NHS
West Suffolk
NHS Foundation Trust

Board of Directors (In Public)

Schedule	Friday 24 April 2020, 9:15 AM — 11:15 AM BST
Venue	Via video conferencing
Description	A meeting of the Board of Directors will take place on Friday, 24 April 2020 at 9:15am via video conference facility
Organiser	Karen McHugh

Agenda

AGENDA
Presented by Sheila Childerhouse

Agenda Open Board 24 Apr 2020.docx

9:15 GENERAL BUSINESS
Presented by Sheila Childerhouse

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

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

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

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

NHS
West Suffolk
NHS Foundation Trust

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

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6. Minutes of the previous meeting
   To APPROVE the minutes of the meeting held on 27 March 2020
   For Approval - Presented by Sheila Childerhouse

   Item 6 - Open Board Minutes 2020 03 27 March Draft.docx

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

   Item 7 - Action sheet report.doc

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

   Item 8 - CEO report.doc

9:40 DELIVER FOR TODAY

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

   Item 9 - COVID-19 report.doc

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

    Item 10 - Board report Cover sheet - M11.docx

    Item 10 - Finance Report FINAL - March 20.docx

10:20 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

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11. Trust improvement plan
    To APPROVE the report recommendations and the plan which addresses the CQC findings
    For Approval - Presented by Rowan Procter

    Item 11 - 20-04-24 CQC action plan Board.docx

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12. NHS resolution – maternity incentive scheme
    To approve the report
    For Approval - Presented by Rowan Procter

    Item 12 - NHS Resolution maternity incentive scheme quarterly report - Q4 April 2020.doc

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13. Freedom to speak up guardian report
    To approve the report for Q4
    For Approval - Presented by Jeremy Over

    Item 13 - Freedom to speak up board report April 2020.doc

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

    Item 14 - Consultant appointment report - April 2020.doc

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

10:50 BUILD A JOINED-UP FUTURE

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16. Integration report
    To APPROVE the report for Q4
    For Approval - Presented by Helen Beck and Kate Vaughton

    Item 16 - April Board cover sheet C-19 WS alliance highlight report_kv.doc

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11:00 GOVERNANCE

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17. Governance changes in response to COVID
To APPROVE the report
For Approval - Presented by Richard Jones

Item 17 - Governance arrangements during COVID response.docx

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

Item 18 - TEG report.doc

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19. Remuneration Committee report
To ACCEPT the report
For Report - Presented by Angus Eaton

Item 19 - Rem Com report.doc

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20. Use of Trust seal
To ACCEPT the report
For Report - Presented by Richard Jones

Item 20 - Use of Trust Seal Report 24 April 2020.docx

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

Item 21 - Items for next Board meeting.doc

11:10 ITEMS FOR INFORMATION

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22. 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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23. Date of next meeting
To NOTE that the next meeting will be held on Friday, 29 May 2020 at 9:15 am in West Suffolk Hospital (note moved from 22 May)
For Reference - Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

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24. 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

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To AGREE any alterations to the timing of the agenda. Please note the following agenda reports have been postponed: quality and performance, mandatory training.

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DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 27 MARCH 2020 AT WEST SUFFOLK HOSPITAL

COMMITTEE MEMBERS- (v)=joined meeting via video link			
		Attendance	**Apologies**
Sheila Childerhouse	Chair	• (v)	
Helen Beck	Chief Operating Officer	•	
Craig Black	Executive Director of Resources	•	
Richard Davies	Non Executive Director	• (v)	
Steve Dunn	Chief Executive	•	
Angus Eaton	Non Executive Director	• (v)	
Nick Jenkins	Executive Medical Director	•	
Gary Norgate	Non Executive Director	• (v)	
Jeremy Over	Executive Director of Workforce and Communications	•	
Louisa Pepper	Non Executive Director	• (v)	
Rowan Procter	Executive Chief Nurse	•	
Alan Rose	Non Executive Director	• (v)	
In attendance			
Georgina Holmes	Trust Office Manager *(minutes)*		
Richard Jones	Trust Secretary		
Kate Vaughton	Director of Integration and Partnerships		
Governors in attendance (observation only)			
Florence Bevan (v), Liz Steele (v)			

Action

GENERAL BUSINESS

20/51 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."

20/52 APOLOGIES FOR ABSENCE

There were no apologies from for absence. The Chair and Non-Executive Directors joined the meeting via video link.

20/53 REVIEW OF AGENDA

The agenda was reviewed and it was noted that the main focus of the meeting would be COVID-19. The following agenda reports had been postponed: questions from the public, matters arising, nurse staffing, appraisal, consultant appointment, 7-day services, education, culture & engagement, NED responsibilities, agenda items for next meeting.

Two questions had been received from governors and it was agreed that they would be addressed under the relevant agenda item:

- Can the governors be assured that the hospital has enough equipment available to them for immediate use, to protect them from being infected by patients with the virus?

- I realise that the CQC action plan, although included in the papers, may be taking second place behind the serious events going on at the moment but in reading the action plan it seems that the governors, apart from staff governors, are not included in the monitoring and assurance. It would seem by putting staff governors in we are splitting the governors into two different groups?

20/54 DECLARATION OF INTERESTS

There were no declarations of interests.

20/55 MINUTES OF MEETING HELD ON 28 FEBRUARY 2020

- The minutes of the above meeting were agreed as a true and accurate record subject to the following amendment:

  Page 8, item 20/41, first paragraph, first two sentences to combined to read, "The staff survey and CQC report had been received by the Trust in the last six weeks; it was important to look at these side by side."

- The new format of the minutes was considered to be an improvement, but the context of discussions needed to be clear.

20/56 CHIEF EXECUTIVE'S REPORT

- The world had completely changed since the last meeting and the country was now in the delay phase of COVID-19. This was therefore the main focus and priority for the Trust, although some business as usual was continuing.

- The executive team were leading on the response to COVID-19 and all their work on this was commended. There had been a fantastic response from staff in creating and freeing up capacity and identifying additional capacity in ITU. This morning of the 480 beds available in the hospital 240 (50%) were occupied. This was due to the magnificent team effort across the hospital and community which meant that WSFT was in one of the best positions across the Integrated Care System (ICS).

- WSFT was working with the independent sector to create additional capacity in the community. It was ensuring that staff were safe and protected; the Trust had a good supply of personal protective equipment (PPE) but there was an ongoing concern amongst staff around the guidance.

- Daily briefings were being issued to staff to keep them as up to date as possible and try to reassure them. Nick Jenkins had also enhanced communication with doctors and there was increased executive visibility through daily walk arounds with senior clinicians capturing staff feedback and concerns. NEDs were also receiving regular briefings and other communications.

- A lot of work was being undertaken on the workforce, led by Jeremy Over. This included free parking and other support for staff.

- Visiting restrictions were in place across the hospital and the reasons for this were being communicated to the public.

DELIVER FOR TODAY

20/57 COVID-19 REPORT

- The written report had been included in the closed rather than open board papers as the Trust did not want it in the public domain given the sensitive nature of some of the content; however, it was trying to be very open with the information it was sharing.

- This was a very unusual situation as organisations did not normally have a month to plan for a major incident. The board thanked those individuals who had been focussing on this and working extremely hard over the past weeks, often in different roles.

- From 1 April the organisation would be moving into a more formal command and control structure for the management of this. All the executive directors (EDs) were leading on separate pieces of work and this was currently 100% of their focus.

Q Can governors be assured that the hospital has enough equipment available to them for immediate use, to protect them from being infected by patients with the virus?

A There had been a major logistics issue for the NHS supply chain but the national team had listened to concerns and was addressing these as fast as they could. WSFT currently had no problem with the general supply of PPE. However, this needed to be used appropriately and carefully so that there wasn't a problem in the future. Currently WSFT had supplies of everything required apart from the fluid needed to test people with masks but it was expected that further supplies would be available shortly.

Q Were there any examples of staff deviating from the guidelines?

A Yes, but guidelines were changing regularly and independent guidelines were being uses by the Royal Colleges which was causing confusion and problems. Further national guidance was being issued today but this was not expected to change dramatically. Guidance was also being considered by the Health and Safety Executive and Public Health England, therefore it was hoped to get firm clarification.

Q Was this a case of staff rebelling or one or two people experiencing difficulties?

A Nurses were being very compliant but were frightened and there had been confusion as guidance was changing around masks etc. Doctors were not rebelling but were also concerned and anxious. There was confusion as the logic behind the guidance was unclear and in some cases differed from advice from the Royal Colleges. Meetings were taking place to try to clarify this and it was recognised that this was causing problems. Until everyone was saying the same clinicians would continue to be worried and want to do what their expert sectors advised.

Q Have any clinicians become ill as a result of this?

A 20% of staff were self-isolating or not at work, mainly due to family members or contacts. No staff had been confirmed positive for COVID-19 or were in hospital as a possible COVID-19 case.

Nick Jenkins cautioned about giving out information about staff who were in hospital and the need to maintain patient confidentiality.

Q What is the situation in primary care?

A Primary care practices were combining to create respiratory hubs which would be operational 24/7 and supported by a visiting service. Wherever possible they were undertaking virtual/telephone consultations. The situation with PPE was very different in primary care as they were classed as non-NHS providers and had not be allowed the same level of priority deliveries. This had now changed and the situation should improve. The inability to test staff was also an issue and a large number were self-isolating due to contact with others etc. Each of three alliance areas were meeting twice a week to consider joined up working wherever possible.

- Social care was aiming to increase capacity by 100%. Patients requiring community and social care were being RAG rated as to the level of care they required and where possible their care was being downgraded and families asked to support them. Suffolk County Council were training 5000 back office staff to enable them to supplement the social care workforce.

- Community services had secured one, possibly two, floors at a new nursing home in Bury St Edmunds and the bed base at Newmarket would be increased by 14 beds next month, with the aim of increasing the community hospital bed base to over 100. The intention was to move people out of hospital into care homes and out of care homes into their own home.

- The county council had done a lot of work to stabilise the care home care market with local providers to give them security and assurance of a financial flow with the expectation that they would take discharges seven days a week.

- The Trust was seeing a rapid transformation in how it was delivering services, eg virtual consultations, discharges, working with social care etc and the system was working very collaboratively to prepare for COVID-19. It was hoped that this would help towards delivering transformation in the future and change the way in which people worked.

Q How would any changes to governance structures over the COVID-19 period be formally recorded?

A NHS Providers had issued a paper on this. It was important to clarify what the Trust would be continuing to do as well as what it would be stopping and then consider how it would move into the recovery phase.

Action: A summary report of governance changes as a result of the COVID-19 response to be taken to the next board meeting. **R Jones**

20/58 INTEGRATED QUALITY AND PERFORMANCE REPORT

Q Were any changes or expectations relating to responses to complaints during the COVID-19 period being documented? If this was the case this needed to be discussed as a board.

A NHSE&I had put a three month hold on any complaints being investigated nationally.

It was not going to be possible to investigate complaints as there would be no senior nursing staff available. A verbal process had been agreed with Cassia Nice who would triage complaints on a weekly basis and identify any themes. There would be template responses to address various themes and these would not be investigated. The ombudsman would not be taking on any cases. The regional office had agreed with this approach and would be sharing it with other health care providers.

The only variation from the triage system was if something needed to be picked up at a later date. There would still be people available from PALs to provide support.

- It was stressed that during this period the Trust could be letting down a lot of patients and missing things that were important. The board needed to understand that the organisation was moving into a completely different world and it would be very difficult for staff to accept that they may not be providing anywhere near the quality of care they would like to. Patient experience would not be the major focus due to the pressure staff were under. It was anticipated that the surge would be in two to four weeks and the board must understand that the Trust would not be able to maintain the standard of care that it expected to deliver.

Q How do we communicate this to the public so that they understand that this may be the situation?

A As this region was two to three weeks behind London a national debate would start before this was needed locally.

Q Was there something about providing limited assurance around managing patients who had heart attacks etc?

A The major incident response was to treat these patients with the same priority as patients with COVID-19, ie all clinically urgent and emergency patients would be treated the same. However, Papworth was not likely to be able to treat patients for primary intervention and preparations were being made to return to using clot busting drugs. Therefore organisations would not be providing the standard of care that they would like to.

Q What had been the effect on RTTs, follow-ups, pathways etc?

A The Trust had virtually stopped all routine activity. This had been worked through at specialty level and there was now list of what would continue and what would stop. The majority had already stopped as staff were being trained to do other roles.

- RTTs- the Trust had written to GPs and asked them to stop sending routine referrals but continue to send urgent and two week waits. Patients had been cancelled due to COVID-19 and the information team had set up a code so that these patients could be identified. RTT 52 waits would increase significantly. Cancer activity was being managed by clinicians through clinical decision making on a case by case basis.

Q Is there a benefit in the Trust being more public about changes in pathways?

A Clinicians were working through this patient by patient and taking a risk based approach to ceasing or reducing routine activities based on patient needs. It was likely that the public will pick this up through the media without a public announcement. The Trust needed to work with GPs to manage this on an individual patient basis.

As the number of ITU beds had been increased there would be very limited anaesthetic cover for surgery. There would be a delicate balance between COVID-19 and non COVID-19 care and this was likely to move towards COVID-19.

Q Where will patients go to ask about scheduled operations, ie in June

A Individuals would know who to contact from their appointment letter and could call the appointment centre teams. Patients were being told that they would be contacted if their procedure is going to be cancelled. June was too far ahead to know what would be happening.

20/59 FINANCE AND WORKFORCE REPORT

- This report related to the end of February. The Trust remained on track to meet its control total with all the interventions discussed at previous meetings. However, things had changed significantly since the last meeting.

- Arrangements had been made to collate and record all COVID-19 related costs. A claim for approximately £1M had already been submitted for estimated costs in March and the team was looking at what costs were likely to be in the future.

- There was also a significant capital element associated with COVID-19 relating to additional equipment, increasing capacity at Newmarket etc.

- Cash would continue to be a concern; it was not an issue currently and was forecast not to be an issue until the end of March. Arrangements were in place so that in April the Trust would receive two contract payments, ie double the amount it would normally receive in April. Therefore, it would be holding an extra month's income in cash terms.

- Income had been calculated centrally and recommendations had been made on increases on the sum that organisations would normally expect to receive. Additional costs incurred were being monitored and there was a central commitment to repay all costs relating to COVID-19; however it was important not to lose control of expenditure.

Q What would be the effect on temporary staff expenditure?

A Expenditure on temporary staff would increase, ie overtime, bank and locum costs. It had been agreed that staff would be paid overtime, which had previously been stopped.

A number of staff were self-isolating or working from home where possible. Where there were clinical roles that required filling these were being filled wherever possible and there were no restrictions on doing this.

Q Are normal procedures for closing year end continuing?

A In acknowledgement of the problems faced by WSFT and its auditors, the timetable had been moved to from Friday 24 to Monday 27 March. It would be a challenge for all organisations to meet the year end timetable.

It was noted that in the commercial world the timetable had been extended by up to six months.

Q Will there be an additional item for COVID-19 in the year end accounts.

A No.

Q Were there policies/HR arrangements in place for the management and payment of staff who were self-isolating and also the management of sickness absence during this period?

A Jeremy Over would share the detail with any NED who wished to see this outside the meeting. Arrangements had been put in place for managers and staff to raise questions relating to this.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

20/60 QUALITY AND LEARNING REPORT

Q Was it likely that issues could still be managed whilst the organisation was focussing on COVID-19?

A No, this would be taken one day at a time. The national Patient Safety Incident Response Framework (PSIRF) had been put on hold during this period.

Q What about processes relating to the investigation of serious incidents?

A This would be included in the governance work on what the Trust would continue to do and what it would stop doing.

Action: Include narrative in this report as to whether the number of investigations required was considered to be good or bad, using benchmarking data if available, and if there were any areas of concern. **R Procter**

20/61 MATERNITY INCENTIVE SCHEME 2020-21

Not discussed.

20/62 PUTTING YOU FIRST AWARD

Jeremy Over read out the citation for the following members of staff who received Putting You First Awards in March: Jess Fuller and Thomas Gooday, biomedical scientists, pathology services:

"*A lot of people do 'what they should have' and many 'a bit more' but Jess Fuller and Thomas Gooday went above and beyond and deserve recognition.*

Jess and Thomas should have left work at 5.00pm and wouldn't have had to deal with the specimens at all had they done sow. Instead they voluntarily stayed until 8.00pm to:

a) Ensure the samples got packaged and sent by courier for specialist testing – we couldn't be sure that the samples would have reached the reference lab without their problem-solving.
b) Deal with the samples in the BSL-3 safety lab, helping to protect blood sciences lab staff, who otherwise would have been dealing with the samples."

The board congratulated Jess and Thomas and thanked them for putting the Trust and their colleagues first.

BUILD A JOINED-UP FUTURE

20/63 TRUST IMPROVEMENT PLAN

Q What was happening to the improvement plan and to what extent could this be delayed or downgraded?

A Discussions had been had with NHSI about capturing some of the actions that would be implemented during this period that would address some of the elements in the plan.

- The improvement plan had in effect been put on overall pause; however there was a detailed plan which required the board's endorsement. This did not capture all of the details from the quality summit but the Trust would seek to implement aspects of the action plan where possible and where a minimum amount of effort to do so was required.

- COVID-19 would take priority over normal business wherever relevant.

- Some of the cultural changes would require a degree of engagement and these activities had been put on pause; however, the recent response from the organisation in preparing for and managing COVID-19 would hopefully mean that some of the issues could be addressed in a different way as there was now greater engagement and closer working relationships between clinicians and the executive team.

Q Rather than looking at this as a plan, should the Trust look at a series of principals and areas that the organisation could apply? Would it be worth looking at the improvement plan alongside the COVID-19 plan and consider if a number of elements could be applied to this situation?

A A number of these actions were being addressed and NHSI and the CQC were having a discussion today. The outcome of this would be reported back to the board.

Q Was it possible to indicate on the plan what actions had been stopped during COVID-19, also opportunities that could continue to be followed up, eg maternity?

A Where possible an indication would be given on what was and was not being paused. Weekend audits were no longer being undertaken in maternity as there was no capacity; the CQC were aware of this. However, patient safety remained the focus and different assurance techniques were being used.

Q Would there be a monthly progress report on the improvement plan?

A This would need to be considered in the current circumstances; as the organisation moved into the next phase of COVID-19 all elements of business as usual would be suspended. It was important for the non-executive directors to understand that implementing the action plan would not be a priority.

Action: Review the improvement plan to be clear which improvements were paused and proposed monitoring for those ongoing. **R Procter**

Q Whilst it was understood that the improvement plan would not be a priority it was suggested that work on this should not stop completely and should continue in some areas.

A Every clinician in this organisation had a professional qualification but they would be undertaking jobs that they only had a certain level of competency in, eg a nurse looking after a patient on a ventilator, with minimum training in this area. It had been recognised by all authorities that these were extenuating circumstances. . Everyone would want to continue to deliver a level of patient care and safety but due to lack of staff it was not possible to provide assurance that this would be the case.

The organisation would do everything in its power to give patients the best possible care but as demand became more challenging the expectation was that it would not be possible to maintain other things, ie auditing and documenting.

- It was the board's responsibility to ensure that the Trust got through this challenging time and that it could demonstrate why decisions made were reasonable and were recorded. Clinicians should not be caught up in bureaucracy but there needed to be mechanism to record why actions/decisions had been taken.

- This linked to how COVID-19 was being managed as an incident and how decisions etc were being recorded. Decisions made were being logged and there was a framework in place which included an ethics group and workforce group were making rapid decisions that were evidence based.

- At each meeting the groups tried to ensure that discussions and decisions were very clear. There was an action log and a decisions log so that these could be referred back to if necessary. They were trying to make these decisions in a team structure rather than by an individual in order to support people in decision making. The Trust was very mindful of the need to be able to justify the decision making process.

- It was suggested that the command structure that was in place should be made more transparent to the board.

GOVERNANCE

20/64 TRUST EXECUTIVE GROUP REPORT

The board received and noted the content of this report and that the priority was COVID-19.

20/65 CHARITABLE FUNDS COMMITTEE REPORT

Investments made had depreciated due to the effect that COVID-19 was having on the stock market. The decision had been made to continue with these on the basis that they were long term investments

ITEMS FOR INFORMATION

20/66 ANY OTHER BUSINESS

- The board acknowledged the huge amount of work that was being undertaken during this challenging time.

- The NEDs acknowledged everything that the executive team were doing during this challenging time. They considered that it was their role to provide support to the executive team and ensure that there was a process for recording key decisions and actions so that there could not be any repercussions in the future.

20/67 DATE OF NEXT MEETING

Friday 24 April at 9.15am in the Northgate Room, Quince House, WSFT.

RESOLUTION TO MOVE TO CLOSED SESSION

20/68 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 – 24 April 2020

Agenda item:	7			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	17 April 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
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**. 27/4/20 Focus of quality and performance reporting during COVID being considered at Board and Audit Committee.**	CB	~~31/01/2020~~ 24/4/20	Paused
1805	Open	31/1/20	Item 8	Provide a detailed report to Scrutiny committee on 18 weeks improvement plans, including detailed service-level plans with proposed target date for improvement	Elective care programme only dealing with patients who can be treated virtually in outpatient setting. To be addressed as part of the COVID recovery plan	HB	27/03/20	Paused

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1822	Open	28/2/20	Item 8	Provide a summary of the proposed amended process for duty of candour and confirm when this will be implemented	**Duty of candour (DoC) response has improved for March, with only one DoC outstanding relating to a pressure ulcer in the community. It is recognised that we need to update of duty of candour procedures to reflect the general duty of candour (irrelevant of the level of harm). This is ongoing but has been delayed as a result of the need to engage with relevant clinical staff.**	RP	26/6/20 ~~27/03/2020~~	Green
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	HB	27/03/20	Paused
1825	Open	28/2/20	Item 8	Confirm timing of report to Board on outpatient transformation (supports cancer and RTT)	Significant outpatient transformation has been achieved as part of COVID planning and response. Full assessment of the longer-term impact will form part of the COVID recovery plan.	HB	27/03/20	Paused
1826	Open	28/2/20	Item 10	Implement the new quality walkabout process, including capturing the soft intelligence	**Quality walkabouts suspended and will be revisited post COVID.**	RP	24/04/20	Paused
1828	Open	28/2/20	Item 16	Maintain Board oversight of non-urgent patient transport performance, with formal review report to Board in May	All outpatient transport on hold during COVID. To be considered when organisation returns to business as usual.	HB	29/05/20	Paused

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1830	Open	28/2/20	Item 21	Review and consider Board agenda and report structure. Provide greater focus on staffing/people over transactional issues	Board agenda and reports significantly reduced in response to COVID	SC / RJ	24/04/20	Paused
1836	Open	27/3/20	Item 10	Develop the learning report to include benchmarking data when available	Feedback requirement to the team who will take this on board but are restricted by the ability to obtain reliable benchmarking information. This has been escalated to the CCG.	RP	26/06/20	Green

Closed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1752	Open	27/9/19	Item 8	Noted overview of nutrition performance in the IQPR and quarterly learning reports. However, agreed that need a clear plan, including timescales, to deliver improvement (including feedback from the F9 pilot).	Nutrition compliance is improving and continues on an upward trajectory due to continued focus at Ward level. There continues to be specific areas of concern and this mainly centres around paediatrics. There are plans to split the data from adults and paeds to present the trajectory in this format with an aim to achieve 95% by April 2020 in adult compliance. We are meeting with the information team to ensure the criteria is correct for this and we are capturing all the data. There has been increased focus in paediatrics and an action plan has been requested. With regard to the pilot on F9, this has been placed on hold due to being unable to recruit into the position for the trial. There has also been a change in the Service Manager, and the vacancy has also lead to the pilot being put on hold. This will be discussed at the Nutrition Steering Group this month. **17/4/20 Reported position for March is 93%. This will be kept under review as part of business as usual reporting post COVID.**	RP	~~29/11/2019~~ 24/4/20	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1791	Open	29/11/19	Item 2	Provide an update on the plan for development of the new hospital, including financial implications of the loan. The development must be underpinned by engagement with stakeholders	Governance structure for new development was submitted to the Scrutiny Committee and will be reported to the Board in April as part of the strategic outline case (SOC). **Agenda item of closed Board**	CB	24/04/20	Complete
1807	Open	31/1/20	Item 10	Consider how the positive approach of asking 'anything you'd like to escalate' question for doctors could be applied to other groups	This now forms part of the daily safety huddles which includes nurses, porters, security, RPI, infection prevention and safeguarding	RP	27/03/20	Complete
1824	Open	28/2/20	Item 8	Confirm the outcome of the information review to ensure no patients have been lost during e-Care 'cutover'	Confirmed with the information team that the scenario for the patient concerned related to a clinic for which 'outcomes' were not recorded. This was reviewed and confident that other patients not effected by the same issue.	HB	27/03/20	Complete
1827	Open	28/2/20	Item 11	Provide assurance on the action to address staff sickness in theatres	Sickness reporting figures now significantly impacted by COIVID and self-isolators. Post COVID any variance will be addressed/escalated through business as usual.	HB	27/03/20	Complete
1829	Open	28/2/20	Item 17	Address gap of operational input to the new hospital development programme	Considered as part of the OBC business case	CB/HB	27/03/20	Complete
1835	Open	27/3/20	Item 7	Prepare a summary report of governance changes as a result of the COVID response	**Agenda item**	RJ	24/04/20	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1837	Open	27/3/20	Item 13	Review the improvement plan to be clear which improvements are paused and proposed monitoring for those ongoing	**Agenda item**	RP	24/04/20	Complete

8. Chief Executive’s report

To RECEIVE a report on current issues

For Report

Presented by Stephen Dunn

Board of Directors – 24 April 2020

Agenda item:	8			
Presented by:	Dr Stephen Dunn, Chief Executive			
Prepared by:	Dr Stephen Dunn, Chief Executive			
Date prepared:	17 March 2020			
Subject:	Chief Executive report			
Purpose:	X	For information		For approval

Executive summary

It feels like the world has changed more than a little in the last month…. our number one priority is now ensuring that we can respond to **COVID-19 demand**, while also meeting the other urgent health needs of our local population.

As always, in responding to this challenge our **greatest asset is our staff** and as ever they have responded amazingly to allow us to plan, prepare and respond to the demands placed upon us. But we need to look after them! As part of the COVID-19 response, we've established a sub-group specifically to look at our workforce and staff support. That group is helping us develop a wider offer of preventative and restorative support strategies, including yoga sessions, mindfulness sessions, mindful walks on health and (social distancing) exercise classes.

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

- Continuing to develop the **clinical guidance** for hospital (acute) clinical staff so they have information on the initial medical management and flow of patients with suspected or confirmed COVID-19
- Reviewing **clinical and bed capacity** to respond to the increasing COVID demand. In addition to additional critical care beds, we have prepared seven COVID wards to help care for the increase in patients we expect to see
- With visiting restrictions in place using Trust iPads the IT department is looking at ways to **support patients to communicate** with their families, friends and carers - and particularly to support end of life patients
- Continuing to support and encourage clinicians to use either **telephone or video conferencing facilities** instead of conducting face to face clinics
- Established a **support helpline and webchat**. With visiting restriction requirements, the purpose of the service is to provide advice and support to relatives of patients in our care quickly, which will also have the added benefit of taking pressure away from clinical areas
- **Supporting emotional wellbeing and mental health** of staff: including a range of practical measures and free access to mindfulness apps 'Headspace' and 'Unmind'
    - Made **car parking free** for all staff at West Suffolk Hospital
    - Extended **catering services** and free hot beverages
    - Free of charge **accommodation** available for staff

- Introduced a specific **staff psychology support team** that colleagues can access for 1-2-1 support
- Providing a coordinated approach to accessing **childcare support** through Suffolk County Council
- Providing advice about who **should be wearing scrubs and where**
- Staff can now access a free national **mental health hotline** to give them support as they help our communities deal with the coronavirus
- We have teamed up with WHSmith, Abbeycroft, the AA, Sainsbury's and EE to provide **staff discount and products**.
- A new **staff information hub** that means staff can now get to all our COVID-19 staff help and information from any internet connection – whether in the Trust, from their mobile, or from home
- Church of England pastoral support for staff
- My WiSH Charity has put together a basic food welfare pack for staff in need in these challenging times. Any staff who have lost an income due to the coronavirus pandemic and are struggling, or that are in financial difficulty, are encouraged to reach out for support
- Clarifying mandatory training and appraisal requirements during the COVID response.

- We are participating in two mandatory urgent Public Health Research **clinical trials** relating to COVID-19.

This report will be received at our second Board meeting during the national response to COVID-19 and with the lockdown in place the meeting will not be open for the public attend. To **maintain transparency**, we have built on our pilot at the last Board meeting and extended the invite to our Governors to observe this month's Board meeting using Microsoft Teams.

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

This is a shorter report than normal but I wanted to take the opportunity to say **thank you** to our community and our amazing staff.

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,	None						

diversity and dignity implications	
Recommendation: The Board note the report	

9:40 DELIVER FOR TODAY

9. COVID-19 report

To RECEIVE a briefing

For Report

Presented by Helen Beck

Board of Directors – 24 April 2020

Agenda item:	9			
Presented by:	Helen Beck, Executive Chief Operating Officer			
Prepared by:	Helen Beck, Executive Chief Operating Officer			
Date prepared:	20 April 2020			
Subject:	COVID-19 Report			
Purpose:	X	For information		For approval

Executive summary:

As outlined in the March board update, the Covid-19 pandemic continues to overshadow all other activity within the Trust.

This paper briefly outlines the organisational changes which have been made and the transformation which is being delivered at astounding speed to enable us to support our community our patients and our staff.

The report outlines current capacity in terms of staff and physical resources and highlights that currently the organisation is coping well with the demand and that overall demand for non Covid related activity is significantly reduced.

Further sections of the report identify the changes to organisational structures and clinical teams to manage the current situation, highlighting the impact on cancer services and plans to increase non-cancer activity over the next 2 weeks.

The importance of good communications, staff wellbeing and patient experience in these unprecedented times are recognised and plans to address these issues are outlined.

Finally, the key risks and issues are outlined along with our approach to mitigating these.

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

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

Previously considered by:	**N/A**
Risk and assurance:	

Legislation, regulatory, equality, diversity and dignity implications	
Recommendations: 1. *To note the content of this report*	

Covid-19 Planning and Response

April Board Update

Introduction

As outlined in the March board update, the Covid-19 pandemic continues to overshadow all other activity within the Trust.

This paper briefly outlines the organisational changes which have been made and the transformation which is being delivered at astounding speed to enable us to support our community our patients and our staff.

Current Capacity Situation

Critical Care capacity

At the time of writing the Trust has implemented phase one of its critical care expansion plan. This has increased capacity from 9 to 19 beds split between 12 beds in an affected area and 7 beds in a non-affected area. Within the affected area there are 9 patients, 6 positives,2 awaiting results and one with a negative result but clinically appears Covid positive and is being treated as such. Activity in the non-affected area has been very low with no more than 2 patients at any time. Phase 2 of the critical care plan will be implemented as required, this will move the non-affected patients into recovery and convert the current non-affected area into additional beds for affected patients.

General and Acute Bed Capacity

To maintain social distancing in all bays 122 beds are currently closed across the site and 322 beds remain open and available for use. Of these 141 have been designated for suspected or confirmed Covid patients and 114 have been designated for non Covid patients. We are currently operating at approximately 60% occupancy across all of the open bed base.

At the time of writing there were 32 patients confirmed as Covid positive with a further 42 awaiting test results. It is recognised that the test has a significant false negative rate and there are a number of patients who have tested as negative but who clinicians believe are clinically presenting as Covid positive and these are being treated in accordance with the clinical presentation. Turnaround times for test results is averaging at about 48 hours.

Display The following Number of Days Worth of Data											14
DoW	Date	ED Attendances	Average Journey Time (minutes)	Number of 12 hr waits	Stranded Patients 7+ Days	Stranded Patients 14+ Days	Stranded Patients 21+ Days	Ambulance Arrivals	Emergency Admissons (Via ED)	Discharges	AEC Admissions
Monday	23/03/2020	136	157	0	118	58	32	48	43	67	5
Tuesday	24/03/2020	119	154	0	104	50	28	52	38	64	8
Wednesday	25/03/2020	101	150	0	93	45	28	45	38	52	8
Thursday	26/03/2020	119	156	0	79	47	24	52	44	66	4
Friday	27/03/2020	105	132	0	77	49	25	38	32	63	11
Saturday	28/03/2020	102	137	0	82	47	24	44	29	23	3
Sunday	29/03/2020	100	152	0	84	47	27	40	33	17	0
Monday	30/03/2020	91	142	0	80	45	23	56	32	40	3
Tuesday	31/03/2020	108	177	0	82	42	22	52	34	41	0
Wednesday	01/04/2020	95	145	0	76	38	20	34	33	40	3
Thursday	02/04/2020	111	163	0	75	35	22	47	31	56	3
Friday	03/04/2020	99	144	0	65	26	19	45	35	48	2
Saturday	04/04/2020	110	160	0	67	26	18	52	44	38	2
Sunday	05/04/2020	95	183	0	70	32	18	43	29	20	0
Monday	06/04/2020	114	153	0	67	29	15	39	37	40	8
Tuesday	07/04/2020	122	161	0	62	26	13	46	31	28	1
Wednesday	08/04/2020	112	139	0	64	29	14	42	33	37	4
Thursday	09/04/2020	99	133	0	57	28	12	43	22	48	6
Friday	10/04/2020	95	130	0	58	26	11	35	38	39	1
Saturday	11/04/2020	91	150	0	65	28	10	38	33	36	2
Sunday	12/04/2020	110	162	0	68	29	13	48	34	31	0
Monday	13/04/2020	117	167	0	70	33	15	36	41	33	0
Tuesday	14/04/2020	123	119	0	68	29	15	44	42	42	8
Wednesday	15/04/2020	93	152	0	69	29	14	41	33	42	5
Thursday	16/04/2020	115	130	0	64	30	16	44	31	35	5

The table above demonstrates the established trend in ED attendances, emergency admissions and stranded and super stranded patients which are all 50-60% down on pre Covid activity levels, contributing significantly to our positive capacity position. This is a national phenomenon which is not clearly understood although there are concerns that patients with non Covid conditions are not seeking appropriate help at this time due to either; fear of contracting Covid in hospital or not wishing to put more pressure on what they perceive to be an overburdened NHS. National and local media campaigns are advising the public that services are still available and that they should seek help if they are unwell.

Community Capacity

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

Staff Availability

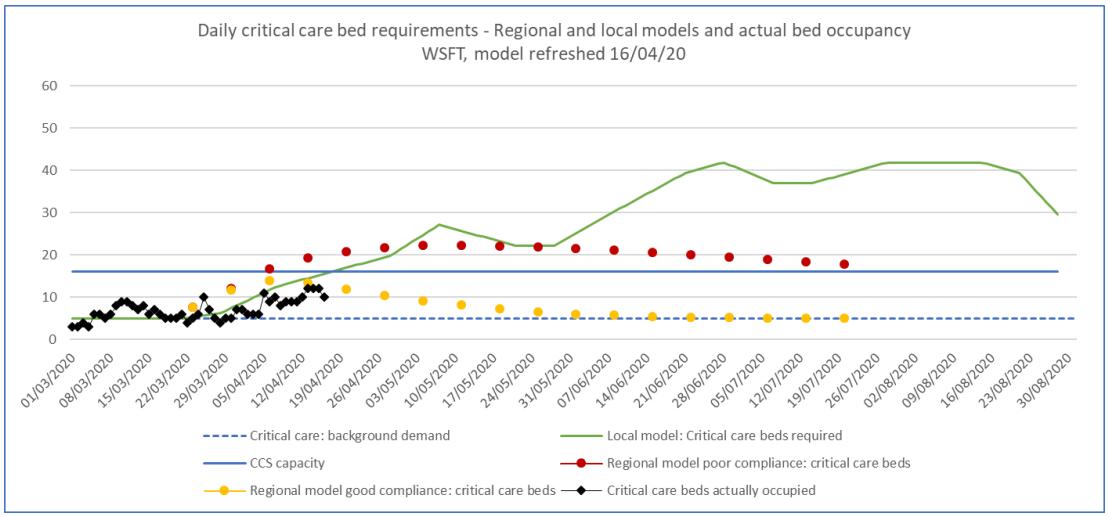
We are monitoring and reporting levels of absence due to staff sickness and self-isolation. For week commencing 13th April overall levels of staff sickness and self-isolation was at 6.95% of which 4.69% as related to Covid sickness or self-isolating and 2.26% was due to other reasons.

These levels of sickness whilst higher than normal Trust sickness absence rates have not led to significant staffing shortages in either the acute or community teams. It is anticipated that the increased capacity for staff swabbing will have a positive impact on the figures for self-isolating.

Nationally it has been reported that large numbers of doctors, nurses and other professional groups are returning to practice. At WSFT we have reduced recruitment time to 4 days and have returned a relatively small number of staff back to work in some key roles. In terms of the national drive we have only had one volunteer identified and they have already joined our team.

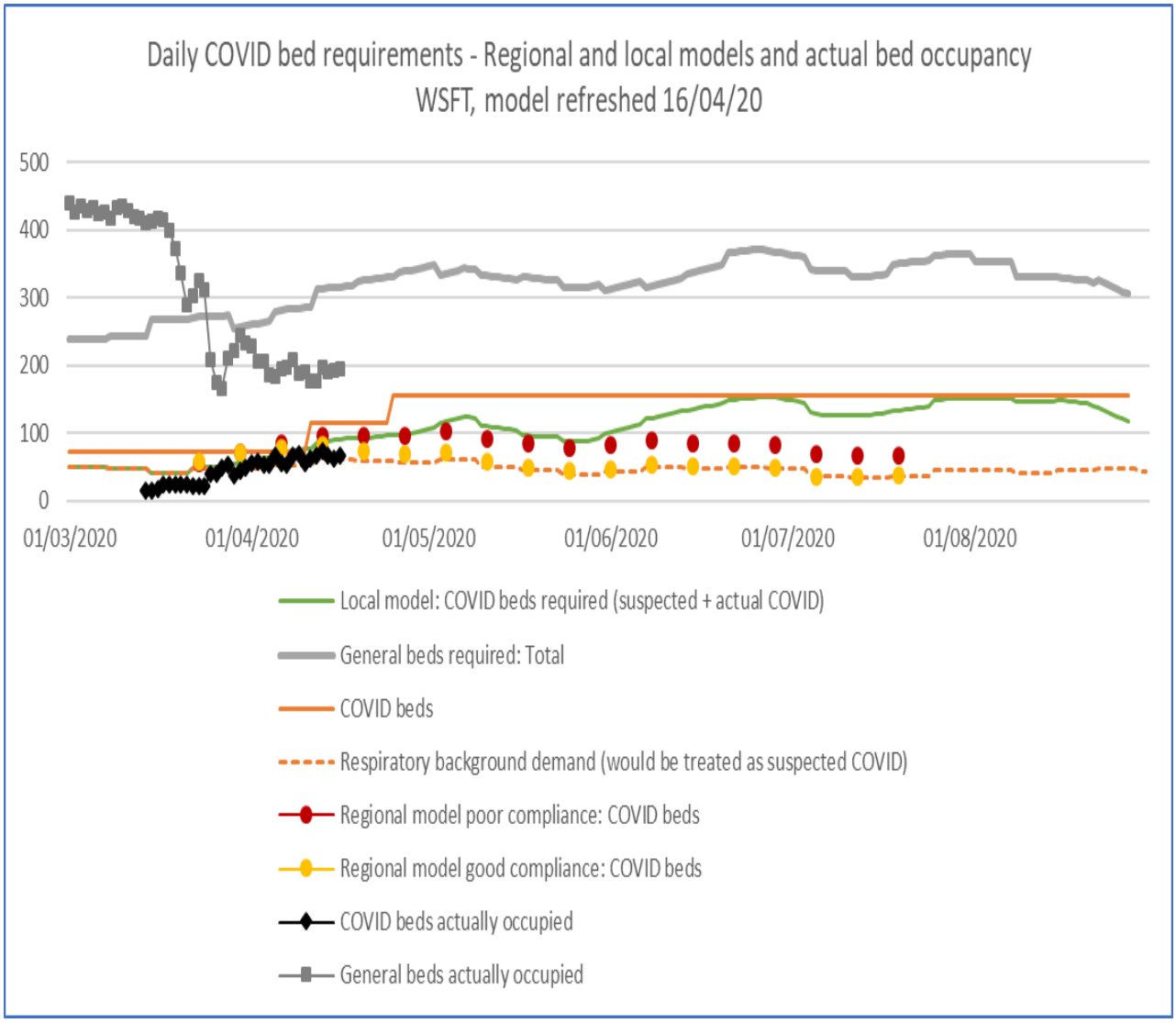
Activity Modelling and Actuals

Members of the board will be aware of the modelling work undertaken by Helena Jopling to support planning assumptions at WSFT. The tables below show the latest refreshed modelling based on updated regional models recently received in light of new data following the national lockdown measures. The first table shows critical care and capacity and the second general and acute bed capacity.



Helena has been very clear that these models are based upon limited data and should be interpreted with caution. However, at the current time this is the best information available to us and as the actual activity shows we are in line with the good compliance (with lockdown) trajectories. The duration of the lockdown, ongoing societal compliance and the impact as

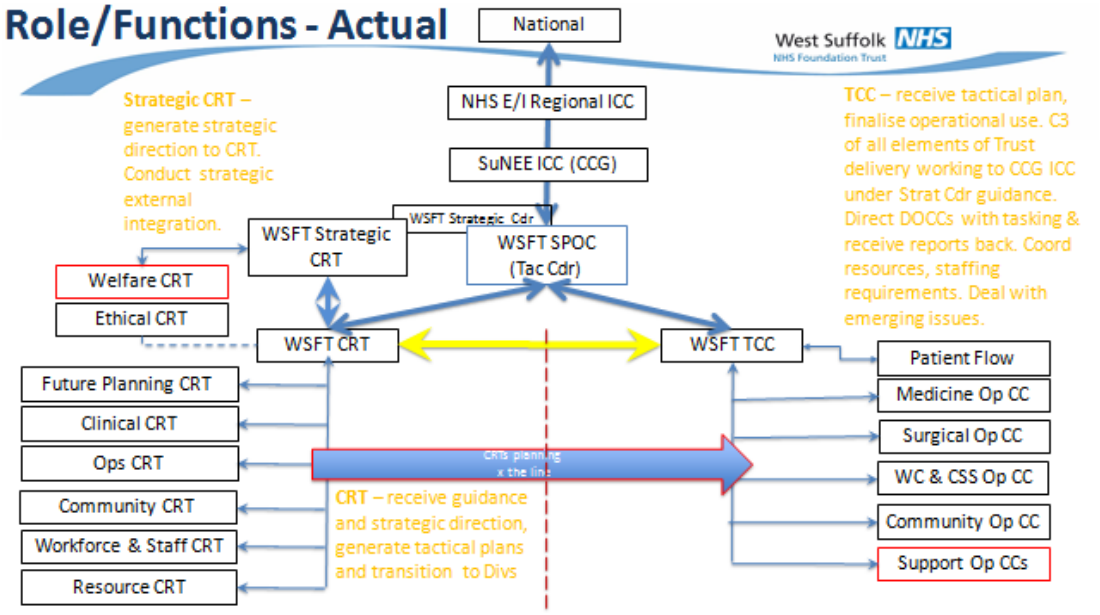
restrictions are lifted are as yet unclear and the local modelling as indicated by the solid green line has taken a more pessimistic view on these factors at the current time.



What is clear is that the exponential increase in cases which we were planning for has been avoided to date for our local population. As a result, we are cautiously moving to increase our capacity for other non Covid activity, recognising that we now have the ability to ramp up Covid related capacity more quickly having test our approach and trained significant numbers of staff in alternative roles.

Management Structures

It is recognised that Covid is a national emergency and as a Trust we have been preparing to respond to a major incident through a command and control structure. The structures outlined in last month's board update were largely around the preparatory phases of work and over the past 2 weeks we have been moving into a responsive phase with the tactical cell being the primary focus of the organisational response.



We have currently established these command and control arrangements 7 days per week from 08:00-20:00 and are monitoring requirements on a regular basis to determine whether we should increase or decrease the resource committed to this. Experience to date is that the teams on duty are not consistently busy, however requests for information and responses to new directives continue to be received at any time over with very short timelines for response.

Clinical Group

The Clinical CRT group chaired by Andrew Dunn (consultant orthopaedic surgeon) has been very active as part of our Covid preparations as it has been necessary to completely revise the working patterns of most of our medical teams. Key achievements of this group include:

- Consultants working consistently across 7 days in all specialities, delivering for example two consultants on each medical ward, every day.
- Critical Care and anaesthetic consultants working in teams, covering 24/7.
- Nursing and therapy teams from theatres and other areas have been redeployed to join the critical care teams to increase capacity in this area.
- Junior doctors did not rotate as planned on 1st April, instead staying with the roles that they are experienced in.

In additional the following has been implemented to maximise clinical activity: Appraisals have been suspended in line with GMC's suspension of revalidation, job planning round has been suspended and EBAC has been postponed.

The ethical subgroup has also considered a number of complex issues arising as a result of the need to protect staff and other patients during the current pandemic. These issues include the restriction of visiting, a decision to suspend home births and guidance around CPR. It has been agreed that Louisa Pepper will chair this group going forward.

Cancer Services

Guidance relating to the provision of cancer services from professional bodies, NHSE/I and the cancer alliance is changing frequently and we are working hard to adapt and respond to these changes and maintain a level of service for our patients.

We are seeing a large reduction in the number of referrals we are receiving, these appear to have reduced by about a half. There is a concern that there will be patients who are delaying attending GP's with potential cancer symptoms and at some point, in the not too distance future we will see

an increase in referrals again. Our current total waiting list is 572, which is significantly below what we are used to, with the biggest drop being in the 0-14 days. There will be other reasons for the drop, including the pathway co-ordinators having the capacity to be up to date with pathway tracking and management.

Given the concerns around this cohort of patients I have provided a detailed summary of the situation in each tumour site below:

Breast – we continue to see new patients and have run as many operating lists as possible up on site, with plans to run 2 all day list per week at the BMI from 23rd April.

Colorectal – Most patients would usually go straight to test in Endoscopy, this is currently not happening due to guidance from JAG and the relevant professional bodies. As a result, there are 150 patients waiting to be investigated at the time of writing. Additional triage is in place and patients are aware of who to contact if their symptoms change, we have also arranged to have the ability to conduct FIT testing in secondary care for any patients the team are particularly worried about. There are currently no patients waiting for surgery, but there will be once Endoscopy is back up and running.

Gynaecology – continue to maintain service, with some patients being managed via alternative pathways. There currently have 8 patients with diagnostics on hold and 1 patient for treatment which will be able to be undertaken in the next couple of weeks as we increase surgical capacity.

Head and Neck – Thyroidectomy's have been risk assessed and delayed, other than that there are no patients waiting surgery and 9 patients on hold for a diagnosis. All of these have been clinically reviewed and are being carefully monitored.

Lung – continue chest X-ray and investigations and referring patients for treatment within Oncology/Papworth

Skin – continue to maintain service, patients having biopsies etc with Dermatology in outpatients and plastic surgery will be moved to the BMI from the WC 27th April. There are however around 16 patients with diagnosis on hold, but this is mainly due to patient choice/self-isolating etc.

Upper GI – most patients would go directly to Endoscopy, the triage process for this has now changed so all patients are having a consultant triage and telephone consultation, those that need an endoscopic investigation are being prioritised so that the highest risk can be investigated when we are able to do so. There are 22 patients currently waiting for Endoscopy.

Urology – patients are still being seen for 1 stop haematuria and suspected prostate cancer. Patients found to have cancer will likely be offered hormone therapy/surveillance, there are 9 patients with a diagnosis on hold and 7 with treatment on hold. There is potential to move this activity to the BMI in due course.

We are now working to actively increase the amount of capacity for cancer surgery and expect to be able to clear all of the above relatively small backlogs over the next couple of weeks. The issue relating to endoscopy is of some concern particularly in relation to colorectal referrals.

Community Group

The community sub group of CRT have worked extensively with a range of system partners as part of the Covid 19 response. It is anticipated that there will be a lengthy impact on community healthcare capacity as more patients will be cared for at home, including at end of life. The CCG have commissioned additional support from the hospice team to support end of life care in the community and the hospice are recruiting additional staff to respond to this. The community teams have undertaken a caseload prioritisation exercise utilising a RAG rating, although currently we are able to continue to deliver the standard level of care.

The community group have led on the implementation of the hospital discharge service requirements issued by NHSE/I, which includes ensuring patients are moved to the discharge waiting area within 2 hours of being declared medically-optimised. As part of these preparations, a multi-professional discharge hub has been established 8am to 8pm, 7 days per week to expedite the discharge process. This includes junior doctors and pharmacy input to ensure the issuing of take-home medication (TTOs) does not hold up the discharge process.

25 additional care beds have been procured by the CCG from Marham Park care home to ensure that patients can move from the acute hospital as quickly as possible. The community assessment bed base at Newmarket is currently being expanded by 14 additional beds and the medical model and cover has been agreed to support this, recognising that these patients are likely to be more acute than their usual reablement patients.

Covid 19 has had a significant impact on care homes nationally, and there is evidence of this locally. This has attracted significant media attention, particularly as the published death figures only include hospital deaths. The community group has led on the implementation of swabbing of patients prior to return to care homes, in line with recent national requirements, working closely with the other Divisions.

System Working

A significant amount of system wide transformation has been achieved as part of the response to Covid, details of which are outlines in the West Suffolk Alliance paper.

Patient Experience

We decided early in the current Covid 19 response to cease all visiting apart from in very specific circumstances and even in these situations visiting is extremely limited. The patient experience team have launched a Keeping in Touch service to enable patients to be in contact with their relatives and friends, via video calls, phone calls or the passing on of a hand-delivered card. The IT team have supported this by providing patients on the wards with re-purposed Ipads on stands for patients to use. In addition, relatives can speak to dedicated clinicians working with the PALS team to find out up to date information about the care and treatment of their loved ones.

My Wish are working with PALS to co-ordinate the production of knitted hearts and condolence cards which can be personalised by staff caring for patients at end of life and sent to grieving relatives.

Communications

Effective Communication is a key strand of the Trist response to Covid. External communications are subject to clear guidance from NHSE/I, for example on how Covid 19 deaths within the hospital are reported. The communications team have ensured that the public website includes a range of useful information for patients, relatives and the wider community.

Internally, the communications team link with the Core Resilience Team to design and issue messages as required, including via the intranet, emails and posters. This has been particularly vital in terms of communicating the changes in relation to PPE guidance. In response to staff requests for a centralised point for information, the communications team have recently launched the Covid 19 staff zone microsite, accessible for staff on or off site. This includes information on cases, clinical guidelines, PPE guides and staff wellbeing support. The communications team also issue a daily staff briefing with the most up to date information. Previous daily briefings are also included on the microsite.

The information team have developed a Covid 19 dashboard and a screenshot is shared on a daily basis with staff. Work is ongoing to ensure this is available live via the microsite, whilst ensuring patient information is kept confidential.

Communication with staff is integral to the CRT and tactical structures. Daily walkabouts are conducted by Executive Team members, accompanied by a senior doctor and nurse, to provide face to face leadership and reassurance to staff. Critical messages can be reinforced and issues raised by staff are fed back to CRT to respond to. The Medical Director issues a weekly bulletin focussed on key messages for medical staff.

The operational and clinical sub groups of CRT are utilised as a mechanism to disseminate key information, and the Divisional Operational Command Cells also play a vital role in communicating with staff. There is a dedicated central Covid 19 email address for staff to ask questions, and as the Divisional Cells become more embedded it is likely more issues will be raised via these.

PPE

The provision of adequate stocks of appropriate PPE has been the cause of much media attention as well as the focus local, regional, and national planning. The good news is that we have managed to maintain a supply of necessary PPE to all staff at all times throughout the pandemic. The situation has been precarious at times due to issues with the supply chain, changes to the specification of the items delivered, which we have no control of, and a shortage of testing fluid to ensure a good fit for the FFP3 masks. We have established a resource group led by Nick Macdonald which has enabled us to have full visibility of all available stocks of PPE and estimates of how long the supply will last. This has been vital as we mange this issue in the context of a just in time delivery service over which we have no control.

Guidance about the correct PPE to wear in different clinical situations has also changed rapidly in the early stages of the outbreak, however definitive guidance endorsed by all of the professional bodies and the Academy of Royal Colleges was issued on 2nd April. The changes to the guidance caused uncertainty and anxiety prior to this which is taking some time to settle in many areas of the organisation. We have produced clear guidance and posters for all clinical areas which designates them as Red, Amber or Green and indicates the required level of PPE for each area and for high risk clinical procedures. We have implemented a daily walkabout by an executive and a senior consultant and senior nurse to visit areas, listen to staff concerns and provide reassurance and advice relating to PPE and other Covid issues.

An emergent issue over recent days has been the national shortage of gowns which are required for high-risk procedures. We were notified of this shortage on a national webinar on 16th April and have been encouraged to restrict the use of gowns and explore the re-using of single-use gowns following revised guidance. Within the Trust we do not have a current shortage of gowns but are working with clinical areas to ensure appropriate use of stocks and a reduction of wastage. A proposal is being developed for nominated PPE champions to provide training, advice and guidance in all clinical areas.

The Core resilience team is considering alternative mitigating options to preserve PPE supplies and the Ethical Group has been asked to consider the issue of staff safety versus patient need in the event that adequate supplies are not maintained.

Workforce and Wellbeing Group

The facilities team have supported staff welfare schemes through the provision of free hot drinks for all staff plus free hot and cold food for all staff on night duty.

The Trust has also waived charges for staff to park on site from 1st April and stopped the provision of the shuttle bus from the rugby club due to social distancing requirements. Staff are still able to park and the rugby club and walk to the hospital if they wish.

Staff are also able to access accommodation on site free of charge to facilitate self-isolation away from families if required.

In addition to these very practical measures the Trust has taken the wellbeing of staff extremely seriously. The new coronavirus microsite has a dedicated wellbeing section which provides details of a range of supports measures for staff including the provision of psychological support from clinical psychologists and psychological therapists already working within the Trust.

Staff swabbing

The issue of staff swabbing has attracted significant media interest and is also an ongoing concern for many staff. NHSE/I have issued guidance to Trusts setting out requirements to deliver swabbing of staff and index cases within households, in order to enable staff who were self-isolating to return to work if negative for Covid 19. Within the Trust, staff and index case swabbing has been undertaken by the Emergency Department, with Divisions prioritising requests from line managers. The Telephone Appointment Centre has facilitated the booking of slots for staff. This is currently available to WSFT and ambulance staff, with imminent plans to extend this to other health and social care colleagues. Due to the national requirement to increase testing to 100,000 tests daily across the NHS by the end of April, co-ordination of booking swabbing will move to a centralised function at Ipswich. One of the national drive-through swabbing centres has been established at Copdock, Ipswich and staff can also access the centre at Stansted. The site at Copdock is planned to have capacity for up to 400 tests per day.

Estates and IT

The estates and IT departments have continued to work at pace to deliver a number of schemes to support the Trusts Covid-19 response.

Work to supply piped oxygen to every bed space on ward F3 was completed early and handed back to the Trust over the Easter bank holiday weekend. At the time of writing this ward has not been put back into operational use due to a decline in the demand for beds. In addition to this work has been carried out to maximise the supply of oxygen to the site, although this remains a potential rate limiting step in our ability to increase our critical care capacity. Regular daily reports of oxygen usage across the site are now circulated and a policy for “good housekeeping” in regard to oxygen use had been developed.

Work is progressing on the additional 14 beds at the Newmarket site and this is due for completion mid/end of May.

The IT teams have facilitated extensive working from home for many teams across the organisation and those working on site have managed to improve their ability to socially distance through relocation of offices.

IT have also accelerated the roll out of the new mobile phones to community teams to enable them to access more Trust resources whilst away from base locations.

Covid-19 reporting tools have been the focus of the work of the information team over the last month.

We were also pleased to be asked to extend our HIE to facilitate potential use of the London Nightingale Hospital by patients from the East of England.

The Estates department are also facilitating the provision of additional mortuary capacity on site. This capacity will provide 200 additional spaces. Current modelling suggests this may not be required but the Suffolk Resilience Forum has decided to make the provision.

Recovery Planning

Craig Black has been identified as the executive lead for recovery. This work is being taken forward by the future planning group which is in the early stages of developing recovery plans. At each stage of planning for Covid related activity changes, consideration has been given to the

need to map and report against any changes so that the recovery team can identify any affected cohorts of patients.

A system call is scheduled to consider the wider recovery implications

Key Risks and Issues

Oxygen

The current situation has created an additional demand on oxygen supplies, both piped oxygen and cylinders. Patients with Covid 19 symptoms often require oxygen therapy as part of their hospital treatment. This has been recognised nationally as a significant risk factor across many sites. We are monitoring our use of piped oxygen and this is currently at the rate we would expect in winter with a full hospital, which demonstrates the increased demand, considering we are operating at approximately 50% capacity on a daily basis. We are also monitoring oxygen cylinder holdings and we are maintaining a good level of cylinders. In order to mitigate the risk we are encouraging “good oxygen housekeeping”, i.e. the appropriate clinical use of oxygen to maintain adequate oxygen saturation rather than automatically using high levels. National guidance has also been issued to advise that clinicians should aim for 92-96% oxygen saturations rather levels above that. It is worth noting that the national pressure on cylinder oxygen also impacts on patients who have home oxygen in the community; this provision is commissioned directly from the CCG.

PPE

As outlined above the supply of PPE is an ongoing risk with supplies and distribution under significant pressure internationally.

Staffing

We are carefully monitoring staff absence due to Covid but at the current time this has not become an issue for us, possibly due to the lower levels of activity at the current time.

Non Covid activity

Rapid access referral and emergency attendances and admissions have both reduced by up to 50% during the Covid pandemic. There is a significant risk that we will see a spike in emergency attendances in the short term and a rise in cancer related activity in the medium term. Local and national communications have been issued to encourage those who need to, to attend their GP or the hospital.

10. Finance and workforce report

To ACCEPT the report

For Report

Presented by Craig Black

Board of Directors – 24 April 2020

Agenda item:	10			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	20th April 2020			
Subject:	Finance and Workforce Board Report – March 2020			
Purpose:		For information	x	For approval

Executive summary:
The planned surplus for the year is to break even, but the outturn position (subject to audit) is a surplus of £0.3m.

As a result the Trust anticipates receiving all PSF/FRF associated with meeting its control total.

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

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

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

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
March 2020 (Month 12)

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

Financial Summary

I&E Position YTD	£0.3m	surplus
Variance against plan YTD	£0.3m	favourable
Movement in month against plan	£3.7m	favourable
EBITDA position YTD	£0.6m	adverse
EBITDA margin YTD	0.2%	adverse
Total PSF Received	£10.395m	accrued
Cash at bank	£2.4m	

Executive Summary

- The planned surplus for the year is to break even, but the outturn position (subject to audit) is a surplus of £0.3m.
- As a result the Trust anticipates receiving all PSF/FRF associated with meeting its control total.
- The Trust has been reimbursed with all costs relating to COVID 19

Key Risks in 2020-21

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

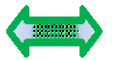
SUMMARY INCOME AND EXPENDITURE ACCOUNT - March 2020	Mar-20 Budget £m	Mar-20 Actual £m	Mar-20 Variance F/(A) £m	Year to date Budget £m	Year to date Actual £m	Year to date Variance F/(A) £m
NHS Contract Income	18.9	16.4	(2.6)	216.5	223.7	7.2
Other Income	2.6	11.7	9.1	37.5	41.6	4.1
Total Income	**21.6**	**28.1**	**6.5**	**254.0**	**265.3**	**11.3**
Pay Costs	14.5	16.4	(1.9)	172.4	177.3	(4.9)
Non-pay Costs	7.0	10.3	(3.3)	80.3	87.4	(7.1)
Operating Expenditure	**21.5**	**26.7**	**(5.3)**	**252.7**	**264.7**	**(12.0)**
Contingency and Reserves	2.3	0.0	2.3	(0.5)	0.0	(0.5)
EBITDA excl STF	**(2.2)**	**1.3**	**3.5**	**1.8**	**0.6**	**(1.2)**
Depreciation	0.7	0.7	0.0	8.1	7.4	0.7
Finance costs	0.3	0.2	0.1	3.9	3.3	0.6
SURPLUS/(DEFICIT)	**(3.3)**	**0.4**	**3.7**	**(10.1)**	**(10.1)**	**0.0**
Provider Sustainability Funding (PSF)						
MRET, FRF/PSF - Financial Performance	1.0	1.0	(0.0)	10.1	10.4	0.3
SURPLUS/(DEFICIT) incl PSF	**(2.3)**	**1.4**	**3.7**	**0.0**	**0.3**	**0.3**

FINANCE AND WORKFORCE REPORT – March 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 – March 2020

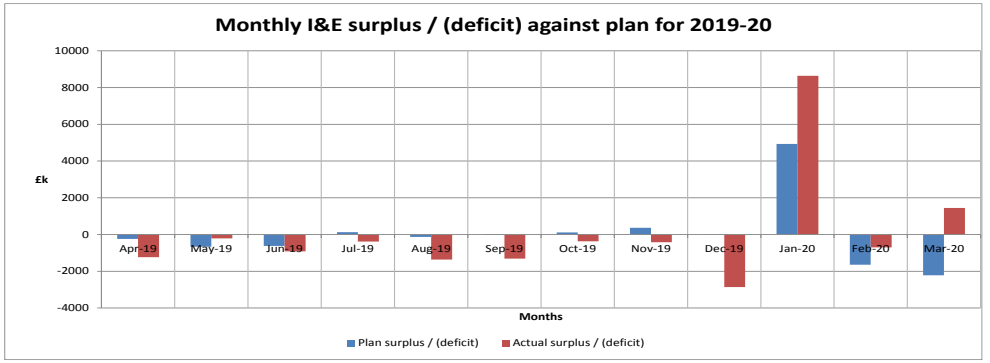
Income and Expenditure Summary as at March 2020

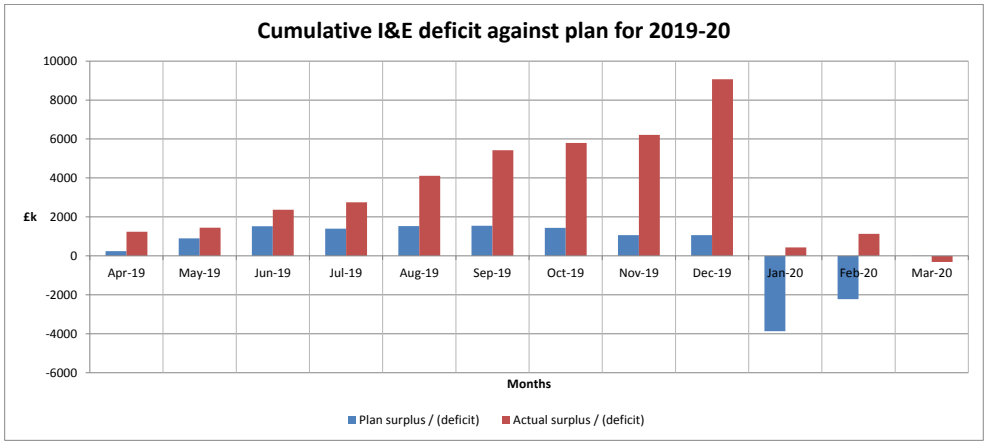
The reported I&E for March is a surplus of £1.4m, against a planned deficit of £2.2m. This results in a favourable variance of £3.7m in March (£0.3m YTD).

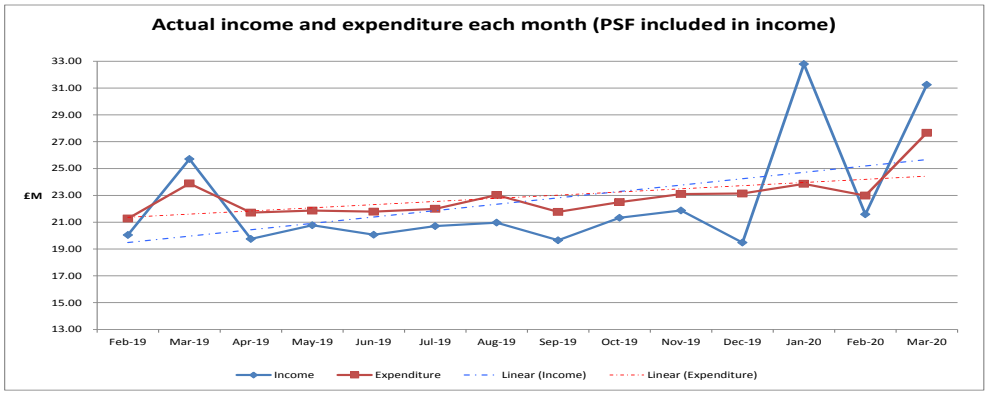
As a result the Trust anticipates receiving all PSF/FRF associated with meeting its control total.

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)	(2,219)	1,446	3,664	↑	Green
YTD surplus / (deficit)	9	316	307	↑	Green
Forecast surplus / (deficit)	9	102	93	↑	Green
EBITDA (excl STF) YTD	1,865	570	(1,296)	↓	Red
EBITDA (%)	0.7%	0.2%	(0.5%)	↓	Red
Clinical Income YTD	(208,593)	(215,234)	6,641	↑	Green
Non-Clinical Income YTD	(55,509)	(60,463)	4,954	↑	Green
Pay YTD	172,362	177,346	(4,984)	↑	Red
Non-Pay YTD	91,731	98,034	(6,303)	↑	Red
CIP target YTD	8,856	9,098	242	↑	Green







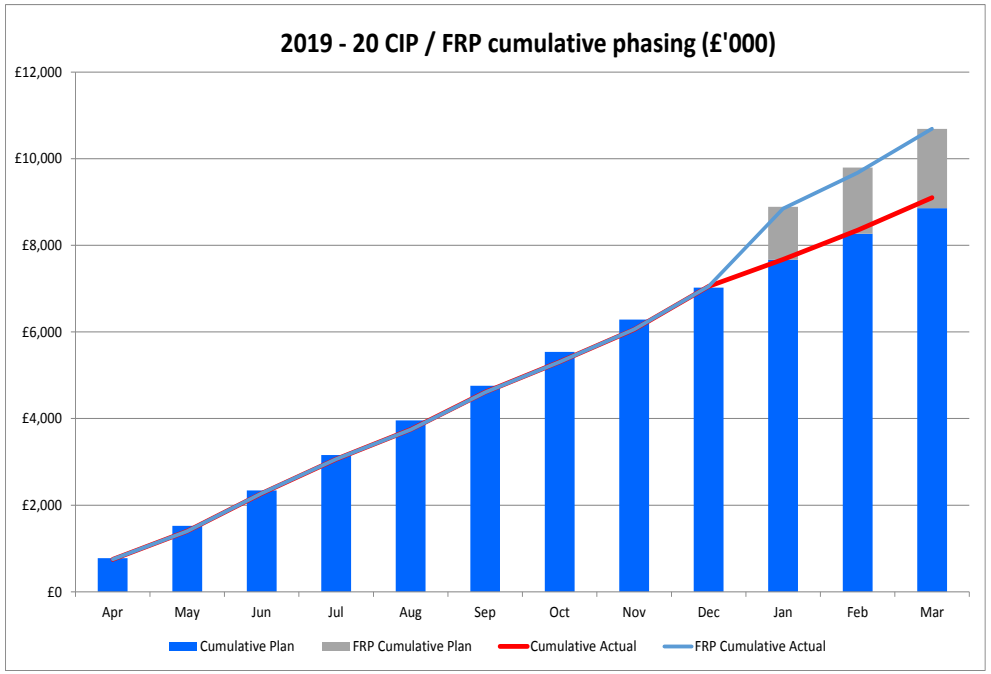
Cost Improvement Programme (CIP) 2019-20

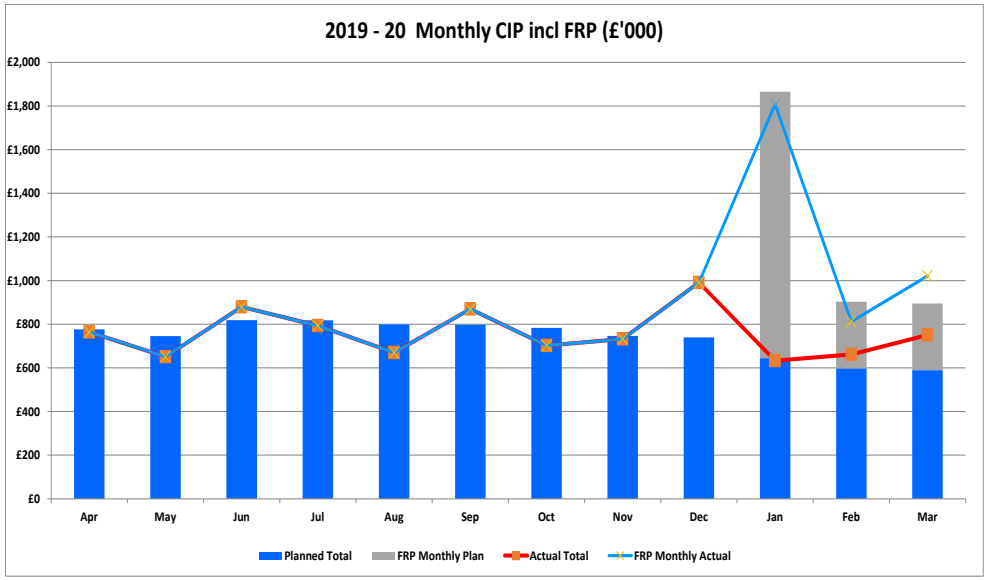
In order to deliver the Trust's control target in 2019-20 we needed to deliver a CIP of £8.9m (4%). We achieved £9.1m £242k better than plan.

We also developed a Financial Recovery Plan (FRP) to deliver £1.8m of savings this year. We achieved £1.6m being £236k worse than plan.

In total the CIP and FRP were achieved.

Recurring/Non Recurring	2019-20 Annual Plan	Plan YTD	Actual YTD
	£'000	£'000	£'000
Recurring			
Outpatients	100	100	92
Procurement	696	696	1,069
Activity growth	-	-	-
Additional sessions	15	15	3
Community Equipment Service	575	575	495
Drugs	1,740	1,740	1,910
Estates and Facilities	60	60	86
Other	1,311	1,311	1,463
Other Income	1,740	1,740	1,870
Pay controls	361	361	304
Service Review	20	20	16
Staffing Review	1,076	1,076	1,059
Theatre Efficiency	178	178	71
Recurring Total	**7,873**	**7,873**	**8,438**
Non-Recurring			
Estates and Facilities	87	87	98
Other	522	522	143
Pay controls	376	376	419
Non-Recurring Total	**984**	**984**	**660**
Total CIP	**8,856**	**8,856**	**9,098**
Financial Recovery Plan			
Pay Controls	443	443	274
Additional Sessions	294	294	165
Non Pay	143	143	103
Drugs	252	252	252
Medical	58	58	58
Nursing	138	138	138
Income	131	131	131
Other Income	72	72	72
Agency	45	45	70
Other	256	256	333
Total FRP	**1,832**	**1,832**	**1,596**
Grand Total	**10,688**	**10,688**	**10,694**

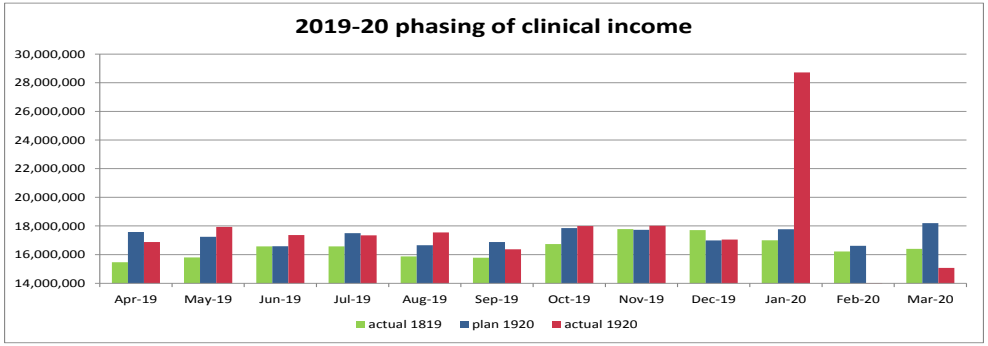




FINANCE AND WORKFORCE REPORT – March 2020

Income Analysis

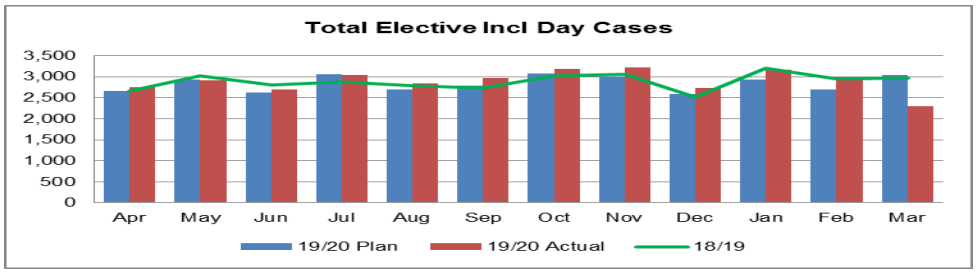
The chart below demonstrates the phasing of all clinical income plan for 2019-20, including Community Services. This phasing is in line with phasing of activity.

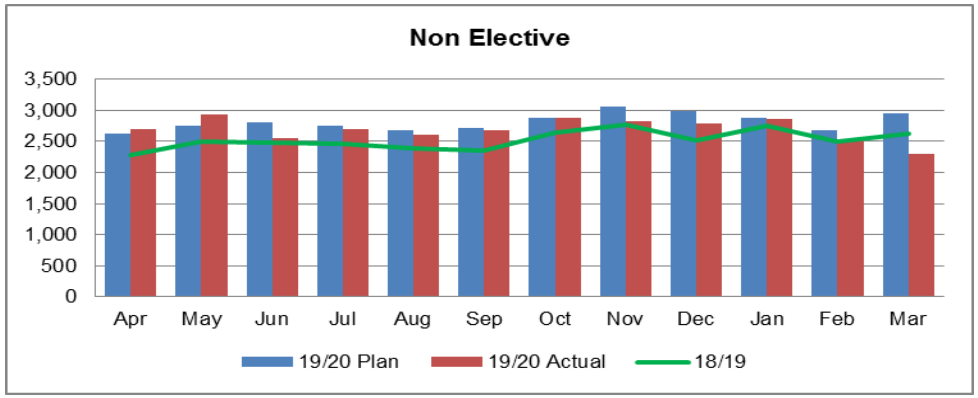


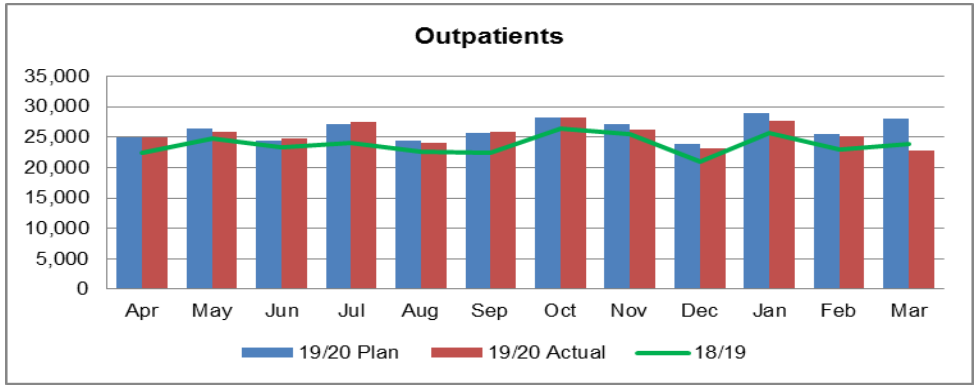
The income position was under plan for March. The main areas of underperformance were within Elective and Outpatients.

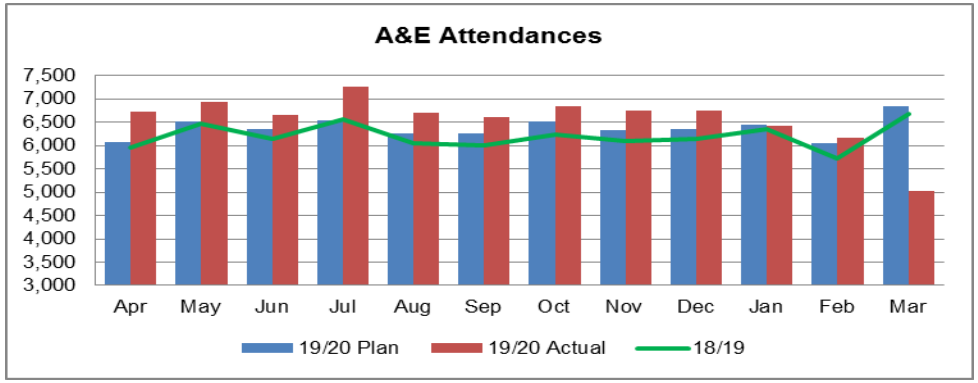
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	975	747	(228)	10,892	11,422	530
Other Services	2,057	1,485	(572)	27,926	35,949	8,023
CQUIN	185	158	(27)	2,078	2,056	(22)
Elective	3,021	2,009	(1,011)	33,304	32,737	(566)
Non Elective	6,714	6,775	62	75,297	75,108	(189)
Emergency Threshold Adjustment	(371)	(371)	0	(4,171)	(4,171)	0
Outpatients	3,370	2,580	(790)	37,849	36,877	(972)
Community	2,988	2,988	0	33,344	33,749	405
Total	**18,939**	**16,372**	**(2,567)**	**216,519**	**223,727**	**7,208**

Activity, by point of delivery



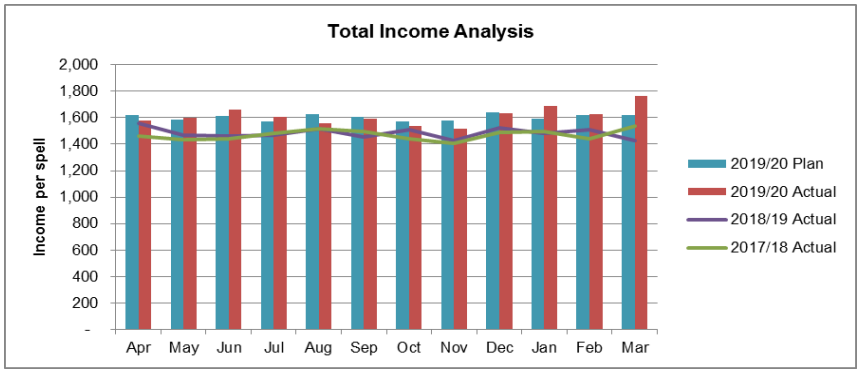


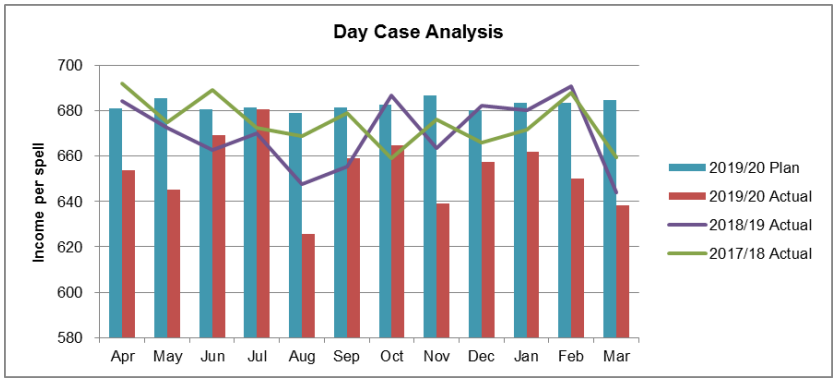


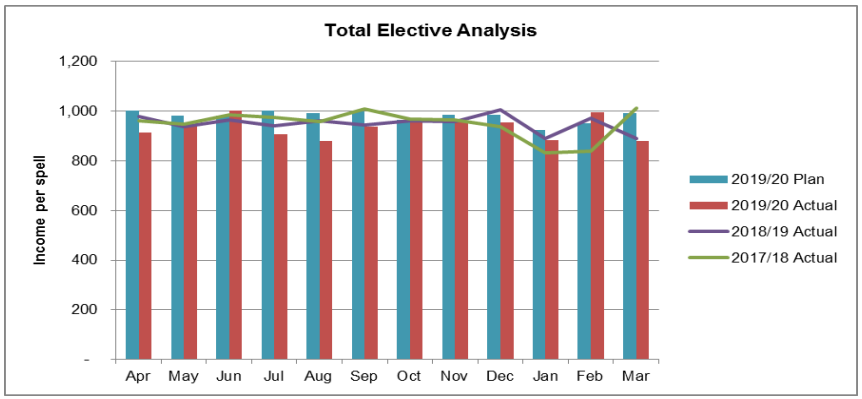


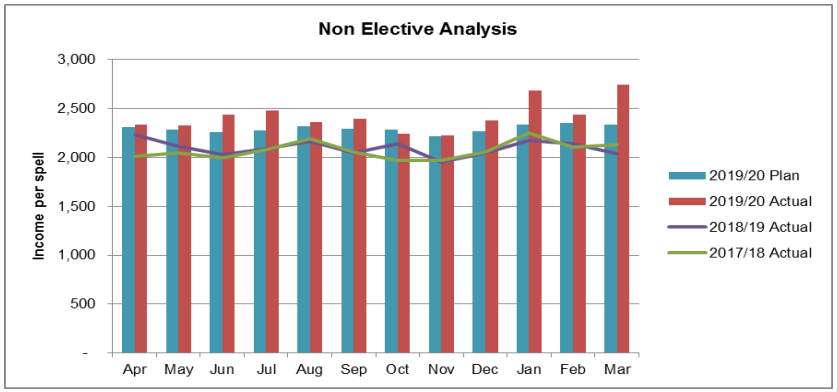
FINANCE AND WORKFORCE REPORT – March 2020

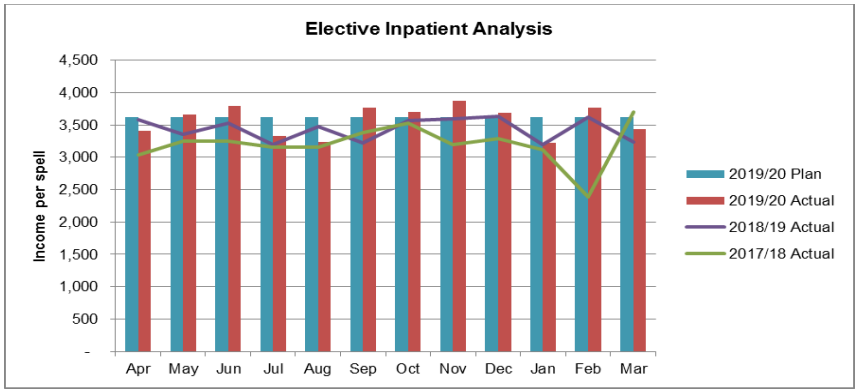
Trends and Analysis

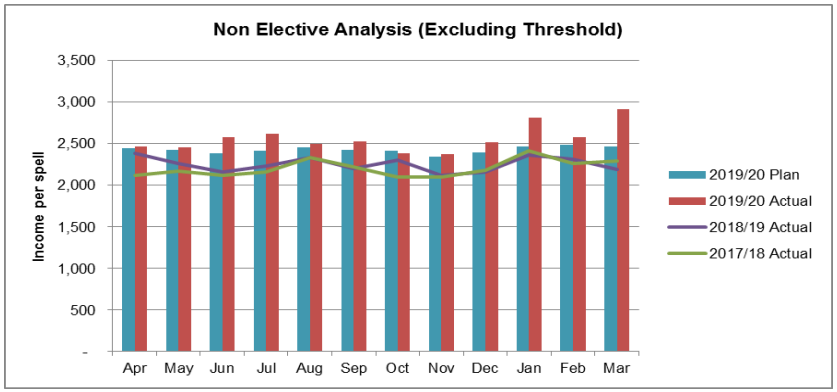












FINANCE AND WORKFORCE REPORT – March 2020

Workforce

Monthly Expenditure (£) Acute services only				
As at March 2020	Mar-20	Feb-20	Mar-19	YTD 2019/20
	£'000	£'000	£'000	£'000
Budgeted costs in month	**12,738**	**12,816**	**11,885**	**151,575**
Substantive Staff	12,933	11,806	11,247	138,464
Medical Agency Staff (includes 'contracted in' staff)	232	183	220	1,869
Medical Locum Staff	276	234	213	3,290
Additional Medical sessions	285	214	240	3,015
Nursing Agency Staff	196	127	243	1,683
Nursing Bank Staff	355	365	238	3,530
Other Agency Staff	98	135	31	926
Other Bank Staff	160	161	131	1,753
Overtime	52	59	167	1,298
On Call	67	70	104	819
Total temporary expenditure	1,721	1,550	1,587	18,183
Total expenditure on pay	**14,654**	**13,356**	**12,834**	**156,647**
Variance (F/(A))	(1,916)	(540)	(949)	(5,072)
Temp Staff costs % of Total Pay	11.7%	11.6%	12.4%	11.6%
Memo : Total agency spend in month	526	445	494	4,478

Monthly Expenditure (£) Community Service Only				
As at March 2020	Mar-20	Feb-20	Mar-19	YTD 2019-20
	£'000	£'000	£'000	£'000
Budgeted costs in month	**1,753**	**1,753**	**1,561**	**20,787**
Substantive Staff	1,698	1,726	1,449	19,781
Medical Agency Staff (includes 'contracted in' staff)	0	(6)	12	104
Medical Locum Staff	7	3	3	55
Additional Medical sessions	2	1	1	14
Nursing Agency Staff	14	11	23	171
Nursing Bank Staff	31	27	23	320
Other Agency Staff	7	(1)	(24)	55
Other Bank Staff	14	9	8	96
Overtime	3	4	7	64
On Call	3	3	3	41
Total temporary expenditure	82	52	54	918
Total expenditure on pay	**1,780**	**1,778**	**1,503**	**20,700**
Variance (F/(A))	(27)	(25)	58	88
Temp Staff costs % of Total Pay	4.6%	2.9%	3.6%	4.4%
Memo : Total agency spend in month	22	5	10	329

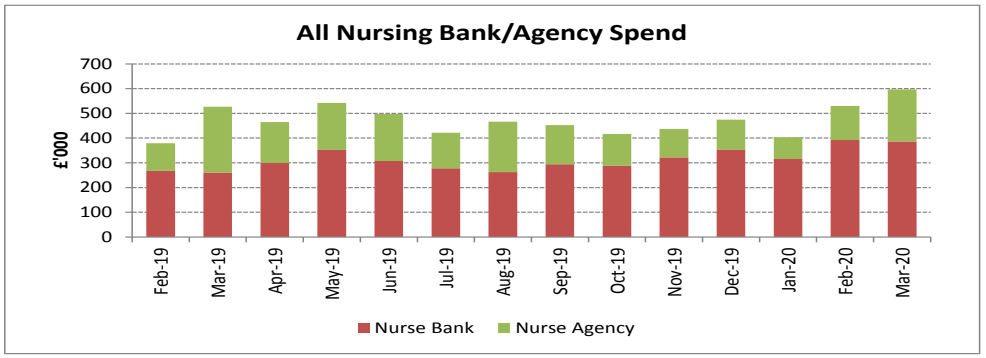
Monthly Whole Time Equivalents (WTE) Acute Services only			
As at March 2020	Mar-20	Feb-20	Mar-19
	WTE	WTE	WTE
Budgeted WTE in month	**3,346.5**	**3,348.2**	**3,237.9**
Employed substantive WTE in month	3203.48	3161.39	2971.5
Medical Agency Staff (includes 'contracted in' staff)	9.84	11.67	26.38
Medical Locum	28.18	27.46	14.49
Additional Sessions	22.08	17.34	20.73
Nursing Agency	30.04	27.54	34.91
Nursing Bank	111.53	105.55	72.2
Other Agency	21.05	21.62	7.68
Other Bank	65.11	67.7	57.21
Overtime	13.5	14.6	52.18
On call Worked	6.23	6.04	6.01
Total equivalent temporary WTE	**307.6**	**299.5**	**291.8**
Total equivalent employed WTE	**3,511.0**	**3,460.9**	**3,263.3**
Variance (F/(A))	(164.5)	(112.7)	(25.4)
Temp Staff WTE % of Total Pay	8.8%	8.7%	8.9%
Memo : Total agency WTE in month	60.9	60.8	69.0
Sickness Rates (February/January)	3.52%	4.05%	4.16%
Mat Leave	1.89%	1.91%	2.94%

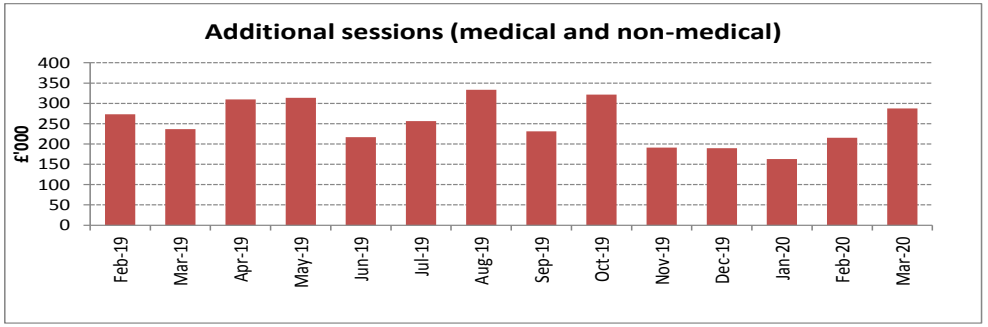
Monthly Whole Time Equivalents (WTE) Community Services Only			
As at March 2020	Mar-20	Feb-20	Mar-19
	WTE	WTE	WTE
Budgeted WTE in month	**542.00**	**542.12**	**486.25**
Employed substantive WTE in month	503.15	513.72	476.31
Medical Agency Staff (includes 'contracted in' staff)	0.00	0.00	0.74
Medical Locum	0.35	0.35	0.35
Additional Sessions	0.00	0.00	0.00
Nursing Agency	2.00	1.58	3.16
Nursing Bank	8.84	7.66	6.55
Other Agency	1.96	4.48	0.80
Other Bank	4.64	2.69	2.29
Overtime	1.14	1.30	2.13
On call Worked	0.00	0.00	0.00
Total equivalent temporary WTE	**18.9**	**18.1**	**16.0**
Total equivalent employed WTE	**522.1**	**531.8**	**492.3**
Variance (F/(A))	19.92	10.34	(6.08)
Temp Staff WTE % of Total Pay	3.6%	3.4%	3.3%
Memo : Total agency WTE in month	4.0	6.1	4.7
Sickness Rates (February/January)	5.00%	4.68%	4.62%
Mat Leave	3.10%	3.37%	3.08%

FINANCE AND WORKFORCE REPORT – March 2020

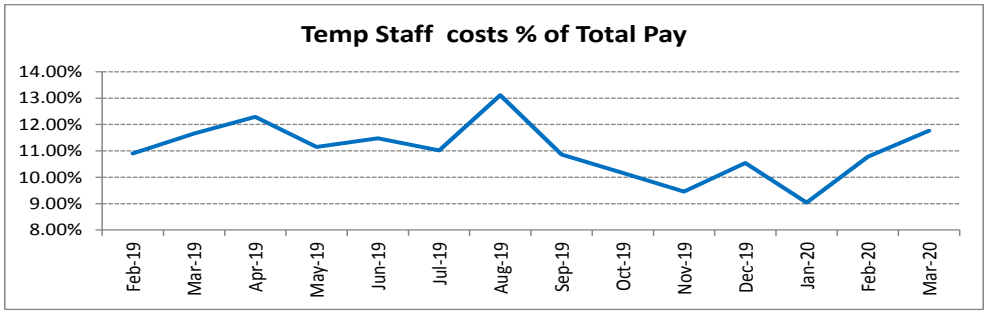
Pay Trends and Analysis

During March the Trust overspent by £1.9m on pay (£5.0m YTD). Much of this is associated with COVID-19 staffing costs which have been reimbursed.

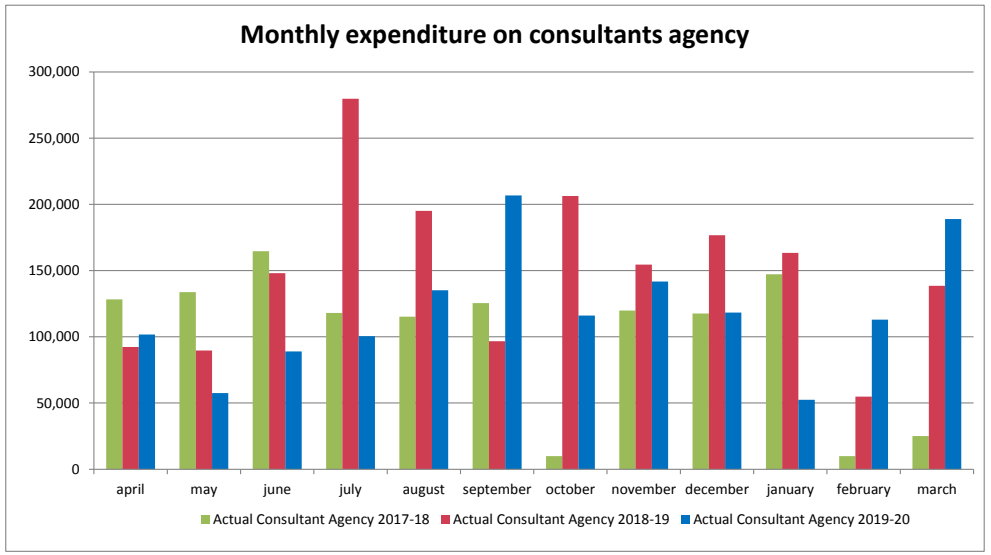


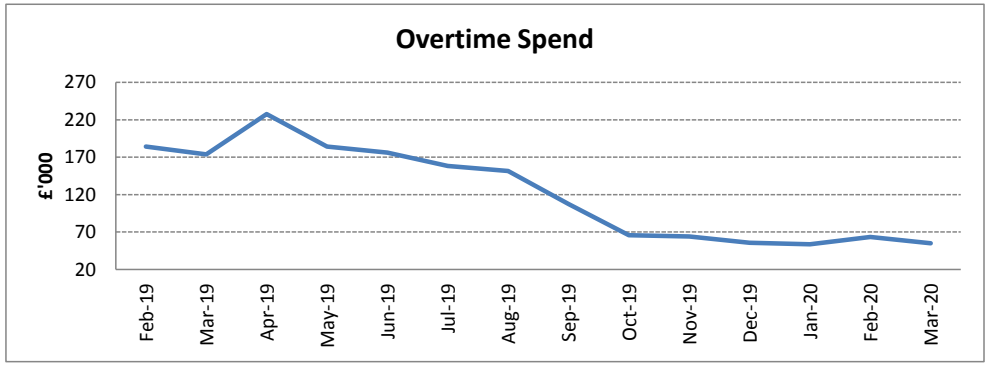


Expenditure on Additional Sessions was £287k in March (£215k in February)



The Trusts proportion of temporary pay expenditure fell to 9.0% in January 2020 which has been our target, but increased to 10.8% in February and 11.8% in March.





Use of resources Use of Resources (UoR) Rating

The Single Oversight Framework (SOF) assesses providers' financial performance via five "Use of Resources (UoR) Metrics.

The key features of the UOR ratings are as follows:

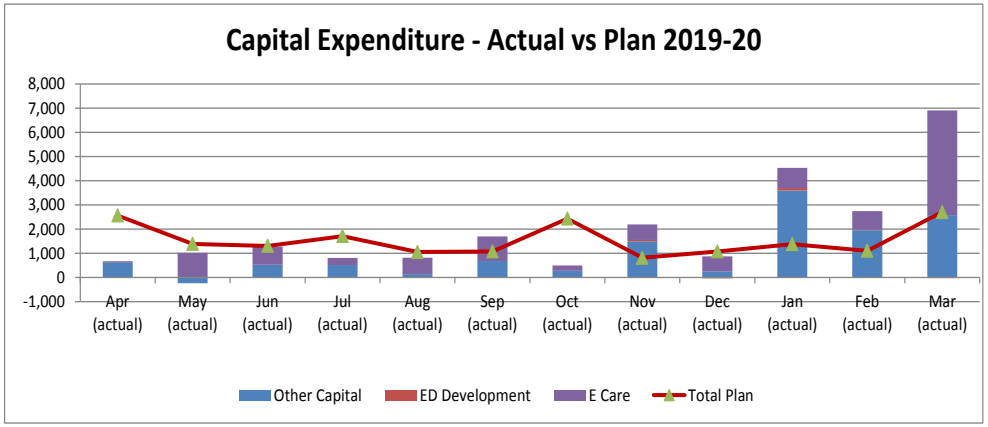
- 1 is the highest score and 4 is the lowest
- The I&E margin ratio is based on a control total basis rather than normalised surplus (deficit).
- The Agency rating measures expenditure on agency staff as a proportion of the ceiling set for agency staff. A positive value indicates an adverse variance above the ceiling.
- The overall metric is calculated by attaching a 20% weighting to each category. The score may then be limited if any of the individual scores are 4, if the control total was not accepted, or is planned / forecast to be overspent or if the trust is in special measures.

Metric	Score	Plan
Capital Service Capacity rating	4	4
Liquidity rating	4	4
I&E Margin rating	2	2
I&E Margin Variance rating	1	1
Agency	1	1
Use of Resources Rating after Overrides	**3**	**3**

Based on the draft year end Accounts, the Trust is scoring an overall UoR of 3, which is consistent with previous months.

The I & E margin rating and the Capital Service Capacity rating are closely linked and reflect the Trust is not generating a surplus in revenue to fund capital expenditure.

Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Actual £'000	Aug Actual £'000	Sep Actual £'000	Oct Actual £'000	Nov Actual £'000	Dec Actual £'000	Jan Actual £'000	Feb Actual £'000	Mar Actual £'000	Total 2019-20 £'000
E Care	34	1,019	743	290	679	1,018	214	640	608	839	771	4,331	11,187
ED Development	0	0	0	0	0	0	0	60	-40	99	20	-30	109
Other Schemes	636	-242	534	512	138	683	278	1,494	260	3,598	1,952	2,581	12,424
Total / Forecast	670	777	1,277	802	817	1,700	492	2,194	829	4,536	2,743	6,882	23,720
Total Plan	2,560	1,385	1,305	1,710	1,050	1,075	2,434	815	1,075	1,380	1,101	2,702	18,592

The initial capital budget for the year was approved at the Trust Board Meeting on 26 April as part of the operational plan approval.

The capital programme for the year is shown in the graph above. The ED transformation scheme has now been approved subject to Full Business Case approval for £14.9m less £1.5m for an anticipated asset sale. This scheme is shown separately in the table above. It is now due to commence in 2020/21.

The original capital programme was significantly delayed as a result of waiting for conformation of a capital loan from the centre. This was received in November and the schemes were started and although progress was made all of the delays could not be made up before the year end. This together with the Coronavirus pandemic resulted in delays to a number of schemes particularly the Electrical Infrastructure scheme which was £1.1m behind its original budget figure.

The Trust was asked if they could accelerate capital expenditure from 2020/21 into the current financial year. This principally related to IT schemes. A revised CDEL (Capital Delegated Limit) target of £23,578k was agreed. The outturn position shows capital expenditure for the year of £23,720k but after deducting the value of assets provided by MyWish the actual CDEL for the year was £23,469k slightly below the target.

Statement of Financial Position at 31st March 2020

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2019	Plan 31 March 2020	Plan YTD 31 March 2020	Actual at 31 March 2020	Variance YTD 31 March 2020
	£000	£000	£000	£000	£000
Intangible assets	33,970	35,940	35,940	50,165	14,225
Property, plant and equipment	103,223	115,395	115,395	101,398	(13,997)
Trade and other receivables	5,054	4,425	4,425	5,707	1,282
Total non-current assets	**142,247**	**155,760**	**155,760**	**157,270**	**1,510**
Inventories	2,698	2,700	2,700	2,872	172
Trade and other receivables	22,119	20,000	20,000	32,335	12,335
Cash and cash equivalents	4,507	1,050	1,050	2,441	1,391
Total current assets	**29,324**	**23,750**	**23,750**	**37,648**	**13,898**
Trade and other payables	(28,341)	(32,042)	(32,042)	(33,661)	(1,619)
Borrowing repayable within 1 year	(12,153)	(3,134)	(3,134)	(63,579)	(60,445)
Current Provisions	(47)	(20)	(20)	(67)	(47)
Other liabilities	(1,207)	(992)	(992)	(1,933)	(941)
Total current liabilities	**(41,748)**	**(36,188)**	**(36,188)**	**(99,240)**	**(63,052)**
Total assets less current liabilities	**129,823**	**143,322**	**143,322**	**95,678**	**(47,644)**
Borrowings	(84,956)	(99,186)	(99,186)	(47,489)	51,697
Provisions	(111)	(150)	(150)	(744)	(594)
Total non-current liabilities	**(85,067)**	**(99,336)**	**(99,336)**	**(48,233)**	**51,103**
Total assets employed	**44,756**	**43,986**	**43,986**	**47,445**	**3,459**
Financed by					
Public dividend capital	69,113	70,430	70,430	74,065	3,635
Revaluation reserve	6,931	9,832	9,832	8,367	(1,465)
Income and expenditure reserve	(31,288)	(36,276)	(36,276)	(34,987)	1,289
Total taxpayers' and others' equity	**44,756**	**43,986**	**43,986**	**47,445**	**3,459**

Non-Current Assets

Throughout the year the net capital investment in intangible assets and property, plant and equipment (PPE) is higher than originally planned. The Capital Programme for 2019/20 was increased since it was set at the start of the year and therefore the asset base increased. The Capital Programme was achieved for 2019/20. However, as part of our year end processed, the land and buildings were revalued. This resulted in a large decrease in value of £10m, which relates in the main to the impact of COVID-19 on the property market.

Trade and Other Receivables

Receivables have increased by £1m since February and are higher than plan. A large proportion of the increase is due to additional funding received for over performance of activity.

Cash

The cash balance continues to remain stable towards the year end, which the cash balance being slightly above plan. The Trust received additional funding for over-performance in March, which enabled us to pay off a large amount of our aged creditors.

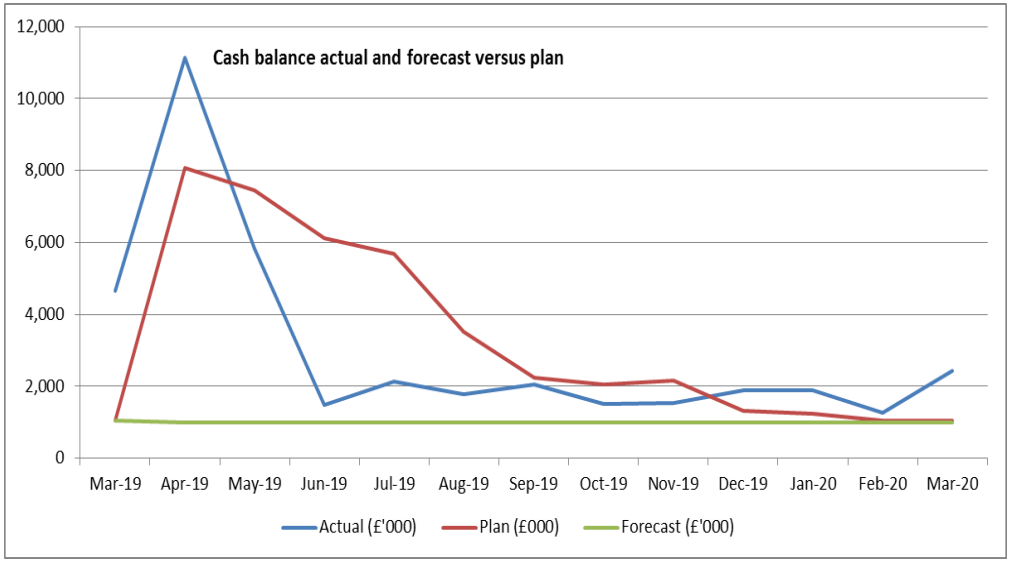
Borrowing

No further revenue borrowing was required in March and the final instalment of our capital loan of £0.8m was received. On 1 April 2020 the Government announced that all revenue and interim capital loans would be written off and replaced with PDC. The Trust has £54m of revenue and interim loans that will be paid off on 30 September 2020. Therefore this whole balance is shown as current within the balance sheet. This will be reported as a post balance sheet event in the year end accounts.

FINANCE AND WORKFORCE REPORT – March 2020

Cash Balance Forecast for the year

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

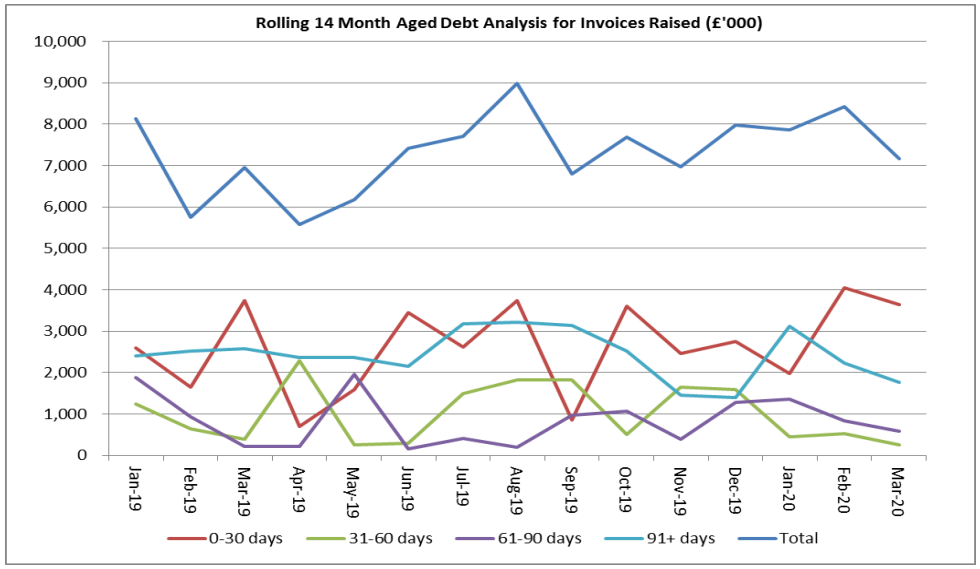


The cash position continued to be rigorously monitored on a daily basis to ensure that the minimum level requirement of £1m was maintained. The year-end position as at 31 March 2020 was slightly above plan. This was mainly due to some capital funding that was received just before the year end, but for which the items are shown as capital creditors as the invoices had not been paid.

The 2020/21 cash forecast is looking more favourable, mainly due to income being received in block contracts and in advance due to the unpredictability of the current climate.

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 decreased by £1.2m since February, mainly due to lots of invoices being settled pre year end. Over 82% of these outstanding debts relate to NHS Organisations, with 34% of these NHS debts being greater than 90 days old. We are actively trying to agree a position with the corresponding NHS Organisations for these debtor balances.

10:20 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

11. Trust improvement plan

To APPROVE the report recommendations and the plan which addresses the CQC findings

For Approval

Presented by Rowan Procter

Trust Open Board – 24 April 2020

Item:	11			
Presented by:	Rowan Procter, Executive Chief Nurse			
Prepared by:	John Connelly, PMO Rebecca Gibson, Compliance Manager Richard Jones, Trust Secretary			
Date prepared:	22 April 2020			
Subject:	CQC Improvement plan			
Purpose:		For information	X	For approval

Background

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

For each finding (or related group of findings) a plan has been drawn up which sets out

Ref	Locally-assigned reference number for each finding. Where multiple findings have been combined into one improvement plan (e.g. all those relating to mandatory training) there will be a list of reference numbers in one plan
Finding	The narrative from the CQC inspection report setting out: '*The Trust MUST*…' or '*The Trust SHOULD*…'
Overview of planned improvement	Narrative description of the plan to provide an overarching summary
Action log	The individual actions required to progress the improvement plan
Evidence for delivery	Outline of the metrics/information that measure performance *
Monitoring and assurance	How and where performance against the identified metrics/information is reported*

** Not provided where finding (e.g. a security enabled door) is measurable simply through completion of the action plan. This will be reviewed on an ongoing basis.*

Involving our commissioners in the improvement plan development includes the following steps:

- CCG's Head of Quality & Safety undertaken a 'reasonableness check' of the proposed improvement plans. The output of this fed back to the Exec and management leads to enable refining of proposals if required.
- Once a plan is reported as '*Implemented'*, a review of evidence by the CCG's Clinical Patient Safety and Effectiveness Lead to provide assurance of that status. (NB: this has not yet commenced).
- Only once the assurance of that implementation has been confirmed, will the action be marked as '*Complete'*.

With the impact of the COVID-19 response it was acknowledged that items within the improvement plan would of necessity be paused and, at the Executive Directors meeting 1st April, it was agreed to review each element of the improvement plan to define it as:

Able to CONTINUE	PARTIAL	PAUSED
Able to continue all elements of the plan	Able to continue but only some actions within the plan	Needs to be put on hold due to the COVID response

Table 1 below sets out the number of plans that fall into each category and Annex 1 provides the full improvement plan.

Table 1 – Improvements plans by Executive lead and by COVID-19 status

Exec lead	Implemented Assurance Pending	COVID-19 status (for remainder)			Total
		CONTINUE	PARTIAL	PAUSED	
CB	0	1	1	1	3
HB	1	0	1	8	11
JO	2	0	4	2	8
NJ	0	0	2	2	4
RP	5	4	5	15	29
Total	8	5	13	28	55*

**Totals plans is less than total findings as some plans address multiple findings*

A copy of this Board paper will be submitted to the CQC as part of the official submission of the WSFT CQC Improvement plan (Annex 1). Where progress summaries are still pending at date of issue (20th April), a verbal update on those outstanding areas will be provided to the Board meeting (24th April) and the final version of Annex 1, with all progress summaries completed, will form the version submitted to the CQC.

Recommendation

1. Board approve the improvement plan and its submission to the CQC
2. For future Board meetings receive updates on:
    a. Progress of individual plans
    b. Outcome of CCG evidence review testing
3. Board to receive a review the status on improvements categorised as 'COVID paused' in July to consider whether these can be progressed

Annex 1: Improvement plan

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	Summary of progress	COVID status	Rationale for Covid-19 Status
7	The trust must take definitive steps to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant.	CB	RTT: • Implement Cerner service pack to fix current manual workarounds (once tested by other organisation). • e-Care RTT training programme to improve RTT information data quality • Update Data Quality Strategy to include provision for routine auditing of RTT information held in e-care, with a feedback cycle to users included. Theatres: • Theatres dashboard uses Power BI tool, (more intuitive and self-service tool for users). • Incorporate theatre utilisation figure into next iteration of IQPR	RTT reporting has a reduced number of fixes included in the processing steps. RTT audit data (subject to DQ Strategy and DQ Manager in place) Theatre utilisation dashboard version 2 developed	Surgical Divisional Board will receive output of audits and this will be shared with all the specialties that have an RTT waiting list and/or utilise theatres Theatre utilisation dashboard is to be presented to scrutiny committee to determine what if any of the theatres indicators should be presented to Board via the IQPR.	Cerner RTT System Fix delayed (non WSFT delay) In interim fix placed in non-PROD for test which identified some issues still requiring resolution. Training was progressing, currently paused but will recommence when able. Data quality (DQ) strategy to be supported by a new DQ manager post (pending).	Paused	RTT paused because the reporting staff are focussing on Covid-19 Theatres RTT - original Trust plan pre CQC valid however timeframes will have unavoidably slipped

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	Summary of progress	COVID status	Rationale for Covid-19 Status
8	The trust must continue to develop information technology systems and integration across the community services	CB	Proposal to invest £2.26M to provide Community Health Staff Information Technology and uplift IT Revenue by close to £600K to sustain this. On authority of the CFO project been initiated with appointment of a Project Sponsor (Exec Director), Technical Lead and Project Manager. Community Sites will be subject to technical survey (planning for change) ahead of infrastructure Implementation and Service Migration. By end FY20/21 all Community Staff will have up to date technology, access via modern networks and will see a notable reduction in downtime and service interruptions. Once this modern technical platform is in place then the ability to commence far wider service integration and leverage many of the advanced technologies use at the West Suffolk Hospital become possible. Project Board and a Project Team formed. Project Initiation Document and draft Project Plan for sign off at the Project Board.	Project Initiation Document will set scope and timeline Weekly Project RAG Reports will document progress, record issue and confirm milestones Monthly Project Highlight Reports will confirm progress, manage risks and issues and report on finances Project Exception Reports/Plans will document any variation away form critical path	Project Board is chaired by Chief Operating Officer (COO) and reports via Pillar 3 Programme Board to Trust Digital Board Project Team meets fortnightly is heavily engaged with users and will deliver workstreams Project Manager will generate Weekly RAG reports and monthly Highlight reports	Two elements of work being maintained: [1] migrate community paediatricians on to Olympus digital dictation system [2] roll out of smart phones across community to allow staff access to WSFT email, intranet and Microsoft support teams. 100 currently being rolled out with a further 200 planned imminently	Partial	Outline project plan to implement infrastructure and migrate services in 20/21 will be delayed as will wider integration with advanced WSFT technologies 21/22 due to covid-19 pandemic and social distancing measures, as the work will involve accessing buildings, engaging staff re input of new equipment and removal of old. Project re-start will be subject to lifting of pandemic restrictions

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	Summary of progress	COVID status	Rationale for Covid-19 Status
68	The trust should ensure that facilities for audiology assessments in the Ipswich child development centre improve.	CB	Business case submitted and work in progress to build new pod on site as part of Site improvement works (anticipate in place Summer 2020)	Completion of pod	Updates from Estates to NSH and from NSH to MG	Work is in progress - groundworks completed and delivery plan for end of May is on track unless Estates advise otherwise. Estates to lead on this as they are overseeing the project deliverables Key planned items for completion in latest highlight report to 27.04 are: - Complete timber frame and make building water tight - Fit out audiology suite	Able to continue	In general works continue although at a slower rate as we have reduced the number of contractors on site to keep in with the 2m working rule. Generally, materials continue to be delivered and some pre order of items such as cladding have been made to ensure delivery.

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	Summary of progress	COVID status	Rationale for Covid-19 Status
4.1 41 65	(4.1) The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - clinical audit is monitored and reviewed to drive service improvement. (41) The trust should ensure that appropriate action plans to address national audit shortfalls are implemented and effectively monitored. (65) The trust should ensure that governance and oversight are strengthened to ensure performance and local audit are monitored and measured to improve practice.	NJ	Review of Governance and oversight team and function to include within this local audits required to inform quality assurance will be formulated.	There will need to be structured evidence collected centrally demonstrating implementation into clinical practice of trustwide learning from clinical audit.	This will be monitored and reported by the quality/patient safety/clinical learning team.	Paper presented to Exec directors set out clinical audit & effectiveness functions and pause in greater detail.	Paused	Nationally HQIP / NHSE / NHSI have paused the clinical audit programme. In addition locally: 1. The Clinical Audit & Effectiveness Co-ordinator is being seconded to another role during COVID 2. The input from clinicians (e.g. national audit participation and response) will of necessity be paused to enable focus on clinical work.
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.**	NJ	The trust learning from deaths strategy contains specific elements relating to M&M reviews as part of a wider plan to share learning with the primary aim "*move from learning into action*"	There will need to be structured evidence collected centrally demonstrating implementation into clinical practice of trustwide learning from mortality reviews.	This will be monitored and reported by the quality/patient safety/clinical learning team.	The wider learning from deaths work plan continues including virtual LfD group meetings and the development of a LfD newsletter	Partial	There is work continuing in the background but the overarching plan will have its deadlines unavoidably slipped. Some senior members of the team are involved directly in providing clinical care within COVID-19 areas of the trust

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	Summary of progress	COVID status	Rationale for Covid-19 Status
33	The trust should ensure that consultant and team communication is improved in relation to the North East Essex and Suffolk Pathology Services (NEESPS). The trust should ensure that a review of the current working environment, equipment and processes within Pathology services is undertaken to identify and address any immediate ongoing concerns.	NJ	Regular meetings with pathology leadership team - execs, Scrutiny Committee, ESNEFT and NEESPS leadership. Face-to-face communication with lab teams. Written updates on progress to pathology clinical leadership. There will also need to be an estates review of working environment and equipment.	Evidence of the enhanced communication and the estates review as well as results from medical engagement scale.	This will be monitored at Scrutiny Committee and will be an ongoing piece of work.	A plan to address the elements of this finding is being developed in coordination with the ADOs	Partial	The overarching plan may have some deadlines unavoidably slipped and regular meetings / face to face communication will be affected by social distancing restrictions

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	Summary of progress	COVID status	Rationale for Covid-19 Status
43	The trust should consider displaying information on how patients and visitors can lead healthier lives.	NJ	1. Improved permanent resourcing for the public health team a. a new half time public health coordinator post has been established, repurposing time from an existing role. The role needs to be recruited to. 2. Understand the potential barriers in medicine and the drivers of success elsewhere a. The public health consultant will work with the medicine triumvirate to explore any barriers and understand whether an active decision has been made not to display health promotion materials b. The public health coordinator will establish relationships with service managers and administrators in the other clinical services and understand how the areas showing good practice are achieving it 3. Create an action plan a. A collaborative plan will be agreed with the medicine leadership team, based on the learning that is generated b. The public health coordinator will solve any problems with consistent supply and distribution of health promotion materials that are found in the other clinical services	Delivery will be evidenced by the action plan being completed. The provision of health promotion materials in clinical areas is an ongoing need, not a one-off objective, and it is only one of a number of methods used to promote healthy lifestyles and raise brand awareness for OneLife, so the deliverables are qualitative rather than quantitative. The action plan will include mechanisms for maintaining ongoing provision. We will then establish a quarterly 'walkabout' audit of the estate to measure how well it works.	This needs working up as there isn't a governance mechanism for delivery of the partnership workplan at the moment. The plan does make provision for a small number of indicators to be added to the board integrated quality and performance report to promote and celebrate its impact, which hasn't been done yet, and none of the subcommittees currently has responsibility for assuring the trust's work on prevention and health promotion. Both these gaps will be addressed as part of this work.	Not yet started as agreed low risk Assurance that current information is in place throughout trust premises on how patients and visitors can lead healthier lives	Paused	The management lead is exclusively working on COVID-19 response and (as per narrative in improvement plan details) there isn't a governance mechanism for delivery of the partnership work plan at the moment.

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	Summary of progress	COVID status	Rationale for Covid-19 Status
6 30 46 62	(6) The trust must ensure that robust processes are embedded for patient follow up appointments and those on surveillance pathways. To include systems and process for regular oversight and assurance that patients are not being lost to follow up across all specialties within the organisation. (30) The trust must ensure there is an effective process in place for monitoring patients requiring a follow up appointment and for those on surveillance pathways. (46) The trust should ensure effective processes are in place for oversight of referral to treatment times across all specialties with action plans in place to improve the specialties where national standards are not being met. (62) The trust should consider a system to monitor the average waiting times for a follow up appointment.	HB	Review, Identify and design process for follow up and surveillance bookings. Revision of SOPs to include new processes and escalation in the event of capacity gaps. Consideration of feasibility to produce a report of all unbooked patients with follow up appointment as the clinic outcome code. To implement and facilitate training to all specialities on the new processes for Follow Ups and Surveillance patients.	Recruitment of 2 members of staff in TAC for ward follow up booking - Completed use of message centre consult template to replace paper clinic outcome slips - change request submitted use of specialty worklists on e-Care for PA/Service managers to track patients they are unable to book - change request submitted SOPS generated - for each specialty on Booking processes, use of message centre, use of worklists Virtual Clinics to be set up for each specialty by Service manager Audit of e-Care follow up list Training to be given on Booking of Follow Ups & Surveillance patients and using Worklists/Message Centre	Relevant service manager to oversee worklists to monitor capacity this will then be reported into individual division weekly RTT meetings, and escalated to weekly Access meeting if required.	Detailed plan in place including specific elements for outpatients, clinic follow ups, ward follow ups, endoscopy and surveillance	Paused	Surveillance patients are paused safely as they are all kept on the waiting list/managed in the same way as they are normally are. All patients remain with the Trust. Any cancelled patients are recorded so using a new cancellation code 'Covid19' so that cancelled patients can safely be identified. A lot of patient appointments have either been deferred and booked later in the year or moved to telephone appointments.

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	Summary of progress	COVID status	Rationale for Covid-19 Status
928	(9) The trust must continue to take action to improve performance against national standards such as the 18 week referral to treatment (RTT) standard, six week diagnostic standard ad access standards related to suspected and confirmed cancer management (28) The trust must ensure patients can access the service when they need it and receive the right care promptly in line with national targets.	HB	Business cases to be developed for Orthopaedics, Ophthalmology, General Surgery and Gynaecology which will include up to date demand and capacity models, which will shape the direction of the business cases. The business cases are expected to outline plans and costs to reduce the current backlog and balance the demand to enable the services to meet the national standard. Action plans for all other specialities will continue to be updated on a monthly basis and will be discussed at the new RTT steering group meeting with the ADO's. A comprehensive action plan is under development for Endoscopy now not that demand and capacity has been completed and this will be discussed and reviewed at the new bi-weekly Endoscopy oversight meeting.	A reduction in the overall RTT waiting list size. Increase in compliance to national standard to that of the national average. Reduction in 52 week breaches. Compliance with national diagnostic standard. Reduction in cancer PTL size and compliance with national standard back to 85% by July.	Monthly RTT steering group meeting, weekly access meeting, Cancer PTL meeting, Cancer steering group meeting with the CCG.	Plans are in place to ensure that patients can be picked up safely in the recovery phase after a safe pause as the patients are all kept on the waiting list/managed in the same way as they are normally are. All patients remain with the Trust. Any cancelled patients are done so using a new cancellation code 'Covid19' so that cancelled patients can safely be identified. A lot of patient appointments have either been deferred and booked later in the year or moved to telephone appointments.	Paused	Project re-start will be subject to lifting of pandemic restrictions and be integrated with COVID recovery plans

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	Summary of progress	COVID status	Rationale for Covid-19 Status
19	The trust must ensure that medicines are stored securely within the main and day surgery theatre department.	HB	Implement Drug Security plan. - Replacing locks, identifying and cutting new keys, fitting of keypads and ordering of storage cabinets. - Standard Operating Procedure (SOP) for each area ratified at surgical Divisional Board. - Changes in practices & procedures will be disseminated to key stakeholders & service users. - Update of risk register to reflect all the above	All drugs security devices installed. Training and monitored adherence to SOPs embedded and active. Risk registers reflect compliance in security of medicines within theatres department.	1.Execution of Project plan monitored by senior leads 2.Standard Operating procedure ratified by surgical steering group	Implemented - assurance pending		
29	The trust must ensure diagnostic test results are available in a timely manner.	HB	Confirmation that there are currently no delays in providing patients with test results Time to test results reported at divisional Performance Review Meeting with escalations to the Board. Endoscopy results immediately available Radiology Imaging consistently meets the 6 week reporting standard from request to test Process in place to prioritise the reporting of outpatient imaging in time for the outpatient appointment.	Time to test reported at monthly divisional PRM and board level	Details of all listed activities to be provided to CQC by COO	Implemented - assurance pending		

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	Summary of progress	COVID status	Rationale for Covid-19 Status
31	The trust must ensure staff complete and record patient pain assessments in patient records.	HB	Provide updated written guidance on completion of core assessment template where the Pain tool sits. Follow up with training for SystmOne Superusers to roll out to teams. Audit process to be agreed and rolled out via Governance Steering Group.	Completion of pain assessments	Via Perfect ward app, Include in CREWS updates, Divisional PRM and CQC improvement plan governance	5/7 actions complete including SystemOne templates, written guidance and super users to support training. Further actions around CREWS newsletter and Perfect ward monitoring will follow later in the year	Partial	The actions have been completed but the monitoring (audit process) needs to be agreed and rolled out via Governance Steering Group which is currently unable to meet during COVID response.
42	The trust should ensure team meetings are undertaken to share information with ward staff.	HB	To ensure that team meetings regularly occur within all clinical areas to enable teams to have the opportunity to discuss and learn from the performance of the service.	Minutes from team meetings. Increased staff knowledge of current issues to service. Key performance indicators for areas displayed for staff. Audit data from Perfect Ward.	Key issues from team meetings to be reported at divisional board. Minutes/action plans from team meetings to be displayed for staff within clinical area.	Meetings are undertaken regularly and outcomes shared	Paused	All face to face meetings paused for Covid-19 duration. Important information to all staff shared through pathways such as Intranet and daily COVID-19 briefing circulation,
44	The trust should continue to work to reduce the number of bed moves at night for non-clinical reasons.	HB	Revised SOP and improved performance as evidenced by a reduction in non-clinical bed moves after 10pm.	Evidence of agreed SOP and performance metrics which demonstrate a reduction in non-clinical bed moves after 10pm.	Monthly review of performance report at FLAG (flow action group).	SOP review completed and initial audit (baseline assessment) undertaken. Forward plan developed to focus initially on target wards F8, F6 and G8	Paused	Plan has been put on hold during Covid-19 response

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61	The trust should consider security enabled doors in the paediatric outpatient department.	HB	The department will undertake a risk assessment of security within the childrens' outpatient department. In parallel, options for installing security enabled doors or a locking function to the current doors will be explored with the the Estates and Facilities department. The most appropriate solution will be identified through the requirements in the risk assessment. The risk assessment will be completed and ratified through the Departmental Clinical Governance by the end of February, with a full solution in place by the end of April 2020.	1. Risk Assessment on the risk register 2. Ratification of the risk assessment evidenced in Paediatric Clinical Governance minutes 3. Security solution in place as guided by the risk assessment	Regular review of the Risk Assessment as part of departmental risk management process	Risk assessment has been completed and discussed at the Paediatric departmental meeting in March. Agreed to look at installing magnetic door locks on the internal door between OPD and the main lobby with a high level door release button.	Paused	Quote for additional work has been requested is not being followed up until after COVID-19 response stepped down as these patients are not being brought to the hospital at the moment and so there is no immediate security concern.
66	The trust should ensure that processes are in place and effective to monitor compliance with best practice and national guidance relevant to the service.	HB	Audit programme to be considered to monitor adherence and effectiveness of guidance.. ICPS will liaise with corporate / clinical governance leads to establish more robust interface with the group to consider relevance of published guidance/updates (e.g. NICE) with community service pathways.	Audit programme Central trust record for NICE held on Datix	ICPS Leads will continue to review current guidelines and practices in place and monitor at service meetings. Services will continue to monitor incident themes and any complaints and this in turn will be reviewed by the ICPS Integrated Working Forum and Service Management Group	The service has set up more clearly defined audit programme to ensure compliance with new and existing guidance.	Paused	Paused for Covid-19 duration Once face to face contacts can be recommenced the planned liaison with the central governance functions will be able to take place

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67	The trust should ensure records are maintained to show cleaning has been completed in line with cleaning schedules.	HB	Systems in place already but practice to be reinforced to ensure compliance with cleaning standards. Clinicians have responsibility for cleaning the equipment they have used, which is in line with guidance Perfect Ward app to be reviewed and updated for use with community paediatric teams to assist with audit of standards.	Rotas for main reception areas are recorded by receptionists. If there are no clinics on a given day, then the clinic room cleaning requirement should be crossed off the cleaning schedule.	A formal environmental audit programme will be established when the perfect ward app is adapted and available for use in community paediatric services main bases. A Review of compliance is otherwise undertaken on an ad hoc basis alongside H&S or lead walk rounds.	General cleaning auditing is in place completed by the facilities team	Paused	Opportunities to use Perfect Ward in future will be revisited once COVID restrictions allow
73	The trust should ensure that all senior leaders have the skills to access and use patient outcome data to improve services.	HB	Provide training and guidance to senior leaders on the use of patient outcome data. Quality 2:1's with senior leaders to include a focus on the monitoring of the use of patient outcome data. Senior leaders to be supported to roll out learning to all staff on the unit. MDT review of outcome data to ensure it provides robust information around patient outcomes measures Consultation with patients and stakeholders around outcome measures meaningful to them	MDT review of outcome data Stakeholder consultation outcome Final agreed new outcome measure dashboard	Reports to Business Unit meeting	Initial plan drafted by HoN and ADO	Paused	Part of wider Trustwide leadership programmes currently paused to enable focus on COVID-19

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12	(1) The trust must take definitive steps to improve the culture, openness and transparency throughout the organisation and reduce inconsistencies in culture and leadership. To include working relationships and engagement of consultant staff across all services. (2) The trust must ensure the culture supports the delivery of high quality sustainable care, where staff are actively encouraged to speak up raise concerns and clinicians are engaged and encouraged to collaborate in improving the quality of care.	JO	We know that hospitals where staff feel more engaged and supported have better outcomes, lower mortality, reduced infections, fewer mistakes and are more efficient, (M West, 2012: King's Fund). This is why supporting and staff and growing the best culture is crucial for our future. An overarching cultural improvement plan, informed by what staff think and feel, will be developed. It will involve the following approaches: 1. More and better listening to staff feedback to inform how we lead and improve 2. Focused and better support for specific issues and teams identified in the CQC report 3. Greater focus on leadership development and continuous learning across WSFT to ensure we have the best culture	Staff Survey and Medical Engagement Scale scores Collated feedback and ideas from staff Evidence of staff suggestions put into practice	Reporting to Trust Executive Committee Reporting to Trust Board of Directors Consultation with and feedback from staff representatives - staff governors and union representatives	Implemented confidential communication pathways (email and telephone line) to enhance the already in place options available as set out in trust whistleblowing policy PP056	Partial	The right to speak up about concerns around Covid-19 must be maintained and hence partially paused, whilst the main body of work associated with this action would be paused for the Covid-19 duration.

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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.	JO	1. To undertake a review of HR policies to ensure that they are kinder and more compassionate 2. To use the HR Case Review meetings to include, policy compliance, staff support and learning points. 3. To implement the "Just Culture" approach to HR processes in accordance with the national guidelines "Improving People Practices".	1. Policy reviews will be developed in partnership with union representatives and presented at "Trust Council" for ratification. 2. Learning Points and agreed actions will be shared with Trust Council and the Trust Negotiating Committee (Medical & Dental) 3. Implementation programme for embedding the Just Culture approach to be in place with recorded milestones and process for evaluation of impact.	Reporting to Trust Board; consultation and feedback from staff; union representatives and from Staff Governors; and the Health and Wellbeing Steering Committee.	HR investigation training specifically focusing on the "Just Culture" provided via a workshop in Nov '19 Pre-investigation assessment introduced to determine if a formal investigation process is required or whether an alternative approach would be more appropriate. A communication plan and health check assessment has been added to investigation Terms of Reference template.	Partial	Developing plan to deal with these issues during the pandemic
11	The trust must ensure effective processes are in place to meet all the requirements of the fit and proper persons regulation	JO	Non-adherence to F&PP (excluding those due to length of service of board member) will be formulated into an action plan to enable both ED and NED F&PP pathways and record keeping are appropriate and robust. Initial focus will be on the non-executive directors pathway and a local review will be undertaken.	A fully completed F&PP file for every appointee	HR will undertake a review of the F&PP files on an annual basis. Executive and NED appraisal compliance will be monitored in line with standard trust process. Annual compliance report to the Audit Committee	Implemented - assurance pending		

12 32 48 63 70	(12) The trust must ensure that mandatory training attendance, including training on safeguarding of vulnerable children and adults, improves to ensure that all staff are aware of current practices and are trained to the appropriate level (32) The trust must ensure all staff complete mandatory training including safeguarding training. (48) The trust should ensure a higher percentage of staff complete mandatory training including PROMPT. (63) The trust should continue to improve mandatory training completion rates to meet the trust's target completion rate of 90%. (70) The trust should continue to improve mandatory training in key skills to all staff to meet trust targets.	JO	• Review of mandatory training subjects, renewal period and delivery methods. • Ongoing streamlining of junior doctors induction process to include, working with other trusts to transfer existing compliance and supported e-learning on site. • Review of community training data following concerns raised as to accuracy of the data (identified an overwriting of data). • Safeguarding Children Level 3 change to yearly, not three yearly. • PROMPT training compliance to be included in wider midwifery training review • Implementation of ESR Manager Self Service will enhance local availability of MT reports and individual compliance • Data cleansing of OLM career management following mandatory training review • Meetings with community leads to ensure mandatory training requirements are correct • Applicant Portal (allows applicants to access their ESR record) launched. Portal allows applicants to access and complete their mandatory e-learning training prior to their start date and confirm and track their recruitment status. Any training which has been completed at a neighbouring Trust which is part of the Streamlining project will show on the applicant's portal as already compliant. • Review of Induction programmes (acute and	A monthly mandatory report is taken from the trusts HR system (electronic staff record - ESR). This is reported in a number of ways; line managers receive a compliance report outlining all staff, using a RAG system, subject compliance is also reported to the subject matter experts , and the trust board receive monthly reports though the IPQR reporting process.	Monthly directorate meetings review compliance levels. In addition a quarterly appraisal and mandatory board report, including progress with the recovery plan, is reported and discussed at board level.	Community training data concerns being rectified. New induction programme started in Jan20 ESR supervisor self-service has had implementation postponed due to COVID restrictions New starters being offered alternative routes for mandatory training e.g. e-learning during COVID	Partial	Refresher training requirements will be suspended for the duration of the COVID-19 crisis. However, staff with the capacity and facilities to undertake e-learning mandatory training should be identified by their line manager and required to do so

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			community) with implementation of changes to content of training and delivery. This should enable a balance between staff being trained appropriately and safely whilst minimising delays in starting in the workplace.					
18	The trust must ensure that all bank and agency staff have documented local inductions.	JO	West Suffolk Professionals • A generic trust induction checklist is to be enhanced and re-implemented for all new agency and bank workers. • This will be followed up with a local area induction to be completed during first worked shift. Agency and Bank workers will complete local area induction on the commencement of their first shift. If additional shifts are undertaken in different areas, it is the expectation of the trust that a local induction will be conducted for each new area worked. • All bank staff training is to be reviewed and recorded on OLM. Medical Staffing • All Agency staff are given induction booklets before their first day, which they are required to sign and return a statement confirming they have read and understood this on their first day. • Bank medical staff are formed by current training and trust doctors, therefore are covered by local induction process.	West Suffolk Professionals - Local inductions will be recorded using a standard template issued to the worker on appointment which will be signed by both the individual and the area manager once local induction has been completed. Medical Staffing - Signed confirmations are filed on their personal files.	Ad hoc audit checks will be undertaken by both the West Suffolk Professionals and Medical Staffing teams to ensure compliance. This will be reported to the HR Director on a quarterly basis. The first report will be produced in quarter 2.	Action plan developed however the first action deadlines have slipped due to impact of COVID-19.	Partial	Reduction in face-to-face contact means that formal trust induction has been paused however all new starters are being offered alternative routes for mandatory training e.g. e-learning. Catch up sessions (e.g. meet CEO) provided New staff (including bank) working as part of Covid-19 support will still receive all appropriate induction training

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34	The trust should ensure that effective processes are in place to promote and protect the health and wellbeing of all staff.	JO	The Trust has a comprehensive Health and Wellbeing plan overseen by the Health and Wellbeing Steering Committee. Action in the plan to support mental wellbeing will be reviewed and updated as necessary to ensure the emotional and mental wellbeing of staff is supported during times of significant stress e.g. staff involved in investigations, disciplinary and grievance processes, coronor's cases. Action identified will build on that in finding 5. specifically actions to ensure a just culture undertaken as part of our improving people practices plan.	West Suffolk Wellbeing Plan 2019 - 221: staff health and wellbeing evaluation framework and dashboard. Metrics used: NHS staff survey (morale, health and wellbeing themes), sickness absence (anxiety, stress, depression, other psychiatric illness).	Reported to WSFT Health and Wellbeing Steering Group (quarterly), Trust Executive Group (six monthly), Trust Board (annually	Implemented - assurance pending		

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45	The trust should continue to promote the freedom to speak up (FTSU)guardian so that all staff understand what the role is and know who their guardian is.	JO	Internal audit review of robustness of processes and compliance with FTSU Policy, including the FTSU Guardian to identify additional management actions to support understanding and awareness of the role. Review of methods of communication Trust uses to promote a positive culture to speak up to be undertaken jointly with the National Guardian's Office as part of WSFT 'improving culture' plan Review role of FTSU Guardian to identify options to increase promotion of the role to all staff throughout the Trust Build on and spread existing good practice in promoting FTSU Guardian role e.g. use of posters promoting role and discussions at regular team meetings, events including induction Analyse 2019 NHS Staff Survey RAG report results to identify departments and/or staff groups with a score 3% or greater score below the Trust average for questions relevant to FTSU. Continue implementation of Improving Everyone's Experience Action Plan launched Sept19	NHS Staff Survey 2019 - overall report and RAG reports for divisional/staff group data. RSM Audit Report findings. PRM Meeting notes FTSU Guardian reports to Trust Board Report of NGO review	(1) Trust Audit Committee (2) Trust Executive Group (3) Trust Board	FTSU guardian included in Trust "Staff Supporters" section of Intranet highlighted on front page FTSU guardian web page including contact details and pen portrait (aims to clearly identify individual in the role)	Partial	The right to speak up about concerns including but not limited to those around Covid-19 are being maintained The main body of project work associated with this action is paused for the Covid-19 duration.

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55 64 71	(55) The trust should ensure that appraisal rates are met for staff. (64) The trust should continue to improve appraisal completion rates to meet the trust's target completion rate of 90%. (71) The trust should continue to improve appraisal completion rates to meet the trust's target completion rate of 90%.	JO	• Dedicated support to areas struggling to reach 90% from Workforce and HR as well as executive support to improve uptake. • Trust working towards ESR manager self – service which gives managers the responsibility to log appraisals for their own staff. This will remove the potential for appraisal information to be mislaid. • Implementation of agenda for change pay progression policy which will require all staff to have an up to date appraisal recorded on ESR, before they can progress an increment. • Support managers/ appraisers with on-going delivery of both refresher and initial appraiser training sessions. • Raise profile of appraisal compliance throughout the trust • Investigate possibility of an appraisal dashboard in Greensheet. • Ongoing work with Trusts across region to achieve best possible data transfer through Electronic Staff Record system appraisal data.	A monthly appraisal report is taken from the trusts HR system (electronic staff record - ESR). This is reported in a number of ways; line managers receive a compliance report outlining all staff, using a RAG system, senior managers also receive this report to see directorate compliance levels, and the trust board receive monthly reports though the IPQR reporting process.	monthly divisional appraisal report to line managers (includes, individual staff appraisal information, RAG ratings, and compliance figures by department and division), monthly board reporting through IPQR, quarterly report on actions to improve compliance as part of quarterly Appraisal and mandatory training board report	Appraisal reporting already in place	Paused	Reporting of appraisal KPIs suspended for Covid-19 duration. Communication to staff and managers that appraisal can be completed if there is time but they are not a priority

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3 4.3 39	(3) The trust must ensure that processes for incident reporting, investigation, actions and learning improve are embedded across all services and that risks are swiftly identified, mitigated and managed. The trust must ensure that incident investigations and root cause analysis are robust and that there are processes for review, analysis and identification of themes and shared learning. (4.3) The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation - incidents are monitored and reviewed to drive service improvement. (39) The trust should ensure shared learning from never events with staff across the hospital.	RP	Implementation of the WSFT local Patient Safety & Learning (PS&L) strategy with specific reference to key principle 4. 4. 'Continually learning and improving' AND local implementation of the NHSI's Patient safety incident response framework (PSIRF)	1. reports to meetings listed below 2. minutes of meetings below 3. completion of NHSI's PSIRF 'readiness assessment' template 4. updated Incident reporting policy 5. copies of shared learning documents (bulletins, agendas, committee reports, etc.)	PS&L strategy implementation plan will be reported to the Quality group in a monthly basis. There is a standalone implementation plan that sets out PSIRF progress will be reported to Trust Board via the Quality & Risk committee. PSIRF is also subject to external monitoring as it is a system wide project led by the Director of Nursing and Quality Suffolk (East and West) and North East Essex CCGs)	PS&L strategy implementation on hold however incident management continues during Covid-19. Thematic analysis of no harm or minor 'green' incidents on a weekly basis by Executive and patient safety lead. Amber incident management continues. SI's reported as CCG instruction. NE reported as CCGT instruction. Current investigations continue. All 'Covid-19' related incident shared on daily basis with divisions. Weekly and monthly governance reports for divisions. Shared learning events postponed however publication continues. Preparation for PSIRF continues as capacity allows.	Partial	PSIRF project nationally paused. Local ongoing incident reporting and investigation workstreams continue (see summary) however strategy implementation will be delayed.

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4.435	(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. (35) The trust should ensure that complaints are responded to in a timely manner, within trust policy.	RP	Weekly monitoring by Executive and monthly by the Board Additional staff appointments	1. tracking spreadsheet 2. monthly Board report	Weekly review of compliance	All staff in place. Processes changed and fully up and running	Able to continue	Able to continue

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10	The trust must ensure that the duty of candour is carried out as soon as reasonably practicable, in line with national guidance	RP	Implementation of the WSFT local Patient Safety & Learning (PS&L) strategy with specific reference to key principle 2. 'Being open and honest'. which describes four key actions: 1. Carry out duty of candour for patients promptly, sensitively and sympathetically. 2. Report via the IQPR and CDs meetings. 3. Continue to support 'freedom to speak up' by promoting staff guardians 4. Give opportunity for patients, families and carers to participate in SI investigations. Ensure open comms channels throughout process. NB: This has an overlap (but is not directly the same as) CQC ref 3+4.3 with regard to the implementation of the NHSI's Patient safety incident response framework (PSIRF) The DoC project will include looking at WHY we do not have timely DoC completion (which is likely to be multifactorial) not just HOW.	1. IQPR DoC indicators (timeliness, verbal overdue, written overdue) 2. minutes of meetings below 3. updated Being Open policy	PS&L strategy implementation plan will be reported to the Quality group on a monthly basis. There is a standalone implementation plan that sets out the details	Ongoing actions to ensure compliance with timely DoC completion are not paused and continue to be recorded and monitored.	Paused	Implementation of the improvement plan requires consultation with / involvement of staff who are currently otherwise involved in the COVID response. This plan, through the use of human factors and QI methods aims to achieve improvements in 'Being Open'.

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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.	RP	e-Care change requests put in place to amend: 1) Changes to triage form, mandate safeguarding concerns yes/no box 2) Changes to triage form, mandate falls history/risk of yes/no box, to then generate ED falls assessment if yes ticked 3) Changes to ED safety checklist, to mandate all fields, to add n/a column, to move pressure area assessment from 2nd hr to 1st hr, to add drop down box on pressure area assessment to choose from skin intact, DTI, category 1-4 (to be able to choose more than one) 4) To mandate observation, pain score fields on triage form for both adult & paediatrics 5) To communicate changes to staff 6) To complete weekly audits to monitor compliance 7) To request compliance data from the information team 8) To have 1-1 with staff which are non-compliant 9) Add to perfect ward	Staff compliance data for new safety checklist will be used to complete staff 1-1 Perfect ward data Weekly audits of 10 patients to monitor compliance	Review of audit data in ED governance meetings	New e-Care changes to triage form and patient safety checklist completed and live on system 14/01/20 Changes communicated to ED team via email and added to weekly hot topics t	Paused	Clinical staff currently directly involved in COVID response Clinical care / risk assessments maintained but audit has paused

14 20	(14) The trust must ensure staff record medication temperatures and escalate any concerns in line with its medications policy. (20) The trust must improve monitoring ambient room temperatures in drugs rooms.	RP	1) Pharmacy to audit all fridge temperatures with in Emergency Department. The maximum temperatures reached are as expected for drug fridges. Some temperatures were almost certainly due to the door being open whilst trying to find stock. Action to address issue resulting from temperature audit: - Introduction of trays into the fridge to keep stock together to minimise time looking for drugs - Pharmacy Assistant responsible for stock replenishment to return all excess fridge stock to pharmacy to improve airflow within the unit - Assess requirement of rigid cold blocks in fridge and remove if unnecessary - Installation of more accurate external fridge thermometers on advice of pharmacy - Request monthly audits from pharmacy to ensure continued compliance 2) Ambient temperature monitoring Ensure appropriate systems and processes are in place to monitor ambient room temperatures in areas where drugs are store and appropriate esclation processes where required. Actions to address issue: - Installation of thermometers in all rooms used for storage of drugs. - Introduction of ambient room temperature checking on to existing fridge temperature	Outcome and recommendations from pharmacy temperature audit Communications to staff via email and hot topics. Examples of escalations from staff to unit manager (email examples available) Examples of escalations from unit manager to pharmacy (email examples available)	Daily checks of fridge and ambient room temperatures. Monthly perfect ward audits. Outcomes of pharmacy audits.	Implemented - assurance pending

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			checks - Compliance to be audited within monthly perfect ward assessments 3) Escalation of increased temperatures Ensure appropriate escalation of increased temperatures to Unit Manager to ensure appropriate action taken Actions to address issues: - Email communication to all staff to remind to escalate high temperatures to Unit Manager (regular escalations since communication.) - Issue included in weekly hot topics discussed at all handovers. - Unit manager informs pharmacy of any escalations to ensure appropriate actions if required. 4) Long term strategy: Trust wide consideration of centralised temperature monitoring					

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15 16	(15) The trust must ensure that staff records in relation to equipment and medication checks are completed. (16) The trust must improve medicines management, particular in respect of management of controlled drugs, storage of patients' own medications and monitoring ambient room temperatures in drugs rooms.	RP	1) Review of documentation for equipment and medication checks Departmental review of existing documentation with a view to simplifying checklists and improve compliance. Actions: - Conducted a review of documentation in January - Removed unnecessary extra checklist for daily paediatric checks - Simplification of resus checks including reduction of date checking from weekly to monthly. - Inclusion of back stacks checking into resus one checklists 2) Review of online checking Duplication of paper and online checking was causing confusion and impact on compliance. Decision taken to remove requirement for online checking while improved paper checks were embedded within the normal practices of the department. Long term strategy to replicate improved paper checklist on to the online system. - All changes communicated to staff via email and hot topics	Improved checklists Emails and hot topics communication to staff	Completed checklists Perfect ward provides assurance for compliance with completion of checklists Monthly audit for quality of checks	Majority of actions already completed. One final action pending "Liaison with IT to request updated paper documents or replicated on online checking system"	Partial	Final elements to be completed once restrictions allow

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21 22 23 24 25 60	(21) The trust must improve monitoring of women's records and ensure that a greater number of records are audited monthly. (22) The trust must ensure that carbon monoxide monitoring assessments and records are in line with trust policy. (23)The trust must ensure that women are asked about domestic violence in line with trust policy. (24) The trust must ensure that they implement a nationally recognised monitoring vital observations tool for women attending triage on labour suite and the maternity day assessment. (25) The trust must ensure they implement a national recognised monitoring vital observations tool for new born babies on the labour suite and F11 ward. (60) The trust should ensure that women's pain scores are consistently completed.	RP	To adhere with the requirements of Section 29A warning notice Audits to measure compliance with key standards to be introduced / continued with sufficient volume to allow meaningful interpretation. 2020/21 audit programme to be developed and implemented. New Clinical and Quality Assurance midwife post to be responsible for the development and implementation of the audit programme and associated quality improvements	Audit programme Audit reports JD for CQA midwife	Local monitoring at Women's health Governance	Some audits ongoing but others have been paused. All ongoing audits are now moving to monthly All relevant audits demonstrate high levels of compliance With specific regard to domestic violence. Unable to provide normal standards as part of social distancing elements of the COVID response. Interim arrangements to safeguard vulnerable women put into place.	Partial	CQA midwife appointment progressing and, dependant of suitable appointment, audit programme will continue but to a reduced level whilst COVID response takes clinical priority. Some audits are not being carried out as clinical activity is changed during COVID response and thus the audit standards are not comparable. For example the national decision to pause CO monitoring as part of social distancing elements of the COVID response. These audits will recommence once appropriate
26	The trust must ensure they carry out daily checks of resuscitation equipment.	RP	Ward Manager on F11 to check daily. Labour Suite co-ordinators to check daily. Service manager to check weekly compliance in all areas.	Outcome of compliance checks	Reporting of compliance checks to Women's Health Governance	Checks being undertaken daily	Partial	Ongoing equipment checks in place but compliance monitoring and reporting has paused for now.

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27	The trust must ensure clinical guidelines are up to date.	RP	Business Case for Clinical effectiveness midwife/ safety/audit midwife to be completed. Bank Band 7 midwife to undertake role in the meantime.	Survey all guidelines to produce spreadsheet of out of date guidelines/ due to expire soon. Chase up/allocate guidelines. Collate feedback	Approval via clinical governance	Bank midwife covering role until required clinically	Partial	All non-COVID new appointments placed on hold
36	The trust should ensure all staff follow infection prevention and control procedures and bare below the elbow guidance at all times.	RP	Reminder to all staff of how to challenge visiting staff (i.e. not just department staff).	Positive audit results	weekly review and where there are failings weekly audit and ward manager and senior matron attend a meeting with the ECN to discuss improvement plan	Infection control guidance and bare below the arm policies being implemented and followed during the Covid-19 pandemic.	Able to continue	Infection prevention and control procedures and bare below the elbow practice is continuing with heightened intensity for COIVD-19 duration Wider action plan developed for post-COVID implementation including communication to staff (posters, Greensheet, link practitioner days, world hand hygiene day) and actions to address compliance failures
37	The trust should ensure that cleaning chemicals hazardous to health are stored in an appropriate locked location.	RP	All wards will have access to a locked location in order to safely store cleaning chemicals hazardous to health. Staff will be aware of their responsibilities under COSHH and adhere to policy.	Perfect ward/peer review inspections will evidence rate of compliance for each ward area; with the aim of meeting a 100 % target.	Perfect ward to be completed monthly and shared with the Matrons/HoN at performance meeting. Where compliance is <100 an action plan will be completed.	Implemented - assurance pending		
38	The trust should ensure that all sharps and syringes are stored securely away from patients and visitors.	RP	Perfect ward update to ensure audited and where required actions put into place. Linking in with workplace inspection programme	Perfect ward/peer review inspections will evidence rate of compliance for each ward area; with the aim of meeting a 100 % target.	Monthly audit will need to meet a 100% compliance rate. Results will be shared at the matrons/HoN quality meetings and if the target is < 100% an action plan will be put into place.	Implemented - assurance pending		

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	Summary of progress	COVID status	Rationale for Covid-19 Status
40	The trust should display safety thermometer data and utilise this to improve services.	RP	Ward accreditation programme (as per NHSI) will be supported by a review of nursing quality metrics (including but not limited to Safety thermometer) including data distribution, display and data sharing, use in improvement not just performance and reporting via IQPR and other pathways is planned, led by HoNs and supported by Governance. this will link into the ongoing wider review of the IQPR led by the Performance team	Updated IQPR metrics (expected to be in place for 2020/21 reporting cycle) will provide further source of assurance to Board	Ward accreditation working group report to Quality group	Working group convened prior to COVID-19 pause and leads have visited an organisation to bring back learning	Paused	Implementation of new project has been paused to enable key staff to focus on COVID-19 planning and management.
47	The trust should ensure that the labour suite coordinator is supernumerary.	RP	Business Case for supernumerary Labour Suite co-ordinators to be completed.	Submission and approval of Business case	Once post holders are in place	Labour Suite co-ordinators have been reminded of their supernumerary status. Escalation policy communicated to all staff via 'Take- 5' and Community leads meeting Voluntary core on-call to be offered to assist with times of escalation.	Able to continue	Posts advertised
49	The trust should ensure team meetings are held to share information with ward staff.	RP	Minutes of applicable meetings to be e-mailed to all staff. Unit meeting to commence from Feb20 and held monthly thereafter on first Thursday of the month. All staff to be e-mailed date/time/venue.	Minutes of meetings Copies of emails demonstrating distribution of same	Can be evidenced to provide assurance if required	Unit meetings in place (now paused)	Paused	Face to face meetings paused to maintain social distancing requirements.

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	Summary of progress	COVID status	Rationale for Covid-19 Status
50	The trust should ensure there is effective audit of the use of the World Health Organisations (WHO) and five steps to safer surgery checklist and take actions on results that do not meet trust standards.	RP	All checklists are audited. Action plans to address non-compliance to be recorded more transparently within Maternity central action plan documents	Results on the Maternity Dashboard	Dashboard presented at Women's Health Governance & Performance Meetings on a monthly basis. Theatre manger given the results to feedback to individuals.	Paused	Paused	Trustwide the WHO audit has paused.
51	The trust should ensure that staff report all incidents in line with trust policy.	RP	List of reportable incidents to be next to each computer on Labour Suite/F11/MDAU/Birthing Unit.	Incident reporting data is available through central Datix records.	Trustwide oversight of incident reporting patterns including highlight of potentially low reporting areas	Incident reporting levels maintained	Able to continue	There is an expectation that incident reporting should be maintained and this has been communicated to all staff via the daily COVID briefings
52	The trust should ensure that they close incident investigations within trust deadlines.	RP	Reminder to all senior staff at all meetings/e-mail/Take 5. Risk midwife to check on a weekly basis for compliance.	Incident reporting data is available through central Datix records.	Trustwide oversight of incident reporting patterns including timeliness of turnaround	Timely investigations have been maintained	Paused	During COVID-19 the requirement to investigate individual green incidents had been paused and replaced by thematic review. This means that timely response cannot be measured. Once restrictions lifted, focussed feedback (to all divisions) will enable more timely responses
53	The trust should consider displaying safety performance information.	RP	White board to be placed in Labour Suite staff room to display information. Board on F11 corridor to be updated with current results.	Whiteboard in place	F11 noticeboard to be checked regularly to ensure data is current	Noticeboard in place. Currently displaying COVID-19 specific data	Partial	Publication and display of current data records to be maintained although recognition that not all data is currently being collected due to COVID restrictions
54	The trust should ensure that action plans are created and followed for national and local audits.	RP	Business Case for Clinical effectiveness (CE) midwife/ safety/audit midwife to be completed. Once audits presented, action plan created and updated monthly at clinical governance.	Job description Audit programme (local and national) Action plans (recorded more transparently within Maternity central action plan documents)	Monthly clinical governance meeting updates.	Recruitment of CE midwife still ongoing	Paused	Will not be able to achieve the planned improvements until restrictions are lifted

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	Summary of progress	COVID status	Rationale for Covid-19 Status
56	The trust should ensure that processes are in place for the supervision of midwives.	RP	Discuss with regional lead regarding implementation of the A-EQUIP Model. Business case for Professional Midwifery Advocates and training.	Copy of Business case Outcome of benchmarking exercise	Outcome of benchmarking will be reviewed locally within Maternity management to agree implementation	Benchmarking being undertaken to review how to fulfil requirements	Paused	This will be progressed once restrictions are lifted
57	The trust should ensure the collection of friends and family data in all areas.	RP	New Patient Experience team in place will support collection	Data available	In quality report and local reports	Data available (for months prior to COVID pause)	Paused	Will recommence once restrictions are lifted
58	The trust should ensure consumable equipment is not opened prior to use to prevent infection prevention and control risks.	RP	Seek clarification to ensure trust local practice conforms to Resus Council national requirements Ensure staff are aware of requirements Ensure relevant policies reflect national best practice requirements	Statement from Resus Council and/or copy of relevant national guidance referenced within local policies	Standard Infection prevention audit programme on Perfect Ward reported to Women's Health Governance	Still awaiting outcome of (Trustwide) response to requirements of the Resus Council	Paused	All local infection prevention practices in place are currently COVID-19 specific.
59	The trust should ensure an evidence-based bereavement care pathway is put in place.	RP	Business case for Bereavement midwife to be completed. Bereavement Care pathway to be reviewed by bereavement midwife in conjunction with all applicable professional, in line with current evidence based guidance.	Updated care pathway	Presentation of updated pathway to Womens Health Governance	Job description and banding complete	Paused	All non-COVID new appointments placed on hold
69	The trust should consider using an acuity tool to assess whether there were enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.	RP	Implementation of metrics and a method for gathering and reporting data for analysis around patient acuity, levels of patient harm and safe staffing.	Acuity tool data Minutes of meetings Output of LAM/HoN review.	Via Business Unit and Divisional Board Meetings.	Actions completed - Ensure all senior staff competent to undertake daily acuity scoring using agreed tool. - Implement temporary, paper-based acuity data tool at Glastonbury Court.	Paused	Remaining actions now on hold until COVID-19 restrictions are lifted

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	Summary of progress	COVID status	Rationale for Covid-19 Status
72	The trust should ensure that patients individual needs and preferences are taken into account when planning care.	RP	Consider the provision of support to meet the personal, cultural and spiritual preferences/needs of patients. Establish a process around gathering this information and how to share with team. Appoint 'Individualising Patient Care' champions to share and drive this initiative.	Outcomes from Patient Satisfaction Survey/Perfect Ward audit/Quality Assurance Visits.	Ward Clinical Governance Meeting minutes. Business Unit Meeting minutes. Divisional Governance Steering Group Meeting minutes.	Actions completed: - Feedback from CQC shared with Rosemary Ward colleagues regarding need to individualise patient care - Volunteers from team to become 'Individualising Patient Care' Champions in 'Rosemary News' and via information in Staff Room. - Confirmed Care Co-ordinator support for fortnightly meetings	Partial	Remaining actions now on hold until COVID-19 restrictions are lifted
74	The trust should ensure that individual goals and outcome measures are routinely monitored and audited to improve care.	RP	Current outcome measures to be reviewed and launched/re-launched, with involvement around progress/achievement of goals with patient/family/colleagues.	Agreed functional tools/outcome measures to be assessed on admission to inpatient beds, during admission and upon discharge.	Ward Clinical Governance Meeting minutes. Business Unit Meeting minutes. Divisional Governance Steering Group Meeting minutes.	Actions completed: - Meetings with Ward leaders and Inpatient Therapy Teams to share CQC feedback and enlist support / expertise regarding outcome measures. - Confirmed Care Co-ordinator support for fortnightly meetings	Partial	Remaining actions now on hold until COVID-19 restrictions are lifted

12. NHS resolution – maternity incentive scheme

To approve the report

For Approval

Presented by Rowan Procter

Trust Board Meeting 24 April 2020

Agenda item:	12			
Presented by:	Rowan Procter, ECN			
Prepared by:	Jane Lovedale Clinical Risk Manager Women and Childrens Services			
Date prepared:	April 2020			
Subject:	Quarterly Report on the use of the National Perinatal Mortality Tool to review perinatal deaths.			
Purpose:	√	For information		For approval

Executive summary:
The Women & Children's Division, as part of the maternity incentive scheme – year 3 (NHS Resolution) must provide a report each quarter as evidence that they are using the National Perinatal Mortality Review Tool to review eligible perinatal deaths to the required standard and within the timeframe of Friday 20th December to Thursday 17th September 2020.

The report outlines the standards and includes details of the deaths reviewed from December 20th 2019 to March 31st 2020.

Subsequent reports will be submitted each quarter up to the deadline for reporting to NHS resolution by Thursday 17th 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**
	√	√	√

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

Previously considered by:	The Scrutiny Committee July 2019 (compliance for CNST 2019)
Risk and assurance:	*[Detail relevant issues within the report*
Legislation, regulatory, equality, diversity and dignity implications	*[Detail relevant issues within the report]*

Recommendation:
The Board receives and notes the quarterly report that includes details of all deaths reviewed and consequent action plans.

Background to the PMRT

The Perinatal Mortality Review Tool (PMRT) was established in January 2018. The WSH maternity service follows the specific principles outlined below and in accordance with the guidance *Supporting high quality local perinatal reviews 'Guidance for Trusts and health Boards July 2018*

- Comprehensive and robust review of all perinatal deaths from 22+0 days gestation until 28 days after birth (excludes termination of pregnancy) and those with a birth weight of <500g.
- Use of a standardised nationally accepted tool.
- A multidisciplinary group should review each case as guidance on PMRT website.
- Scope for parental input –material to support parental engagement used.
- Action plan generated for each review, implemented and monitored.
- Written report produced and shared with the family.
- Reporting to the Trust Board executive should occur regularly resulting in organisational learning and service improvements.
- Findings from local reviews fed up regionally and nationally to allow benchmarking and publication of results ensuring national learning.

The babies whose care should be reviewed using the Mortality review tool.

- Late fetal losses 22 +0 to 23 +6
- Antepartum and intrapartum stillbirths
- Neonatal deaths from birth to 28 days
- Post-neonatal deaths where baby dies after 28 days following care in a neonatal unit.

Maternity incentive scheme - year three

Safety Action 1: Use of the PMR review tool to review perinatal deaths to the required standard between December 20th 2019 to Thursday 17th September 2020.

Required standard

a) A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from **Friday 20 December 2019** will have been started within four months of each death. This includes deaths after home births where care was provided by your trust staff and the baby died.

b) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your trust, including home births, from **Friday 20 December 2019** will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool, within four months of each death.

c) For 95% of all deaths of babies who were born and died in your trust from **Friday 20 December 2019,** the parents were told that a review of their baby's death will take place, and that the parents' perspectives and any concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your trust staff and the baby died.

d) Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the trust maternity safety champion.

Evidence required by the board

The perinatal mortality review tool must be used to review the care and draft reports should be generated via the PMRT.

A report must be received by the Trust Board each quarter from Friday 20 December 2019 until Thursday 17 September 2020 that includes details of the deaths reviewed and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met.

Cases reviewed using the PMRT

A detailed case review for the three cases since December is presented in closed Board. This is due to the level of detail provided which could make individuals identifiable.

One investigation has been completed within the prescribed timescale and two investigations are ongoing - both are due by June 2020.

References

PMRT Supporting high quality local perinatal reviews
Guidance for Trusts July 2018 Version 1.2

Maternity incidentive scheme –year three revised safety actions Tuesday 4th February 2020
Ten maternity safety actions with technical advice

13. Freedom to speak up guardian report

To approve the report for Q4

For Approval

Presented by Jeremy Over

Board of Directors – 24 April 2020

Agenda item:	13			
Presented by:	Jeremy Over, Executive Director of Workforce and Communications			
Prepared by:	Nick Finch, FTSU Guardian			
Date prepared:	April 2020			
Subject:	Freedom to speak up			
Purpose:	✓	For information		For approval

Executive summary:
This report outlines the work I have carried from November 2019 to April 2020 as the Freedom to Speak Up Guardian for the Trust.

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

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

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

Recommendation:
Over the last 6 months a steady number of staff have approached me in my role as the Freedom to Speak up Guardian. COVID-19 has added additional stress for staff, so new concerns have emerged.

I feel that being visible and the role being well advertised gives staff confidence to come forward with issues and know they will be listened to and in some cases given the help they need.

I recommend the Trust board note this report.

Introduction

Background

In February 2015, Sir Robert Francis published his final report which made a number of key recommendations under five overarching themes with actions for NHS organisations and professional and system regulators to help foster a culture of safety and learning in which all staff feel safe to raise a concern. Two key elements include the appointment of a local Guardian in each Trust and a national Guardian for the NHS.

In April 2016 NHS Improvement published a national policy for raising concerns for NHS organisations in England to adopt as a minimum standard. The Francis report emphasises the role of the NHS constitution in helping to create a more open and transparent culture in the NHS which focuses on driving up the quality and safety of patient care.

Role of the Guardian

Independent in the advice they give to staff and Trust senior leaders, to be free to prioritise their actions to create the greatest impact on the freedom to speak up culture and be able to hold Trusts to account for: creating a culture of speaking up; putting in place processes to support speaking up; taking actions to make improvements where needed; and displaying behaviours that encourage speaking up.

Impartial and able to review fairly how cases where staff have spoken up are handled.

Empowered To take a leading role in supporting staff to speak up safely and to independently report on progress on behalf of a local network of 'champions' or as the single role holder.

Visible To all staff, particularly those on the frontline, and approachable by all, irrespective of discipline or grade.

Influential With direct and regular access to members of trust boards and other senior leaders.

Knowledgeable in Freedom to Speak Up matters and local issues, and able to advise staff appropriately about speaking up.

Inclusive and willing and able to support people who may struggle to have their voices heard.

Credible with experience that resonates with frontline staff.

Empathetic to people who wish to speak up, especially those who may be encountering difficulties and able to listen well, facilitate constructive conversations, and mediate to help resolve issues satisfactorily at the earliest stage possible.

Trusted by all to handle issues fairly and take any action wh necessary, act with integrity and maintain confidentiality as appropriate.

Self-aware and able to handle difficult situations professionally, setting boundaries and seeking support where needed.

Forward thinking and able to make recommendations and take action to improve the handling of cases where staff have spoken up, and freedom to speak up culture more generally.

Supported with sufficient designated time to carry out their role, participate in external Freedom To Speak Up activities, and take part in staff training, induction and other relevant activities with access to advice and training, and appropriate administrative and other support.

Effective monitoring the handling and resolution of concerns and ensuring clear action, learning, follow up and feedback.

Updates

Current work undertaken by the Freedom to Speak Up Guardian for West Suffolk NHS Foundation Trust to date includes:

- I have attended and met with the new overseas Nurses at their induction giving them a good insight into my role.
- A working link with the Senior Independent Non-Executive Director.
- Working with the National Guardians Office.
- Continued to work with the Eastern Region Guardians Office and Guardians.
- Continue to attend Trust Inductions.
- I have met with the Junior Doctors.
- I have met with the Trade Unions.
- I have worked with External Auditors to audit the role of the Freedom to Speak Up Guardian at West Suffolk NHS Foundation Trust.
- Since the outbreak of COVID-19 I have had contact with several members of staff who have raised concerns surrounding PPE. I have not only been able to help them as the Guardian but give them advise and assure them using the knowledge from my day job.

Concerns Raised with the Freedom to Speak Up Guardian

Concern theme	Numbers	Occupational Group	Status
Bullying and harassment	1	Admin	Concluded
Bullying and harassment and non-compliance	1	Pathology (NEESPS)	Handed to the Colchester Guardian and closed
Safety Issue	1	Community Staff	Concluded with line managers
Internal dispute	1	Therapies	Resolved by HR
Internal dispute	1	Admin	Pending
Internal Dispute	1	Admin	Pending
Miscellaneous concerns	3	Unknown	Advised/concluded
Miscellaneous	1	Admin	Pending

This table shows the number of concerns raised over the last six months where the FTSUG has been asked to investigate and has or is currently working with staff.

Bullying and harassment one case was concluded in that the member of staff felt supported by the Freedom to Speak Up Guardian and HR and the case was closed with a satisfactory outcome. The second case was someone **not** employed by West Suffolk NHS Foundation Trust but North East Essex and Suffolk Pathology Services. This was sent to the Colchester NHS Foundation Trust Freedom to Speak Up Guardian who was unable to make any further contact with this member of staff and the case was closed.

Safety issue I was approached by two members of a staff group who raised safety concerns. They had not spoken to their line managers but upon doing so were able to resolve the situation. No further action was required by the Freedom to Speak Up Guardian.

Internal disputes I have been involved in a total of three Internal disputes, one has been resolved by HR and the other two are still pending.

Miscellaneous concerns/Miscellaneous I have been contacted anonymously by three members of staff raising concerns regarding PPE. I have been able to reassure them not only as the Freedom to Speak Up Guardian but in the capacity of my day job. I have one case still pending.

Future plans

- To continue meeting with all staff groups to advertise of the role and support where necessary.
- Attend staff departmental meetings
- Meet with staff at Newmarket Hospital.
- Continue to raise the profile so that staff are fully aware who I am and how I can be approached.
- To continue to work with the Executive Directors, Non–Executive Directors, Senior managers and governors.

14. Consultant appointment report

To NOTE this month

For Report

Presented by Jeremy Over

Board of Directors – 24 April 2020

Agenda item:	14			
Presented by:	Jeremy Over, Executive Director of Workforce and Communications			
Prepared by:	Medical Staffing, HR and Communications Directorate			
Date prepared:	20th March 2020			
Subject:	Consultant Appointments			
Purpose:	x	For information		For approval

Executive summary:
Please find attached confirmation of Consultant appointments.

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

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

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

Recommendation:

For information only

POST:	Consultant in Geriatrics
DATE OF INTERVIEW:	Thursday 27th February 2020
REASON FOR VACANCY:	New
CANDIDATE APPOINTED:	[redacted]
START DATE:	Thursday 27th February 2020
PREVIOUS EMPLOYMENT:	[redacted]
QUALIFICATIONS:	[redacted]

	[redacted]
NO OF APPLICANTS: **NO OF INTERVIEWED:** **NO OF SHORTLISTED:**	3 1 2

POST:	Acute Consultant in Paediatrics
DATE OF INTERVIEW:	Thursday 12th March 2020
REASON FOR VACANCY:	New
CANDIDATE APPOINTED:	[redacted]
START DATE:	To be confirmed
PREVIOUS EMPLOYMENT:	[redacted]

	[redacted]
QUALIFICATIONS:	[redacted]
NO OF APPLICANTS: **NO OF INTERVIEWED:** **NO OF SHORTLISTED:**	10 5 5

POST:	Acute Consultant in Paediatrics
DATE OF INTERVIEW:	Thursday 12th March 2020
REASON FOR VACANCY:	New
CANDIDATE APPOINTED:	[redacted]
START DATE:	To be confirmed
PREVIOUS EMPLOYMENT:	[redacted]
QUALIFICATIONS:	[redacted]
NO OF APPLICANTS: **NO OF INTERVIEWED:** **NO OF SHORTLISTED:**	10 5 5

15. Putting you first award

To NOTE a verbal report of this months winner

For Reference

Presented by Jeremy Over

10:50 BUILD A JOINED-UP FUTURE

16. Integration report

To APPROVE the report for Q4

For Approval

Presented by Helen Beck and Kate Vaughton

Board of Directors – 24 April 2020

Agenda item:	16			
Presented by:	Kate Vaughton, Director of Integration			
Prepared by:	Renu Mandal, Senior Project Manager, Joint Transformation Team			
Date prepared:	17 April 2020			
Subject:	West Suffolk Alliance COVID-19 Highlight Report			
Purpose:	X	For information		For approval

Executive summary:

The purpose of this report is to provide Board with an overview of how the West Suffolk Alliance and the wider ICS is responding to COVID-19 and provide an update on progress made so far.

The Suffolk and North East Essex Integrated Care System (ICS) has set up 10 workstreams to adopt a whole system response to COVID-19. ICS wide programmes of work focus on Demand and Capacity Planning; Workforce; Voluntary Care Sector; Communications and Engagement; Finance and Procurement Planning; Clinical Professional Forum; Digital; Recovery and Estates. Individual Alliance Locality Cells, of which the West Alliance Coordination Cell ('**West Alliance Cell**') is one, have been set up to ensure resources are coordinated and utilised effectively while responding to COVID19.

The main duties of the West Alliance Cell are to:

- Provide the overall view, decision-making forum and assessment of West Suffolk response to Covid 19 preparations.
- Monitor the impact of the Covid 19 response as a whole, including unintended consequences and agree the appropriate strategic system response.
- Consider the recommendations made by Covid 19 West Suffolk Cell Alliance members.
- Identify and utilise appropriate individuals, organisations and groups in support of the response.
- Support and ensure promotion of integration and close working between all partners.
- Use high level data to develop, monitor and review the Covid 19 response to ensure that necessary measures are in place for patients and the wider community.
- Identify relevant funding streams, as needed, in the delivery of the Covid 19 response.
- Escalate items to the ICS Tactical Support Group as necessary, in line with points above.
- Continue to provide support for our patients, providers and partners while responding to COVID19.

The overarching objectives of the West Suffolk response to Covid-19 are:

- To preserve life and minimise harm to all those caught up within the COVID19 through working collaboratively across agencies.
- To participate appropriately in multi-agency command and control forums managing the emergency.
- To provide accurate, adequate and timely information to the media either directly or through media cells including partner agencies.
- Where necessary provide support to multiagency media cells.
- To ensure effective internal and external communication. Using social media effectively.
- To be responsive to requests for assistance from partner agencies and other members of the health community.
- Actively seek additional resources from within our local system or through wider mutual aid.
- To ensure effective and timely communication with other parts of the health community including our neighbouring CCG's, NHS England/Improvement and the Dept of Health and Social Care.
- To provide support (including wellbeing) to staff, patients and members of the public during the incident and in the aftermath.
- To make provision to return to normal activity (recognising there may be a new reality) as soon as possible.

To deliver these objectives the West Alliance Cell has developed a multi-agency work programme with a focus on 5 broad themes; Community Activity; Primary Care; Community Collaborative Board; West Alliance Clinical Cell and Mental Health. Highlight reports are provided to the COVID-19 Planning Forum on a weekly basis who monitors progress.

Key Points:

- A new county wide group has been set up to co-ordinate the care home response to C19 and provide support and links to locality teams.
- A shared approach to managing shielded patients is being trialled in Bury Town locality.
- Primary Care respiratory Hubs have been agreed and operationalised.
- Contingency plans are in place between GP Practices and Out of Hours for each locality to provide 24/7 cover.
- Virtual consultations in place across all practices.
- A test and learn approach is being taken in Newmarket to explore how volunteer capacity can be integrated with community health and care teams.
- A medical model to support community beds between acute and primary care teams has been worked up.
- Mental Health, First Response Service and community model in partnership with Suffolk MIND is now live and running successfully.

Upcoming work programme:

- Mobilisation of community bed model.
- Finalise model of delivery on End of Life care.
- Finalise End of Life formulary of access to medication out of hours.
- Agreeing longer term model of 7 days working across primary care.
- Supporting the development of the integrated test and learn model in Newmarket and planning roll out of learning.

The highlight report for w/e 17th April is included as Appendix 1 for 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**
	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:	**N/A**
Risk and assurance:	
Legislation, regulatory, equality, diversity and dignity implications	

Recommendations:

1. *To note the West Alliance Highlight Report, included as Appendix 1.*

Appendix 1: COVID-19 West Alliance Highlight Report

Key actions this week	Progress	Risks and Issues	Mitigations
Community Activity – Health and Social Care: • Increase 24/7 service provision capabilities • Enhance community bed base and discharge processes • Develop proactive community planning • Enhance clinical modelling	• Sharing/overlap of practice/ community lists to be tested for shielded patients in Bury Town Locality with 2 GP Practices. Plan to start w/c 20 April. • SOP for Case load prioritisation and risk stratification to be competed by 20 April • New care homes cell county wide convened, will co-ordinate case home contacts/status / and link with locality teams depending on each homes RAG status • EOL – Changes made to DNACPR and drug administration charts signed off • EOL- VOED, combined model with GP Fed drafted for sign off at EOL group tomorrow	• Resilience relating to overnight care for 24/7 provision if staffing levels depleted	• Currently managing with existing capacity. Scenario planning - proactively developing workforce requirements and system contingency plans to manage depleted workforce.
Primary Care: • Further refine hot/cold and respiratory hubs • Resolve access to PPE issues • 24/7 visiting service in place • Verifying death model worked up with SGPF	• Estates in place, IT equipment in place • Primary care Respiratory hubs agreed • Ongoing delivery of PPE and agreement to share across practice sites • Contingency plans in place between practices and OOH for each locality over the weekend to support if activity levels escalate • CARE UK to share offer on 2 cars (1 per Resp' site)	• Workforce nominations • Limited supply of PPE, external influencing factors raising concern levels • Additional funding required to Implement/test 24/7 visiting service	• Enhanced funding offered • PPE- Escalation process for Primary Care • Prioritisation ; Possible scope for national CV-19 monies
Collaborative Community Board: • Implement enhanced medication delivery • Email inbox set up for HBNA queries in relation to health issues • Working with CCB Task and Finish Group around expanding capacity within INTs through working with the VCSE • Exploratory meeting with WSFT and Suffolk Family Carers about their model of support for families	• New CCB Finance task and finish group providing advice about benefits and finances • CCB developing a website for 'Home but not Alone' service to include information on sources of help • Meds delivery system is going live from 20 April. HBNA Back office staff being supported by the CCG to get to grips with the system • From 20 April, a test and learn approach is being taken in Newmarket to explore how volunteer capacity can be integrated with community health and care teams	• Identifying uncertainty around medium to long term funding for the VCSE • Requirement to test out VCSE involvement in our teams at pace – and whether we can get people the technology they need to do their job • Report that there a lot of volunteers from all different platforms that aren't being matched with	• Addressed through the VCSE funding task and finish group • Taking a pragmatic approach to the project ensuring that we are coherent with the agreed direction of travel as a Alliance • West Alliance Workforce lead to support allocation of volunteer staff
West Suffolk Alliance Clinical Cell: • Membership reviewed and enhanced to improve system coverage of all disciplines • ToR for group and interdependencies refreshed	• Final work up of medical model to support community beds between acute and primary care teams • EOL Guidance and Formulary discussed • Discontinued services and plan for recovery post C19	• Ensuring equity in terms of decision making across ICS • Ensuring not duplicating with other forums	• MS and NE providing ICS level join up and oversight • Improved links into WSFT clinical group/LPC/EOL
Mental Health – West Suffolk • Inpatients • First Response Service • Community work with Primary Care	• Southgate operating as Cohort ward – 0 COVID patients. 17 Patients on Northgate wards (21 bedded ward). Abbeygate (later life) has 4 patients self isolating. • First response service has gone live. Received 133 calls in 29 hours. • Community work with Primary care is still ongoing	• Insufficient capacity	• Speaking to estates to create more space and pulling in more staff to support

Key actions next week	Risks and Issues	Mitigations
Community Activity – Health and Social Care: • Mobilisation of community bed model from Tuesday 21/04/20 • Finalisation of the model of delivery for integrated EOL care • Implementation of latest care home guidance	As per previous slide	As per previous slide
Primary Care: • Finalising EoL formulary and model of access of medication out of hours • Agreeing longer term model of 7 days working across primary care • Ensuring all measures in place to identify and support shielded patients • Matching additional staff to practices to improve capacity to support management of shielded patients • Further work on the provision of phlebotomy services with report back to CCG Clinical EXec • Wash up from Easter opening and planning for weekend coverage going forward	As per previous slide	As per previous slide
Development of Integrated Neighborhood Team model • Setting up Newmarket Test and Learn and gathering feedback on the pilot • Support structures for developing the model • Developing sit rep of non hospital elements of the system including care homes • Working with District Council partners regarding addressing wider determinants of health • Planning roll out of wider Integrated Team model		

11:00 GOVERNANCE

17. Governance changes in response to COVID

To APPROVE the report

For Approval

Presented by Richard Jones

Trust Open Board – 24 April 2020

Agenda item:	17			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance Rebecca Gibson, Compliance Manager			
Date prepared:	20 April 2020			
Subject:	Governance arrangements during COVID response			
Purpose:		For information	X	For approval

Executive summary:

It is acknowledged that many of 'business as usual' activities will of necessity be paused during the COVID-19 response.

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:			Executive Directors meeting 8th April 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 and approve the arrangements to provide governance oversight during the COVID response
2. Agree that the arrangements are subject to review no later than the Board meeting at the end of July

Annex 1: Arrangements for specific elements

1. Management of Trust committee agendas and meetings

While it is acknowledged that there is an urgent need to avoid unnecessary face-to-face group contact and release staff to focus on clinical / operational roles; the committee structure should still be providing a structure to maintain oversight of their area of responsibility.

This could be achieved either by holding virtual meetings (using the Microsoft Teams application for example) and/or by circulating information (based on a shortened agenda / reports) by email for review and comment.

Committee	Status
Trust Board (open and closed)	Continue with Teams - with reduced agenda agreed with Chair
Audit Committee	Continue with Teams - with reduced agenda agreed with Chair and deliver the mandated requirements to support submission of the annual report and accounts
Scrutiny Committee	Continue with Teams - agenda mandated by annual report. Assign as Board COVID meeting for escalation purposes
Charitable Funds Committee	Cancel. Decisions to be taken in compliance with the standing orders and scheme of delegation
Quality & Risk Committee Corporate Risk Committee (CRC) Patient Experience Committee (PEC) Clinical Safety & Effectiveness Committee (CSEC) Quality Group	Cancel these meetings but prepare a reduced pack of reports based on forward plan. Issues to be considered on exception basis by Scrutiny Committee
Sub-committees of CSEC / PEC / CRC	Decision making around the individual committees is currently being progressed through contact with the group's chair / specialist lead.

2. Process for managing complaints during the COVID period

National guidance from NHS England & NHS Improvement supports a system wide "pause" on the complaints process. https://www.england.nhs.uk/contact-us/complaint/

Locally the following has been put into place to manage in the interim:

- All new complaints received will still be triaged, recorded and RAG rated for severity and impact.
- Datix updated so, once national pause is lifted, a full analysis into the complaints received and all relevant information relating to the complaint during the pandemic can be published.
- All Green/Amber complaints will be acknowledged but not be passed on to staff for investigation until further notice. If possible, a low-level investigation will be completed.
- All Red complaints will be acknowledged and placed on hold until further notice. Complainants will be advised that we are unable to provide a response timescale during this situation.
- Backlog recovery plan - All open complaints have holding letter to provide an update on their complaint with circa 50% of the current backlog aiming to be responded to by end April. This will provide more capacity in the future to respond to any Red complaints that have been received during this time.

- All local resolution meetings have been placed on hold until further notice. All complainants requesting a face-to-face meeting have been contacted and are understanding and agree to postpone until COVID situation has eased.

3. Management of incident reporting and investigation

Red incidents	National guidance on quality & safety activities is expected imminently from NHSE following the approval of the Coronavirus Act 2020. Whilst this is still awaited, guidance has been sought from the CCG who have indicated that serious incidents and Never Events should continue to be reported however opportunities for use of more concise reporting templates can be explored. Any RCA / review meetings required are being undertaken virtually using Microsoft Teams or email cascade. Duty of candour requirements for these incidents remain
Amber incidents	Where an incident has resulted in moderate harm to a patient; investigations will still take place supported by the required duty of candour conversations. The use of an 'after action review' tool is to be trialled both to reduce requirement for extensive report productions by local clinical staff but also to trial a method that might be suitable for the PSIRF (the implementation of which has been nationally paused)
Externally reportable incidents	A number of regulatory bodies have indicated that reporting and investigation of incident will remain unchanged (and may include additional COVID related reporting requirements). The local specialists will maintain an oversight and a watching brief on these cases. This includes HSE (RIDDOR reporting), MHRA, SHOT (serious hazards of transfusion), IRMER (radiation safety) etc.
Green incidents	During this time of COVID response we are not asking staff to undertake individual investigations for incidents reported as no harm / minor harm (green). As a consequence, staff reporting incidents will not receive the normal investigation narrative feedback email. Instead the following will be put into place (and staff made aware of this through the auto-feedback message from Datix) • All incidents are reviewed locally on a daily basis at the matron-led safety huddle and on a weekly basis by the Executive Chief Nurse and acting Head of Patient Safety • All patient safety incidents are also uploaded to the NHS Improvement national reporting and learning system which provides country-wide learning and actions (through the national safety alert system) • In addition; during the period of COVID response we have introduced thematic data reviews with feedback to divisions on a monthly basis. • Any incident which highlights an ongoing risk as a consequence of the above review will be captured to ensure appropriate mitigations are in place and therefore continued reporting during this time is greatly appreciated

4. Mandatory training and appraisal

Staff group	Mandatory training requirement
New bank staff including medical staffing bank	All core mandatory training will be completed as part of the induction process.
Existing bank staff including medical staffing bank	Refresher training requirements will be suspended for the duration of the COVID-19 crisis.
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 will be suspended for the duration of the COVID-19 crisis. However, staff with the capacity and facilities to undertake e-learning mandatory training should be identified by their line manager and required to do so.
Substantive staff currently working in usual location or from home who have **not** completed training in all core mandatory training subjects	The small number of staff affected will be advised by the HR Education Team on an individual basis of what core mandatory training they need to complete and how this will be done.
New substantive staff	All core mandatory training will be completed as part of the induction process.
Existing substantive staff changing role that results in additional mandatory training requirements	The small number of staff affected will be advised on an individual basis by the Clinical Education Team of what core mandatory training they need to complete and how this will be done.

5. IQPR

It is acknowledged that many of the indicators measured via the IQPR may have less meaning during the COVID response. For example the RTT targets will unavoidable deteriorate but this is already acknowledged (and will mirror the national position). Similarly, it may be that other indicators look artificially positive (investigation timeframes for green incidents which are being closed down centrally).

In addition, the narrative elements of many IQPR indicators are provided by operational / clinical staff who are heavily involved in the COVID response and, where action plans to address ongoing non-compliances already exist, these are likely to have been paused.

The challenge is to provide an appropriate level of assurance on quality, safety, operational and financial performance whilst not reporting spurious data-sets. There may also be COVID specific data, not usually available, that it would be advantageous to report at this time.

The March IQPR has therefore been produced as a smaller data set than usual, without many of the narratives usually provided and not provided as a standalone paper to the Open Board. Instead the Audit committee on 24 April will undertake a deep dive review of “Quality and performance reporting during COVID”. This will include input from our internal and external auditors.

Annex 2: Governance functions split by individual activities with status / impact and mitigations

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
Information Governance reporting and FOI	Partial	FOI suspended but data security incidents continue to be submitted. Lack of transparency through FOI oversight.	Minimal impact FOI requesters are being contacted to approach us again in 3 months' time
Risk assessments – management of new / current Red risks via face-to-face Exec led meetings	Change	Loss of Executive oversight of progress to address current red risks through agreed actions Lack of Executive approval of newly reported red risks	Follow the existing pathway but use virtual/email – ADO sign-off; exec approval and sharing with relevant leads/specialists.
All aspects of audit programme including national and local audits and the Perfect ward programme	Pause	Lack of oversight of basic indicators of safety at ward level Lack of oversight of compliance with regulatory requirements, national best practice guidance and recommendations of national audits.	Audits to recommence when able (perfect ward COVID audits still ongoing in defined areas). National audits paused across whole health service so no local adverse impact of non-participation
Quality walkabouts and Health & Safety workplace inspections	Change	Potential quality, safety or H&S issues not being highlighted or addressed.	To recommence when able. Daily walkabout by executive team to engage with staff across the Trust.
Inquests	Change	Notification, preparation and planning of inquest cases continues although cases are starting to be postponed this includes two high level cases postponed from May and June	Coroners Office will have a backlog to address. The 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	Pause	Lack of divisional oversight of governance activities	Provide weekly and monthly divisional governance reports via email. This reporting will be targeted at all ADOs , HONs, CDs and operational managers
Production of data for Consultant appraisal	Pause	Suggested as no impact due to the GMC statement that revalidation is being deferred for one year for those due before Sep 20th https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation	To recommence when able.
Patient Experience 'Friends and family' surveys / submission	Pause	National guidance to stop these submissions until further notice. Reduced local oversight as a result of the national pause.	Implement national pause in process

Annex 3: HR functions split by individual activities with status / impact and mitigations

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	Paused	Staff miss some essential mandatory training	New starters being offered alternative routes for mandatory training e.g. e-learning. Catch up sessions (e.g. meet CEO) provided
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 e.g. some apprenticeships, staff, management and leadership development	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.
Recruitment – non-COVID related	Some reduction in recruitment to non COVID related posts	Some possible potential to slow Trust ability to return to business as usual	Large number of bank RN and HCA recruited for COVID – may be able to convert to permanent to cover vacancies after crisis ends
Volunteer service	Paused	No Trust volunteers currently active	Keeping in touch arrangements in place with volunteers – receiving weekly call from volunteer service team.
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.
Job evaluation	Paused	Minimal – some staff dissatisfaction	Details are being recorded and will be backdated to date of request if the post is upgraded.

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
Workforce Race Equality and Disability Equality Standard reporting (2020), Gender pay gap reporting (2019)	Reporting cancelled	Loss of momentum for local inclusion strategy and action plan (national decision – NHS and Government GPG)	Work to restart as soon as circumstances allow. 2019 GPG to be reported.
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.

Annex 4: Operational / Other functions split by individual activities with status / impact and mitigations

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
PMO and Divisional CIP programme	Ongoing	Potential failure to achieve CIPs	The PMO team are working with finance managers and progressing what they can of the divisional CIP programme but without operational and clinical input due to Covid
RTT	Paused	RTT activity is largely paused.	Activity / data is being captured to ensure we can pick up again as part of the recovery work Essential urgent emergency and cancer activity continues
Next phase of e-Care roll out	Paused	Delay in roll out of modules	Roll out will be timetabled once possible
Capital programme	Paused	Contractors working during the shutdown	Reviewing programme to risk assess and prioritise recovery
Operational plan Quality Accounts	Delayed Suspended	National declaration of delayed timeframes and requirements	There is a potential risk, once the COVID response is reduced, that the reporting requirements around the Quality Accounts may be reintroduced. This will require the full data and narrative to be prepared.

18. Trust Executive Group report

To ACCEPT the report

For Report

Presented by Stephen Dunn

Board of Directors – 24 April 2020

Agenda item:	18			
Presented by:	Dr Stephen Dunn, Chief Executive			
Prepared by:	Dr Stephen Dunn, Chief Executive			
Date prepared:	17 April 2020			
Subject:	Trust Executive Group (TEG) report			
Purpose:	X	For information		For approval

Executive summary

6 April 2020

This meeting was undertaken remotely using MS Teams. It focused on reviewing the Trust's emergency response to **COVID-19.** Steve started the meeting by recognising the work undertaken and in progress across the hospital and within the community. The work to support remote clinical consultations and working across the Trust was highlighted as a key enabler.

The plans and battle rhythm for the emergency response were reviewed. The levels of COVID related activity were considered as well as mitigating action to curtail the elective programme - to support preparation and provide appropriate capacity. Discussion took place on some of the operational responses, such as the provision of cohorted areas for suspected COVID patients, launch of the discharge hub, provision of personal protective equipment (PPE) and staff swabbing. The move to instigate the 24/7 tactical command centre was reviewed, including cover of the extended Easter weekend.

It was agreed that in the context of the COVID response TEG would during this period meet monthly to provide oversight of other activities within the Trust.

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

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

Previously considered by:	The Board receives a monthly report from TEG
Risk and assurance:	Failure to effectively communicate or escalate operational concerns.

Legislation, regulatory, equality, diversity and dignity implications	None
Recommendation: The Board note the report	

19. Remuneration Committee report

To ACCEPT the report

For Report

Presented by Angus Eaton

Board of Directors – 24 April 2020

Agenda item:	19			
Presented by:	Angus Eaton, Non-executive director			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	17 April 2020			
Subject:	Remuneration Committee report – 27 March 2020			
Purpose:	X	For information		For approval

The Committee undertook:

1. Discussion took place on the structure and focus of executive director objectives for 2020-21. In the context of COVID meaning that all information was not available it was agreed to defer any decision regarding executive director remuneration. Future arrangements to include executive 360º appraisal.
2. Received a report on the Clinical Excellence Awards Committee scheme and assessment criteria for 2020. It was noted that in the context of COVID-19 national guidance had been issued to pause the process and this is being adopted locally
3. Agreed to extend the Trust's existing pension deferral pilot.

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:	A summary of each meeting of the committee is provided to the Board
Risk and assurance:	Failure to comply with NHSI guidance on remuneration for very senior managers.
Legislation, regulatory, equality, diversity and dignity implications	None

Recommendation:

To receive the report for information.

20. Use of Trust seal

To ACCEPT the report

For Report

Presented by Richard Jones

Trust Board Meeting – 24 April 2020

Agenda item:	20			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Karen McHugh, EA			
Date prepared:	16 April 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. 134
HM Land Registry TRI: The Surgery Lion Road, Glemsford, CO10 7RF, 1 Chestnut Road, Glemsford CO10 7PS and land to north of Chestnut Road SK212856/125233/SK126099 to West Suffolk NHS Foundation Trust - Sealed by Craig Black & Stephen Dunn (30 March 2020)

Seal No. 135
GP Lease, Glemsford Surgery - Sealed by Craig Black & Stephen Dunn, witnessed by Renu Mandal (30 March 2020)

Seal No. 136
Deed of Variation: West Suffolk NHS Foundation Trust and Glemsford Services Limited - Sealed by Craig Black & Stephen Dunn, witnessed by Renu Mandal (30 March 2020)

Seal No. 137
HM Land Registry TRI: The Surgery Lion Road, Glemsford, CO10 7RF, 1 Chestnut Road, Glemsford CO10 7PS and land to north of Chestnut Road SK212856/125233/SK126099 to West Suffolk NHS Foundation Trust (clean document) - Sealed by Craig Black & Stephen Dunn, witnessed by Renu Mandal (30 March 2020)

Seal No. 138
Business Transfer Agreement, Glemsford Services Limited to West Suffolk NHS Foundation Trust - Sealed by Craig Black & Stephen Dunn, witnessed by Renu Mandal (30 March 2020) – *This item was not used as part of the transaction and is therefore VOIDED.*

Seal No. 139
Business Transfer Agreement signature page, Glemsford Services Limited to West Suffolk NHS Foundation Trust - Sealed by Craig Black & Stephen Dunn, witnessed by Renu Mandal (30 March 2020)

Seal No. 140
Business Transfer Agreement signature page, Glemsford Services Limited to West Suffolk NHS Foundation Trust - Sealed by Craig Black & Stephen Dunn, witnessed by Renu Mandal (30 March 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							

21. Agenda items for next meeting

To APPROVE the scheduled items for the next meeting

For Approval

Presented by Richard Jones

Board of Directors – 24 April 2020

Agenda item:	21			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	17 April 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 – 29 May 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
Integrated quality & performance report, including staff recommender scores	✓		Written	Matrix	HB/RP
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					
Nurse staffing report	✓		Written	Matrix	RP
Safe staffing guardian report	✓		Written	Matrix	NJ
Quality and learning report – Q4 (including quality priorities)	✓		Written	Matrix	RP/NJ
Consultant appointment report	✓		Written	Matrix – by exception	JO
"Putting you first award"	✓		Verbal	Matrix	JO
Trust improvement plan report	✓	✓	Written	Standing item	RP
Education report - including undergraduate training (6-monthly)	✓		Written	Matrix	JO
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	RP
Build a joined-up future					
Nursing strategy review		✓	Written	Matrix	RP
Foundation Trust membership strategy	✓		Written	Matrix	RJ
Strategic update, including Alliance, System Executive Group and Integrated Care System (ICS)		✓	Written	Matrix	SD
Governance					
Trust Executive Group report	✓		Written	Matrix	SD
Audit committee report	✓		Written	Matrix	AE
Digital board report, including IM&T strategy update	✓		Written	Matrix	CB
Review of NED responsibilities	✓		Written	Matrix	SC
Board assurance framework review		✓	Written	Matrix	RJ
Scrutiny Committee report		✓	Written	Matrix	GN
Confidential staffing matters		✓	Written	Matrix – by exception	JO
Use of Trust seal	✓		Written	Matrix – by exception	RJ
Agenda items for next meeting	✓		Written	Matrix	RJ
Reflections on the meetings (open and closed meetings)		✓	Verbal	Matrix	SC

11:10 ITEMS FOR INFORMATION

22. 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

23. Date of next meeting

To NOTE that the next meeting will be held on Friday, 29 May 2020 at 9:15 am in West Suffolk Hospital (note moved from 22 May)

For Reference

Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

24. 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