the documentation for a Section 5(2) was unavailable. Information and documentation about Section 5(2) need to be available to staff so they can understand the process to follow. Actions: Provide a clear process and documentation for section 5(2) Hospital command centre to hold Section 5(2) paperwork Remind teams that an MCA should have an ongoing review rather than being in place for a fixed period (e.g. 72 hours) Shared Learning: Medical and Surgical Ward Managers, Divisional Governance Meetings, Shared Learning Bulletin and Email to all consultants
WSH-IR-56475 Stillbirth	Root causes: Concealed placental abruption. Lessons Learned: Ensure are robust pathways in place to follow recommendations from *Saving Babies Lives; A care bundle for reducing perinatal morbidity* (SBL) in relation to: Clear and formal system for booking ultrasound scans for cervical length (following recommendations of SBL). Formal system to ensure women with previous preterm birth are seen by obstetrician in a preterm clinic before 12 weeks gestation. Urinary tract infection in pregnancy is a risk factor for premature labour and any signs such as proteinuria should prompt further investigation. Actions: Review current system of booking ultrasound appointments for cervical length scanning and develop a clear pathway for how these appointments are booked. Agreement with consultant body recommendations in SBL for first consultant appointment for women with previous preterm birth and inclusion in Preterm Birth guideline. Remind staff of importance of excluding UTI particularly where suspicion of premature labour. Shared Learning: Via monthly publication 'Risky Business', through the multidisciplinary team at the Women's Health Governance and through the Learning from Deaths Group

Incident details	Learning
WSH-IR-56761 Stillbirth 36^{+5}	This case was investigated using the National Perinatal Mortality Review Tool At a routine appointment at 36 weeks gestation, midwife noted patient had not been seen since 28 weeks and referred patient for ultrasound as unsure of fetal presentation and suspected possible reduced fetal growth. The ultrasound scan recorded no fetal heart movements and it was sadly confirmed as an intrauterine death that had occurred some time earlier. Root cause: The community team did not have a robust system in place which they monitored to ensure women attended routine appointments and therefore did not identify and refer a baby who was growth restricted at an earlier gestation. Lessons Learned An IUD should be considered a resus 'sensitising event' requiring timely Anti-D administration. Actions: Update clinical guideline / checklist for the management of intra-uterine death. Investigate possibility of building further failsafe into system, whereby midwives can be alerted if a woman misses window for an antenatal appointment at recommended gestations, or has not got an appointment scheduled Implement one style of database recording for all teams to ensure women on caseload do not miss appointments. Shared Learning: Through Maternity 'Risky Business'
WSH-IR-57070 Fracture to left hip following a Fall.	Root causes: Confused patient who was mobilising across to the toilet with their frame and did not see the wheels of the screen segregating the palliative patient and their family resulting in patient tripping and failing to the floor. Lessons Learned: Completion of the post fall care plan. Actions: Audit of areas to make sure that staff are aware. Shared Learning: Shared directly at the ward meeting and disseminated down to all staff members. It will be shared at a matrons meeting and ward managers meetings. All staff will be informed via an article in the Green Sheet staff newsletter.
WSH-IR-56984 Information Governance - Loss of patient identifiable information	Root causes: Reliance on paper records to carry out daily work of doctors Actions: Articles/reminders in green sheet and core brief Include incident as part of IG training T&O team to be supported in the use of powerchart touch using electronic devices Shared Learning: IG Steering group to support wider use of powerchart touch and include this incident in Information Governance training
WSH-IR-53677 Information Governance - Inappropriate use of patient information.	Root causes: Staff member accessed records in line with their role and denies discussing any information with family members. Actions: 1. Articles/reminders in green sheet and core brief. 2. Update mandatory IG training to incorporate and reinforce the importance of following IG procedures.

2. Patient safety incident response framework (PSIRF)

Background - WSFT is participating as an 'early adopter' as part of the local ICS

Requirement to draft a PSIR plan (PSIRP) signed off by Board / CCG / NHSE/I and published on trust website. Project being overseen through a cross-division, multi-professional task & finish group chaired by Richard Jones. Project leads Rebecca Gibson / Lucy Winstanley

Key milestones	Board formal minute signing off support for participation in early adopter programme	Sept Board (this meeting) to formally minute (see below)
	Development of a strategic plan incorporating stakeholder engagement consultation	To be approved at Oct T&F group meeting
	Situation analysis review of current resource and activity	Complete
	Review of local patient safety systems intelligence (incidents, complaints, current clinical risks, etc.)	Complete
	Identification of top 10 local priorities/risks for PSII plan	In progress (see below)
	Agree interventions for incidents that fall outside the PSII plan but require action or new insight	In progress (see below)
	Develop PSIRP	In progress. For Board sign off (Nov)
	External sign off – CCG/NHSE/I	December 2020
	Implement PSIRP	Phased roll out Jan 2021
	Monitor the quality of PSII findings and progress against this PSIRP	Ongoing monitoring through committee review 6 month review report to Board July 2021

Board minute required

The Board on behalf of WSFT expresses 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.

Top local priorities/risks for PSII plan – current proposed subjects

Incident type	Detail
Discharge	Failed discharges. Patient requiring unplanned readmission related to medicines management
Medication	Insulin and diabetes management leading to deterioration requiring interventional treatment
Shared care clinical pathways	Incidents affecting inpatients where the care of the patient is being managed between two or more clinical specialties and where the management of the care resulted in the patient having an extended length of stay or requiring additional treatment/surgery
Deteriorating patients	Incidents occurring out of hours where the assessment of the patient was delayed and timely recognition of deterioration through effective monitoring and actions taken to escalate
	Complex Maternity patient requiring unplanned admission to Critical Care

Incidents that fall outside PSII plan but require action / new insight - current examples

Scheme	Plan
Surveillance / follow-up	Trustwide improvement plan led by COO and overseen by SRO cluster reporting to Improvement board

Pressure ulcers developing or deteriorating within WSFT care	Process audit with agreed sampling methods, collation into a central record by Tissue viability, outcomes incorporated into improvement plan overseen by Pressure ulcer group.

3. HSIB reports

3.1 Issued in Q4 19/20 – Q1 20/21 which relate to the care of a WSFT patient

In 2020 the first HSIB reports which relate to the care of a WSFT patient have been issued and this report contains a high level summary of the learning, local review of content and any actions arising from these reports. A full action plan from each HSIB report received is submitted to the CCG. NB: This specifically excludes the peri-partum cardiomyopathy Maternal death case from October 2018 which will be reported separately in more depth in next month's Maternity Board report

Local ref.	Case (date)	Final report receipt	Key learning points	Safety actions identified following review of HSIB report and recommendations	Stage of WSFT pathway*
52213	Maternal death terminal cancer (May 2019)	Jul 20	High levels of input from the MDT for pain and symptom management (*positive comment*). High levels of individualised care to the Mother and responsive to her request to remain on the oncology ward for the TOP with senior midwifery care (*positive comment*).	No Trust safety actions/recommendations identified. This met the HSIB definition of a reportable Maternal death but was not classified as an incident locally as there were no concerns around the initial diagnosis of cancer or the subsequent maternal and medical care provided. This decision was substantiated in the HSIB issued report	3
49034	Therapeutic cooling (Sept19)	Jul 20	Need for improved communication between health and social care when care is being delivered by two different Trusts.	Communication between the WSH safeguarding midwife and Ipswich community team to discuss the expected pathway for referral of causes of concern.	3
51478	Therapeutic cooling (Sept19)	Jun 20	Need to ensure that the multidisciplinary team can explore and implement mechanisms to improve recognition of changes to planned care including considerations of human factors training.	Review of on call arrangements to improve continuity of senior review on the antenatal ward. Review the routine use of combined spinal / epidural when planning an ARM (artificial rupture of membranes) within the maternity operating theatre	3
53433	Therapeutic cooling (Nov 19)	Aug 20	Requirement for clarification on escalation pathways from the birthing unit and adherence to national guidance on the management of placentae	Review process of escalation on MLBU Trust to ensure there is clarity on the route of escalation from the Midwife Led Birthing Unit (MLBU) to the Labour suite co-ordinator and obstetric team Adhere to national guidelines for the criteria for placental examination including histology PDSA cycle to test small changes to improve compliance.	3
54269	Therapeutic cooling (Dec 19)	Aug 20	Interpretation of CTG / evaluating the clinical picture and the impact of human factors	Systems in place for human factor training for staff	3
*Stage	*1. Report received, 2. Baseline assessment of recommendations in progress, 3.action plan agreed and being implemented*				

3.2 National HSIB reports issued in Q4 19/20 – Q1 20/21

Whilst the HSIB documents are available for specialty level review and learning, there is not currently a formal structured process for receipt and responding to HSIB publications that are not specifically related to the care of a WSFT patient (i.e. national thematic reports). It is intended that this will develop as part of the wider changes following the conclusion of the TEG-led review of quality and safety. In the meantime the list below provides an example of the type of reports being published (there were none published in Q1 20/21).

Issued	Title	Hyperlink
Jan 20	Lack of timely monitoring of patients with glaucoma	https://www.hsib.org.uk/investigations-cases/lack-timely-monitoring-patients-glaucoma/final-report/
Jan 20	Delayed recognition of acute aortic dissection	https://www.hsib.org.uk/investigations-cases/delayed-recognition-acute-aortic-dissection/final-report/
Feb 20	Potential under-recognised risk of harm from the use of propranolol	https://www.hsib.org.uk/investigations-cases/potential-under-recognised-risk-harm-use-propranolol/final-report/
Mar 20	Diagnosis of ectopic pregnancy	https://www.hsib.org.uk/investigations-cases/diagnosis-ectopic-pregnancy/

4. Learning from Deaths

4.1 LfD team activity

The Learning from deaths (LfD) group, meets monthly to oversee the process associated with all learning aligned to LfD. Following a two month gap at the beginning of the COVID response since June this has moved to Microsoft TEAMs which has enabled full participation without the constraints of room capacity.

The last report gave a more detailed update on changes within the LfD team, medical examiners (MEs) and this is not therefore repeated this time around except to confirm that the full complement of MEs are now in post from September 2020.

The first edition of the LfD bulletin was published in June (see hyperlink) and the second is imminent. This will contains articles on the theme of 'Dying well' as well as the MEs 'first 60 days'.

http://staff.wsha.local/Intranet/Documents/E-M/LeadershipandQualityImprovementFaculty/docs/Learningfromdeathsbulletins/Learning-from-deaths-bulletin-May-2020.pdf

4.2 Speaking to families

The LfD team and the Patient Experience team have met and agreed future reporting pathways to ensure timely responses for shared management cases (e.g. a death review that is the subject of a complaint).

The wider issue of coordination of speaking to relatives is also being led by the Patient Experience team to ensure that families do not have to speak to several different people along their journey but also that each element of the pathway can be made aware of the relatives concerns / comments. This can be best highlighted through the (hypothetical) example below:

A family speak to the Medical Examiner who is completing the death certificate and highlight they have concerns with the care provided which they outline at that time. They are given the details of the PALS service to speak to about these concerns. The case is also referred to LfD for review. The LfD review pathway (if the family gives their consent) can involve the reviewer speaking to the family. The case has also been reported as a red incident at the time and is confirmed as an SI. Verbal Duty of Candour is required which, according to best practice would be carried out by the clinician providing care or a senior colleague undertaking the investigation e.g. Head of deteriorating patients.

4.3 LfD data

Table 1: LfD data Q4 (19/20) – Q1 (20/21)

	Deaths	Deaths with an SJR completed	SJRs classified as Poor / Very poor care	Poor care reported as an SI
Jan-Mar	302	72 (134 for SJR)	13	1 (Fall with #)
Apr-Jun	254	99 (161 for SJR)	12	0

4.4 LfD learning

Recent themes from 'learning into action' include the following:

- Rapid action – in response to comments from a distressed family, LfD escalated and communicated the need for clarity and consistency across medical and nursing teams concerning visiting rights around end of life. This was promptly responded to HoN for Medicine (MM) who confirmed that a wider project already being put into place would address this concern.

  Draft patient flow policy encompassing issues of movement throughout the Trust. Will include a flow chart with movement standards to enable an audit pathway for > 3 moves or out of hours transfers. More detail is provided in the Board report IPC BAF.

- Assurance of previous action – Following an SI in 2018 for a patient death (??) a pathway was put into place for 'front of neck access' (plan D). The LfD meeting noted that a similar case occurred on the ward in August. Although thankfully there was not a need to progress to Plan D in this case, the ward staff were able to confidently confirm that they knew where and what it was. Possible future work may surround a flow chart about escalation when Plan D is needed and the deteriorating patient group (DPG) are leading on this.

- Escalation from the Medical Examiners – The MEs raised a query about seeing a number of patients started on antibiotics without a blood culture or urine being sent. The Head of Deteriorating patient attended the monthly ME team catch-up to hear their concerns and provide reassurance that the DPG is already addressing this within its group action plan.

- Clinical concern – A case relating to access to the regional thrombectomy service was highlighted as a concern through LfD and the MEs. The patient safety team were able to provide reassurance that this had been picked up through incident reporting and the underpinning risk was being managed operationally within the Medical division.

All of the above examples (and the narrative around patient communication in the earlier paragraph) demonstrate how joined up working and communication within the wider quality and safety corporate and divisional teams can prevent duplication of effort. These are reported here in the LfD section but actually are not specific to LfD. The wider work around trust quality and safety structures and the implementation of the trust safety & learning and patient experience strategies will also enhance this.

5. Quality Walk About in Q1

During Q4 19/20 the formal Tuesday morning walkabouts ceased to continue as of 3rd March due to the Coronavirus pandemic to reduce visitation to ward areas.

The purpose of walkabouts has developed greatly from the point of evolution to a process which allows the membership to scrutinise an area for safety and quality whilst gaining an overall sense of purpose the area, highlighting not only problems or issues but achievements as well. It has also provided an opportunity for the staff to link with the executive team, NEDs and governors. However, it has been found that this does require timely reporting and a complex process to ensure the information from the walkabout is shared and disseminated.

Due to the unplanned break there has been an opportunity to further review the process to ensure the scope and outcome of the walkabouts are as efficient as possible providing assurance of safety and quality in the organisation. The purpose of the quality walkabouts have been discussed with the interim chief nurse and deputy chief nurse as part of their introduction to the trust and in light of the CQC findings this process has been re-imagined with help from our CCG colleagues.

Quality walkabouts will be redesigned to be aligned with the multi professional QA visits agreed through the Improvement Board, the first of which took place in Maternity in September.

6. Raising concerns

WSFT has in place a number of avenues for staff to raise their concerns internally including opportunities to do this anonymously. Formal pathways include talking to: line managers, member of the human resources department, trade union representative and the 'Freedom to Speak Up' Guardian.

For staff who want to raise a concern anonymously there are two available pathways:

- Fill in the reporting form (intranet link https://www.wsh.nhs.uk/Staff/Raising-your-concern/Raising-your-concerns.aspx)
- Call ext. 2612 internally to leave a message on our anonymous reporting phone-line (answerphone only)

Concerns raised through all the above methods are captured on a trust database held on a secure drive only accessible to the staff who maintain the database in HR (who receive the email messages) and senior staff in the patient safety & quality team (who host, but do not answer, the phone-line).

The database has been active since January 2020 and 33 contacts have been recorded during that time (data as at 31/08/20). Eight of these were raised through the email web-form but none through the anonymous reporting telephone line. Some staff chose to give their details and did not require anonymity.

8/33 concerns included an element of patient safety/quality and 8/33 included an element of bullying and/or harassment. There was no report of staff experiencing detriment as a result of raising their concern.

The phone line has only been used once at its initial instigation by a member of staff enquiring how the line worked and not to raise a concern. Greater thought should be given as to why it does not seem to provide a suitable method for staff to raise concerns.

Route for raising concern	
Freedom to Speak Up Guardian	3
Senior Independent Director (SID)	0
Chief Executive	21
Anonymous phone line	0
Web form	8
Other e.g. NED other than SID	1

Division / Directorate of staff member raising concern			
Medical	9	Clinical support	3
Surgical	8	Women & children	0
Community & Integrated services	1	Corporate	1
Not disclosed	5	Estates & facilities	6

Staff group raising concerns			
Not disclosed	6	Maintenance and ancillary	4
AHP	1	Manager	0
Medical	3	Senior leader	0
Registered nursing and midwifery	12	Professional and technical	1
HCA	1	Other	2
Administrative and clerical	3		

Examples of concerns raised

- A member of staff anonymously reported their concerns about the behaviour of a senior member of staff, who was named. The Deputy Director of Workforce (L&OD) raised the issue in confidence with our Consultant Clinical Psychologist lead for the staff support psychology service. An opportunity was created for the Consultant Clinical Psychologist to speak with staff member about whom the concern had been raised to offer support without referring to the concern. The support offered was welcomed. This proved to be a timely intervention as the individual was under extreme stress due to COVID-19 and their behaviour was not typical for them.
- A doctor (non Consultant level) wrote to the Chief Executive in May setting out concerns around hand-washing facilities in the theatres doffing area. This was escalated to Estates who were already aware of the issues through the maintenance schedule. There had been a plan (prior to COVID) for theatre 1 refurbishment which would have addressed the scrub sinks issue. This had obviously been put on hold due to COVID and a temporary solution had been put into place to provide working taps. It was acknowledged that this was not ideal with taps having either a restricted flow or very hot water. Theatres and Estates met to expedite a working solution and it was agreed that, whilst the areas was only for handwashing after doffing and not scrubbing, the scrub tank would be removed and replaced with three individual sinks with infection prevention approved standard taps and in the interim a mobile sink be made available.

7. Learning from Excellence ('Greatix')

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

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

9. Mitigated red risks

During Q1 there were four red risks downgraded or closed:

1) Potential transfer of haemaglopinopathy screening for pregnant women (datix id 4157)
   The risk assessment has been downgraded to Amber (Annually x Major=Amber)
   The current mitigation includes:
   - There is Trust Board level awareness of the potential transfer of SCT screening to a trust with current UKAS accreditation
   - Ongoing communication with WSFT / NEESPS / NHS England Improvement and PHE to identify clinical, technical (laboratory) and service delivery risks and ways to mitigate risk.

2) Unavailability of Paediatric Cardiac Echos (datix id 4265)
   The risk assessment has been downgraded to Amber (Annually x Major=Amber
   The current mitigation includes:
   - SOP has been developed for the urgent patient group which has been based on the national SOP
   - Pathway for clinical assessment
   - Sessional locums by a consultant with special interest in Cardiology

3) Impact of covid-19 on undertaking births in theatre (datix id 4227)
   The risk assessment has been **closed**

4) Implications for Neonatal Unit staffing in introducing the national recommendations for neonatal Transitional care (datix id 4268)
   The risk assessment has been downgraded to Amber (Annually x Major=Amber)
   The current mitigation includes:
   - Midwifery staff allocated to the baby to care for the postnatal women would attend if the called by the mother.
   - Daily discussion between the midwife caring for the woman and NTC nurse of the care plans for each baby.

10. Learning from RIDDOR incidents

There were 64 incidents in Q1 reported to the HSE under **RIDDOR**, which is an increase of 60 incidents from the previous quarter:

- One incident reported was due to moving and handling of a load
- 63 incidents reported as reasonable evidence the staff member contracted Covid-19 while at work*.

*The HSE changed the reporting definition on the 29th of May (whether or not the person's work directly brought them into contact with a known coronavirus hazard without effective control measures, as set out in the relevant PHE guidance, in place such as personal protective equipment (PPE) or social distancing). Since this date the Trust has not reported any staff positive incident to the HSE

Learning and mitigation included:

- Moving and handling training

11. Learning from patient and public feedback:

13 complaints received in Q4 19/20 - Q1 20/21 were deemed to be upheld at the time of producing this report. Actions from these were as follows:

Ref.	Issues identified	Actions and learning
WSH-COM-1667	Delays in administering medication. Poor communication in delivering bad news to families	The trust is reviewing training levels on eCare prior to agency staff starting their ward shifts. A walk around hand over has been implemented on the ward at the beginning of each day so that nursing staff can introduce new team and ensure details on patient boards are correct. Ward manager has reminded her team of the importance of ensuring patient boards are updated when they are moved in the ward. Ward manager has reminded her team to utilise lockable cabinets for patient medications. Ward has purchased steps to assist patients with getting on and off trolleys that do not lower. F9 ward manager has reminded her team to be sensitive towards families when taking observations from very poorly patients. F9 ward manager has reminded team of the importance of ensuring end of life medications are checked and administered as quickly as possible.
WSH-COM-1671	Lack of communication to family around diagnosis of dementia of patient. Patient did not pass urine for an extended amount of time and didn't eat or drink- no charts were kept to check this	Sister in charge has spoken with her team and reminded them to ensure that food diaries and fluid balance charts are completed accurately and in a timely manner. Ward staff have received refresher training on basic life support to raise their awareness of recognising a deteriorating patient. Staff will also be booked onto acute life threatening recognition and treatment and acute illness management courses throughout the year.
WSH-COM-1689	Behaviour and language used in relation to patient discharging process. Catheter wasn't checked and documented before transferring wards	Sister has reminded her team of the importance of checking patients' catheters following transfer to the ward to ensure they have not been caught up during moving. Early intervention team to increase awareness of services available across county borders. Feedback has been shared with the early intervention team for reflection and learning about the way in which they communicate with patients and their relatives.
WSH-COM-1690	Procedure was unclear during appointment which caused further distress	Patients are now reviewed by a nurse and consultant at the same time to ensure that all of appropriate information and options are given.
WSH-COM-1761	Patient being left alone postnatally with minimal care	Apologies have been given in regards to the patient been left in the recovery room alone and not getting help when needed – Staff have been reminded. Ward manager has made sure that this was discussed with the manager at the time and staff members to make sure lessons are learnt.
WSH-COM-1708	Patient was in severe pain during procedure and staff were not accommodating. Inappropriate comments were overheard when patient couldn't continue with procedure	ED manager and matron to feedback to team about professional conduct and inappropriate comments. Staff have been reminded that if a patient is unable to tolerate an gastroscopy procedure, this should be stopped as quickly as is plausible and sedation should be reviewed if appropriate before proceeding further.

Ref.	Issues identified	Actions and learning
WSH-COM-1695	6 week appointment check wasn't completed. Patient had to wait several month for birth reflections	Review birth reflections backlog and correspondence to families until this backlog has cleared Reminder to community midwives to double check that a 6 week appointment has been booked Lead consultant to discuss care from maternity assistants to ensure the level of care is kept up to the trusts standards. Review the support provided for mothers who have been in for 2+ days.
WSH-COM-1703	Patient had a number of falls whilst admitted	The trust has purchased more wanderguards for high risk patients on the ward. Sister has also reminded her team that patients at higher risk of falling should be placed in bays near the nursing station.
WSH-COM-1717	Inappropriate behaviour from staff. Lack of communication around process of appointment	Staff have been reminded not to take personal calls during appointments and that if a call is work related they should explain this to the patient who is attending the appointment. Staff have also been reminded to ensure that they clearly explain to patients that it is in their best interests to remain on hospital site for the duration of their glucose tolerance test. The staff member who treated the patient has been spoken with and reminded of the trust values.
WSH-COM-1741	Another patients notes were given as part of patients discharge notes	Ward manager will pass on feedback to her team for lessons to be learnt and has made staff aware of taking extra care when finalising discharge notes
WSH-COM-1747	Patient with dementia was discharged into a private taxi and not accompanied by staff.	Sister apologies' that the family experienced such difficulties during the process and would like to reassure the patient that this has been passed on to staff to reflect on. Further training has been rolled out to ensure risks are identified with vulnerable patients when discharging
WSH-COM-1749	Delays in covid test results	Ward manager has taken on the feedback and has changed process of getting results to members of the public to increase efficiency

19. Improvement programme board report

To RECEIVE the report, including the Trust improvement plan

For Report

Presented by Susan Wilkinson and Stephen Dunn

Trust Open Board – 2 October 2020

Agenda item:	19			
Presented by:	Steve Dunn, Chief Executive Sue Wilkinson, Executive Chief Nurse			
Prepared by:	John Connelly, Head of PMO			
Date prepared:	23 September 2020			
Subject:	Improvement programme board report			
Purpose:		For information	X	For approval

The Improvement programme board meeting, held on **14 September**, 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:

- Ten change requests were submitted for approval at September IPB.
- Nine requests were approved, including six requests to extend project end dates due primarily to interdependencies with other projects, which were identified through the Quality Assurance process to review individual plans in preparation for the SRO Improvement Cluster meetings
- Three plans have now been approved at IPB as embedded (Blue rating) including Patient Risk Assessment in ED (CQC finding No 13), approved at September IPB. Community IT Integration (CQC findings No. 8) and Community Paediatric Audiology (Plan No 68) were approved as embedded at August IPB.
- IPB approved to move Diagnostics (CQC finding No 29) to Complete (Black) in September.
- The request to move Recording Patient Pain Assessments (CQC finding No. 31) to Blue was not approved at IPB. Additional actions will be completed to improve compliance levels.
- IPB approval was received to remove Plan No. 9 from the regular IPB review schedule. RTT performance is being reviewed in other governance forums within the Trust and IPB will receive relevant updates from the work in these forums going forward.
- A maternity deep was undertaken on 25th September, supported by the CCG with results presented at the next IPB in October. Co-production will be part of IPB approach going forward to test that improvements are embedded. Joint reviews will be planned for Clinical Audit and Culture. Other deep dives may be planned according to risk
- A focus on benefits and outcomes will be maintained as part of the testing of embeddedness
- The CQC's "Should" findings are increasingly a focus in the SRO Cluster meetings and their progress will be reported through the IPB over the coming months .
- A cross cutting proposal will be presented as an additional appendix in the IPB reporting pack for approval in October. The cross-cutting approach will be designed to ensure that the relevance of all plans are considered divisionally and adopted as appropriate across the organisation.
- An IPB risk log will be developed and maintained

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	Must/ Should	Plan Version	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	MUST	**30.06.20**	Green	**30.11.20**	**Update 09.09.20: Plan remains on track to complete Nov '20. key actions presented below (1 - 5) in response to stated improvement actions.** **1. 'What Matters to You' survey feedback from 1,400 responses and 60 workshops shared at Core Brief, TEG and the executive team. Further plans to share findings with IPB and respond to feedback positively to inform decision making and board development process.** **2. JO to update re executive development programme including 360** **3. Medical Engagement Scale survey work commenced end July 2020. 'Better Working Lives' Survey being undertaken by Paul Molyneux** **4. Appointments made to psychology services led by Emily Baker to support staff through Covid-19. .** **5. IPB Papers go to Trust Board** **Other Updates via SRO Cluster and Planning Reviews:** **- A co-production approach wil be adopted going forward to support the cultural shift.** **- NHS England/I has published its 'People Plan' for the NHS and the proposal is to reflect the recommendations in this plan.** **- Merseycare presented their 'Just and Learning Organisation' findings at the 5 O'clock club. The 5-year improvement journey to date sets a context for the Trust in that the work will be ongoing and the WSFT Trust Board and Executive will agree the approach and timelines for the Trust. Relevant Merseycare policies and templates obtained and executive discussions to follow regarding training.** **- HR Business Partners rcruited to support cultural improvement with review and implementation of HR policies that is consistent.** **- BAME Chair will attend next Trust Board 02.10.20 and present first BAME Report** **- Culture: SRO plan feedback process from IPB Members to achieve consensus ref 'What does**
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	MUST	22.05.20	Green	30.11.20	Update 29.06: See 1 above. - Freedom to Speak Up Guardian position out to recruitment Update 13.07.20: - Interim FTSU Guardian in place whilst recruitment process completes. Important right person recruited and supported to lead developments hence Nov end date. - Additional actions to be added to plan to ensure required improvement happens **Update 10.08..20:** **- Interviews for a guardian completed 11.08.20. Two FTSU Guardians appointed to start w.e.f 01.10.20.** **- New Guardians will lead on lessons learned from internal audit**

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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	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	MUST	17.08.20	Red	31.12.20	**Update 14.09.20:** **Actions in the plan being progressed/delivered internally within constraints of:** **- National PSIRF programme - stalled** **- WSFT review of Patient Safety and Quality** **Expectation PSIRF document accounting for organisational changes complete 31.12.20 as approved at July IPB approval** **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** **- JD for divisional Governance Manager under review taking in to account divisional / service level requirement to support consistency ref: incident investigations, learning 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** **Update 10.08.20: PSIRF work paused due to Covid but now restarted with steering group meetings being held**
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	MUST	05.09.20	Red	31.12.20	**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 Safety 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.** **- There is progress to report regarding backfill / recruitment. It has been agreed to back-fil the vacant Band 5 post for 6 months through a secondment opportunity for a Band 6 (unspent in-year budget provides sufficient funding to cover the increased banding). Should this position be successfully filled it will, (combined with identified administrative support) enable progression of the plan as well as reinstate the wider clinical effectiveness support function (NICE and national audit oversight) . Although this will enable progression, it will have a lag period during recruitment and therefore the plan should, for transparency remains at Red.** **- Key project decision in period is not to procure AMAT software. A review identified that Life QI, and the local standalone clinical audit Access Database provide the required functionality. This may potentially be a cost saving (but only if funding for AMAT had already been allocated)**

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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; implement the LfD strategy including the specific action to streamline and centrally capture learning from local M&M reviews	Nick Jenkins	Jane Sturgess	MUST	18.6.20	Green	31.3.21	**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 is 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 patient 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	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	MUST	17.08.20	Red	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	MUST	28.06.20	Complete	31.10.20	**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 to evidence ward-level service improvement, as a direct result of feedback.**

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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	MUST	09.09.20	Green	**31.03.21**	Update 21.07.20: 1 - 5 Investigation toolkit review work progressing - completion October 2020 - action group meeting fortnightly and plan is being refreshed. 6. TEG agreed to fund HR Business Partners (interviews start late July) leading to kinder, more compassionate and inclusive processes and will support an effective review of policies which is planned (next include grievance and disciplinary) and review of Just and Learning organisation (Merseycare). - Just Culture training completed out by Trust solicitors **Update 09.09.20** **- A detailed review of Plan No 5 has been undertaken since the last improvement board meeting and as a result, the request to the IPB is to agree to an extension of the project end date from 31.10.20 to 31.03.21. There are a number of interdependent actions in the plan including updating policies in the context of lessons learned from Merseycare and the recruitment of a new team of HR Business Partners to deliver a consistent review and implementation of policies and procedures which means that the end date 31.03.21 is realistic for a set of prioritised policies.** **- Plan No 5 review indicates that the overall RAG is correct and should remain green with the majory of actions green or black and no red actions.** **- A context of the cultural improvement work at the Trust is the five-year journey as presented by Merseycare and the work at the Trust will be ongoing for a number of years.**
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	MUST	03.09.20	Red	31.3.21	**Update 02.09.20** **<u>Follow Ups:</u>** **- 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.** **- 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.** **<u>Surveillance:</u>** **- e-Care worklist for Surveilance Patients being demonstrated 16.09.20 which if succesful will be rollled out to all Surveillance Pathways** **- Process to escalate overdue Surveillance will be presented at depratment meetings, divisional boards and weekly access meetings** **- No Surveillance patients being held by services are being collected to establish impact of Covid-19 on surveilance pathways** **- Prioritised SOP's in Urology and Vascular as identified in audit are being prepared.** **<u>Outpatients:</u>** **- Options appraisal will be undertaken 10.09 to agree the message centre pathway to TAC or Secretaries when appointments cannot be booked at the time. Current SOP reflects current practice and will be updated when decision is taken.** **<u>Ward Follow Ups:</u>** **Work undertaken to understand ward follow up process has identified that SOP's will need to be written as the process varies across different areas.**

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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	MUST	29.06.20	Green	31.12.20	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 considered for 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 regarding 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 BAU can 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 to 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. Update 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 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 on Dec 20 completion timeframe.** **- Next steps rationalise plan before next SRO Cluster**
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	MUST	31.07.20	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 process. **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 the plan to Blue (BAU) whilst acknowledging that improvement and change in Community IT will be permanantly ongoing.**

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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	MUST	2.9.20	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:** **Cancer** **- System demonstration planned w/c 07.09.20 to develop cancer training strategy** **Diagnostics** **- Work continuing to assess the impact of new guidance on post polypectomy and post cancer resection surveillance guidance. Now reviewing patients due 2024** **RTT:** **-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 the 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	MUST	08.07.20	Red	31.12.20	**Update 14.09:20** **Request to IPB is to extend the project completion timeframe by 2 months to 31.12.20 as 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 and 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 meetings will be part of escalation mechanism** **- Daily briefings have been key in improving timeliness / now reporting in PR** **- 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 that Compliance is timely including complex patient groups and this is being addressed in the new strategy.**
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	MUST		Green	30.11.20	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 testing 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 agreed at IPB. 2. Process will be auditable from September 20 Update 10.08.20: extension approved at IPB; on track as above **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 internal 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 made any suggested changes to processes. At that point the reporting structure to audit compliance through the audit committee can commence for a period to move the plan to BAU.**

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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	MUST	26.5.20	Amber	31.05.21	Overall RAG Amber. Mandatory training has continued for new starters but not for existing staff for duration of pandemic. Current Mandatory Training Recovery Plan has been reviewed and work restarted. Update 21.07.20 - Detailed recovery planning underway: - Training sessions will resume in August although capacity reduced due to social distancing and e-learning being developed and long end date due to capacity and restrictions at Education Centre - People whose training is out of date or about to go out of date will be prioritised - Compliance data will be presented at next cluster and project end date can be reviewed - Plan to mandate PROMPT Training is in place Update 10.08.20 for Board of Directors and TEG: - Currently 86% overall compliance for whole organisation - Recovery plans in place - Training being converted to e-learning or utilising MS Teams where possible **Update 09.09.20: Compliance slightly down on last month. Mandatory training requirements have increased due to additional winter pressure recruitment and additional provision being made. This is exacerbating existing capacity issues (facilitators and accommodation). Exploring options for new ways of delivery including OOH and external providers. Issues of staff not 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	MUST	08.07.20	Blue	31.8.20	**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 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**

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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	Susan Wilkinson	Dona Bowd	MUST	08.07.20	Complete	31.08.20	**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	MUST	08.07.20	Green	30.09.20	**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 with extended completion timeline for the overall plan, as agreed at August IPB.**

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16	The trust must improve medicines management, particular in respect of management of controlled drugs, storage of patients' own medications and monitoring ambient room temperatures in drugs rooms.	<u>Controlled drugs and storage of patients own mediciation</u> 1. Review of existing policiies (confirmed as fit for purpose) 2. Ensure staff awareness of procedures and put in place systematic review of compliance 3. Ensure effective action is taken to address individual or themes of non-compliance <u>Ambient room temperatures</u> 1. Email communication to all staff to remind to escalate high temperatures to Unit Manager (regular escalations since communication.) 2. Issue included in weekly hot topics discussed at all handovers. 3. Unit manager informs pharmacy of any escalations to ensure appropriate actions if required. 4. Long term strategy: Trust wide consideration of centralised temperature monitoring	Susan Wilkinson	Simon Whitworth	MUST	08.07.20	Green	31.10.20	**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-Care or 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	MUST	26.5.20	Green	**31.05.21**	Update 21.07.20: - New WSP Manager in post and has developed action plan being reviewed in HR to ensure all actions are in place to deliver improvement actions e.g. Trust inductions for bank and agency staff may be delivered via e-learning questionnaire improving monitoring compliance and prompting completion Update 10.08.20: - Work continuing; WSP Manager will give detailed report at next cluster **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 improvement actions with action 4 requiring an extension to the overall delivery plan to review and record training.**

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Must/ Should	Plan Version	Overall status RAG	Project end date	Current status / overall RAG rationale
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	MUST	9.7.20	Green	31.10.20	**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 initial 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 process. 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 review 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	MUST	08.07.20	Complete	28.2.20	**Update 14.09.20:** **- All actions complete, 3 months assurance data being gathered as part of move to BAU process.** **- Review BAU plans at next SRO Cluster** **- Additionally, early work underway on digital system to eventually replace manual monitoring** Update 10.08.20: Review BAU Plans at next SRO Cluster - Trust Guidance now in place for managing adverse ambient temperatures - this is also a risk assessment tool. - As an additional action, Perfect Ward App will be introduced to ensure compliance with requirement around recording temperature monitoring. Action implemented, assurance testing ongoing. Update 08.07.20: Plan 20 is Black (complete) only in context of implementing all actions in current plan. However, there remains a monitoring and reporting risk around ambient temperatures as the actions in the plan are manual. - The Implementation Board may therefore need to consider the introduction of a centrally monitored, continuously recording Ambient room temperature, fridge and freezer monitoring system for the Trust at a potential cost in excess of £100k, to switch the plan to Blue (BAU), for which a business case will be required. - This initiative would need to form part of the Buildings Management Systems strategy with Estates & Facilities monitoring and maintaining the alarms and to ensure that batteries do not expire. - Existing analysis suggests that other options, including air conditioning, are unrealistic given the associated cost and the current fabric of the building. Update 13.07.20: Planned actions complete but need to understand from Board how much monitoring is required to move to BAU and adjust end date. - SW restated that compliance and action will not be dependent on centralised alarm system for maintaining temperatures. Update 21.07.20: All actions complete - BAU evidence is 3 months PW audit data - Still need to develop a log of out of range incidents
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	MUST	07.07.20	Complete	28.2.20	**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 a 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 the 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 visits.

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Must/ Should	Plan Version	Overall status RAG	Project end date	Current status / overall RAG rationale
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	MUST	07.07.20	Complete	28.2.20	Action implemented, assurance testing ongoing. Recognised that pandemic has impacted on our ability to deliver this monitoring - this is mitigated through appropriate referral to the smoking cessation advisor. **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	MUST	07.07.20	Complete	28.2.20	Action implemented, assurance testing ongoing. **Update 14.09.20: See 21**
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	MUST	07.07.20	Complete	28.2.20	Action implemented, assurance testing ongoing **Update 14.09.20: See 21**
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	MUST	07.07.20	Complete	28.2.20	Action implemented, assurance testing ongoing **Update 14.08.20: See 21**
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	MUST	07.07.20	Complete	31.1.20	**Update 14.09.20: Update required from Karen Newbury** 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**
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	MUST	13.2.20	Amber	31.10.20	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**

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Must/ Should	Plan Version	Overall status RAG	Project end date	Current status / overall RAG rationale
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	MUST	9.3.20	Red	31.3.21	See No 9
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	MUST		Black	31.12.20	**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	See No 6	Helen Beck	Hannah Knights	MUST	3.7.20	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	MUST	16.4.20	Amber	31.12.20	**Update 14.09.20: Request to move Plan 31 to Black not approved at IPB.** **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 are 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.**
32	The trust must ensure all staff complete mandatory	See No 12	Jeremy Over	Denise Pora	MUST	26.05.21	Amber	31.5.21	See No 12

20. Consultant appointment report

To ACCEPT the report

For Report

Presented by Jeremy Over

Board of Directors – 2 October 2020

Agenda item:	20			
Presented by:	Jeremy Over, Executive Director of Workforce and Communications			
Prepared by:	Medical Staffing, HR and Communications Directorate			
Date prepared:	21st August 2020			
Subject:	Consultant Appointments			
Purpose:	x	For information		For approval

Executive summary:
Please find attached confirmation of Consultant appointments.

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

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

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

Recommendation:

For information only

POST:	Consultant Otolaryngologist - ENT Department
DATE OF INTERVIEW:	Thursday, 23rd July 2020
REASON FOR VACANCY:	Replacement
CANDIDATE APPOINTED:	[redacted]
START DATE:	Monday, 19th April 2021
PREVIOUS EMPLOYMENT:	[redacted]
QUALIFICATIONS:	[redacted]

	[redacted]
NO OF APPLICANTS:	13
NO OF INTERVIEWED:	1
NO OF SHORTLISTED:	3

21. Putting you first award

To NOTE a verbal report of this months winner

For Reference

Presented by Jeremy Over

11:00 BUILD A JOINED-UP FUTURE

22. Pathology services report

To ACCEPT the report

For Report

Presented by Nick Jenkins

Trust Board – 2 October 2020

Agenda item:	22			
Presented by:	Nick Jenkins – Executive medical director			
Prepared by:	Fiona Berry Karl Love Darin Geary			
Date prepared:	8th September 2020			
Subject:	Future Pathology Services at WSFT 2020/21			
Purpose:		For information	√	For approval

Executive summary:
The cessation of the current pathology partnership arrangement presents an opportunity to improve the provision of pathology services within WSFT and associated stakeholders.

This paper outlines proposals for transforming pathology provision from the WSFT site, seeking to consider provision of this service in the 'new normal' NHS environment as a result of the COVID 19 pandemic.

This paper has had input from pathology service but special thanks must be given to the following contributors: Linda Johnston, Marcus Milner, Sue Partridge, Rebecca Tilley, Matthew Larkin, David Cusack, Mohammed Elkarim, Graeme Ellis, Mike Wallis, Emma Scrivener.

Despite the unforeseen circumstances in which WSFT finds itself, there is, with the correct investment, an opportunity for the Trust to radically improve the pathology service provision. To fully exploit this opportunity, the Trust should seek to deliver the following:

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

The authors have sought to involve the primary stakeholders from all pathology disciplines in this document. The previous pathology strategy papers produced in January 2019 and June 2020 have been used as a basis for this paper.

<table>
<tr><td rowspan="2">Trust priorities
[Please indicate Trust priorities relevant to the subject of the report]</td><td colspan="2">Deliver for today</td><td colspan="2">Invest in quality, staff and clinical leadership</td><td colspan="3">Build a joined-up future</td></tr>
<tr><td colspan="2">√</td><td colspan="2">√</td><td colspan="3">√</td></tr>
<tr><td rowspan="2">Trust ambitions
[Please indicate ambitions relevant to the subject of the report]</td><td>Deliver personal care</td><td>Deliver safe care</td><td>Deliver joined-up care</td><td>Support a healthy start</td><td>Support a healthy life</td><td>Support ageing well</td><td>Support all our staff</td></tr>
<tr><td></td><td>√</td><td>√</td><td></td><td></td><td></td><td>√</td></tr>
<tr><td>Previously considered by:</td><td colspan="7">Trust Board have considered previous versions of the strategy.</td></tr>
<tr><td>Risk and assurance:</td><td colspan="7">Risk is being managed robustly for both the dissolution of NEESPS and the future WSFT strategy.</td></tr>
<tr><td>Legislation, regulatory, equality, diversity and dignity implications</td><td colspan="7">UKAS, MHRA and NHSE/I are engaged in the development of the strategy.</td></tr>
<tr><td colspan="8">Recommendation:
The Board is asked to approve the strategy.</td></tr>
</table>

Contents

1. Background

On 27th April 2020, notice was given that the that North East Essex and Suffolk Pathology Service (NEESPS) networking arrangement will cease between the host, East Suffolk and North East Essex Foundation Trust (ESNEFT) and West Suffolk Foundation Trust (WSFT), no later than 31 October 2020.

The letter informing NEESPS colleagues working at WSFT was shared with WSFT based pathology staff at a face to face briefing on 28th April 2020, followed by written email confirmation to all relevant staff.

Subsequently, a joint working group has been set up between WSFT and ESNEFT to handle the termination of the current working partnership; collaboration being key to this progress. The primary aim of this project is to consult with all ESNEFT and PHE employed staff at all 3 hospital sites and to facilitate TUPE of staff based at WSFT site, to be employees of WSFT. Consultation finished on 18th October 2020. Various joint workstreams cover all necessary aspects of the dissolution.

A fixed term senior Transformation Manager has been recruited in August along with a Senior Pathology Services Manager, via bank. The Senior Pathology Services Manager has significant operational experience to support the service at this time. Local WSFT working groups have also been set up to replicate the dissolution workstreams, which focus on WSFT related issues and actions. Engagement with WSFT Contracts, Finance, Governance, Human Resources, Information Technology, Procurement, BI and WSFT based senior technical lab staff supports the project.

The first action of the main local WSFT working group, has been to commission a review of the current service provision in each pathology discipline, including the provision of a high-level pan-pathology overview of plans for this service post October 2020, when WSFT will have greater autonomy of the running of this service.

Running in parallel to the dissolution of NEESPS, is the transfer of the Microbiology service from PHE to WSFT and ESNEFT respectively. The planned date for this transfer is to, 31st October 2020. The planning of the future of microbiology is being included in the pan-pathology transformation strategy.

2. Considerations

2.1 Contracts

2.1.1 Current issues

All existing contracts held by NEESPS have been received and are being reviewed by senior contract colleagues via the Joint Working Group. All contracts post 31st October 2020 will either be novated to WSFT or WSFT will continue to be a partner to a contract, primarily held by ESNEFT. All contracts will have robust and commercial contract management to strictly manage spend with output.

The Community Pathology Contract commissioned by West Suffolk Clinical Commissioning Group (WSCCG) is due to expire at the end of October 2020.
WSFT needs to continue to provide the GP work and much of the future strategy focuses on how WSFT can improve the service offering to PCN's and GP colleagues, including data provision and more effective communication.
ESNEFT have approached the CCG to provide all community pathology work across the East and West. This could signify their future intentions and pose a significant risk to WSFT. However, in the September 2020 NEESPS Strategic Board, ESNEFT verbally provided assurance that they have no intention of doing anything which would destabilise any existing provider or laboratory. Of course, WSFT cannot be assured until a signed statement of intentions is made available by ESNEFT.
The current CCG proposal, subject to confirmation, is that WSFT will be listed as mandatory subcontractor to ESNEFT, to provide the services in the West. Critical to the future strategy is i) engagement with the CCG to ensure that WSFT can provide a high quality and competitive service when re-tendered and ii) to gain accreditation as early as possible.
The Pathology Transformation Manager has engaged with WSCCG to be involved with the future design of a commissioned community pathology service and is part of the stakeholder group. This will ensure that WSFT can design a service which will align with the proposed tender strategy.

2.2 Quality and Governance

2.2.1 Current concerns

The approach to quality and governance (Q&G) by NEESPS has been to separate Q&G from operations. This approach has led to a lack of overall ownership of delivery of pathology services. The governance structure of NEESPS has continually changed, leading to confusion amongst staff.

This approach introduced a number of issues for WSFT. There is a disconnect with WSFT Governance Structure. The lack of joint arrangements was identified during both MHRA and Histology UKAS visits to WSFT.

2.2.2 Future proposal

Pathology governance will be fully re-established through the current WSFT Clinical Support Services governance framework, giving full accountability back to the Division. The proposed structure is attached under Appendix 1. This will have some impact on the corporate governance team, but this is expected to be minimal as the team currently continues to work in collaboration with NEESPS staff.

WSFT has identified the need for an overall pathology quality/training lead, with speciality quality leads in each discipline, who should ideally also have some form of operational role. The structure includes a Band 8a Quality Manager role with the support from a B7 Q-Pulse Administrator.
The Pathology Transformation Manager is engaged with WSFT Health & Safety Manager who also manages the Datix team to explore the future WSFT strategy for risk and quality management, in light of WSFT purchase of the new Q-Pulse Enterprise QMS, which allows the solution to be scaled across the wider trust. Pharmacy and Cardiology are engaged with the Transformation Manager to understand how they can implement the solution in their services.

As stated in previous pathology strategy documents, the current position with significant non-compliance against regulatory standards for histopathology, biochemistry, haematology, blood transfusion, and microbiology requires considerable investment in staff, in order to meet the expected timescales for achievement. However, should the staffing structure and levels set out in this document be agreed, coupled with the appropriate level of prioritisation of resolving Pathology issues across all departments within WSFT, it is anticipated full accreditation across all Pathology disciplines could be achieved within two years.

2.3 Workforce

2.3.1 Current situation

Whilst minimal work has transferred away from the WSFT labs, there has been a significant reduction in the staffing establishment over the last six years since the inception of the first pathology partnership.

The Consultant body is well established. The Histopathology team benefits from an Advanced Practitioner BMS, working at Consultant level within her specialist area. The Trust has access to a

Biochemical Clinical Lead, but further medical support and availability of a deputy Biochemist may be necessary to meet the requirements for UKAS accreditation.

The Consultants and laboratory staff have a close working relationship, but this can be hindered by the fact the two staff groups are employed by different organisations.

a.) Laboratory Staff Recruitment

Staffing gaps are present across all three NEESPS sites. There remains a national shortage of Biomedical Scientist (BMS) staff. Effective recruitment will remain a risk once staff are TUPE'd to WSFT, but this should not be at the escalated level to the risk currently in place for NEESPS. Once the uncertainty of the management of the WSFT lab has been removed, and the lab is working towards accreditation with investment in new equipment, it is anticipated that the recruitment of qualified and trainee BMS roles will improve dramatically. A WSFT recruitment and retention strategy is being worked on, pulling best examples from other pathology networks, the private sector and further developing our social media presence.

b.) Succession planning

Due to the national shortage of BMS staff, it is imperative that WSFT labs be accredited as training laboratories, to be sustainable. The lab has current Institute for Biomedical Science (IBMS) accreditation so can support trainees until June 2022, but UKAS accreditation will clearly further support recruitment and retention in addition to offering opportunities for service development and networking opportunities with other accredited sites. With optimal staffing levels, in house training and support for post registration specialist portfolios could easily be delivered. The Consultant body are keen to support all training and development programmes across the department. WSFT is compiling a list of all education organisations which may be able to support WSFT with offering suitable training opportunities.

c.) Temporary staff

NEESPS personnel at WSFT have escalated concerns regarding the staff bank processes in place for temporary staff having to use NHS Professionals, which have introduced delays and caused locums to find work elsewhere. This has caused issues for Phlebotomy and Lab staff alike. West Suffolk Professionals processes are more efficient and therefore it would be expected that recruitment of temporary staff would be more successful when needed. Recent examples of recruiting under WS Professionals has seen 4 staff members from the Animal Health Trust start within 4 weeks of initial engagement.

The Trust will aim to significantly reduce the number of locum staff utilised across the department (which has been as high as 80% for band 6 BMS) as locum staff greatly increase pay expenditure. A fully staffed accredited lab will be able to support succession planning with in-house training and

development. WSFT is working with the East of England Collaborative Procurement Hub on an East of England (EoE) Pathology staffing Memorandum of Understanding (MoU), which will control and align how CUH, NNUH, ESNEFT and WSFT utilise temporary staffing. This will include adhering to recruitment principles, aligned framework pay caps, preferred supplier lists and mitigation of transfer fees. This is a proven method used across the EoE when the NHSI agency caps came into force.

d) Support mechanisms for staff

Historically, many issues have arisen because WSFT based lab staff are employed by another NHS trust/PHE. However, most recently, due to the dissolution many of these have been addressed including NEESPS staff have been able to access WSFT occupational health services since 1st August 2020.

As part of the dissolution, WSFT has created a "Day 1" booklet for all staff transferring to WSFT from ESNEFT and which will then be used for any new starters in pathology. This booklet will cover all aspects from useful contact numbers, systems, training, IT, HR etc.

2.3.2 Future proposal

It is proposed that all staff within TUPE will transfer to WSFT from ESNEFT at 00:01 1st November 2020.

To ensure a resilient service capable of providing timely, compliant, and accredited medical laboratory analysis is established; a new staffing structure with increased establishment is proposed and can be found in Appendix 1.

2.4 Information Technology

2.4.1 Laboratory Information System (LIMS) – WinPath enterprise

Pathology Services at WSFT site currently use WinPath, which is hosted by ESNEFT. It is not used at the Ipswich site and is only used in the Histology and Blood Sciences departments at Colchester. Validation of WinPath was not performed to a satisfactory standard prior to its initial deployment. Any change to a new LIMS would require a lengthy tender process, an IT team to implement it and laboratory staff to undertake full system validation.

Following an options appraisal, the below table shows the recommended option and the benefits and disadvantages.

Recommended Option	Advantages	Disadvantages
WSFT will enter into an agreement with ESNEFT to	• Use of an adequate LIMS • Networking with our	• Requires completion of validation work

rent the LIMS already in use.	existing network • Is already used and familiar with staff • Validation work is planned to coincide with version upgrade	• Possible costs to share with ESNEFT • Lack of autonomy over changes (need to be agreed with the owner Trust)

WSFT and ESNEFT will have a robust contract around the continued shared arrangement for the LIMS system. This includes an improved change control process to ensure that any changes are considered equally by both parties. There are robust break clauses for WSFT to exit the current arrangement at annual intervals.

Sharing a LIMS with ESNEFT allows for results to be distributed electronically across sites using IT (once fully implemented at Ipswich and Colchester), therefore facilitating user trusts to consolidate aspects of work in one of the alliance laboratories. Moreover, a common LIMS across more than one site supports business continuity, as it allows for results to be received at the referring site electronically should work be sent away during periods of service failure. A Business Continuity Plan (BCP) will be signed between the two trusts.

WSFT has implemented Cerner Millennium (eCare) as its electronic patient record system. IT have begun drafting a LIMS options appraisal which considers all options for a subsequent solution including the eCare pathology module Path-Net in addition to other suppliers, WSFT and other trusts, including ESNEFT, would explore sharing a procurement with flexibility to award to different providers, reducing overhead procurement costs.

Whilst the validation of WinPath is planned for the next version upgrade, changing LIMS would result in staff having to start the validation process again from scratch. Furthermore, staff across all Pathology disciplines are familiar with WinPath, so any change in LIMS would require staff to adapt to and learn the new system, in addition to all the other pressures faced as the Trust exits the partnership. Purchasing a new LIMS would come at a significant cost to WSFT and would require additional specialist resource to install and train staff in its usage, however is an option which should be considered in the future.
Current issues with LIMS can be addressed by change requests being submitted by the Lab Managers. This will be a priority going forward in the short-term.

2.4.2 Quality Management System (QMS) - Q-Pulse enterprise

To successfully achieve and maintain UKAS ISO 15189 accreditation, it is vitally important laboratory staff have suitable access to an electronic Quality Management system.

WSFT approved a business case for the purchase of the Q-Pulse Enterprise QMS and the implementation of this will be in place, subject to data migration by 31.10.2020. If this is not possible, WSFT will have access equal to the current ESNEFT system until such time as a full migration is complete. WSFT have indicated to ESNEFT a risk mitigation of continued access to a version of a QMS until 31.12.2020.

Consideration will also be required as to the best methodology for reporting incidents and risks via the main NHS Datix system and what would need to be reported in the QMS, with a view to minimising double reporting.

2.4.3 Other IT considerations

Business Information Team (BI Team)

The ESNEFT BI Team provide support for running reports on Clinisys Pathmanager, which extracts data from WinPath.

The BI workstream is focusing on the transfer of responsibilities and reporting to WSFT BI team post dissolution. The proposed structure and budget allow for an additional B7 Information Analyst for Pathology.

Swift Queue

Swiftqueue is an online appointments platform for Outpatient Phlebotomy appointments at West Suffolk (since Jan 2016) and Sudbury Community Health Centre (since Feb 2016). WSFT will continue to contract with Swiftqueue separately.

Telephone booking is also available for outpatients who prefer not to book on-line; these calls are handled by the Pathology Service Desk at Newmarket, (employees of Cambridge University Hospitals). A contract will continue between ESNEFT and CUH, with ESNEFT has a business case approved for this service to be brought in-house. WSFT will re-negotiate the cost of this based on usage but will continue to contract for a service from either CUH or ESNEFT to ensure service continuity. WSFT strategy is to further reduce the use of this service desk where possible, in line with the digital agenda.

End to End Testing Process – Results Pathway

The Pathology team are keen to ensure a robust method for testing the dissemination of pathology results is set up and maintained. IT colleagues currently support this process and the lab staff are keen to ensure the accuracy of results are tested from WinPath right through to eCare, ICE and

SystmOne/EMIS GP practice management systems. This would require resource, test scripts and access to test patients/test environment.

2.5 Procurement

2.5.1 Current issues

NEESPS staff based at the WSFT site use ESNEFT's procurement system Integra to raise orders. NEESPS Managers have expressed concerns with the current processes. These include extremely low sign off values of £500, convoluted methods for ordering non-catalogue items via ESNEFT support team, and unpaid suppliers declining to deliver goods until ESNEFT have settled outstanding invoices.

2.5.2 Future proposal

Procurement functions relating to Laboratory Services at WSFT would transfer under the control of WSFT.

To achieve economies of scale and support standardising processes, agreement has been reached with ESNEFT to form a procurement alliance for equipment and consumables across the two Trusts. WSFT has recruited a B4 to Purchasing to support with Pathology workstreams. A procurement alliance will deliver greater value for money on the purchase of consumables, purchasing equipment and entering managed service contracts. An alliance also supports reducing unwarranted variation across a network in both test price and staff practice, as progressively standardising equipment over time will result in the standardisation of procedures involved in the laboratory analytical process.
Contracts have been novated to WSFT only if there is no financial disadvantage. ESNEFT and WSFT have made it clear to the market that where separate contracts are held, both trusts will be sharing procurement strategy in order to leverage NHS buying power.

2.6 Estate

Pathology services at WSFT are 'landlocked', within an outdated 1970s building. Space has been an issue for over a decade, and this enforced close working environment has proven problematic when trying to support social distancing during the COVID-19 pandemic. Any solution for the future needs to be considered alongside planning for the new WSFT build, but the laboratory cannot continue to operate effectively within the current estate if it is to improve workflow, achieve and maintain the required turn-around-times (TATs).

Priority areas for improvement include:

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

Separate from these works, several areas of pathology require repairs and redecoration. Upon consultation with Estates at WSFT, it is recommended a fund be agreed to facilitate such works. Pathology Transformation has an Estates workstream where the above matters are being considered.

2.7 Finance

The table below summarises the initial costs anticipated following the cessation of the partnership and contrasts them with the expected subsequent costs. The costs are presented net of income so that the total cost can be compared to the current SLA cost of the service so that the overall increase in costs can be seen.

	Initial Cost (£000)	**Subsequent Cost (£000)**
Income	4,608	4,608
Direct Costs	(9,538)	(9,538)
Indirect Costs	(501)	(501)
Regulatory Compliance	(70)	(70)
Service Level Agreements	(1,184)	(1,184)
Total	**(6,685)**	**(6,685)**
Current Cost to the Trust	**(6,457)**	**(6,457)**
Cost Difference	**228**	**228**
Capital Assets	(559)	(100)

The key points relating to the analysis are as follows:

- The income offsetting the costs is the West Suffolk CCG Community Pathology income and the Direct Access Pathology income attributable to the Trust.

- The staffing requirements are based on the likely needs of the service. The figures are based on detailed 'bottom up' style workings that augment the establishments of the current service.

- The pay costs have been uplifted for the increased staffing levels that are to be introduced to increase the quality standards delivered by the service. This should help the service increase its standing with regulators. The increased cost of inheriting pay incentives under TUPE arrangements has been factored into the analysis.

- The quality and management costs are based on an assessment of the resources required to enable the department to obtain and maintain accreditation.

- The costs for training have been estimated based on the Trust's commitment to improving the working environment and the quality of service.

- The costs of running the Microbiology service are based on the current cost of the microbiology SLA that NEESPS hold on West Suffolk's behalf with Public Health England. Further information is being gathered to confirm whether the cost of running the Microbiology service will increase or decrease following dissolution.

- The costs of regulatory compliance could vary in reality dependent upon the number of inspections required.

- The costs for service level agreements have been estimated based on West Suffolk's share of the current partnership cost.

- No costs have been included for estates related investment, repairs & maintenance.

- No costs have been included for Work In Progress (WIP) as the value of WIP has not yet been confirmed by PHE. In addition, payments for WIP are not included in the current version of the NEESPS dissolution principles.

- The initial cost for capital assets is high because of estimated payments to NEESPS and PHE for stock. A capital cost of £100k per annum spans both periods to facilitate an asset

replacement programme. This is particularly relevant as the capital equipment in Histopathology and Microbiology is well overdue for replacement.

- It has been confirmed that the managed service contracts held by the partnership are accounted for as revenue costs. Consequently, no additional capital budget is being requested to cover the assets that are currently paid for via managed service contracts.

- The initial revenue costs are the same as the subsequent revenue costs because all of the costs for the substantive staff required to attain the accreditation standard have been added to the initial cost. There are no plans to revise the structure in the subsequent period. If the recruitment is not agreed, the locum spend to cover gaps could amount to gross £1.2m but will be offset by permanent vacancy savings.

- The impact of inflation has not been included so that operational cost increases can easily be observed.

It is anticipated that the revenue cost of running the pathology service will not increase upon its dissolution. However, the discussions pertaining to the sharing of additional dissolution costs are ongoing. Once the necessary non-recurrent capital costs have been incurred, the provision of WSFT's pathology services can be improved.

3 Changing our networking model

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

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

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

For WSFT to acquire full control of the operational delivery, governance and quality elements of the laboratory analytical service provided on its site, WSFT will be replacing the existing model with an alliance contracting model which satisfies the networking instruction from NHSI. WSFT are approaching ESNEFT and other pathology networks where suitable to enter into alliance agreements, setting out agreed shared areas of cooperation, with each Trust taking the lead on a designated area.

The proposed shared areas are:

a.) Procurement of equipment and consumables

As mentioned in '2.5 Procurement', WSFT or other trusts within the new network agreement, would lead on procuring equipment, consumables, and maintenance service contracts to achieve economies of scale. A recent example of this is the joint procurement of the Roche Biochemistry analysers. Standardising equipment will also aid the standardisation of processes and support business continuity.

b.) Shared LIMS

As Identified in '2.4 Information Technology', maintaining the current LIMS is the preferred option. ESNEFT currently own the contract. Sharing a LIMS will allow the Lab IT Manager to participate in cover arrangements with counterparts at ESNEFT, sharing staff resource and reducing cost. ESNEFT need to complete the roll-out of Winpath to the Ipswich site for this to be valid across all three sites.

Opportunities for future collaboration

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

- **Sharing good clinical and technical practices with neighbouring accredited laboratories**

  WSFT Pathology are exploring avenues for collaboration with other accredited laboratories in the way it currently works with Cambridge University Hospitals for Haematopathology and Oncology Diagnostic Service (HODS). Should more regional labs obtain accreditation this could include networking with ESNEFT, Norfolk and Norwich, in addition to the already accredited lab in Mid- Essex, to share good clinical and technical practice, aiding WSFT Pathology staff in the maintenance of its own accreditation. This could be achieved through

joint quality meetings to share and encourage good practice, in the form of a (virtual) regional forum.

- **Research and development**
  Transferring Pathology Laboratory services to WSFT, investing in staffing and equipment, and achieving accreditation could mean the laboratories have capacity to support research work, either from the Trust (as took place in the past), other Trusts or private organisations. This work could be undertaken collaboratively with larger laboratories and could lead to income generation.

- **Digital Pathology Network**
  A distributed network for digital pathology could include WSFT, Cambridge University Hospitals (CUH) and North West Anglia Foundation Trust (NWAFT), Eastern Pathology Alliance (EPA) and ESNEFT.

4 Speciality review

Staffing proposals for each discipline can be found in the Pathology Staffing Structure documents in Appendix 1. In addition to a request for additional staffing, each discipline has outlined their equipment and operational concerns in the following section.

A number of pan-pathology projects are being progressed in the transformation including:

- Trust wide tender for temperature monitoring and mapping to include pharmacy and ambient drug fridges. Pathology installation should be complete by 31.12.2020.
- Improved planning of late clinics to co-ordinate with pathology services.
- All service areas to be provided with pathology cost reports to identify duplicate testing/ordering and increase process efficiencies.
- Improved data sharing with WSFT, WSCCG and GP practices.
- New communication strategy to introduce the new pathology service and engage all stakeholders in the future of the pathology service.
- All send-away tests will be subject to a benchmark exercise (mini-tender) to establish best value, supported by robust SLAs and SOPs as per accreditation requirements.
- Digital pathology is currently being explored nationally, following CUH's recent board approval.
- LIMS – options appraisal for the future solution.
- A robust and innovative recruitment and retention campaign is being developed with HR, learning lessons from other pathology providers both private and public.
- Duplicate testing – a project being led by PMO which is being taken to the CCGM in September 2020.

4.1 Cellular Pathology

Due to reduction in routine work at the start of the COVID outbreak, the Cellular Pathology team have with support from the Consultant body, reduced their back-log and increased the proportion of cut-up that is performed by BMS staff. This is to continue but will have to flex dependent on the current staffing situation and any vacant positions.

Storage of slides for MDT is an issue within this department and will need to be addressed when reviewing the optimal layout for this department, once equipment upgrades have been agreed.

Most of the equipment within the laboratory is over the manufacturer's guaranteed lifetime and will need to be replaced, according to an agreed schedule, which will be established through assessment of risk to the service of breakdown and loss.

Cellular pathology has applied for UKAS accreditation under ESNEFT, submitted September 2020. The legal entity of the application will be changed to WSFT accordingly, post dissolution. This will be the first WSFT laboratory to apply for accreditation and will set a benchmark for progressing the other disciplines.

Cellular pathology will continue to utilise the existing CUH cancer pathway network for histopathology but is also exploring further research opportunities with services, such as ENT, across both trusts.

WSFT will retain the current on-site service which works closely with surgical and oncological teams.

WSFT will continue to use CUH for tertiary referral centre work and further strengthen the existing network with Birmingham for molecular testing of malignancies.

WSFT will continue to utilise the existing molecular analysis networks for histopathology with Birmingham and CUH.

Digital networking is key for the success and progression of cellular pathology.

WSFT will utilise other labs for immunochemistry including CUH and ESNEFT for infrequently requested tests. Any send-away tests will be included in the joint WSFT and ESNEFT referral test benchmark project, identifying highest quality service for best value, aggregating volume where financially beneficial.

4.2 Biochemistry

Roche 8000s have now been installed and are live and significant improvement in lab processes has been noted since installation. The new P612 (standalone pre-analytical) has also been installed.

As part of this recent upgrade to Roche equipment, the Vitamin D generation 2 assay was verified and deemed acceptable to use which may negate the need for a mass spectrometer to process Vitamin D.

Current Tosoh G8 analyser processes both HBA1C and Haemoglobinopathy samples. Tosoh G8 is currently part of the Roche contract and is due to be upgraded this year, however, the current COVID situation is impacting this. Consensus within Biochemistry and Haematology is to keep current set up with upgrade to the instruments.

Additional MLA support has been allocated for out of hours during COVID pandemic.

Spectrophotometer required for processing Xanthochromias. Current situation of sending Xanthochromias to Colchester is not ideal due to delay in reporting and cost of sending transport as these require processing 24/7.
Protein electrophoresis was removed from WSFT site and these samples are processed at Ipswich. Biochemistry would be keen to explore bringing this back in house and this could be done under the Roche contract or separately depending on the set -up after lab staff return to WSFT. This is likely to cost in the region of £12k pa for the lease of this equipment. An options appraisal is being drafted to consider the costs of bringing this in-house vs. outsourcing to ESNEFT or another lab.

Options are being explored to bring other tests in house. Currently due to verify BNP, CA19-9, AFP, Caeruloplasmin & PCT.

An options appraisal is being drafted to look at the screening of tests on site before sending away for confirmation specifically high-volume tests i.e. ANA and TTG and CCP antibodies.

4.3 Blood Transfusion & Haematology

Haematology

Bone marrow aspirate reports are not being uploaded automatically onto Clinisys WinPath or Cerner eCare and this requires additional functionally within NPEx, as soon as possible as manual processes are not sustainable. The manual report process means that results have to be entered by hand locally and this give rise to transposition errors. It is also essential that the same reference ranges are used in both IT systems.

Antenatal screening for Haemoglobinopathy has remained with WSFT (contract for WSCCG is with this Trust) for patient safety reasons.

A review of the phlebotomy service is being explored with WSCCG and other commissioners whom we provide the service to e.g. SNCCG.

WSFT will continue to network with CUH for HODS testing however, WSFT are exploring how we can network with North West Anglia to address the increasing prices being charged by CUH.

WSFT is drafting an options appraisal for the repatriation of some tests currently sent to CUH including clotting factor assays, Anti-Xa assays for other anti-Xa drugs.

The WSFT Cepheid PCR analyser will be shared with Microbiology.

INR tests for monitoring patients on warfarin in the community to remain at WSFT.

Haematology Equipment:

- Sysmex XN-2000 FBC analysers installed 2015 (under Ipswich Sysmex MSC)
- Third Sysmex XN FBC analyser due to be installed November 2020 (under Ipswich Sysmex MSC) in part exchange for Inversa below
- Vitech AutoCompact ESR analyser installed 2018 (reconditioned) (reagent rental contract with Advanced instruments)
- Vitech Inversa installed 2015 (part of Ipswich Sysmex MSC)
- Werfen ACL TOP 550 coagulation analysers installed 2018 (under Ipswich Werfen MSC)

Logistics

- ERS Medical logistics provide pathology courier transport; all collections and deliveries can be tracked.
- Service provides GP surgeries with consumables (ordered via pathologyservices@wsh.nhs.uk and packaged by Specimen Reception team) and collects specimens for all disciplines for delivery to Pathology Specimen Reception

ESNEFT and WSFT have agreed to extend the current ERS contract to 1.4.2021 at which point ESNEFT will tender the requirements and have drafted a business case to bring the service in-house. WSFT will contract with the most economically viable method.
WSFT will have careful management of additional costs under the ERS contract from 31.10.2020 to 1.4.2021.

Transfusion

- WinPath.
  - Review of the original validation has been completed. It anticipated that it will take ~1 year for version 7.23 of Winpath to be available, which will be an improvement on version 7.22. This upgrade will be carefully managed by WSFT as a party to the contract.
- Equipment.

- Haemonetics blood tracking system is live as the BARS replacement.
- Grifols ERYTRA blood grouping analysers working well. The WSFT department can run on just 25% of the Griffols' capacity.

Regulatory

- MHRA
    - Inspections Jan'17, Mar'17, Jun'17 and Jan'18
- UKAS ISO15189
    - Resource required to address significant deficiencies in documentation
- CPA assessment 2014
    - Transfusion Accreditation; suspended by CPA Apr'17
    - '*Suspensions should not normally exceed a period of three months…*'
    - Biochemistry and Haematology; voluntary suspension Nov'17

WSFT will continue to refer work to RCI Colindale and NHSBT.

WSFT will have a contract with ESNEFT to take recombinant clotting factors that may go out of date to prevent wastage.

Kleihauer test to be repatriated to WSFT subject to business case approval.

4.5 Microbiology

All staff in Microbiology, except for the Consultant Microbiologists, are employed by PHE and therefore on Civil Service contracts but there are a number of staff still on legacy agenda for change contracts dating back to the TUPE transfer to TPP. Staff salaries are lower than NHS equivalent bands and pension arrangement are more favourable; the staff on legacy T&Cs have had no pay increment since the TPP transfer. This team are currently in TUPE Transfer process from PHE to WSFT with a completion date of 31.10.2020.

Molecular Microbiology: The MicroPathology service is generally cheaper, provides quicker turnaround times and better quality than NHS/PHE services in the field of molecular microbiology. However, it should be noted that for large volume testing it is not the cheapest solution and, in these scenarios, an in house or networked solution is preferable. WSFT is engaging with this private provider to establish possible opportunities.

Historically, much work has been directed to PHE Cambridge, however WSFT are exploring serology and virology networking opportunities with NNUH, Bristol & Chelmsford.

WSFT focus is on providing services previously lost where WSFT are awaiting tender date from NHSE/I expected late 2020.

On-call provision

The microbiology lab is open 7 days a week from 09.00 to 17.30 and any clinically urgent samples that arrive out of this time are sent to Cambridge PHE for rapid analysis. WSFT will continue to contract with PHE for any services required post 31.10.2020 however, it is the aim to understand how we can expand the service to provide on-site out of hours provision.

In the main these samples consist of CSF and joint fluids. The frequency and workload presented by these samples is not sufficient enough to justify the cost of a 24-hour shift system and modern techniques mean that viable and clinically useful alternative strategies exist and can be managed within the current blood science out of hours service if the following equipment is made available:

- BioMerieux FilmArray (Capital cost around £25K + each test is around £100 – workload 300 samples per year).
- Access to cell count analysers in Blood Sciences at West Suffolk

Staffing Establishment and Budget

This is being worked through in the TUPE transfer from PHE to WSFT.

Laboratory Equipment

- Most analysers at WSFT are >15 years old, and WSFT's Microbiology laboratory is ~10 years behind the times.
- PHE has recently spent around £130K on new general laboratory equipment – in the main this includes various fridges, freezers and incubators. However, it also includes a new Diasorin Liaison XL serology analyser. These were purchased with agreement with NEESPS where the netbook value would be reimbursed by NEESPS following the transfer of management from PHE.
- The laboratory has a Cepheid GeneXpert 2 slot molecular platform purchased by PHE primarily used for *Clostridium difficile* and Influenza A&B/RSV. This machine has two issues, firstly it really requires a further 2 slots to make workload manageable; and secondly; the use of the respiratory virus screening is largely cost prohibitive.
- The use of a molecular platform for screening faeces samples for routine causes of GI tract infection, C difficile DNA screening and Norovirus screening has been agreed in principle and is currently being worked up as a business case with WSFT. This is an example of where investment in Microbiology can provide WSFT with the means to improve patient flow and reduce expenditure on unnecessary diagnostic testing (e.g. cancer pathways).
- Diasorin Liaison analyser has been purchased and installed at WSFT. It is up and running for some assays, others to follow. Turnaround times are vastly improved – this platform is

capable of performing the majority of required serology testing quicker and cheaper than previous equipment.

- There is a requirement for a molecular platform to test for *Chlamydia trachomatis*, *Neisseria gonorrhoeae* in addition to respiratory virus screening. Some of this work may be suitable for a solution shared with other laboratories. However, it would be necessary for the respiratory virus solution to be onsite as results are required same day particularly in winter to facilitate more efficient patient treatment and bed management.

- Blood cultures:
  - National KPI is for blood cultures to be on a machine within 2 hours of sampling – so these should be tested on site.
  - Current machines need replacing but in the next 2-3 years
- Microbial Identification and Antibiotic Susceptibility
  - Antibiotic susceptibility testing platform is ageing and does not have the confidence of the Consultant Microbiologists
  - Better platforms are available that provide more accurate results, cheaper running costs and ultimately better patient care
  - MALDI –ToF Mass Spectrophotometer is utilised by most UK labs and would provide quicker and more accurate identification of organisms – in addition these machines, whilst a large capital outlay (~£150k), do reduce recurrent expenditure (on currently used ID systems) from £2-£3 per test to £0.02 per test
  - MALDI can be used to rapidly identify organisms in blood cultures – so the clinicians would have a result is hours rather than days
  - A MALDI is on-site and being validated
- CL3 facility and Autoclaves:
  - Both items required to sustain a microbiology service on site
  - Current CL3 has a lifespan of 2-3 years and current autoclave has insufficient capacity
  - Outline business case approval from WSFT being drafted as a matter of priority.

4.6 Point of Care Testing (POCT)

Within the proposed structure POCT fits in as a standalone discipline within pathology. This service is still in its infancy at WSFT and is not yet working at 'business as usual' as Band 4 team require additional training to be fully competent.

The service provision is multidisciplinary, with blood gas analysers, glucose/ketone meters, HbA1c analysers, elements of urinalysis and pregnancy testing link closely with biochemistry, whereas, Hemocues and CoaguCheks link with haematology and coagulation. Additionally, the elements of urinalysis and flu/RSV testing linking with Microbiology/Infection Prevention. A key requirement to best support growth of this service, is to ensure that the Band 4 staff remain dedicated to POCT and do not rotate across other pathology disciplines.

The team plan to recruit an administrator soon to remove the majority of the basic administration tasks, thus enabling the team to focus on training, quality, and service development.

4.7 Out-Patient Phlebotomy

The outpatient phlebotomy team has been subject to on-going staff shortages; often struggling to retain Band 2 staff, who can move on to Band 3 roles elsewhere in healthcare, once phlebotomy trained. Medical students were previously a valued source of locum cover for this team during school holidays and will be much easier to employ if WSH Professionals can be used.

Stock ordering has been problematic under NEESPS but phlebotomy will be included in the future WSFT pathology structure and will access all WSFT processes and systems.

Service development considerations include:

- Could support discharge planning by taking early morning bloods (prior to starting outpatient service provision at 7.30am) to ensure availability of results prior to discharge.
- Continue blood taking service in Macmillan Unit and consider on-going support to IP service.
- Significant scope for phlebotomy to generate income e.g. phlebotomy training for GP and private healthcare staff.
- Provision of private blood test (e.g. for overseas employment requirements. This would a robust route for invoicing of private phlebotomy patients and GP paediatric cases.
- Improvement of blood taking provision at SCHC, if the sluice room could be converted into a 3rd blood taking bay. Alternative venues with improved local access have been scoped previously e.g. Sainsbury's supermarket.

5.0 Conclusion

There has been extremely limited investment in the Pathology department at WSFT since 2010 when the EoE SHA's pathology project commenced, which envisaged the vast majority of pathology services being moved off-site at centralised pathology hubs.

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

Some investment is required to improve the working environment within the lab. This will be limited to essential work only as the Trust moves forward with plans for a new hospital build. The provision of an externally facing specimen reception is key to limiting non-pathology staff access to the busy and crowded department. This has been an issue during the COVID-19 pandemic.

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

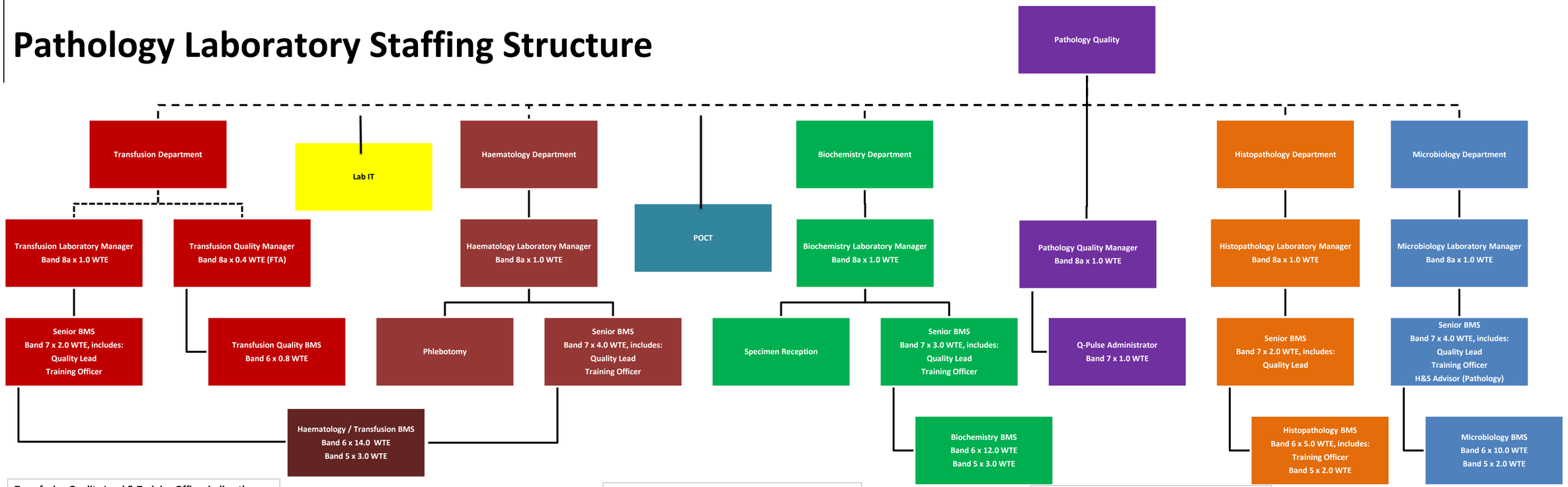
As the investment in staff and equipment develops, the department will continue to collaborate with ESNEFT to benefit from efficiencies of bulk purchasing, whilst also networking with other regional and national trusts. WSFT will seek to form alliances with other accredited laboratories, for example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

Appendix 1- Governance and Staffing structure


Pathology Staffing Structure 24.8.2020.xl


Pathology Governance Structure

Pathology Laboratory Staffing Structure

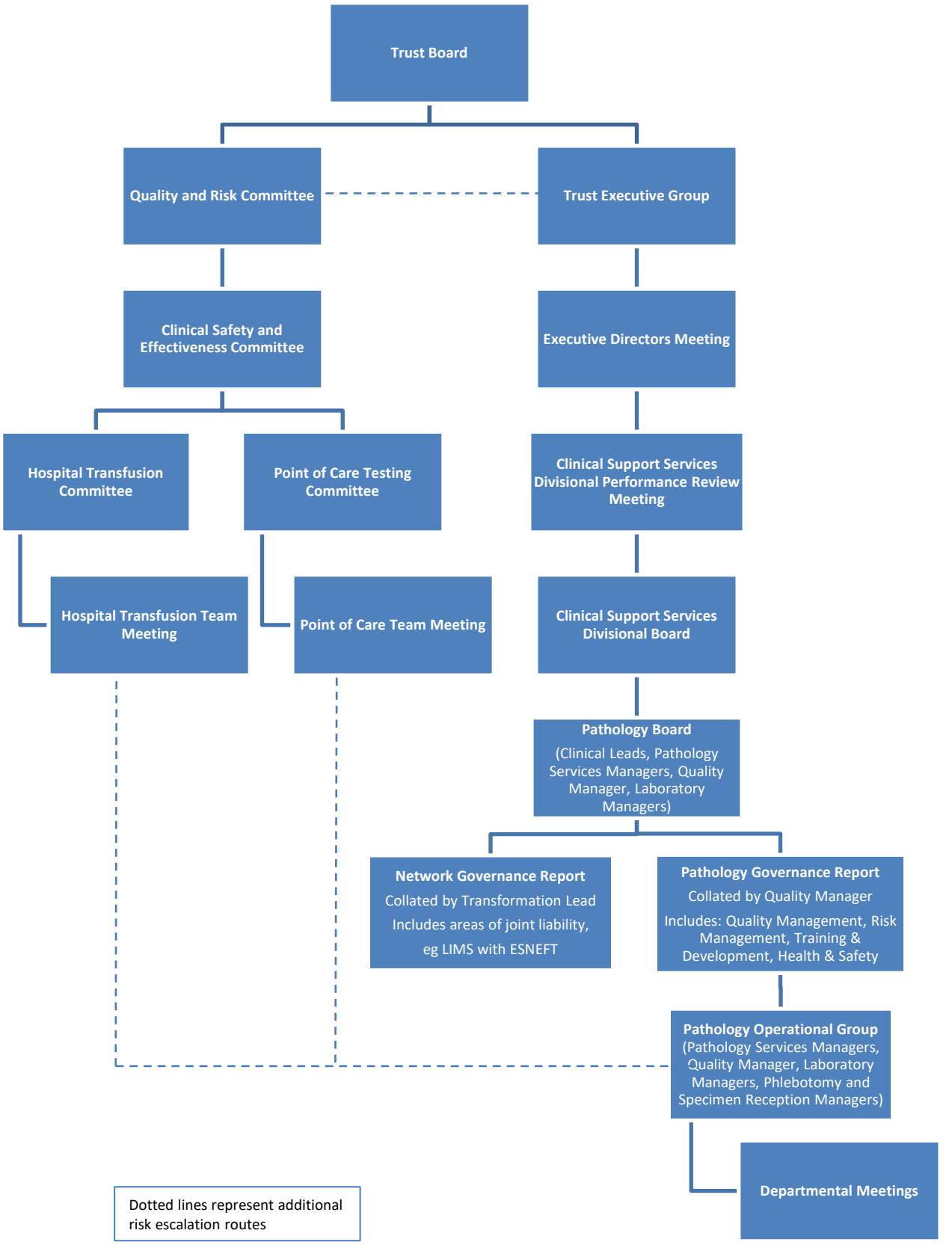


Transfusion Quality Lead & Training Officer indirectly report to Transfusion Quality Manager

All departments require identified Health & Safety (H&S) Link persons from within the staffng structure

Departmental Quality Leads & Training Officers indirectly report to Pathology Quality Manager

Pathology Governance Structure



23. WSFT digital board report

To APPROVE a report

For Approval

Presented by Craig Black

Trust Board – 2 October 2020

Agenda item:	23			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Sarah Jane Relf, Head of Digital Transformation			
Date prepared:	21 August 2020			
Subject:	To receive update from Digital Board			
Purpose:		For information		For approval

Executive summary:
This paper confirms key points of interest raised and discussed at the Digital Board on 30 July 2020.. Of particular note are the achievements of the IT team during the coronavirus pandemic and details of how the digital programme focus had changed as a result.

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

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

Previously considered by:	*Separate pillar group meetings and Digital Board.*
Risk and assurance:	*Full risks are reviewed at each meeting with any high level risks reported through to board assurance framework as appropriate.*
Legislation, regulatory, equality, diversity and dignity implications	*GDPR consideration is applied to all projects.*

Recommendation:
The Board is asked to note the update.

1. Background

1.1 In May 2016, the trust embarked on a major change programme to introduce a new electronic patient record (EPR). The EPR was built around the Cerner Millennium product and was locally branded e-Care. Over time we have significantly enhanced the original e-Care offer with the introduction of new Cerner modules, implementation of other complimentary digital solutions and the extension of e-Care to other departments.

1.2 The West Suffolk NHS Foundation Trust (WSFT) is one of 16 hospitals chosen to become a flagship Global Digital Exemplar (GDE). As part of the GDE programme funding was awarded to those hospitals considered to be the most advanced digitally with the hospital receiving £10million.

1.3 The GDE funding concluded in 2019. However WSFT continues to report into the GDE programme until such time as all funding milestones are achieved. The outstanding milestones are:

- JAC pharmacy interface
- Health information exchange (HIE) link to social services
- Extension of e-Care to maternity
- Achievement of HIMSS level 6

We are behind schedule on all of the above milestones as many aspects of our digital programme were paused due to focus on COVID. We will be agreeing revised dates with NHSX to achieve these milestones.

1.4 There are four main pillars for the digital programme of the trust. These are:

Pillar 1	Digital acute services	Large scale digital programmes supporting delivery of care within the acute hospital site.
Pillar 2	Supporting the integrated care organisation	Creating the digital platform to support the regional ambitions of integrated care and population health.
Pillar 3	Digital community services	Large scale digital programmes supporting delivery of care within community services.
Pillar 4	Hardware and infrastructure	Ensuring that we have a robust and compliant infrastructure at the foundation of the programme

Currently the digital programmes for acute and community are run separately as they have different clinical systems and community infrastructure sits under a third party provider. Over time we will aim to merge these two pillars.

1.4 The Digital Board had already agreed a programme of work for 2020/21. However the coronavirus pandemic meant that many digital programmes had to be delayed or reduced in scope. At their July meeting the Digital Board received an update on what activity the IT team had completed during COVID and an update from each pillar lead on which projects had been stopped, which had been reduced in scope and which had been able to progress.

2. Achievements during COVID

2.1 The Digital Board acknowledged the significant achievements that the IT team had made to support the trust response to COVID. These incude:

- Building 500 personal computers and laptops
- Significantly increased capacity for remote access and remote control

- Installed and configured two video conferencing solutions (Visionable for patient consultation and TEAMS for organisational communications).

2.2 The Digital Board praised the IT team for what they had achieved during these difficult times and noted the positive impact of their work on other staff within the trust.

3. Pillar one

3.1 The main programmes that had been paused were:

- Extension of e-Care to include maternity services
- MMODAL implementation (voice recognition software)
- DrDoctor (digital appointment letters and reminders)
- Switch to version 2 of Medic Bleep (clinical communications tool)

3.2 The upgrade to 2018 code for Cerner Millennium (currently on 2015 code) has been brought forward as this was a project that would not impact on clinical front line staff during coronavirus. This was due to go live in October 2020. This change will have minimal impact on the end user experience of using e-Care. However further developments and enhancements to e-Care would be prohibited if we remained on the out of date code. At some point Cerner would also stop supporting 2015 code. This was therefore an important update to be done which the coronavirus situation gave us the opportunity to progress.

3.3 Other smaller projects had also been run in parallel with the 2018 code upgrade work. These included addition of warfarin, scanning for safety, infection control modules and closed loop blood transfusion. The team had also been able to extend e-Care into Glastonbury Court facilities.

3.4 The current planning assumption for the go live of maternity services is Spring 2021. This will obviously be subject to review depending on coronavirus situation at that time.

4. Pillar two

4.1 Progress with the population health programme had slowed as resources were required to support the coronavirus reporting requirements. The on boarding of GP data had progressed but the capacity to take forward pilots on how we will utilise the data is currently limited. Cerner had been working in the background to progress the risk stratification model.

4.2 Video conferencing had accelerated both within the hospital and community services. It was noted that there were some reporting issues in identifying exactly how many virtual consultations had taken place and the team were working hard to rectify this.

4.3 Coronavirus focus had also enabled us to progress the health information exchange tool at pace. This included extending the facility to community colleagues so that this can be viewed within SystmOne. It was noted that we are currently collecting case studies on how this wider access to health records was impacting on care and outcomes for patients. The Digital Board will receive details of this work at their next meeting.

5. Pillar three

5.1 IT support for community services is currently provided by a third party supplier. This will be brought ‘in-house’ with the original migration due to have completed by October 2020. The migration will now commence in September 2020 with projected conclusion by end of March 2021.

5.2 Many other projects had progressed at pace including introduction of video platforms for both corporate use and in delivering clinical care. This included running virtual exercise and support groups through virtual platforms which had been well received by service users.

6. Pillar four

6.1 Pillar four had been able to continue to make some progress during COVID. Windows 10 roll out had continued and 40% of the trust had been converted. It is projected that the roll out

will complete by end of March 2020 at the latest.

6.2 We also continue to make progress with introduction of radio frequency identification (RFID) tagging which initially was focussing on tracking of equipment and beds.

7. Miscellaneous

7.1 It was reported that the trust does not currently have an identified Safety Officer role which is a statutory requirement when undertaking digital programmes. Nick Jenkins (Medical Director) as Clinical Safety lead for the trust confirmed that he will be putting arrangements in place and that this had been added to the risk register in the meantime. Sarah Jane Relf is fulfilling the role until permanent recruitment is complete.

7.2 It was confirmed that the Care Quality Commission (CQC) plan included requirements that required digital improvements. Helen Beck (Chief Operating Officer) was ensuring that the Digital Board had oversight or all requirements.

8. Recommendation

8.1 The trust board is asked to note the report.

Sarah Jane Relf
Head of Digital Transformation

11:10 GOVERNANCE

24. Trust Executive Group report

To ACCEPT the report

For Report

Presented by Stephen Dunn

Board of Directors – 2 October 2020

Agenda item:	24			
Presented by:	Steve Dunn, Chief Executive			
Prepared by:	Richard Jones, Trust Secretary			
Date prepared:	23 September 2020			
Subject:	Trust Executive Group (TEG) report			
Purpose:		For information	X	For approval

7 September 2020

The structure and approach to the meeting was different. The focus of the agenda was on key strategic issues with a focus on engaging senior leaders on the developments and future plans.

1. Quality, safety and improvement

An updated structure was received to oversee and develop **quality, safety and improvement**. It was recognised that this work had evolved from the feedback during the TEG workshops in June and July as well as discussion at the TEG meeting in August. The proposed framework is heavily influenced by the *National patient safety strategy (2019)* which is structured around:

1. **Insight** – Improve understanding of quality and safety drawing on multiple sources of information - what the data says (internal and external). Key enabler - effective quality and safety measures.
2. **Involvement** – give people the skills and opportunity to inform and improve services. Key enablers - effective engagement and skill sets to assess service needs and delivery improvement e.g. patient safety syllabus from Academy of Medical RCs and QI methods.
3. **Improvement** - effective improvement programmes at corporate and service level. Key enablers - structured understanding and support of QI methods.

The proposed structure (Annex A) had been developed with relevant specialist to address feedback, including: **divisional accountability**. The revised framework ensures that divisions are able to 'push-up' issues (successes and challenges) in a way which allows cross-divisional sharing of solutions and learning. The structure will allow the 3i committees to review national requirements, corporate priorities and divisional priorities in the context of the Trust's strategy and objectives.

The proposed framework would **replace the existing board assurance structure** and as a result the following committees/groups would no longer be required: quality & risk committee; clinical safety & effectiveness committee (CSEC); patient experience committee; quality group and improvement programme board (subsumed within the improvement committee). Under the proposed structure TEG would also no longer exist. Instead, its responsibilities would be delivered through the 3i committees, as well as the strategic planning committee and the proposed monthly joint-divisional oversight and review meeting with execs. This meeting would include each division's triumvirate and provide a forum for exchange of developments and concerns, but avoid duplication of the other committees' roles. It was recognised that as part of the development of the new committees' terms of reference consideration needs to be given as to how to engage the wider senior leadership from the TEG membership.

The accountability of **specialist groups** will need to be reviewed, removing redundancy whenever possible, and determining the most appropriate accountability arrangements e.g. falls and drugs & therapeutics.

Key enablers were recognised to allow people, divisions and groups to work more effectively within the proposed structure. This includes corporate partners in key areas and it is recognised that access to timely and relevant information is critical to the success. How these teams best coalesce to provide divisional support, while ensuring consistency and cross-learning, is still to be finalised but the consensus is to structure the teams centrally with a clear divisional allocation of support. This would mean that each division is supported by the following specialists and teams:

Central team, with named partners to support and coach divisions in:
- Human resources
- Finance
- Information
- Quality and governance

Networked specialist support and coaching, including:
- Patient safety partners (public/patient), specialist (staff) and coaches (staff)
- Human factors coaches – supporting both safety and improvement
- QI tiered support - coaches, champions, faculty

The establishment of two new roles as part of the **enabling structure** for quality and safety was supported by TEG - associate director and associate medical director. Costing for the enablers will be developed with the specialists and consider by the executive team for approval.

There was positive feedback from TEG members on the process that had been used to listen and respond to the identified need. It was agreed that the proposed structure be **recommended to the Board** for approval in principle to allow the detailed work to be undertaken on terms of reference of the committees and enabling structures.

2. What matters to you

A presentation was given on the background of the survey and five key themes for change. This data has been brought together with the Better Working Lives survey with doctors and also from Emily Baker with her well-being support. The findings as presented are summarised below.

- The importance of great line managers
- Creating an empowered culture
- Building relationships
- Appreciating all of our staff
- The future and recovery

A copy of the summary provided in the Green Sheet to staff in terms of these themes and the commitment to respond is appended to this report (Annex B). TEG welcomed the presentation and the work undertaken by the team to gather the quantitative and qualitative results, including the engagement meetings. It was recognised that as senior leaders we need to think about the teams we work with, and we need to build this into the way we move into the next phase.

3. Strategy refresh

A presentation was received which explained that our current strategy is in its last year of life and therefore, we need to develop our next five-year plan. A plan on a page was reviewed to answer the following questions:

- What's happened since last time?
- What's changed outside?
- What will we do in the next five years?
- Where will this get us to?

The engagement with staff and others will inform the strategy refresh and future plans. TEG members

supported the proposed approach to co-produce the strategy based on feedback and engagement.

4. Future systems

A report was received which set out the work being undertaken to support the future systems programme. Progress with establishing the team to support the programme was noted, including plans to recruit co-production leads to with staff and partners on the clinical design. It was stressed that the process of co-producing the clinical design will last throughout the 5 years of programme, however, in the next three months it needs to have advanced sufficiently to answer the key strategic questions concerning the mix and scope of services to be offered within the new facility. In order to achieve this goal, the Programme team intend to run a pilot focussed on producing a design for the Endoscopy department. In parallel, the programme team are consulting colleagues on how best to define the units of care and the structure of the design process.

Discussion took place on the engagement process across all disciplines and areas, including community. This was recognised and welcomed as a fantastic opportunity.

7 September 2020

At the start of the meeting it was noted that the agenda had been developed to focus on key areas and developments. Discussion took place on the matter referred by the clinical safety and effectiveness committee regarding NICE and clinical audit. Plans were outlined to strengthen the central support to enable divisions to undertake these activities.

The **COVID recovery and winter plan** was presented and reviewed. The complexities as we approach this winter were recognised and the learning is being applied from the first wave of COVID. Alongside the clinical and operational pressures, it was recognised that the important structural work we are undertaken could prevent us from delivering the required levels of activity. The plans were welcomed and reflected significant work with staff. Further iteration will be informed by further staff engagement across the hospital and community, including primary care.

Board reports were received and noted, including IQPR, finance and workforce reports and the improvement plan. The pressure on clinical time was recognised and it was agreed that with the range of activities taking place it needed to be valued.

The **red risk report** was received, this included 'top risks' for staff engagement and raising concerns; COVID response and recovery; building structure and provision of suitable estate; and pathology services. Two new red risks were reviewed relating to COVID capacity and the regional stroke thrombectomy service. No red risks were downgraded/closed. A separate report was received by TEG on the structural risk, this included the issue of capacity to allow acceleration of the remedial structural works.

A report was received from the **Quality Group** which summarised its activities. Work is ongoing to consider how best to consider hospital episode statistics (HES) data

A report was received from the **Digital Board** which set out activity in the four key pillars: digital acute services; supporting the integrated care organisation; digital community services; and hardware and infrastructure.

The updated **standards of business conduct policy** was approved.

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

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X	X	X	X	X	X	X
Previously considered by:	The Board receives a monthly report from TEG						
Risk and assurance:	Failure to effectively communicate or escalate operational concerns.						
Legislation, regulatory, equality, diversity and dignity implications	None						

Recommendation:

1. The Board to note the report

2. The Board approve in principle the proposed committee structure (Annex A) to allow the detailed work to be undertaken on terms of reference of the committees and enabling structures

Charitable funds committee
Remuneration Committee
Scrutiny Committee

Trust Board

Audit Committee

Quality Board

Led by NED/Director with deep understanding of quality and QI

Non-Executive Chair	Chief Executive	Additional Non-Executive Director(s)
Director of Resources	Executive Chief Nurse	Executive Medical Director
Chief Operating Officer	Exec. Director of Workforce	Head of Information
Associate Director - Quality and Safety	AMD – QI	AMD – Q&S
Head of Patient Safety	Trust Secretary	

Focussed on ensuring standardised approach to quality as well as quality planning and prioritisation

Exec. Directors Meeting

Including a monthly oversight and review meeting with all divisions (supports cross divisional working)

Insight Committee

Potential attendees: chair – exec COO?, NED, clinical governance leads, patient safety/quality managers, patient safety, audit and risk, QI, triumvirates, head of information, AD Q&S, AMD – Q&S, divisional triumvirate rep.

Considering external reports and 'must dos', IQPR, risk registers, incidents/complaints

- Mandatory clinical audit/clinical governance (note most audit 'improvement' would move to IC)
- IQPR particularly performance/must dos
- CQC compliance
- NICE guidance
- NHSE/I - national 'must do' directives
- NHSR – litigation
- Incident reporting (including PSIRF)
- Risk register
- Information governance
- Complaints
- Medical devices
- Internal and External audit

Involvement Committee

Potential attendees: chair – exec workforce?, NED, pt experience team, human factors lead, pt safety lead, AMD QI, learning from deaths, DMD better working lives, lead junior doctors better working lives, BAME and LGBQT leads, staff/pt experience, divisional triumvirate rep, AD Q&S

Considering involvement and engagement across and through organisation: developing and supporting programmes to ensure enabled culture

- Patient Safety partners
- Incident learning/engagement
- Deteriorating patients
- Learning from deaths/family involvement
- Human factors
- QI strategy – capability and capacity
- Pts/carers forum for QI
- Patient experience/insights, staff feedback (WMTY)
- Better working lives
- BAME group
- LGBTQ group

Improvement Committee

Potential attendees: chair – chief nurse?, NED, triumvirates, divisional QI representatives, QI team, head of performance, pt safety/quality managers, AD Q&S, divisional triumvirate rep.

Considering divisional and cross-divisional improvement projects as well as Trust improvement priorities

- Directorate triumvirate/priorities
- GIRFT
- Organisational improvement projects/objectives
- Standardising approaches for QI (data/metrics, learning etc)
- QI walkabouts/improvements from pt/staff experience
- Learning from death improvements
- QI strategy

Note: moves beyond initial focus of CQC improvements and cost improvement projects

Strategic Planning Committee

Potential attendees: NED, execs, AD of Quality and Safety, AMD – QI, divisional triumvirate

Considering planning framework for:

- Commissioning/Contracts
- Business cases – divisions and corporate
- Strategic and operational planning – annual cycle and prioritisation (quality driven)
- Quarterly sharing/learning event
- Subgroups for: Alliance, New Hospital; Digital programme; Pathology transformation; Emergency planning

Operational Divisions

Divisional triumvirate supported by partners and coaches for: HR, finance, DCIO, patient safety, effectiveness, patient experience, human factors and QI

What Matters to You: five key themes

Over the last three months we have been listening to 'What Matters to You'. You have given us so much to think about and lots of ideas to take forward. So what next?

All of this work has identified five key themes to take forward together. These key themes will form the basis of a major organisational development plan that we will work with you to create over the next few weeks. However, we didn't want to lose any time and wanted to give you an update on the main themes now so that you can be discussing and thinking about these with your teams and your colleagues.

This feedback will lie at the centre of how we improve working lives at WSFT and as an executive we are committed to listening to what you have said. However, we will need your help – we cannot achieve this alone!! Over the next few weeks we will look forward to working with you and your teams to flesh out the organisational development plan that will outline how we can collectively work to achieve these priorities.

The importance of great line managers

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

Our commitment to you is to invest in development for new and existing managers so that this is the experience for every one of you. You have lots of ideas on how we could do this including development ideas and mentoring schemes etc.

Creating an empowered culture

You have told us that it can feel like there is 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.

Our commitment to you is to change our behaviours as a leadership team – and to encourage others to do the same. We want the organisation to be one where our staff are working together to maximise new opportunities and to develop solutions to problems. And where we as an exec team are supporting and empowering you to do this.

Building relationships

What Matters to You has shown 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.

Our commitment to you is to introduce a dedicated programme of work to bridge this gap, bringing staff together to start to build relationships and ensuring that leaders are much more visible to community staff. This is one we cannot do alone however – we need your help in order to succeed.

Appreciating all of our staff

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, who often feel that their contribution is not understood or recognised. You told us how much you appreciated the extra things we did to look after you during COVID. Things such as the well-being service, free tea and coffee and on-site parking for acute staff. However not everyone was aware that they could access these things – and some staff felt that they were excluded from these. We also need to do more to

help our colleagues that are and have been shielding at home.

Our commitment to you is to take the time to understand how all of us contribute to patient care and ensure that we recognise and appreciate the things that all teams achieve. Through the ongoing engagement work we will ensure that all parts of the trust are included. We want to hear your stories.

We also commit to continuing with as many of the additional well-being extras as possible. We won't be able to keep everything for very practical reasons! Car parking is an example of this. We have already agreed that the well-being service will become business as usual and invested in additional posts to support this. We also commit to making sure there is equity across the organisation in how people can access these, particularly for community and shielding staff.

The future and recovery

You have told us that you are fearful of recovery and how we will be able to 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 that you would like to keep home working (for those that are able to do so).

Our commitment is to work with you to understand how we will collectively reintroduce services. You will have the ideas on how this could work and we will listen to these. We also commit to making sure that home working becomes part of our culture where it is possible for staff. This includes ensuring that you have what you need to work effectively from home and helping managers
to understand how to support their teams to work in
this way.

25. Audit committee report

To ACCEPT the report

For Report

Presented by Angus Eaton

Trust Board Meeting – 2 October 2020

Agenda item:	25			
Presented by:	Angus Eaton, NED and Chair of the Audit Committee			
Prepared by:	Liana Nicholson, Assistant Director of Finance			
Date prepared:	21 September 2020			
Subject:	Audit Committee report - meetings held on 19 June and 31 July 2020			
Purpose:		For information	X	For approval

Executive summary:

The Audit Committee met on 19 June 2020 for the approval of the Trust's Annual Report and Accounts. The key issues and actions discussed were:-

- **Going Concern** – The Committee considered the Trust's going concern status and agreed that the Accounts should be prepared on a going concern basis.
- **External Audit Report to Those Charged with Governance** - the Committee considered the issues highlighted by the External Auditors including:
    1. The 2019/20 Annual Accounts – The Auditors did not identify any issues in relation to their work performed on key risk areas. A small number of disclosure amendments were required to the Accounts, one being material, however this was only a misclassification between headings in the statement of comprehensive income.
    2. The audited elements of the Annual Report
    3. Value for money conclusions
- **2019/20 Annual Report** – the Committee reviewed the audited Annual Report and recommended approval to the Trust Board.
- **2019/20 Annual Accounts** – following consideration of the External Auditor's Report the Committee recommended approval of the Accounts to the Trust Board.
- **Internal Audit** – the final 2019/20 Head of Internal Audit Opinion was considered and accepted.
- **General Condition 6 and Continuity of Service Certification** – this document was approved.

The Audit Committee meeting was held on 31 July 2020. The key issues and actions discussed were:-

- **BAF Deep Dive – 'IT Update' -** This session was led by Mike Bone (Chief Information Officer). An update was provided on the current IT projects, including the migration of Community Staff to become an integral part of the Trust. Mike confirmed that they are on

track to complete this project by Christmas 2020. Mike also provided an update on the Trust's current working ways during the COVID pandemic and provided some statistics on the current use of remote access and Microsoft Teams. The Committee praised the IT Department for its dedication and huge efforts over the past months in engaging the Community Staff and also in assisting to enable staff to work from home during the pandemic.

- **Internal Audit** - The Internal Audit Progress Report confirmed that the one remaining report for 2019/20 had been finalised and that two reports from the 2020/21 Audit Plan had been issued since the last report to the Committee. A further two reviews were near completion. Internal Audit have been able to conduct all of their reviews remotely and thanked the Trust for their cooperation in adapting to this new way of working.

- **Counter Fraud** – The Counter Fraud Progress Report was presented, which confirmed that the 2020/21 Plan is progressing. The 2019/20 Annual Report was also presented.

- **External Audit Annual Audit Letter** - The 2019/20 Annual Audit Letter was reviewed:

    1. The auditors issued an unmodified true and fair opinion on the 2019/20 Financial Statements. An emphasis of matter was included in respect of the material uncertainty included in the Valuer's Report in relation to the valuation of the Trust's land and buildings.

    2. Although the Trust met its control total in 2019/20, due to the ongoing financial challenges faced by the Trust, the External Auditors issued a qualified 'except for' Use of Resources opinion.

- **External Audit My Wish Audit Plan** – The Audit Plan for the Charity was presented and was approved by the Committee,

- **Annual Review of Waivers** – The annual summary of waivers approved in 2019/20 was presented. This showed that a total of 54 waivers were issued during 2019/20, with a value of just over £2m. Waivers are reviewed by TEG on a quarterly basis.

- **Annual Review of Losses and Special Payments** – The annual summary of losses and special payments made in 2019/20 was presented. This amounted to £314k. Losses and special payments are reviewed by TEG on a quarterly basis.

- **Audit Committee Annual Report** – The Committee approved the Annual Report to the Board summarising the work completed by the Committee over the past 12 months.

- **Review of Terms of Reference** – The Committee is required to review its Terms of Reference annually. Some minor amendments were made and were approved by the Committee.

- **Two Yearly self-assessment of the Audit Committee** – A self-assessment was completed and the results were presented to the Committee with an action plan in place to address some issues raised.

- **Supply Chain Risk Report** – The annual report on supply chain risk considerations was presented. The report detailed the assessment performed on the top 50 suppliers used by the Trust and concluded that the current level of risk was manageable.

- **Report to the Council of Governors** – the Committee approved the report to the Council of Governors on the performance of External Audit.

- **Tender for External Audit Services from 2021/22** – The Committee agreed that the tender process should be deferred for one year and recommended to the Council of Governors that a direct award contract is given to the Trust's current External Auditors.

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

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

Previously considered by:	*This report has been produced for the monthly Trust Board meeting only*
Risk and assurance:	*None*
Legislation, regulatory, equality, diversity and dignity implications	*None*

Recommendation:
The Board is asked to:

- Receive and note the Audit Committee report for meetings held on 19 June and 31 July 2020.

Audit Committee – 31 July 2020

Agenda item:	Item 9.1			
Presented by:	Liana Nicholson, Assistant Director of Finance			
Prepared by:	Liana Nicholson, Assistant Director of Finance			
Date prepared:	13 July 2020			
Subject:	Audit Committee Annual Report			
Purpose:		For information	X	For approval

Executive summary:

The Audit Committee is required to produce an Annual Report detailing the work undertaken during a financial year. Attached is the report for the year ended 31 March 2020.

The Committee is asked to review the report and agree a final submission to the Trust Board.

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

Trust ambitions	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	✓	✓	✓	✓	✓	✓	✓

Previously considered by:	*N/A*
Risk and assurance:	*None to note.*
Legislation, regulatory, equality, diversity and dignity implications	*None directly relevant to this report but the work of the Committee provides the Trust with assurance on compliance in a number of areas.*

Recommendation:
The Audit Committee is asked to review and agree a final version for submission to the Trust Board.

1. Background

1.1 The Audit Committee of West Suffolk NHS Foundation Trust is established under Board delegation with approved Terms of Reference that are in line with those set out in the NHS Audit Committee Handbook.

1.2 This report covers the year from 1 April 2019 to 31 March 2020.

1.3 The Committee consists of a minimum of 3 Non-Executive Directors, one of whom has recent and relevant financial experience. The Committee has met on 5 occasions during the year to discharge its responsibility for scrutinising the risks and controls that affect all aspects of the organisation's business.

1.4 The meetings have also been attended, by invitation, by the Chief Executive, the Executive Director of Resources, the Executive Chief Nurse, the Deputy Chief Nurse, the Medical Director, the Trust Secretary and Head of Governance, the Assistant Director of Finance or Deputy Director of Finance, Internal Audit, External Audit and the Counter Fraud Service. The Chair of the Trust has also attended the Committee meetings.

1.5 The Committee focuses on all aspects of Corporate Governance including assurance on clinical governance and risk management.

1.6 This report deals with the Audit Committee meetings held between 1 April 2019 and 31 March 2020. Therefore, reports that are approved outside this period would be covered in the following year despite the subject matter of the report relating to the year. E.g. the Annual Report and Accounts for 2019/20 will be reported in the year they were approved by the Committee i.e. 2020/21.

2. Meetings during 2019/20

2.1 There were 5 meetings of the Committee during 2019/20: 26 April 2019, 23 May 2019, 26 July 2019, 1 November 2019 and 31 January 2020, with the following member attendance:

Name	Title	Attendance / No. possible
Angus Eaton (Chair)	Non-Executive Director	4/5
Gary Norgate	Non-Executive Director	5/5
Alan Rose	Non-Executive Director	4/5
Richard Davies	Non-Executive Director	5/5
Louisa Pepper	Non-Executive Director	5/5

2.2 There are no sub-committees of the Audit Committee. The Audit Committee is supported by the Quality and Risk Committee, the minutes of which are considered at every Audit Committee meeting.

3. Principal Review Areas

3.1 Annual Governance Statement

3.1.1 The Audit Committee reviewed the 2018/19 Annual Governance Statement for the Trust for the 12 months to 31 March 2019 in May 2019 and confirmed that it was consistent with the view of the Committee on the Trust's system of internal control. Note that the Annual Governance Statement for 2019/20 was reviewed in June 2020.

3.1.2 The Audit Committee received the Head of Internal Audit opinion 2018/19 in May 2019 which concluded:

The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.

Specific issues highlighted were:

- North East Essex and Suffolk Pathology Service (Partial Assurance)

  Although there had been a lot of engagement between the Trust and NEESPS to inform progress towards UKAS accreditation and the actions that needed to be taken to resolve quality issues, the approach for which had been approved by the Trust Board, it did not take into account how quality related risks identified from various gap analysis are mitigated. The reporting did not provide confidence that the solution will be delivered in a timely fashion, or what the additional exposure to risk was.

- Annual Leave Management (Partial Assurance)

  Inconsistencies were identified with the information in the Trust's policy documents and Healthroster, with the system note being used robustly to capture annual leave entitlements and carry forward days. Therefore performance reporting from the system was open to challenge and criticism due to data quality and completeness issues.

- The Cambridge Graduate Course in Medicine (Partial Assurance)

  During the course of the audit and number of areas for improvement were identified to the control framework being used to manage the funds for this area. There was also not set budget for this area and therefore no defined reporting against spend.

3.2 Annual Accounts Approval

3.2.1 The Committee reviewed the draft accounting policies proposed and considered the significant accounting estimates and judgements in advance of the production of the accounts.

3.2.2 The Committee reviewed the 2018/19 Annual Accounts, Annual Report and the Letter of Representation for the 12 months to 31 March 2019 and recommended these for approval by the Trust Board.

3.3 Terms of Reference

3.3.1 The Committee is required to review its Terms of Reference (ToR) during the year.

3.3.2 A revised version of the Terms of reference was agreed at the meeting in July 2019.

3.3.3 The key requirements included in the Terms of Reference, and whether they have been met during the year, have been considered in the Appendix to this report.

3.4 Governance Documents

3.4.1 The Committee has a duty to undertake a review of the Trust's Governance Documents every other year, unless there are matters that require review at an earlier date. These comprise the Standing Orders, Standing Financial Instructions and The Scheme of Delegation. These were reviewed at the Audit Committee meeting on 25 January 2019 and therefore were not reviewed again during 2019/20.

3.5 Governance

3.5.1 In respect of Governance the committees responsibilities are set out in the terms of reference as:

- The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. The Audit Committee will look to the Quality & Risk Committee for assurance on items of clinical quality and corporate risk, including: health & safety, research and information governance.

3.5.2 The Committee achieved this through a number of actions:-

- Monitor and review the Annual Governance Statement
- Receiving the annual Head of Internal Audit opinion
- Receiving the audit report of the External Auditors on the Annual Accounts
- Reviewing the effectiveness of the Board Assurance Framework (with support from internal audit)

3.5.3 Board Assurance Framework Deep Dive Reviews – during the 2019/20 financial year the Committee conducted deep dive reviews of key areas within the Trust:

- ***GDE Digital Road Map*** – Mike Bone (Chief Information Officer) made a presentation on the digital status of the Trust and the future goals that the IT Department are working on to make the Organisation 'extremely digitally mature' including the integration of the Community Team.

- ***Towards a West Suffolk Estate Strategy*** – Jacqui Grimwood (Estates and Facilities Development Manager) made a presentation on the Trust's structure and the structural issues that have been identified. Jacqui presented a full background of the history of the structure at the Trust and the issue that has been identified with the safety of the planks used in the structure of the main hospital building. A plan of action was presented which showed the steps and actions required in order to ensure that the structure meets all safety requirements.

- ***Suffolk and North East Essex ICS Draft Five Year System Strategic Plan*** – The Committee received a presentation from Susannah Howard (ICS Programme Director) on the draft five year Plan that has been developed. Susannah noted that the Plan had been written from an outcome perspective and that it had been developed with joint working and input from key stakeholders, including members of the public.

- ***Improving our Culture and Staff Support*** – Jeremy Over (Director of Workfoce) held a discussion around the proposed audit to be undertaken by Internal Audit on 'Freedom to Speak Up'. The scope of the review was discussed, which would incorporate the 'must do' recommendations raised by the CQC. The Director of Workforce also provided an update on what the Trust was doing in terms of addressing the recommendations raised by the CQC in terms of 1. Speak up and 2. Open and transparent culture and relations with medical staff.

3.6 Charitable Funds Annual Accounts

3.6.1 The Board delegated authority to the Audit Committee to approve the Charitable Fund accounts for the full year to 31 March 2019. The committee approved the accounts at its November 2019 meeting.

3.7 Clinical Audit

3.7.1 A clinical audit progress report is presented to the Committee at every meeting by the Deputy Chief Nurse or their representative.

4. Other work undertaken

4.1 Internal Audit

4.1.1 The Committee received the following reports from the Internal Auditors:-

- Progress report against the Audit Plan at every meeting including implementation of recommendations
- 2018/19 Head of Internal Audit Opinion – April 2019
- 2020/21 Internal Audit Plan – January 2020

4.1.2 RSM were re-appointed as the Trust's Internal Auditors from 1 April 2019 for a period of 3 years.

4.2 External Audit

4.2.1 The Committee received the following reports from the External Auditors:-

- 2018/19 Report to Those Charged with Governance (ISA 260) - May 2019
- 2018/19 Report on the Quality Report to the Council of Governors - May 2019
- 2018/19 Annual Audit Letter - July 2019
- 2018/19 Charitable Fund Accounts Report to Those Charged with Governance (ISA 260) - November 2019
- 2019/20 External Audit Plan- January 2020

4.3 Counter Fraud

4.3.1 The Committee received the following reports from the Local Counter Fraud Specialist provided by RSM:

- Progress Report- all meetings
- Regular Fraud Notices
- Counter Fraud Annual Report 2018/19 – July 2019
- Self-Assessment Tool – April 2019

4.3.2 RSM were appointed as the Trust's Local Counter Fraud Specialists from 1 April 2019 for a period of 3 years.

5. Audit Committee Responsibilities – performance

5.1 As part of its responsibilities the Committee should assess its performance against its terms of reference not less than every 2 years. The Committee completed the HFMA self-assessment checklist in March 2020 and the results can be seen on agenda item 11.1.

6. Audit Committee Impact

6.1 It is important that the Audit Committee makes an impact on the Trust, particularly around ensuring the robustness of the Governance Structure.

6.2 In assessing this, it is important to note that the main reports submitted to the Committee by External and Internal Audit supported the robustness of the Governance structure.

6.3 There were a number of specific areas where the Committee undertook action to address issues or where specific items were raised and discussed amongst these were:

- The Committee received a report on losses and special payments. This report is reviewed on an annual basis.
- The Committee received a report on waivers and critically reviewed the drivers behind the number of waivers. This report is reviewed on an annual basis.
- The Committee received reports for the approval of debt write offs.
- The Trust critically reviewed management responses to Internal and External Audit Reports to ensure risks were being managed adequately and in a timely manner.
- The Committee received a report on the Supply Chain risks.

6.4 The above items reflect that the Committee has had a positive impact on the governance arrangements of the Trust

7. Conclusion

7.1 This report highlights the main areas of work undertaken by the Audit Committee during the period. It demonstrates that the Committee operated effectively and had a positive impact on the Trust.

7.2 The Committee is asked to review the report, make any changes and approve a final version for submission to the Trust Board.

Appendix – Key requirement included in Terms of Reference

Para Ref	Requirement of Terms of Reference	Requirement Met?	Date
5.6	Committee to hold a private meeting with both Internal and External Audit.	✓	November 2019
6.1	Meetings will be held at least three times a year.	✓	April 2019, May 2019, July 2019, November 2019, January 2020
8.1.1.2	Monitor and review the effectiveness of systems of internal financial and budgetary control and the integrity of reporting statements.	✓	Completed through Internal Audit reviews
8.1.1.3	Monitor and review the effectiveness of systems for ensuring the optimum collection of income.	✓	Completed through Internal Audit reviews
8.1.1.4	Monitor and review the effectiveness of risk management systems.	✓	Completed through Internal Audit reviews
8.1.1.5	Monitor and review the effectiveness of the Board Assurance Framework (BAF).	✓	Every meeting
8.1.1.6	Use of a 'deep dive' programme of reviews to test the BAF.	✓	Every meeting – except the May meeting, which is just for the approval of the Annual Report & Accounts
8.1.1.7	Monitor and review the Quality Report assurance and review alongside the Annual Report and Accounts.	✓	May 2019 for the 2018/19 Quality Report
8.1.1.8	Monitor and review the systems for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements.	✓	Completed through relevant reviews throughout the year
8.1.1.9	Monitor and review the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority.	✓	Completed through Counter Fraud reviews
8.1.4	Review the minutes from the Quality & Risk Committee.	✓	Every meeting
8.2 & 8.2.5	Review of the effectiveness and quality of the Internal Audit Function.	✗	Performance for 2018/19 considered as part of the tender process, however this will formally be completed and brought to the Committee in November 2020.
8.2.2	Review of the Internal Audit Strategy and Operational Plan.	✓	January 2019 for 2019/20 Audit Plan and January 2020 for 2020/21 Audit Plan
8.2.3	Consideration of major findings of Internal Audit investigations and the effectiveness of the management response.	✓	Every meeting

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Appendix – Key requirement included in Terms of Reference

Para Ref	Requirement of Terms of Reference	Requirement Met?	Date
8.3	Review of the effectiveness of the Counter Fraud Service.	✖	Performance for 2018/19 considered as part of the tender process, however this will formally be completed and brought to the Committee in November 2020.
8.3.2	Consideration of major findings of Counter Fraud investigations and the effectiveness of the management response.	✓	Every meeting
8.3.4	Receipt and review of the annual review of work undertaken by the Counter Fraud Service.	✓	July 2019 for 2018/19.
8.4	Review of the effectiveness and quality of the External Audit Function, including their independence.	✓	July 2019 (for 2018/19 performance).
8.4.3 & 8.4.4	Review of the External Audit Plan, before the audit commences.	✓	January 2020 for the 2019/20 Audit.
8.4.5	Review reports from External Audit, together with management responses.	✓	May 2019
8.5.1	Review the Annual Report and Financial Statements of the Trust and the Charitable Funds, covering: • The Annual Governance Statement • Changes in, and compliance with, accounting policies • Explanation of estimates and provisions having a material effect • Unadjusted misstatements • Major judgemental areas • Schedule of losses and special payments • Significant adjustments resulting from the audit. These are reviewed prior to endorsement by the Board of Directors (for the Trust accounts).	✓	May 2019 for the Trust's 2018/19 Annual Report and Accounts. November 2019 for the 2018/19 Charitable Fund's Annual Report and Accounts.
8.6.1	Review changes to Standing Orders, Standing Financial Instructions and Scheme of Delegation.	✓	N/A for 2019/20 as the review is complete bi-annually (last completed in January 2019)
8.7.1	Review Schedule of Waivers.	✓	July 2019 – reviewed annually
8.7.2	Review schedules of losses and compensations.	✓	July 2019 – reviewed annually

Appendix – Key requirement included in Terms of Reference

Para Ref	Requirement of Terms of Reference	Requirement Met?	Date
8.7.3	Monitor the process to ensure that Supply Chain Risk is identified and appropriate actions have been taken.	✓	April 2019 – reviewed annually
9.2	Review the Terms of Reference Annually.	✓	July 2019
9.3	Undertake a self-assessment of the Audit Committee performance (bi-annually).	✓	July 2020 (last completed July 2018)
9.4	Complete an Annual Report on activities of the Audit Committee.	✓	July 2020 (for review of 2019/20)

26. Council of Governors report

To ACCEPT the report

For Report

Presented by Sheila Childerhouse

Board of Directors – 2 October 2020

Agenda item:	26			
Presented by:	Sheila Childerhouse			
Prepared by:	Georgina Holmes, Foundation Trust Office Manager			
Date prepared:	24 September 2020			
Subject:	Report from Council of Governors, 11 August 2020			
Purpose:	X	For information		For approval

This report provides a summary of the business considered at the Council of Governors meeting held on 11 August 2020 via Microsoft Teams. The report is presented to the board of directors for information to provide insight into these activities. Key points from the meeting were:

- Due to COVID social distancing requirements the public were excluded from attending this meeting.
- The Chair welcomed and introduced David Wilkes, Non-Executive Director.
- A written report was received from the Chair which provided a summary of the focus of the meetings and activities that she had been involved in over the last three months.
- The Chief Executive's report provided an update on the ongoing challenges facing the Trust due to COVID. An update was provided on the work to inspect the structure of the main building and the remedial actions being taken. Details of the work being undertaken on staff engagement were also provided.
- Responses to governors' issues raised were received and further clarification requested on a number of the issues.
- A report was received on COVID including progress with the recovery phase.
- The finance and quality and performance reports were reviewed and questions asked on areas of challenge.
- David Wilkes gave a short resume of his career and his interests within the health system.
- A report was received on the Trust improvement plan and areas of responsibility.
- An update was provided on pathology services and the progress being made.
- The Council of Governors received the annual report and accounts for 2019/20
- The annual audit letter was received from Matthew Waller from BDO.
- The amendment to the constitution enabled electronic communication by the Council of Governors to support quoracy and decision-making (voting) was noted.
- Reports were received from the nominations committee, engagement committee, lead governor and staff governors.
- The Council of Governors approved the audit committee's recommendation that BDO should remain in appointment as the Trust's External Auditors for one further 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		X		X		
Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	 *Deliver personal care*	 *Deliver safe care*	 *Deliver joined-up care*	 *Support a healthy start*	 *Support a healthy life*	 *Support ageing well*	 *Support all our staff*
	X	X	X	X	X	X	X
Previously considered by:	Report received by the Board of Directors for information to provide insight into the activities and discussions taking place at the governor meetings.						
Risk and assurance:	Failure of directors and governors to work together effectively. Attendance by non executive directors at Council of Governor meetings and vice versa. Joint workshop and development sessions.						
Legislation, regulatory, equality, diversity and dignity implications	Health & Social Care Act 2012. Monitor's Code of Governance.						

Recommendation:

The Board is asked to:

- Note the summary report from the Council of Governors.

Appendix A

Membership Engagement Strategy

April 2019 to March 2021

Engagement Strategy

Contents Page **Page**

1. Introduction

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

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

1.1 Purpose of strategy

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

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

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

1.2 Engagement objectives

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

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

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

2.0 The membership

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

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

Our members will:

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

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

2.1 Becoming a member

Our potential members can be drawn from the following:

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

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

All members must be 16 years of age or over.

A person can become a member by:

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

2.2 Defining our membership

2.2.1 Public

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

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

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

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

2.2.2 Staff

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

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

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

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

3.0 Recruitment of members

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

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

3.1 Methods of recruitment

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

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

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

Methods of recruitment used in the past include:

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

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

3.2 Who is responsible for recruiting members?

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

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

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

3.3 Recruitment plan

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

3.3.1 Public members

Direct recruitment plan

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

Indirect recruitment plan

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

Media coverage

- membership newsletter

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

3.3.2 Staff

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

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

4.0 Engaging with public and members

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

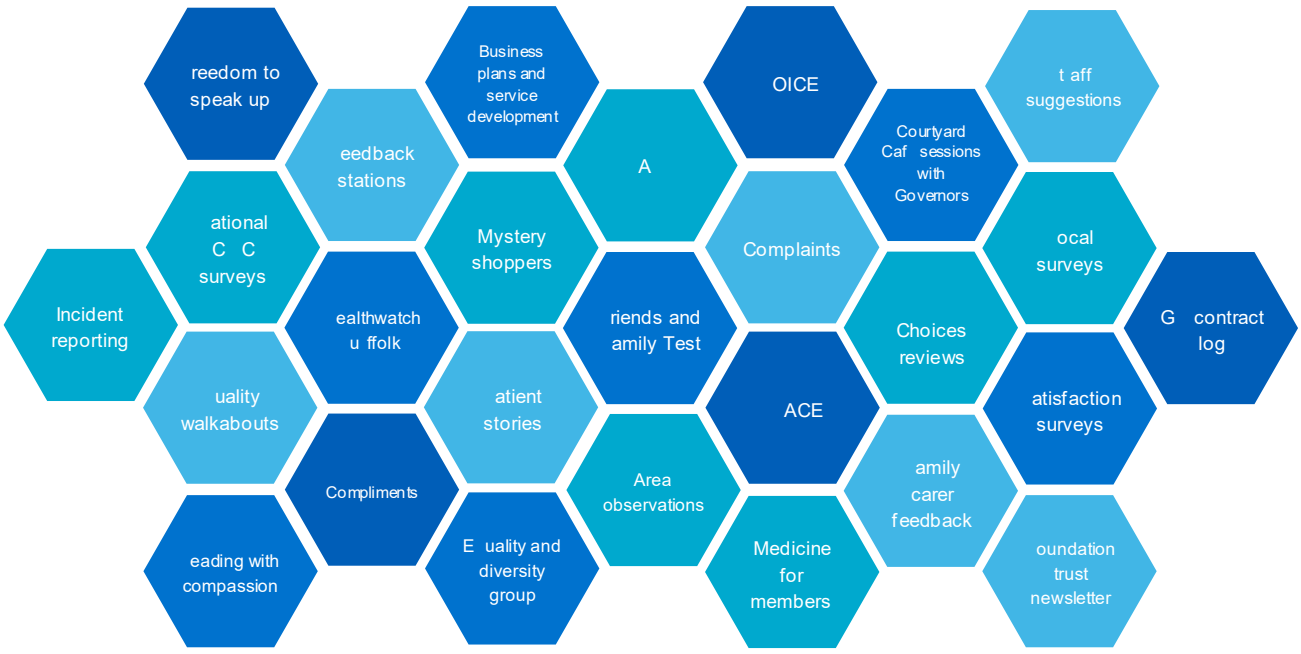

Figure 1: Feedback collection methods from Experience of Care Strategy

4.1 Members' newsletter

The membership newsletter is distributed to all members.

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

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

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

4.2 Public and Member events

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

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

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

4.3 Staff involvement

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

4.4 Engagement plan

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

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

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

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

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

5.0 The membership register

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

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

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

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

6.0 Monitoring success

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

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

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

6.1 How will the success be measured?

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

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

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

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

Appendix 1

PUBLIC CONSTITUENCY OF THE TRUST

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

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

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

27. Review of COVID governance arrangements

To ACCEPT the report

For Report

Presented by Richard Jones

Trust Open Board – 2 October 2020

Agenda item:	27			
Presented by:	Richard Jones, Trust Secretary			
Prepared by:	Richard Jones, Trust Secretary Rebecca Gibson, Compliance manager Denise Pora and Claire Sorenson, Deputy Directors of Workforce			
Date prepared:	23 September 2020			
Subject:	Governance arrangements during COVID response			
Purpose:		For information	X	For approval

Executive summary:

In April 2020 the Board received a report that acknowledged that many of 'business as usual' activities will of necessity be paused during the COVID-19 response. This included an assessment of activities that were paused or able to continue.

This report provides an update on this position

This report provides a list of the full scope of functions split by individual activities which are:

a. **Paused**, this includes those activities where a national decision to pause has been issued as well as those where a local decision has been made following Executive team review.
b. Able to **continue** but required to being provided in a different way e.g. supporting social distancing. Where an activity remains ongoing without any need for change in management pathways it is not included in this report.

Where an activity is being paused, the narrative includes an assessment of the potential impact of stopping the activity and the mitigations being put into place to lesson that impact and/or recover the position once the activity is able to resume.

Annex 1 provides additional for the following specific elements:

- Management of Trust governance committee agendas and meetings
- Process for managing complaints during the COVID period
- Management of incident reporting and investigation
- Mandatory training and appraisal
- IQPR
- *CQC and improvement plan (provided as a separate Board agenda item)*

Further information is provided for following areas:

- Governance functions (Annex 2)
- HR functions (Annex 3)
- Operational / other functions (Annex 4)

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

Previously considered by:	Trust Board meeting May 2020
Risk and assurance:	
Legislation, regulatory, equality, diversity and dignity implications	See individual references throughout the document

Recommendation:

1. The Board to note the report
2. Approve that the small number of outstanding areas are subject to further review and update to the Board on 4 December 2020

Arrangements for specific elements

1. Management of Trust committee agendas and meetings

Guidance on social distancing is being maintained by holding virtual meetings (using the Microsoft Teams).

Committee	Status
Trust Board (open and closed)	Business as usual – using Teams Planned review of agenda to ensure appropriate focus of the Board time. **ACTION** - sustained social distancing measures consider options for including public in Board meeting e.g. as used at the annual members meeting - Looking to model a similar approach to volunteers for NEDs and governors to undertake face-to-face activities. In addition continuing to develop virtual connections, including with the community.
Audit Committee	Business as usual – using Teams
Scrutiny Committee	Business as usual – using Teams
Charitable Funds Committee	Business as usual – using Teams
Remuneration Committee	Business as usual – using Teams
Quality & Risk Committee (Q&RC)	Business as usual – using Teams including topics for presentation s with Governor invites N.B. Committee structure review proposal to Board on 2 October 2020
Sub-committees of Q&RC: Corporate Risk Committee (CRC) Patient Experience Committee (PEC) Clinical Safety & Effectiveness Committee (CSEC) Quality Group	Business as usual – using Teams
Council of Governors and sub committees (Engagement committee and Nominations committee)	Business as usual – using Teams Limited engagement activities but considering how this can be undertaken through face-to-face work or electronically (see Board action above)

2. Integrated quality and performance report (IQPR)

Prior to Covid the structure of the IQPR was under review and a plan had been adopted to deliver a more targeted performance report to the Board. Early in our Covid response an interim IQPR was developed which was well received. The previous plan to upgrade the IQPR has been updated taking into account these developments as part of the Covid response. It has been decided that we will not use statistical process control (SPC) charts as the filter for areas of performance that need greater focus but the metrics will be escalated to the Board based on a physical review. To enable this task to be manageable and meaningful, a 'watch list' of at-risk metrics will be developed from the full the IQPR. This list will exclude metrics that always perform well and require little attention – these will remain in the full list.

Each month, the watch list will be reviewed by the Head of Performance and Efficiency and the information team and any indicators that are under/over performing will be escalated into the Board report. A longer list will be maintained of all the metrics which will continue to be monitored. The

watch list and the full longer list of KPIs will be reviewed quarterly and metrics moved between lists as appropriate. For example, if a metric on the watch list has had sustained performance improvement over the previous quarter, it may be moved into the longer list and not reviewed until the next quarter. In the same way, if a metric on the long list has deteriorated in the last quarter this would move to the monthly watch list and it could be subject to Board reporting. More detail is presented in the performance report as part of the main agenda.

3. Governance functions split by individual activities with status / impact and mitigations

Activity	Recommenced status
Information Governance reporting and FOI	Now restarted
Health & Safety workplace inspections	Now restarted
Risk assessments – management of new / current Red risks via face-to-face Exec led meetings	Red risk assessment reviews are now completed on Microsoft Teams
Patient Experience 'Friends and family' surveys	Recommenced on 1 August
Management of incident reporting and investigation (Red, Amber and Green incidents)	All now back to pre-COVID status
Complaints	Back to usual complaint timeframes for any complaints received 1st August onwards. All red complaints that were paused are being given timeframes for response and will all be closed as soon as staff responses are received. Many have already been responded to.
NICE baselines assessment compliance	Follow up in July was supported by clinical staff who are shielding / working non-clinically - this ended when these staff returned to work but has recommenced in September Backlog escalated at CSEC/TEG and additional resource being identified
Inquests	Notification, preparation and planning of inquest cases continue. Specific cases highlighted as of concern to the organisation will still take place at some time in the future, dates tbc and the appropriate oversight of lessons learned / action completion will be revisited
Divisional governance steering group / board meetings	Now taking place on Microsoft Teams
Production of data for Consultant appraisal	Recommenced
All aspects of audit programme including national and local audits	Still paused. Vacant posts within central governance team have impacted on this. Secondment being put into place to address this in October subject to suitable applicants. National audits paused across whole health service so no local adverse impact of non-participation. Escalated at CSEC/TEG.
Quality walkabouts	Currently paused due to COVID restrictions but to recommence in September/October starting with maternity services as a pilot

4: HR functions split by individual activities with status / impact and mitigations

Activity	Recommenced status
Recruitment – non-COVID related	Recruitment moving back to BAU
Job evaluation	Recommenced
Mandatory training existing staff (not bank)	Face-to-face mandatory training update days restarting in August 2020 these will only cover the face-to-face sessions that have an annual review cycle i.e. basic life support, manual handling.
Mandatory training / Induction - Bank staff including medical staffing	All core mandatory training will be completed as part of the induction process for new bank staff Refresher training requirements were reinstated on 15th July
Staff returning to the NHS to support the response to COVID-19	Core mandatory training mandated by NHS Employers as a minimum.
Substantive staff currently working in usual location or from home who have previously undertaken training in all core mandatory training subjects	Refresher training requirements reinstated on 15th July for all e-learning.

Activity	Status	Potential impact of stopping activity	Work required to recover the position in future and/or structure required to be in place in the interim to mitigate impact
ESR supervisor self service	Implementation postponed	Loss of efficiency gain particularly around sickness absence reporting and appraisal	Update implementation plan and set new date
Pay progression for staff covered by Agenda for Change	Implementation postponed	Delay to implementation of more robust system for pay progression within AfC pay bands. National decision	New national timescale for implementation to be decided
Trust Induction – non clinical	Paused	Staff do not have access to important but non-mandatory training.	Mandatory training provided by e-learning. On-line Trust induction with input from CEO and EDWC to be provided from October.
Trust induction – clinical	Business as usual	Continued throughout pandemic period	
Appraisal	To continue wherever possible	Negative impact on directing workforce effort/resources, identification of education and training needs and morale	Managers encouraged to continue with at least an annual appraisal where capacity allows this.
Education and training – non mandatory	Paused	Negative impact on capability of the workforce e.g. around Human Resources	Priority non-mandatory training to be identified and re-started as soon as circumstances allow. Exploring options for on-line e-learning e.g. for appraisal training

Activity	Status	Potential impact of stopping activity	Work required to recover the position in future and/or structure required to be in place in the interim to mitigate impact
Volunteer service	Paused	No Trust volunteers currently active	Keeping in touch arrangements in place with volunteers – receiving weekly call from volunteer service team. Plan being implemented to start to bring volunteers back where risks can be mitigated sufficiently
Investigations / disciplinary / grievance processes	Review on an individual basis	Negative impact on staff morale and performance.	If a patient safety element: review if the employee can be redeployed (to remove the risk) or suspended (if risk is significant) or if the investigation needs to go ahead due to nature of the risk.
Workforce Race Equality and Disability Equality Standard reporting (2020), Gender pay gap reporting (2019) PSED	Reporting cancelled and then reinstated PSED reporting requirement suspended	Loss of momentum for local inclusion strategy and action plan (national decision – NHS and Government GPG) Trust complying with PSED reporting in 2020 despite suspension to maintain momentum around inclusion	Work to restart as soon as circumstances allow. 2019 GPG has been reported. Both WRES and WDES have been completed and report going to Trust Board on 2.10.20. Reports will be published on WSFT website in line with requirements
Job planning for medical staff	Suspended	Delay in agreeing duties, responsibilities and objectives for the coming year	Any urgent issues to be addressed on an ad hoc basis.
Employer Based Awards Committee	Postponed	Award of discretionary points and clinical excellence awards to senior medical staff delayed.	Payments will be backdated.

5: Operational / Other functions split by individual activities with status / impact and mitigations

Operational recovery is reviewed at the Board and Scrutiny Committee on a monthly basis. It is not considered separately here.

28. Use of Trust's seal

To APPROVE the report

For Approval

Presented by Richard Jones

Trust Board Meeting – 2 October 2020

Agenda item:	28			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Karen McHugh, EA to CEO			
Date prepared:	28 September 2020			
Subject:	Use of Trust's seal			
Purpose:	X	For information		For approval

Executive summary:

To note use of the Trust Seal, pursuant to Standing Order section 8. The Trust Seal was used on the following occasions:

Seal No. 142
Deed of Variation of a lease relating to Glemsford Surgery, between WSFT, Dr Melissa Williams & Dr Matthew Thomas Piccaver - Sealed by Craig Black & Stephen Dunn, witnessed by Ruth Williamson Mandal (24 September 2020)

Seal No. 143
Licence to assign relating to Glemsford Surgery between WSFT, Dr Mary Emma Giblin, Dr Matthew Thomas Piccaver & Dr Melissa Williams and Dr Matthew Thomas Piccaver & Dr Melissa Williams - Sealed by Craig Black & Stephen Dunn, witnessed by Ruth Williamson (24 September 2020)

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

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

Previously considered by:	None
Risk and assurance:	None
Legislation, regulatory, equality, diversity and dignity implications	WSFT's Standing orders

Recommendation:
To note the use of the Trust's seal

Putting you first

29. Agenda items for next meeting

To APPROVE the scheduled items for the next meeting

For Approval

Presented by Sheila Childerhouse

Board of Directors – 2 October 2020

Agenda item:	29			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	23 September 2020			
Subject:	Items for next meeting			
Purpose:		For information	X	For approval

The attached provides a summary of scheduled items for the next meeting and is drawn from the Board reporting matrix, forward plan and action points.

The final agenda will be drawn-up and approved by the Chair.

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

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

Previously considered by:	The Board receive a monthly report of planned agenda items.
Risk and assurance:	Failure effectively manage the Board agenda or consider matters pertinent to the Board.
Legislation, regulatory, equality, diversity and dignity implications	Consideration of the planned agenda for the next meeting on a monthly basis. Annual review of the Board's reporting schedule.

Recommendation:

To approve the scheduled agenda items for the next meeting

Scheduled draft agenda items for next meeting – 6 November 2020

Description	Open	Closed	Type	Source	Director
Declaration of interests	✓	✓	Verbal	Matrix	All
Deliver for today					
Patient story	✓	✓	Verbal	Matrix	Exec.
Chief Executive's report	✓		Written	Matrix	SD
COVID-19 report	✓		Written	Action	HB
Integrated quality & performance report	✓		Written	Matrix	HB/SW
Finance & workforce performance report	✓		Written	Matrix	CB
Risk and governance report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
Invest in quality, staff and clinical leadership					
People and OD report, including: - Guardian of safe working report – Q2 - Freedom to speak up guardian report – Q2 - Mandatory training - Q2 - Staff Health and Wellbeing - annual update	✓		Written	Matrix	JO
Nurse staffing report	✓		Written	Matrix	SW
Improvement programme board report	✓		Written	Standing item	SD/SW
Annual review of: - Quality improvement strategy - Safety and learning strategy	✓		Written	Matrix	 NJ SW
National patient survey report	✓		Written	Matrix	SW
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	SW
Consultant appointment report	✓		Written	Matrix – by exception	JO
"Putting you first award"	✓		Verbal	Matrix	JO
Build a joined-up future					
Integration report – Q2	✓		Written	Matrix	KV / HB
Pathology services report	✓	✓	Written	Matrix	CB/NJ
Strategic update, including Alliance, System Executive Group and Integrated Care System (ICS). Including timetable for strategy review.	✓	✓	Written	Matrix	SD
Governance					
Trust Executive Group report	✓		Written	Matrix	SD
Quality & risk committee report, including annual report	✓		Written	Matrix	SC
Planning report for annual governance review	✓		Written	Matrix	RJ
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
Use of Trust seal	✓		Written	Matrix – by exception	RJ
Agenda items for next meeting	✓		Written	Matrix	RJ
Reflections on the meetings (open and closed meetings)		✓	Verbal	Matrix	SC

11:20 ITEMS FOR INFORMATION

30. 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

31. Date of next meeting

To NOTE that the next meeting will be held on Friday, 6 November 2020 at 9:15am in West Suffolk Hospital

For Reference

Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

32. 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