Board of Directors (In Public)

Schedule	Friday 31 July 2020, 9:15 AM — 11:30 AM BST
Venue	Via video conferencing
Description	A meeting of the Board of Directors will take place on Friday, 31 July 2020 at 9:15. The meeting will be held virtually via electronic communications
Organiser	Karen McHugh

Agenda

AGENDA
Presented by Sheila Childerhouse

Agenda Open Board 31 July 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

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

6. Minutes of the previous meeting
   To APPROVE the minutes of the meeting held on 26 June 2020
   For Approval - Presented by Sheila Childerhouse

   Item 6 - Open Board Minutes 2020 06 26 June Draft.docx

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

   Item 7 - Action sheet report.doc

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

   Item 8 - Chief Exec Report Jul '20.doc

9:40 DELIVER FOR TODAY

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

   Item 9 - Covid 19 Response.docx

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

    Item 10 - 20-07-31 COVID IPC assurance framework.docx

    Item 10 Appendix 1 - WSFT Ass framework.pdf

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

    Item 11 - Integrated quality and performance report - July 2010.pdf

12. Maternity services quality and performance report
To APPROVE a report
For Approval - Presented by Susan Wilkinson

- Item 12 - Maternity quality and performance report.docx
- Item 12 Appendix 1 - PMRT Quarterly report.docx
- Item 12 Appendix 2 - Continuity of carer.pdf

13. Finance and workforce report
To ACCEPT the report
For Report - Presented by Nick Macdonald

- Item 13 - Finance and workforce Board report Cover sheet - M03.docx
- Item 13 - Finance Report- June 20 FINAL.docx

10:30 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

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

- Item 14 - Nursing staffing report - July Board 2020.pdf.pdf

15. Safe staffing guardian report – Q1
To ACCEPT the report
For Report - Presented by Nick Jenkins

- Item 15 - coversheet - Safe staffing guardian report April - June 2020.doc
- Item 15 - Safe staffing Guardian Quarterly Report Quarter 1.docx

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

- Item 16 - Improvement programme board report Jul 2020.docx
- Item 16 Annex A - Improvement programme board T0R July 2020 DRAFT v3.0.doc
- Item 16 Annex B - WSFT improvement plan 200724.pdf

17. Mandatory training and appraisal report
To APPROVE a report
For Approval - Presented by Jeremy Over

Item 17 - Appraisal Mandatory Training Trust Board July 2020 FINAL.docx

---

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

Item 18 - Consultant appointment report July 2020.doc

---

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

11:00 BUILD A JOINED-UP FUTURE

---

20. Integration report – Q1
To APPROVE the report
For Approval - Presented by Kate Vaughton and Helen Beck

Item 20 - WSFT Integration Board Report - July 2020.docx

11:10 GOVERNANCE

---

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

Item 21 - TEG report.doc

---

22. Emergency preparedness, resilience and response strategy
To approve the strategy document
For Approval - Presented by Helen Beck

Item 22 - Cover sheet for EPRR Strategy.doc

Item 22 - EPRR Strategy v2.0.pdf

---

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

Item 23 - Items for next Board meeting.doc

11:20 ITEMS FOR INFORMATION

24. 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

25. Date of next meeting
    To NOTE that the next meeting will be held on Friday, 2 October 2020 at 9:15am in West Suffolk Hospital
    For Reference - Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

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

9:15 GENERAL BUSINESS

Presented by Sheila Childerhouse

1. Resolution

The Trust Board is invited to adopt the following resolution:

“That representatives of the press, and other members of the public, be excluded from the meeting having regard to the guidance from the Government regarding public gatherings.”

For Reference

Presented by Sheila Childerhouse

2. Apologies for absence

To NOTE any apologies for the meeting and request that mobile phones are set to silent

For Reference

Presented by Sheila Childerhouse

3. Declaration of interests for items on the agenda

To NOTE any declarations of interest for items on the agenda

For Reference

Presented by Sheila Childerhouse

4. Questions from the public relating to matters on the agenda

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

Presented by Sheila Childerhouse

5. Review of agenda

To AGREE any alterations to the timing of the agenda.

For Reference

Presented by Sheila Childerhouse

6. Minutes of the previous meeting

To APPROVE the minutes of the meeting held on 26 June 2020

For Approval

Presented by Sheila Childerhouse

DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 26 JUNE 2020 AT WEST SUFFOLK HOSPITAL
Via Microsoft Teams

COMMITTEE MEMBERS			
		Attendance	**Apologies**
Sheila Childerhouse	Chair	•	
Helen Beck	Chief Operating Officer	•	
Craig Black	Executive Director of Resources	•	
Richard Davies	Non Executive Director	•	
Steve Dunn	Chief Executive	•	
Angus Eaton	Non Executive Director	•	
Nick Jenkins	Executive Medical Director	•	
Gary Norgate	Non Executive Director	•	
Jeremy Over	Executive Director of Workforce and Communications	•	
Louisa Pepper	Non Executive Director	•	
Alan Rose	Non Executive Director	•	
Sue Wilkinson	Interim Executive Chief Nurse	•	
In attendance			
Georgina Holmes	Trust Office Manager *(minutes)*		
Richard Jones	Trust Secretary		
John Troup	Interim Head of Communications		
Andrew Dunn	Clinical Director for Surgery		
Dawn Godbold	Associate Director of Integration Partnerships		
Lucy Hampton	Executive Coach		
Governors in attendance (observation only)			
Florence Bevan, Peta Cook, Judy Cory, Gordon McKay, Adrian Osborne, Joe Pajak; Liz Steele, Martin Wood			

Action

GENERAL BUSINESS

20/122 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."

20/123 APOLOGIES FOR ABSENCE

Apologies were received from Kate Vaughton; Dawn Godbold attended the meeting on her behalf.

- The Chair welcomed Sue Wilkinson, Interim Executive Chief Nurse and John Troup, Interim Head of Communications to the meeting.
- WSFT would be facing a considerable challenge in recovering from COVID, however this was also a great opportunity to capitalise on the changes and development in working practices during this period.
- There was a probability that the organisation would face another COVID peak and it needed to be prepared for this, as well as focussing on recovery.

- Lucy Hampton, who would be joining the meeting later, was leading on the development of the Board and this would be resumed as the Trust moved out of COVID.

20/124 DECLARATION OF INTERESTS FOR ITEMS ON THE AGENDA

There were no declarations of interest.

20/125 QUESTIONS FROM THE PUBLIC RELATING TO MATTERS ON THE AGENDA

Q Was there any pressure that could be put on anyone about the fact that WSFT was only being allocated 50 in-house COVID tests per week, even though considerably more needed to be undertaken?

A The Trust had received a great deal of support to try and address this, including from two local MPs, but it had still not been resolved. WSFT was currently in discussion with a supplier and was waiting for permission from the regional office to purchase a machine, however there was also the issue of the reagent required for testing.

Action: Board to be updated on actions being taken to resolve this. **N Jenkins**

Q How was the Trust being affected by the changes in lockdown measures and what were the views of the Board on social distancing being reduced from 2 metres to plus 1 metre, considering issues in other parts of the country?

A The implications of this were uncertain. There was a balance between trying to contain the spread of COVID and also encouraging a degree of recovery for everyone. Recent events had shown that people were not observing the 1 metre rule, let alone 2 metres. Everyone needed to be aware that the virus was still active and would only be overcome if it petered out, treatment options improved or a vaccine was developed.

WSFT would continue to encourage 2 metre social distancing as well as focussing on other infection control measures that were in place.

20/126 REVIEW OF AGENDA

It was noted that there was an additional paper under agenda item 9, COVID report, relating to breast screening.

20/127 MINUTES OF MEETING HELD ON 29 MAY 2020

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

20/138 MATTERS ARISING ACTION SHEET

The ongoing and completed actions were reviewed and there were no issues.

It was noted that not all actions from the last meeting were recorded in the matters arising report.

Action: Review actions points from last meeting to ensure recording in action arising sheet. **R Jones**

20/139 CHIEF EXECUTIVE'S REPORT

- It was very important that BAME staff felt supported by the organisation and this would continue to be an ongoing focus. A BAME forum had been set up and several executives had attended the first meeting.

- A lot of work was being undertaken to ensure that the Trust had a robust improvement plan. This was incorporated as part of the CQC action plan and included some of the changes implemented as a result of COVID.
- WSFT had been fortunate not to be over-whelmed during the peak of the COVID outbreak. During this period the Trust had ceased a lot of activities which had resulted in an increase in waiting times. Work was now being undertaken to increase elective activity again.
- National guidance on PPE continued to be received and the Trust was implementing this, including all staff wearing masks.
- Community teams were now co-located at West Suffolk House which would further benefit partnership working.
- Gary Norgate was part of the team working on the development of a new hospital and Helen Jopling had been appointed as associate medical director for the new healthcare campus.
- Lakenheath had lost a member of their team and the Trust's thoughts and condolences were with his family and colleagues.

Q Recognising the work being undertaken by the Trust to address BAME issues, how would it move forward with other key partners to ensure the local community was more inclusive and aware of the issues?

A The feeling across many leaders in the public sector was that this required vocal and visible leadership. The Integrated Care System (ICS) was considering what it might do and as WSFT reflected on its own organisation it needed to ensure that people were supported and freedom to speak up arrangements enabled this. It needed to consider how to support BAME colleagues and realise their potential at all levels, particularly at leadership level. There would be a focus to try and provide greater opportunity to BAME staff for development and progression.

WSFT needed to continue with its commitment to this and listen, learn and act. Stories from the BAME forum had highlighted that there was an issue in the Trust that needed to be addressed. A number of discussions were taking place across the region and within the ICS.

The board assurance framework (BAF) needed to look at the quality of risk assessments for BAME staff to ensure that they felt they were supported in managing their anxieties.

There was also a need to look at this with partners in the community, eg police colleagues and neighbourhood teams and work together to ensure this was included in neighbourhood plans/strategies etc. The Alliance and ICS also needed to continue to work across the system to address the issues.

DELIVER FOR TODAY

20/140 COVID-19 REPORT

- The level of COVID activity had reduced considerably.
- In accordance with government guidelines the testing facility at Newmarket had been mothballed. Patients and members of the public should go to Stansted, Copdock or WSFT if they required a test.

- The level of emergency activity had increased but was not quite back to pre-COVID levels.
- The Tactical and Core Resilience teams had worked hard to ensure that the Trust complied with national guidance so that all staff and visitors had access to masks. Masks and hand sanitisers were now available at every entrance and exit of the hospital.
- In accordance with government safer workplace guidance a number of areas had been designated as COVID secure where people were able to maintain social distancing of 2 metres and did not need to wear masks, eg Quince House. A number of risk assessments and a robust process had to be undertaken before an area could be designated as COVID secure.
- The Trust now had a significant problem with backlogs for diagnostics and treatment. However, the overall waiting list size had reduced due to a reduction in the number of referrals received.
- 52 week waits had previously reduced to single figures but as at the end of May this had increased to 176 and was now at 250-300.
- Cancer backlogs for treatment were small but there were significant numbers waiting for diagnostics to confirm or exclude cancer, specifically endoscopies, as national guidance stopped all endoscopies during the early stages of the pandemic. These were now being booked at WSFT and the BMI but everything took much longer due to PPE and procedures that needed to be followed as a result of COVID.
- Given the waiting times it was more likely that patients would be treated in order of priority not just time on the waiting list. This meant that waiting times for diagnostics would not recover for some time.
- Outpatient activity was starting to increase.

Q To what extent were GPs and patients being informed about the extended waiting times?

A GPs had been issued with specialist level information on what services were open and what activity was being done. There had been very helpful advice from the Royal College about communication to patients and what they could and could not expect; the teams were working through this to send out to patients.

Harm reviews were undertaken for longer waiting patients and the Trust was trying to use social media to give an indication of what was happening and what it was and was not able to do.

Q This report and the IQPR stated that emergency attendances were increasing and that patients with a greater acuity were being looked after in the community rather than in hospital. How could WSFT prepare the public for the backlog as there did not appear to be a solution to this? Was the Trust able to manage this or was it going to be a real problem?

A There was a need to be clear that this was not just a WSFT problem but the NHS as a whole. Work was starting to be undertaken to look at alternative pathways and what could be done differently with patients. Plans had been submitted to the region and a regional plan was being looked at nationally. However, these plans had significant financial requirements for both capacity and staff. The Treasury and Department of Health (DH) were having discussions about this.

Although this would be challenging the system needed to work hard together and look at what could be done to maximise capacity and consider evening/weekend working subject to their being sufficient staff. It was hoped that the independent sector could be used, although this facility was limited. The next stage was to break this down, prioritise things and try to work through this.

This report highlighted all the changes and challenges and how these were being addressed, however it was not yet fully understood how big the challenges would be as waiting lists to would continue to increase until the COVID situation was resolved. This situation was likely to continue and it was very important to undertake harm reviews and clinically prioritise all patients to ensure that people had access to treatment where there was a real need for it.

- A phenomenal amount of work had been undertaken by a number of people on the ICS recovery plan.
- Critical care assumptions were that this would revert to baseline capacity and if there was a second surge the Trust would make use of the regional surge centres at Papworth and Addenbrookes.
- The Trust was trying to mitigate the impact of social distancing in the bays and was working with infection control and microbiology as to whether the reduction of two metre to one metre plus was safe to do. It was also working with ESNEFT on barriers between beds to try and reduce transmission risk.
- The real concern was the structural issue, currently one ward was out of commission while structural repairs were being undertaken on a rolling basis, but this could be a significant issue as the organisation moved into winter. The Trust was working hard to mitigate capacity issues. The ESNEFT plan was included in this report to provide the board with a comparison, however it was not possible to deliver the same levels of activity on this site.
- The plan was to put more elective activity through day cases and use the independent sector, however this was constrained by the number of beds available.
- Outpatients were less of a concern due to virtual and telephone consultations. It was anticipated that this would recover more quickly over the next few months, which would address a lot of the backlog.
- Work was being undertaken to look at what could be done about additional diagnostic capacity, eg mobile CT and MRI scanners but this would be a challenge due to the electricity supply issues on this site.

Action: Ensure reporting arrangements provide assurance that activity planning and delivery is in place to address elective care demand — **H Beck**

Q Could the board be assured that satellite centres eg Sudbury and Newmarket, featured in maximising capacity issues and providing opportunities for physiotherapy, screening etc?

A This was this case and also included Thetford Healthy Living Centre for some diagnostics. The Trust was maximising the use of Newmarket, Sudbury and all of the community sites, beds at Newmarket and additional community beds.

140.1 <u>COVID infection prevention and control assurance framework</u>

- This report explained the information that had been submitted to NHSE/I and highlighted where WSFT was partially or non-compliant following a self-assessment process.

- The ventilation requirements were unlikely to be met due to limitations of the estate.
- Time to testing met the requirements for tests undertaken on site but the Trust did not have any control over those undertaken off-site.
- If it was suspected that a patient had COVID they would always be treated as such and isolated where possible, however WSFT had a limited number of side-rooms.

Q On the premise that this was looking for assurance as to where the organisation was in this context and there were areas where it had/could not meet the required standards, at what point should the Board decide that something fundamental needed to be done? The Trust needed to be transparent about this, ie due to the constraints of the estate.

A It would be difficult to meet every requirement unless a Trust was a big, perfect organisation. Therefore, it would be required to show mitigations and that it was robust enough to provide safe care to patients. This should also be included in the risk register, showing mitigating actions that had been put in place. Other organisations would be in the same position due to the age of their buildings. As long as they could demonstrate that they had taken every step to acknowledge where they had issues. Transparency was to put this on the risk register.

Action: include findings and mitigations from the COVID infection prevention and control assurance framework in the risk register. **S Wilkinson**

The Trust had already made some big decisions, ie the development of a new hospital and the need for antigen testing on site.

140.2 <u>Recommencing West Suffolk Breast Screening</u>

- This had been suspended at the start of COVID and Public Health England (PHE) required approval to recommend that this was recommenced.
- It was important to encourage people to attend screening.

Q This could increase the workload of GPs; had there been effective communication about this problem/process?

A This was not the decision of WSFT, but PHE's decision, therefore if GPs were not aware of this it meant that there had not been effective communication from PHE.

The Board approved the recommendation to recommence West Suffolk breast screening.

20/141 PERFORMANCE REPORT

- This report provided data on what was happening with activity and performance as previously outlined in the COVID report.

Q The governors had requested that there should be more information on maternity and it would also be good to introduce SPC charts into this in due course.

A It was recognised that these were valid points.

Q Considering the size of the waiting lists; should there be an understanding of what was happening to the shape and distribution of waiting lists?

A This would be reflected in future reports including IQPOR and COVID recovery.

- Duty of candour had improved and work was being undertaken to ensure that this continued.
- There had been a reduction in falls over the last few weeks, however this coincided with a reduction in bed occupancy and had not reduced comparatively per thousand bed days. The heads of nursing and their teams were being encouraged to re-focus on this. All falls continued to be reviewed and the Trust had recently appointed a falls practitioner which was a very positive move.

Q Over time these metrics, eg falls, had not improved significantly and the board would welcome a fresh pair of eyes and view on this.

A This would be looked at in greater deal, particularly with the appointment of the new falls practitioner.

Q Could the board be assured that this report included community as well as the hospital?

A It was confirmed the number of falls included all patients in the community. It may be possible to look at the breakdown between the hospital and community.

- Pressure ulcers; the tissue viability nurses had moved back into clinical practice during COVID which meant that the team had been reduced. However, they were now back to full capacity and would continue to focus on this.
- The complaints team were also now at full capacity and supporting the clinical telephone lines and ensuring that complaints were responded to in a timely manner.
- Although the number of complaints had reduced during the COVID period, it was anticipated that there could be a significant increase over the next couple of months as patients reflected on what had happened to them while in hospital.
- Very positive feedback had been received about the Keeping in Touch helpline, both internally and externally and had enabled shielding staff to work productively and support the hospital.
- The perfect ward data was noted. Teams were being encouraged to re-focus on fundamental KPIs and not just COVID. The heads of nursing had been asked to review and put forward a plan as to how to return to business as usual.

Action: ensure that sufficient information on maternity and community services is included in this report. **H Beck / S Wilkinson**

20/142 FINANCE AND WORKFORCE REPORT

- The accounts for last year were submitted yesterday and had been the focus of the finance department for the last few weeks.
- The finance report for this month was similar for month one with a breakeven position, as would be expected to be reported throughout the financial year.
- Operating expenditure was £1m more than budgeted but the income received in terms of COVID funding would match this additional expenditure.
- The Trust was doing less activity which meant that there was an underspend as a result of this, particularly on non-pay. However, this was being more than compensated for by the additional expenditure on COVID activity, mainly staffing.
- The cash position had increased significantly as the Trust received in money in advance.

- There had been some movement around the capital programme and discussions continued, mainly about the additional spend required to continue work on the structure.
- Pathology was not included in the forecast this year. However, whatever was spent would be covered by additional income.
- The more material issue would be about next year and what this would do to the underlying position and this would be the focus of future finance reports.

Q Over the next few months would staff be able to start focussing on CIPs and achieve the majority of plans to make next year's position as positive as possible?

A The Trust was currently under achieving its CIP by approximately £0.5m compared to plan. This was mainly around staffing as it was not yet possible to reduce staffing levels during the current situation and this was unlikely to change for this year due to constraints in the organisation's ability to deliver activity. Any shortfall in CIPs would become a recurring cost pressure, assuming income did not change and there was a need to establish what the new baseline would look like.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

20/143 NURSE STAFFING REPORT

- This report was in a different format to previous months and it was proposed to develop this further to provide the assurance required that the Trust was delivering safe staffing.
- Information was provided on ward areas where there was a fill rate of less than 80% or more than 100%. Details on patient safety issues in the context of staffing, staff sickness and agency and bank usage were also provided.
- There would be a review of current establishment, budgets and the situation for each ward to ensure true alignment. There would also be a full establishment review using the patient safety tool and a report on this should be available in the next few months.

Action: board to receive report on establishment review. **S Wilkinson**

Q Why have the number of vacancies increased in such a short period of time?

A This was being reviewed and details of the current situation were provided in this report. During May despite the number of vacancies, due to reduced capacity the Trust had been able to provide safe staffing for patients.

Q There was currently a shortfall of 100 nurses which was quite high compared to the number several months ago. At what point would the Trust reintroduce its recruitment plan?

A A recruitment plan would be introduced as soon as the review was completed; it was important to continue to recruit. The recruitment team continued to work on this and it was hoped that the student nurses would want to remain at WSFT. There was a risk around international recruitment which the Trust had relied on over the last few years.

Q What was the reason for the level of staff sickness in F8 and theatres? Was F8 COVID related and was this a concern?

A F8 was part of the COVID outbreak which was probably linked to this. Sickness in theatre staff was a combination of sickness and a significant number of staff who were shielding and would be included in these numbers.

Q Did the Trust have an effective strategy to ensure that staff took annual leave, taking into account the probability that there would be peaks in COVID; was it managing staff leave and supporting their wellbeing and health?

A It was important that staff took any leave they had booked as they needed to look after their own health and wellbeing. They were being encouraged to do this and this message had been shared with staff from the start of COVID. However, it was acknowledged that some people were not always able to do this and the Trust was trying to be flexible around carrying forward an increased number of days but within parameters.

20/144 MEDICAL REVALIDATION REPORT

- Trusts were required to submit an Annual Organisational Audit to NHSE, however due to COVID they had been advised that they were not required to do this.
- Appraisals had been suspended for 12 months from April 2020 until April 2021. However, consultants whose appraisals should have been undertaken before April 2020 had been contacted and asked to complete these in the near future to ensure there was not too long a period between their appraisals.
- Consultants whose revalidation was due in the next 12 months have had their revalidation date moved forward 12 months.
- Although appraisals had been suspended for 12 months, these were still undertaken occasionally if there was a particular need/reason.
- The Board accepted the Annual Report, noted the contents and approved it for submission to the higher-level Responsible Officer.

20/145 TRUST IMPROVEMENT PLAN

- This report was in a different format to previously and work was being undertaken with the teams and external colleagues to make this more focussed with measurable actions.
- The 'must dos' would be focussed on first and an improvement board had been set up and would be meeting on 1 July to consider terms of reference. The first operational meeting of this board, including external partners, would take place on 13 July.
- Prior to 13 July cluster meetings would take place and the outcome of these would be reported to the improvement board. Any actions requiring amendment/ agreement would be taken to the improvement board for oversight. There would be monthly calls with the CQC.
- A number of previous actions may need to be adapted to meet the current situation as a result of COVID.
- The status of the actions were colour coded; actions with a blue status, ie 'action implemented and assurance evidenced that action is embedded with agreed cycle of ongoing assurance', would need to be approved by the improvement board.
- Completed actions would be re-visited on an ongoing basis to ensure they were fit for purpose.

Q Would an updated version of this plan be available on the Trust's website?

A This report to the board was on the website.

Q Were the board assured that this provided sufficient transparency or did this need further consideration?

A This needed to be considered. It should be focussed on as an improvement plan rather than a CQC action plan.

Action: review how to provide transparency to the public of the improvement plan. **S Wilkinson**

Q The improvement plan suggested that the freedom to speak up guardian may not be in post until November. Was this the case, as these seemed a long time to wait; what was the process for recruiting to this position?

A Expressions of interest for a new freedom to speak up guardian would go out next week and an individual would be appointed as soon as possible. The board would be kept updated on how this was progressing. The November date related to lessons learned from the external review.

Action: update board on progress for appointment of freedom to speak up guardian. **J Over**

Q Would the improvement board review areas/services that were good or outstanding to ensure that these standards were being maintained, or would they just look at the actions that needed to be addressed?

A The main focus would be on the 'must dos'. There was a concern that the previous action plan did not give enough priority to these issues.

It was acknowledged that there was a need to ensure that other areas/services were maintaining standards. The board needed to constantly assure itself that progress was being made and also that actions were embedded and this would continue to be monitored.

20/146 CONSULTANT APPOINTMENT REPORT

The board noted the following appointment:

Mr Dimitrios Krikonis, Consultant in Plastic Surgery

20/147 PUTTING YOU FIRST AWARD

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

Dr Heather Dinsey, ward G9:
Dr Dinsey went out of her way to help a gentleman who was on end of life care, awaiting transfer to a care home. At times he became quite anxious and would shout out. During his time on G9, Heather would sit with him while doing her work, chatting to him and making sure he had food that he liked and wanted. She assisted him with his meals and generally went out of her way to ensure he was comfortable and well cared for.

Gina says she has honestly never seen a doctor being so attentive to a patient's needs.

Emma Barrell, specialist occupational therapist, wheelchair service and
Kevin Sturgeon, rehabilitation engineer technician, wheelchair service:
On driving away from a patient's property, Emma and Kevin noticed smoke coming from a first floor window of a nearby house, and someone's face at the window. They immediately stopped and, while Kevin called the emergency services, Emma entered the house and went upstairs. However, it was too dangerous to enter the room.

Using a neighbour's ladder, Kevin climbed up and tried to open the window, but the safety lock could not be released. He managed to pull the window from its hinges, and the gentleman was able to descend the ladder after which he was taken to hospital by the emergency services.

Kevin and Emma displayed true courage to help save this man's life and went above and beyond the call of duty.

The board congratulated the above individuals on the compassion they had shown and the actions they had taken.

BUILD A JOINED-UP FUTURE

20/148 PATHOLOGY SERVICES REPORT

- A joint working group had been set up between and ESNEFT and WSFT to oversee the dissolution of NEESPS and alternative arrangements. Louisa Pepper would be the NED representative on this group.
- The report provided details of the work being undertaken by the sub-groups to manage the process. Further work was required on the finances.
- Staff consultation would start early next week; it was important to ensure that staff were fully engaged in the process.
- Since this report was written further progress had been made with ESNEFT and the CCG around the GP contract for pathology work. It had been agreed that the current arrangements would continue which meant that a procurement process would not be required.

GOVERNANCE

20/149 TRUST EXECUTIVE GROUP REPORT

The board received and noted the content of this report.

20/150 CHARITABLE FUNDS COMMITTEE REPORT

- The team had spent most of last month focussing on the distribution of donations received from the community and other organisations.
- It was noted that the strategy of the charity was approximately four years old and should be reviewed in due course.

20/151 QUALITY & RISK COMMITTEE REPORT

- It was noted that a decision had been made not to hold this meeting while there was a requirement for social distancing as it was primarily used for presentations.

- Reports from the sub-committees to this committee would continue to be received in order to to provide assurance and governance.

20/152 GENERAL CONDITION 6 AND CONTINUITY OF SERVICES CONDITIONS 7 CERTIFICATE

- The Board approved the six corporate governance statements and certification for training of governors.
- The Board received in public session the general condition 6 and continuity of services condition 7 certificates

20/153 AGENDA ITEMS FOR NEXT MEETING

The board received and noted the content of this report.

ITEMS FOR INFORMATION

20/154 ANY OTHER BUSINESS

There was no further business.

20/155 DATE OF NEXT MEETING

Friday 31 July at 9.15am.

RESOLUTION TO MOVE TO CLOSED SESSION

20/156 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 – 31 July 2020

Agenda item:	7			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	24 July 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. **Reporting of quality and performance during COVID considered at Board and Audit Committee. The IQPR continues to evolve to provide a wider focus and quality and performance charts and supporting narrative. The 'interim' COVID IQPR will form the building block for the new reporting with the aim of providing an outline plan to the Board by September.**	CB	~~31/01/2020~~ ~~24/4/20~~ 2/10/20	Amber

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1823	Open	28/2/20	Item 8	Sepsis – assess impact of establishing super-RAT within ED	RAT area in ED is now the COVID area so will be revisited as part of COVID recovery when workflow re-established. **Capital bid submitted to increase the footprint of the current ED to recreate the RAT area. Currently awaiting clarity for external process and timeline for approval. Verbal update on position in meeting**	HB	~~27/03/2020~~ Review 31/7/20	Red
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. **We are continuing to see much reduced outpatient activity - verbal update to meeting**	HB	~~29/05/2020~~ Review 31/7/20	Amber
1830	Open	28/2/20	Item 21	Review and consider Board agenda and report structure. Provide greater focus on staffing/people over transactional issues	Following careful review of governance Board agenda and reports reduced during COVID response. **The board development session to hear the results of the 'What matters to you' work will allow the Board to reflect on how if considers staff/people issues.**	SC / RJ	~~24/04/2020~~ 28/8/20	Green

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1841	Open	24/4/20	Item 17	Agreed to add to the COVID governance document NED and governor activities during COVID as well as the workings for the Remuneration Committee.	The additions have been made to the document and a review of the arrangements will be completed at the end of July (given meeting timings the report will be submitted to the Scrutiny Committee in August)	RJ	31/07/20	Green
1853	Open	29/5/20	Item 11	Spend on COVID compared to other organisations to be provided to a future board meeting, together with trend information as the Trust moved through the next few months.	The trend on current staffing establishments is included within the finance report. ICS benchmarking is being obtained.	CB	25/09/20	Green
1858	Open	26/6/20	Item 9	Ensure reporting arrangements provide assurance to the Board that activity planning and delivery is in place to address elective care demand	The performance and Covid reports will be developed to ensure this is captured. **LINKED TO 1805**	HB	25/09/20	Green
1863	Open	26/6/20	Item 14	Provide an update on recruitment of the replacement FTSU guardian	Expressions of interest have been received from three individuals. Interviews will take place in August - the interview panel will consist of Sheila Childerhouse, Jeremy Over, Martin Wood and Fran Dawson (lead speak-up guardian at Norfolk and Norwich FT). Pending appointment Francesca Crawley has agreed to take up the FTSU guardian role on an interim basis. As the current Guardian of Safe Working Francesca is well placed to undertake the role and responsibilities.	JO	31/07/20	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).	**AGENDA ITEM (IQPR) F9 pilot has been stopped which trialled 'ward hosts'. The aim is to achieve an increase in nutrition assessment (MUST). All patients are review and data captured on e-Care – reintroduced into IQPR for June data. The narrative improvement plan will be strengthened to set out what will be delivered by when. Future monitoring of this indicator will be achieved through monthly updates in the new IQPR.**	SW	~~29/11/2019~~ ~~24/4/20~~ Review 31/7/20	Complete
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	**COVID recovery planning is ongoing. This will remain a standing item for Scrutiny Committee as it is likely to take some time. Board approval of Scrutiny work plan in place. Visibility will also be provided to Board through activity reports and IQPR.**	HB	~~27/03/2020~~ Review 31/7/20	Complete

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). **Performance is monitored on a monthly basis through the new IQPR and will be underpinned by improvement narrative. As part of the patient safety improvement plan the patient safety and learning strategy is being reviewed to ensure that is adequately addressed duty of candour requirements and is underpinned by training and support for staff. Progress is linked to PSIRF implementation and will be reported to the Board through the IQPR and Trust improvement plan (finding number 10).**	SW	26/6/20 ~~27/03/2020~~	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
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. **With increasing activity starting to take it is proposed to provide a outpatient transformation proposal for the September Board as part of COVID recovery planning - this would be a new action for the Board (proposed to close this action on this basis)**	HB	~~27/03/2020~~ Review 31/7/20	Complete
1826	Open	28/2/20	Item 10	Implement the new quality walkabout process, including capturing the soft intelligence	**Duplication and incorporated into action point 1811**	SW	~~24/04/2020~~ Review 31/7/20	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. **AGENDA ITEM - update to be provided as part of the workforce report**	HB	~~27/03/2020~~ Review 31/7/20	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1840	Open	24/4/20	Item 11	CQC improvement plan - schedule regular updates, including review of 'paused' improvements in July '20. Agreed to add to improvement reference 6, 30, 46, 62 that the review of historic harm is paused as staff are focused on COVID activities.	Update made to the wording of the plan regarding review of historic harm. Review of plan included in forward plan for Board, including review of 'paused' improvements in July. **AGENDA ITEM**	SW	31/07/20	Complete
1846	Open	29/5/20	Item 19	Provide an update on the pathology investment requirement along with plans and timescales for disaggregation (via discussion at Scrutiny Committee)	**AGENDA ITEM**	NJ	26/06/20	Complete
1854	Open	29/5/20	Item 14	Identify NEDs to sit on the improvement programme board and consider how they linked in.	**AGENDA ITEM** Proposed two NEDs on the improvement programme board	SC	31/07/20	Complete
1855	Open	29/5/20	Item 24	Update Constitution to reflect agreed changes	Updated constitution submitted to NHSE/I	RJ	31/07/20	Complete
1856	Open	26/6/20	Item 4	Provide update on progress to increase provision of local antigen testing. Agreed to provide a summary of action taken and any further escalation	This remain challenging locally and nationally. This has been raised at regional and national levels. It has been accepted that the Trust needs additional on-site testing capacity and we are awaiting confirmation of when this will be available. Action complete but remains unresolved.	NJ	31/07/20	Complete
1857	Open	26/6/20	Item 7	Review action points from last meeting to ensure properly captured in the action sheet	Three actions from open board meeting added to the report (1853, 1854 and 1855)	RJ	31/07/20	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1859	Open	26/6/20	Item 9.1	The findings and mitigations from the infection prevention and control board assurance framework to captured within the relevant risk assessment on the risk register	**AGENDA ITEM**	SW	31/07/20	Complete
1860	Open	26/6/20	Item 10	Ensure that quality and performance reporting to the Board adequately considers maternity and community services	**AGENDA ITEM**	CB / SW	31/07/20	Complete
1861	Open	26/6/20	Item 12	Report the results of the full ward staffing reviews	**Included within nurse staffing report**	SW	31/07/20	Complete
1862	Open	26/6/20	Item 14	Consider how to make the Trust improvement plan available to the public	An up-to-date version of the Trust improvement plan is now published via the "Our quality" section of the Trust website	SW	31/07/20	Complete

8. Chief Executive’s report

To RECEIVE a report on current issues

For Report

Presented by Stephen Dunn

Board of Directors – 31 July 2020

Agenda item:	8			
Presented by:	Steve Dunn, Chief Executive Officer			
Prepared by:	Steve Dunn, Chief Executive Officer			
Date prepared:	24 July 2020			
Subject:	Chief Executive's Report			
Purpose:	X	For information		For approval

Executive summary:

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

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

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

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

Recommendation:

To receive the report for information

Chief Executive's Report

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

Happy 72nd birthday NHS in what has been the most challenging year in NHS history. Over the last few months the NHS has stepped up in ways never seen before to work out how to deliver services differently following lockdown, recruit tens of thousands more staff, returners and volunteers and even build hospitals to respond to the COVID-19 global pandemic. But the unprecedented challenge facing the NHS would have been made all but impossible without the help and support of countless individuals and organisations around the country, the key workers, from bus drivers and refuse collectors to care givers and shop workers. And the public too, who embraced the lockdown measures to help protect the NHS and their communities, whether by staying at home, helping their neighbours with the shopping, maintaining social distancing or washing their hands more often. The NHS is grateful to the nation for its efforts – great and small.

Over the last few weeks we have been undertaking a major engagement exercise across the organisation under the banner of '**What works for you'**. There has been an amazing response, with 1,380 staff completing the survey and more than 50 workshops and interviews held so far too. As part of this work, we are also looking at how we can engage with our colleagues that are shielding at home.

What staff have said	What we will explore in the workshops
The importance of genuine **appreciation**.	What can we do to make staff feel really valued and supported in your roles?
The importance of **leadership** and the impact this can have on people when done well.	Discussions around what staff would like to see from leaders - what should they be focused on doing and how should they treat staff?
The impact of strong **team working**.	How can we help staff teams to develop even stronger bonds and feelings of mutual support?
Communications – for some staff the communications throughout the pandemic has worked well, but some of you have struggled.	Discussions around how we can best communicate with staff and their teams. What works for staff and what doesn't?
Returning to normal – some staff have said you are tired and feel cautious about returning to a world beyond COVID – including home working colleagues.	How do we support staff through this next part of the COVID journey? How do we keep the good bits and lose what isn't working? How do we protect staff and their teams?

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

The engagement that we are undertaking with our staff is an important part of our response to the concerns raised earlier this year by the CQC. The external reviews' investigation of the issues raised in this report has now recommenced and we are working closely with the team to support this important work and ensure that we are best place to learn and improve from this experience.

Building a culture where everyone feels confident and **safe to speak up and raise concerns** is of the utmost importance across the NHS, and of course to us here at WSFT, and we are looking for our new lead Freedom to Speak Up Guardian to help us achieve this. We are currently seeking expressions of interest and recruiting to the important Guardian role and I wanted to highlight and thank Dr Francesca Crawley who has become our acting lead Freedom to Speak Up Guardian until we recruit to the role. As acting lead, Francesca is available to all staff as an independent and impartial source of advice at any stage of raising a concern. To help her carry out the role she has access to anyone in the organisation, including myself, or if necessary, outside the organisation.

In June, the first staff forum for the newly created **BAME Network** at the Trust took place, with over 30 participants attending virtually over Microsoft Teams. The session, which lasted just over an hour, was led by chair of the network Dr Ayush Sinha. Dr Sinha also gave a presentation to attendees about the importance of the establishment of a BAME network and how the network aims to ensure career opportunities and experiences of work are not predetermined by ethnicity, nationality or race. Myself and other members of the executive team attended, answering a wide array of questions from participants about such as positive working environments as well as addressing any concerns. There was a very positive vibe around the first forum and Dr Sinha as well as deputy chair of the network, Balendra Kumar, have extended a big thank you to everyone who attended to make the opening meeting a success. Forums will take place on a quarterly basis and all BAME and non-BAME staff are welcome to attend. Future events will see different speakers and topics to be addressed with future dates being advertised in Green Sheet.

Happy Eid al-Adha to colleagues and friends. Eid al-Adha ('The Festival of Sacrifice'), is the most important feast of the Muslim calendar. The festival may also be known as Eid al-Kabeer, which means 'The Grand Eid' or Eid el-Lahma ('The Festival of Meat'). It has this more important status as, in religious terms, this Eid lasts for four days, whereas Eid al-Fitr is one day, even though most countries observe about the same number of public holidays for both Eids. This festival is celebrated throughout the Muslim world as a commemoration of Prophet Abraham's willingness to sacrifice everything for God. Eid al-Adha falls on the tenth day of Dhu al-Hijjah, the twelfth and final month in the Islamic calendar.

Members of WSFT's community team received a welcome morale boost in July when Secretary of State for Health and Social Care, **Matt Hancock MP**, made a flying visit to Newmarket. Mr Hancock was making his first visit to his parliamentary constituency since the start of lockdown and had crews from BBC Look East and ITV Anglia in tow. After a whistle-stop tour of Newmarket High Street, the Minister headed up Exning Road to the town's community hospital to thank staff for their sterling efforts during the coronavirus pandemic.

As part of our **response to COVID-19** we continue to take a wide range of actions to support patients, carers and our staff. During our COVID response we have continued the work to survey our reinforced autoclaved aerated concrete (RAAC) and address these findings. I want to recognise the support and commitment of our staff to ensure this work continues at a time when operational pressures are already so challenging. Over the last few weeks a team of structural engineers having been carrying out a structural survey of the external RAAC wall planks around the outside walls of this hospital. This part of the project has now been completed and it's time to go inside the hospital and carry out the same structural survey of all the external walls within the hospital's 20+ courtyards. We are currently planning to work our way around the hospital clockwise. This will mean that for the next few weeks the survey team will have to transport scaffolding equipment along the corridors of the ground floor of the hospital at varies times of the day. Our plan will be to try and inform the departments/wards that may be affected by this work in advance, but as this work will sometimes be affected by bad weather we may not be able to in some cases.

I was delighted to Chair our new improvement programme board in July which includes representatives from the clinical commissioning group (CCG) and the regional office. A report from the meeting and a copy of the **Trust improvement plan** are included in the open Board agenda.

As previously indicated in April 2020, East Suffolk & North East Essex NHS Foundation Trust (ESNEFT) announced that the current North East Essex & Suffolk Pathology Service (NEESPS) networking arrangement with the Trust will cease no later than 31 October 2020. A joint working group has been set-up between ESNEFT and WSFT to oversee the transition and to work on finding an alternative solution to the current arrangements. Multiple workstreams continue to ascertain how the **future of WSFT pathology networking** is designed. A pathology transformation lead has now been appointed to oversee the dissolution and further develop the transformation of the pathology services at WSFT.

The **Trust and Glemsford Surgery** have embarked on a special project to work together to improve patient care, and have now officially joined as integrated partners in healthcare. From the buildings to the staff, we will support the surgery and work together to create a new, innovative, strong and sustainable healthcare service in Glemsford and the west of Suffolk. Together we will deliver safe, effective and more joined up models of care, ensuring patients receive the right care, in the right place at the right time. There are a wide array of benefits from this new partnership project, and at the heart of them all is patient care. The traditional barriers between hospitals, GPs and community services will be removed. For example, patient records will be able to be shared between providers. This and other quality improvements from working seamlessly together will allow GPs and our staff to jointly identify and address population health issues. We look forward to working alongside Glemsford Surgery colleagues to reap the benefits of this closer working relationship.

After the success of cataract go live in 2019, the intention was to **go live with glaucoma and medical retina** in May or June this year. There was concern that COVID-19 might derail these plans when lockdown started in March. However, reduced clinical throughput created a perfect opportunity to go live with no further reduction in patient numbers. Thanks to support from the IT projects team and the supplier, ABEHR Digital, the system was configured, tested and went live on 11 June. The scope was expanded and, in addition to glaucoma and medical retina, the go live included general clinics and eye emergencies, meaning that approximately two thirds of the eye treatment centre workload is now in OpenEyes. The benefits are already being seen: streamlined virtual clinics and simple, easily generated correspondence to patients, GPs and optometrists (using OpenEyes, one of our secretaries was able to generate 28 letters in just over 40 minutes). Thank you to everyone who has been involved in this project, including IT, the team at ABEHR and our colleagues in the eye treatment centre for their patience and willingness to embrace new ways of working.

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

9:40 DELIVER FOR TODAY

9. COVID-19 report

To RECEIVE a briefing

For Report

Presented by Helen Beck

Board of Directors – 31 July 2020

Agenda item:	9			
Presented by:	Helen Beck, Chief Operating Officer			
Prepared by:	Helen Beck, Chief Operating Officer Jeremy Over, Executive Director for Workforce & Communications Alex Baldwin, Deputy Chief Operating Officer			
Date prepared:	27 July 2020			
Subject:	Covid-19 Report			
Purpose:	X	For information		For approval

Executive summary:

This paper provides an update of current levels of Covid and other emergency activity across the Trust as well as indications of diagnostic and elective activity levels and recovery planning.

Some highlights around community services have also been included this month.

Ahead of a full report at next month's board this paper also provides a summary of actions to support Black Asian and Minority Ethnic Groups across 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		

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

Recommendation:

For Information.

Current Capacity Situation

Critical Care – We continue to manage critical care patients in the main unit and have not needed any additional capacity during the month. Plans to use regional surge centres however appear not to be supported by the region and hence should a second wave materialise we may need to reoccupy the second unit. Staffing of these additional beds would have a significant negative impact on our ability to run our elective programme.

General and Acute Beds – Isolation capacity remains the same as reported in June across wards F12, F7 and G4. Within this bed base we currently have 3 confirmed Covid patients with a further 17 awaiting a swab result, plus 11 patients with negative swab results but who have been clinically designated as Covid.

Non elective Activity
The table below illustrates that ED attendances and emergency admissions are increasing but have still not reached pre Covid levels. Stranded patient number have increased which has a negative impact on patient flow. Further work is underway to address this issue.

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
Wednesday	01/07/2020	172	124	0	93	33	18	49	51	67	9
Thursday	02/07/2020	177	137	0	90	33	20	56	52	70	22
Friday	03/07/2020	174	137	0	87	31	19	51	39	71	14
Saturday	04/07/2020	150	170	0	90	37	20	58	39	26	3
Sunday	05/07/2020	221	149	0	100	39	21	55	47	30	4
Monday	06/07/2020	203	153	0	106	40	23	68	56	49	14
Tuesday	07/07/2020	191	155	0	110	42	22	62	46	55	10
Wednesday	08/07/2020	214	180	0	105	43	22	76	69	65	15
Thursday	09/07/2020	187	160	0	98	38	20	57	50	63	10
Friday	10/07/2020	172	137	0	113	43	20	55	61	64	16
Saturday	11/07/2020	183	149	0	117	40	21	73	43	44	1
Sunday	12/07/2020	211	166	0	101	40	19	78	54	34	8
Monday	13/07/2020	202	167	0	111	44	20	68	60	78	9
Tuesday	14/07/2020	226	166	1	117	45	22	83	62	67	12
Wednesday	15/07/2020	199	173	0	120	51	24	61	60	82	12
Thursday	16/07/2020	173	185	0	111	49	24	60	59	64	11
Friday	17/07/2020	182	190	1	105	48	23	69	59	73	5
Saturday	18/07/2020	201	158	0	107	48	24	73	64	43	7
Sunday	19/07/2020	211	157	0	119	53	23	63	52	32	3
Monday	20/07/2020	225	163	0	125	51	25	63	55	57	10
Tuesday	21/07/2020	199	178	0	132	50	22	59	53	87	11
Wednesday	22/07/2020	181	175	0	126	50	22	44	47	106	13
Thursday	23/07/2020	201	157	0	127	47	24	63	59	75	10
Friday	24/07/2020	196	184	0	122	42	21	62	51	96	13
Saturday	25/07/2020	224	173	0	123	41	20	59	51	70	7
Sunday	26/07/2020	192	179	0	142	51	25	51	55	33	1

Phase 2 Activity and Backlog Levels May - July 2020

In line with national guidance we are continuing to step up more urgent clinical services, but despite this out backlogs continue to grow and our usual performance metrics continue to show a deteriorating position.

Summary of RTT backlog:
At the end of June the total waiting list size had increased to 18267 with 483 patients over 52 weeks and performance at 48.45%. This position will continue to worsen.

In terms of first outpatients we have in excess of 6000 patients waiting for a first appointment, with the biggest numbers being in ENT/Audiology, Ophthalmology, Orthopaedics, Urology and Dermatology

Summary of Cancer backlog
The table below gives an indication of where our delays are – mostly within Lower GI due to the Endoscopy issues.

Type	Total on PTL	1st Seen date not present	1st seen date after today's date	Awaiting diagnostic	Awaiting Treatment	Recent Covid 19 +ve	104 days or beyond
Breast	180	0	107	1	0		1
Gynae	60	2	16	2	0		2
Haem	4	0	0	0	0		0
Head/ Neck	111	2	22	5	4		10
Lung	25	6	3	0	0		0
Lower GI	301	134	65	200	0		52
CUP	1	0	0	0	0		0
Skin	223	10	97	6	5		4
Upper GI	94	27	27	9	0		6
Urology	78	7	13	6	7		4
	1077	**188**	**350**	**229**	**16**		**79**

The number of 104 day waits for cancer treatment continues to be higher than normal at 70 (up from 68 in June). 47 of these are within Colorectal due to Endoscopy delays, but most of these Patients now have dates and we are working through this backlog as a priority. All the 104 day waits are being reviewed for clinical harm once they have a diagnosis. The 104 day waits may continue at a higher rate as we are investigating and treating patients with the biggest clinical concerns rather than by waiting times. Within lower GI this will mean investigating those with a FIT+ test first.

There is currently adequate access to main theatres for cancer patients, but this may become a risk as we start to receive higher referrals and diagnose more cancers. We are still only receiving around 70% of our baseline referrals.

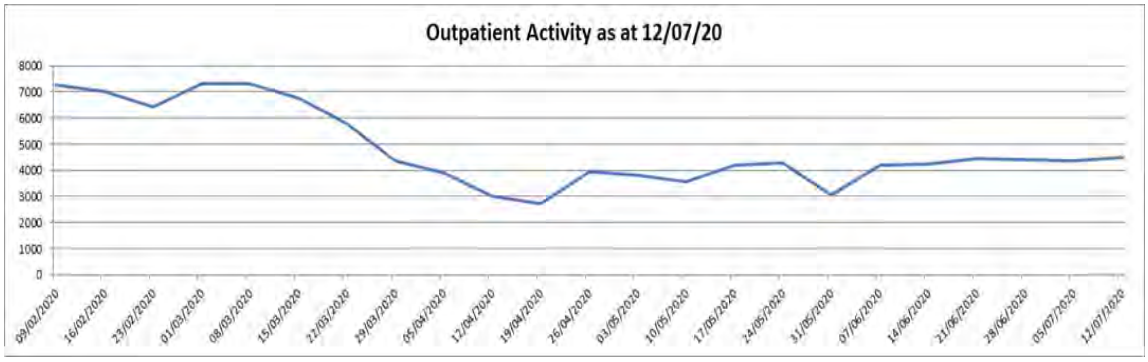
Modality	Procedures waiting	
	May	June
MRI	952	794
CT	652	735
Ultrasound	1297	1160
Endoscopy	1560	1210

The above investigations would usually be completed in line with the 6 week diagnostic standard. Whilst the CT backlog has increased slightly there have been notable reductions in endoscopy and MRI backlogs as activity restarts in line with our recovery plans. This will have a significantly positive impact on our cancer pathways however as yet we remain some way off the 6 week diagnostic standard.

The diagnostic team are finalising a detailed recovery plan but inclusive of additional resource and insourcing options we do not expect to recover the waiting time standard before the turn of the year.

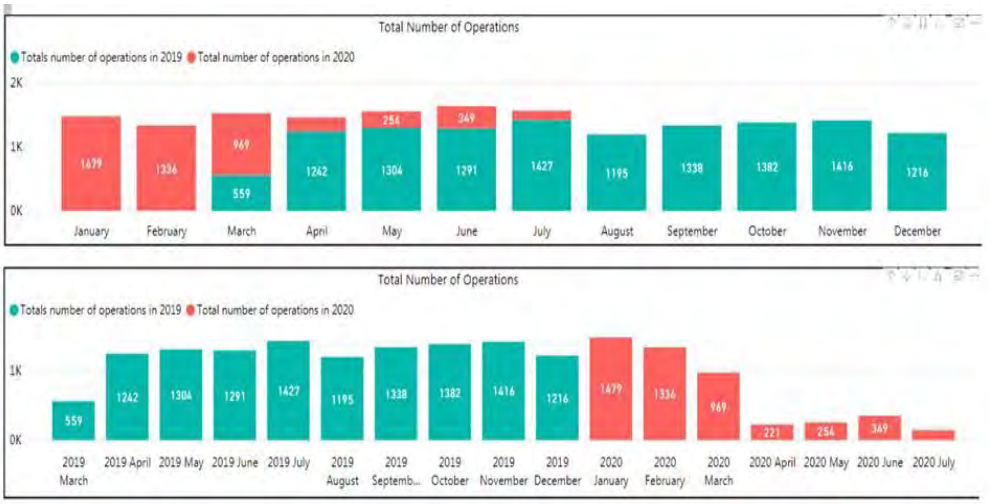
Recovery Planning
The wider recovery planning continues and we are starting to see an increase in delivered activity. However, as expected, this recovery is slow.

Outpatients - Whilst the has been a steady increase in OPD activity since the middle of April the total volume of appointments is significantly below pre Covid levels. Furthermore, whilst face to face OPD clinics have largely 're-opened', with appropriate social distancing measures, as the graph below demonstrates there is further scope for virtual clinic adoption. This will be a key workstream in the Phase 3 recovery activity.



Theatres
Theatre activity is now increasing following the opening of DSU on 13th July and a fourth list in main theatre. It is anticipated that the volume of activity that will be seen in DSU will increase quite rapidly following the initial opening phase. Our recovery remains in line with our anticipated activity plans as set out in last month's board paper.

Furthermore, we are making good use of the BMI for Breast, Plastics, General Surgery, Pain, T&O and endoscopy and have now added an additional patient to each list as teams adapt to the new procedures.



Clinicians have been conducting harm reviews on patients and we have just received additional national guidance around this and will be working to ensure our processes are compliant. Letters have also been sent to patients waiting for surgery to explain the limitations of current services and manage expectations. At a system level we are working with other providers to offer alternative pathways or manage risk through the provision of advice and guidance, therapy support or the provision of aids.

Phase 3 Recovery Planning

Our phase 3 recovery plans are being iterated on an ongoing basis with system partners. The most recent submission, on 15th July, made minor adjustments to our elective and diagnostic plans and provided greater detail around Paediatric ED attendances, minor ED attendances, bed occupancy and cancer recovery plans.

Whilst we generally remain on track with these plans there are a number of key constraints which have emerged.

1. Limited capital funding which hinders delivery of enhanced elective recovery in the medium to long term (specifically for the Newmarket elective hub).
2. Reduced ability to access regional surge centres in the event of a local surge in critical care demand (this is subject to further conversation as an emergent theme despite it featuring as a core element of our recovery plan since the first submission).
3. Impact on the elective recovery plan of 2 above (i.e. the impact on delivering the recovery plan through necessary use of additional critical care surge capacity on site).
4. Impact on the elective recovery plan of the ongoing RAAC plank investigation / mitigation plans.
5. Impact of limited on site Covid testing. This has a disproportionate impact on patient flow as it delays discharge in some cases and delays the release of capacity on contact bays where discharges have already occurred.

These constraints / challenges are a significant focus of our future planning effort and more specifically our winter plans. Planning for winter has commenced and will report to the board separately. In the event of a second Covid surge the winter period could be one of the most difficult the NHS has faced for many years, if not ever.

Testing

The lack of on-site testing remains a major challenge for us as a Trust. Unfortunately, the cost per test (>£150) has meant we have chosen not to pursue the procurement of the available ePlex analyser. We are still trying to make an appropriate molecular microbiology capital purchase but availability of both analysers and reagents continues to be a challenge.

In June we transferred over to Source Bioscience as our provider for staff and patient PCR testing. This initially improved turnaround times but we have now been informed that their contract with the NHS will not be renewed at the end of July and we are currently sourcing an alternative NHs provider. ESNEFT have supported us with a small amount of testing capacity over the past week along with supplying some Cephid reagents for on-site use from their limited supplies. Unfortunately, as there is no IT link between ESNEFT and WSFT this limits the option to move testing to them on a permanent basis due to the significant transcription involved in the manual process.

On a positive note we are progressing with the validation of some SAMBA point of care testing devices which will give us a limited on site capacity in the near future.

Community Services

Within our paediatric community services we have continued to support those patients on our caseload where there may be safeguarding concerns and we have contributed remotely to safeguarding case conferences.

The paediatric team are also trialling an IT platform called Moodal, as a key development to support parent groups. The team have indicated that this will transform their ability to provide support to parents going forward if the business care is supported.

The adult pulmonary rehab team were successful in a funding bid to Active Suffolk to fund equipment to support virtual rehab classes. Supported by Sarah Judge and the IT team they have become recognised nationally as trailblazers in providing virtual interactive groups.

The ASD diagnostic pathway has been significantly negatively impacted by Covid service restrictions:

- There are currently 329 children awaiting diagnostic assessment, (185 of which have had some form of initial assessment).
- There are also a number of questionnaires which have been sent to parents and schools, which if all are accepted onto the caseload will increase the figure to 416
- The issue has been added to the trust risk register and escalated to the CCG as the assessment pathway cannot be concluded for most children due to current Covid restrictions. Communication to families and wider networks regarding support available at this time is currently being drafted.

Supporting our Black, Asian and Minority Ethnic colleagues

As we have previously reflected on, emerging evidence shows that black and minority ethnic (BME) communities are disproportionately affected by COVID-19, particularly those with comorbidities who are presenting adverse outcomes at a younger age. The reasons for this are not yet fully understood, but the health inequalities present for BME communities have long been recognised.

It is imperative that as a Board we are assured as to the effectiveness of our response to this workforce risk, and a full briefing paper developed in partnership with our BAME Staff Network Chair will be presented to the next meeting of the Board. This update provides an interim report of progress to date

National direction and data returns
On 24 June 2020 NHS England wrote to all NHS organisations to promote the crucial importance of staff health risk assessments. This was in response to a national-level concern that NHS staff might not be benefitting from a risk assessment process. The letter rightly set the expectation of “significant progress” being made on this within the following month.

This included requiring organisations to publish:
1. Whether a risk assessment process is in place and offered to staff

2. The overall percentage of staff with risk assessments completed
3. The overall percentage of staff known to be 'at risk' with an assessment completed
4. The overall percentage of BAME staff with an assessment completed

Two data returns have been scheduled for July: one on 17th and the other on the 31st of the month.

Situation at WSFT

With the support and input of our occupational health team, a staff health risk assessment process has been in place at WSFT since 19 March. This risk assessment tool has been updated throughout the pandemic as the evidence base has developed. As the understanding of the risks became more apparent, our Strategic COVID group determined in late April that completion of the risk assessment should be mandatory for all staff and set a 18 May timeframe for completion. This yielded a response of 90% completion.

The national data collection requirement has provided the opportunity to review our data and ensure that every single member of staff has benefitted from a risk assessment discussion.

This work is nearing completion and the data submission for the 31 July will be shared when it is ready. The interim position submitted on 17 July is as follows:

Question	Response
1. Have you offered a risk assessment to all staff?	Yes
2. What percentage of your staff have you risk assessed?	95%
3. What percentage of risk assessments have been completed for staff who are known to be 'at risk'?	93%
4. What percentage of risk assessments have been completed for staff who are known to be from a BAME background?	91%

The number of completed assessments is 5,062. The 5% of staff where we have not yet confirmed completion of a risk assessment equates to 268 individuals and these are being followed-up during the remainder of July. Of this 268, 63 are known to be of BAME background.

The divisional and demographic breakdown of these numbers is as follows:

Divisional:

	No		Yes		Total No. staff
At Risk Group (Y/N)	No. staff	% Group	No. staff	% Group	
179 Clinical Support Directorate	13	2.91%	434	97.09%	447
179 Community Contract	73	8.28%	809	91.72%	882
179 Corporate Services (balance)	6	42.86%	8	57.14%	14
179 Corporate Services Directorate	41	3.26%	1216	96.74%	1257
179 Estates & Facilities Directorate		0.00%	515	100.00%	515
179 Medical Directorate	61	5.49%	1050	94.51%	1111
179 Surgical Directorate	65	8.38%	711	91.62%	776
179 Women and Child Directorate	9	2.74%	319	97.26%	328
Grand Total	268	5.03%	5062	94.97%	5330

Demographic:

	No		Yes		Total No. staff
At Risk Group	No. staff	% Group	No. staff	% Group	
Y	**143**	**7.29%**	**1819**	**92.71%**	**1962**
BME	63	9.31%	614	90.69%	677
Not Stated	6	7.59%	73	92.41%	79
White	74	6.14%	1132	93.86%	1206
N	**125**	**3.71%**	**3243**	**96.29%**	**3368**
Not Stated	34	12.41%	240	87.59%	274
White	91	2.94%	3003	97.06%	3094
Grand Total	**268**	**5.03%**	**5062**	**94.97%**	**5330**

Further assurance will be provided to the Board at its next meeting, including the feedback from BAME staff that has been gleaned through the Trust-wide "What Matters to You" staff engagement work – which completes at the end of this month.

10. Infection prevention and control assurance framework

To RECEIVE a report

For Report

Presented by Susan Wilkinson

Board of Directors – 31st July 2020

	X - OPEN			
Presented by:	Sue Wilkinson Exec Chief nurse			
Prepared by:	Anne How, Lead Infection Prevention Nurse / Rebecca Gibson – Compliance Manager			
Date prepared:	July 2020			
Subject:	NHSE ICT assurance framework			
Purpose:	x	For information		For approval

Background

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

It is anticipated that this report will be re-presented to the next Board meeting to provide an update on progress to address areas of non/partial compliance as well as the output of any monitoring/audits agreed.

The report sets out:

- Responding to CQC and CCG
- How we have undertaken this review
- Findings to date including non/partial compliance and risk register records
- Evidencing compliance and monitoring

Responding to CQC and CCG

As part of the CQC Emergency support framework (ESF) a request for further information has been received (by all trusts) with a requirement to submit a response to enable the CQC to input into the national monitoring framework by the end of July 2020. The ESF template is provided in Annex 1. Many elements of the ESF document are contained within the BAF.

This paper has been provided (prior to the Board meeting) to the CQC in order to meet their internal deadline request for information. It has been submitted with the proviso that the Board have not been able to comment and therefore the final response may be subject to additional comment and clarification.

Following the Board meeting the report will also be submitted to the CCG.

How we have undertaken this review

- Undertaken self-assessment against BAF including review of estates and isolation facilities.
- Initial review of BAF by Lead Infection prevention & control nurse and Compliance manager to identify leads (and complete elements specific to IPC team).
- Centrally coordinated distribution to leads to collate responses at specialist level including: IPC, housekeeping, estates, occupational health, antimicrobial pharmacy, trust clinical psychologist, patient flow and purchasing
- Set up an DIPC/Exec-led task & finish group to oversee this (first meeting 24/07/20)
- Collection of a structured response (in Appendix 1) in the format

Quality standard (1-10)	Key lines of enquiry (KLOE) (63)	WSFT compliance (Y/N/Partial)	How might we evidence this?	Gaps in assurance and Mitigating actions

Findings to date

As reported to last month's meeting an initial self-assessment highlighted three areas of non-compliance: Ventilation, Timely receipt of testing results and Isolation.

An update to the review has identified three further areas where we cannot confidently confirm full compliance without an audit or deep dive review. These include patient moves, contact tracing, and timely taking of swabs. This does not mean that the trust is necessarily non-compliant but it would benefit from scrutiny before making any declarations.

ACTION A number of reports will be drawn from eCare to identify patient groups to test these.

The KLOE "*Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection - a record of staff training is maintained*" was also deemed to be partially compliant because, although infection prevention records are maintained through trust induction and mandatory training, the Covid specific training provided to staff at the onset of the pandemic was not recorded. FFP mask training was recorded.

ACTION This was highlighted as a gap and any future training will now be documented.

The gaps in assurance and mitigation for all these items need to be described within risk assessments. A review of current risk register entries identified that whilst the isolation facilities are clearly described within RR15 *Management of outbreaks and cases of infection in the Trust* there is not an obvious record for some other aspects.

ACTION complete a BAF risk assessment for the full document and link to current risk register entries where they already describe elements of the document.

Evidencing compliance and monitoring

Within Appendix 1 is a narrative of how elements we are declaring compliance for might be evidenced. In a few examples that evidence has already been provided. Some items do not immediately lend themselves to documentary evidence but might be better suited to verbal feedback (e.g. supporting staff - we could give the number of people who have been supported whilst off sick and the number of people have supported in their return to work, but anything else would be confidential and difficult to share/evidence however a conversation with Emily Baker describing the work of her team would be a more powerful source of assurance).

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

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

Previously considered by:	IPC task & finish group (met 24th July 20)
Risk and assurance:	As per attached assurance framework
Legislation, regulatory, equality, diversity and dignity implications	NHSE
Recommendation: Receive this report for information	

Annex 1 – CQC ESF and IPC BAF - Questions for inspectors on infection prevention and control for NHS acute and mental health trusts

1.	Has the trust's board received or carried out an assessment of the infection prevention and control procedures and measures in place across all services since the COVID-19 pandemic was declared? Does this include an assessment of the estate/isolation facilities?
	If not, is the trust planning to produce an assessment, and when?
	If yes, how did you carry out the assessment?
	Which services did you assess?
	What did you learn?
	How did you assess the environment and estate?
2.	Are there systems in place to manage and monitor the prevention and control of infection? Do these systems use risk assessments and consider the susceptibility of service users, and any risks that their environment and other users may pose to them?
	What is the governance around infection prevention and control (IPC)?
	How do you know that risk assessments are carried out?
	How do you consider the susceptibility of service users?
	How is risk assessed at the front door?
	How do you ensure staff know about national guidance on moving patients, for example, transfer or discharge from hospital?
	How are risk registers used for IPC risks?
3.	Are there systems in place to provide and maintain a clean and appropriate environment in managed premises, facilitating the prevention and control of infections?
	How are different rooms cleaned systematically to the required standard?
	What have you learned from audits?
	Are there specific teams for specific processes?
4.	Is there appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance?
	What did you learn from antimicrobial or prescribing audits?
	Are there any areas not covered by audits?
	How are antiviral stocks monitored?
5.	Does the trust provide suitable accurate information on infections, in a timely way, to service users, their visitors and any person concerned with providing further support or nursing/medical care?
	Did you have a communications plan for this? What have you put in place?
	What challenges have you experienced in providing information to service users, visitors, and people concerned with their care?
6.	Is there a system in place that ensures prompt identification of people who have, or are at risk of developing an infection, so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people?
	How do you identify people who have, or are at risk of, infection, and at what stage?
	Have you evaluated understanding of your protocol to identify and manage these patients?
	How do you minimise the risk of cross-infection?
	How is contact tracing actioned?
7.	Are there systems in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection?
	How do you ensure that PPE training is up to date with advice?
	How are bank/agency staff trained?

	How do you audit hand hygiene and use of PPE and what have you learned?
8.	Are there secure or adequate isolation facilities?
	What facilities do you have for isolation?
	How do you know whether there are enough isolation rooms to meet demand?
	Is there a system for monitoring isolation guidance?
	How do staff know when and how to cohort patients with any infection?
9.	Is there adequate access to laboratory support?
	Is your laboratory support external or in-house, and how do you ensure that this runs smoothly?
	What is the testing capacity, and is there a prompt turnaround of results?
10.	Is there evidence that the trust has policies designed for the individual's care that will help prevent and control infections?
	What are your policies regarding preventing and controlling infections? How do you know whether they are effective?
	Did you develop any new policies in response to COVID-19?
11	Does the trust have a system to manage the occupational health needs of staff regarding infection?
	What is the system for testing the fitness of staff to work?
	What action is taken on results?
	What support is given to staff who are living with mental or physical impacts of COVID-19?

Appendix 1 - IPC BAF

Ref	Quality standard	Key lines of enquiry	Compliance	How would we evidence this?	Gaps in assurance	Mitigating actions
1.1	1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users	infection risk is assessed at the front door and this is documented in patient notes	Compliant	1. ED Signage is in place processes have been in place since January 2020 2. Surgery in place pre surgical checklist 3. Maternity/EPAU - All women are asked the COVID symptom questions on the phone prior to admission. If the woman has any symptoms she is admitted to one of the Labour Suite single rooms. It is documented on a Triage form 4. (if not admitted via ED) F14 woman are assessed over the phone and if any symptoms the site manger would be informed.		
1.2		patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	Partial	Processes in place with designated wards however we are unwilling to state full compliance at this time until it can be evidenced. Action agreed to undertake an audit to validate.	absence of audit	follow agree policies/SOPs Undertake a spot check (planned)
1.3		compliance with the national guidance around discharge or transfer of COVID- 19 positive patients	Compliant	Documented local guidance Evidence of updates from national guidance Notes from strategic meeting Daily staff COVID briefing		
1.4		all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	Compliant	1. PPE trained. Mask training records available 2. Access to PPE. Stock levels of all COVID areas that are checked twice daily between 8am and 9am and then between 4pm and 5pm by Purchasing. Purchasing daily records of available PPE, including issues and stock levels		
1.5		national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	Compliant	Minutes of tactical command central repository and initiate through tactical command meeting. Posters & online training sessions ad hoc as required and always when an area is designated Covid 19 affected		

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

Ref	Quality standard	Key lines of enquiry	Compliance	How would we evidence this?	Gaps in assurance	Mitigating actions
2.4		increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	Compliant	cleaning records / audits demonstrate compliance with at least twice daily cleaning, more if required		
2.5		attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas	Compliant	cleaning records / audits demonstrate compliance with at least twice daily cleaning, more if required		
2.6		cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	Compliant	cleaning records demonstrate cleaning with chlorine base products as per national guidance		
2.7		manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products	Compliant	Adherence to manufacturers guidance		
2.8		'frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and contaminated with secretions, excretions or body fluids when known to be	Compliant	cleaning records / audits demonstrate compliance with at least twice daily cleaning, more if required		
2.9		electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily	Compliant	All undertaken by housekeeping (and when required clinical team) except staff's personal mobile phones and tablets.		
2.10		rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	Compliant	cleaning records in conjunction with respective staff groups for appropriate timing of cleans		
2.11		linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	Compliant	All areas have alginate bags for infectious linen and staff are aware of the process to add an outer linen bag. Portering staff will not remove alginate bags alone		

Ref	Quality standard	Key lines of enquiry	Compliance	How would we evidence this?	Gaps in assurance	Mitigating actions
2.12		single use items are used where possible and according to single use policy	Compliant	Single use items are purchased as a priority by the purchasing department as a standard for the Trust. Where a reusable item is required there is a process for establishing the protocol for this		
2.13		reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance	Compliant	Single use items are purchased as a priority by the purchasing department as a standard for the Trust. Where a reusable item is required there is a process for establishing the protocol for this		
2.14		review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission	Partial	Not all areas have forced ventilation and therefore rely on natural ventilation via windows being open	Air circulation minimal, Restrictors on windows predominantly in place as per Patient safety risk assessment	No fans in use in any waiting areas. Windows open where possible

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

Ref	Quality standard	Key lines of enquiry	Compliance	How would we evidence this?	Gaps in assurance	Mitigating actions
4.4		infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	Compliant	Transfer document eCare record		
5.1	5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people	front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection, as per national guidance	Compliant	Signage, Evidence of working processes in place		
5.2		mask usage is emphasized for suspected individuals	Compliant	Masks are provided for patients if they do not have one. Mask signage in place and masks available for all at all entrances to hospital buildings		
5.3		ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff	Compliant	Screens are being placed on reception desks		
5.4		for patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible	Partial	1. isolation achieved through cohorting on dedicated ward (or sideroom on specialty ward if required).	contact tracing cannot be declared as compliant until it can be accurately described	IPC meeting with key leads to obtain narrative) including referral to track and trace
5.5		patients with suspected COVID-19 are tested promptly	Compliant	All suspected patients are tested. Clinical care records and swab dates		
5.6		patients who test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced	Compliant	Patients with suspected Covid are moved to a Covid affected area. Bays are closed and contacts identified and tested. Bed flow and clinical care records record this		
5.7		patients who attend for routine appointments and who display symptoms of COVID-19 are managed appropriately	Compliant	Patients are asked if they have symptoms on arrival and advised to return home and request a swab if the appointment is non urgent and rebook.		

Ref	Quality standard	Key lines of enquiry	Compliance	How would we evidence this?	Gaps in assurance	Mitigating actions
6.1	6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection	all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	Compliant	Each area has access to the guidance and posters are in place both demonstrating the correct processes, advising on top tips and links to the guidance. Areas are trained on a rolling programme when designated as Covid areas Presentation from Infection Prevention Team and Head of Nursing for Medicine to discuss COVID and the challenges that this posed. Question and answer session provided / FFP3 Mask Fitting / Donning and Doffing training and posters / RAG rating posters to establish individual area risks to support practice / Social distancing		
6.2		all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation, and on how to safely don and doff it	Compliant	FFP3 Mask Fitting / Donning and Doffing training records		
6.3		a record of staff training is maintained	Partial	Training records are kept for induction and mandatory training (both of which cover infection prevention) and the data is reported as a standard. Mask training records also available	COVID specific training in the period Mar-June did not have records maintained though attendance numbers were good in all cases	All future training sessions will have attendance records taken
6.4		appropriate arrangements are in place so that any reuse of PPE in line with the CAS alert is properly monitored and managed	Compliant	through policies and procedures		
6.5		any incidents relating to the re-use of PPE are monitored and appropriate action taken	Compliant	Datix incident reporting system		
6.6		adherence to PHE national guidance on the use of PPE is regularly audited	Compliant	audits		
6.7		staff regularly undertake hand hygiene and observe standard infection control precautions	Compliant	Audit data		

Ref	Quality standard	Key lines of enquiry	Compliance	How would we evidence this?	Gaps in assurance	Mitigating actions
6.8		hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	Compliant	Hand dryers in public toilets only. Estates have turned them off & Put up 'Out of Order Notices. Estates have put up hand towel dispensers & HK's will manage topping paper towel dispenser		
6.9		guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	Compliant	Posters on hand hygiene are available in all toilets		
6.10		staff understand the requirements for uniform laundering where this is not provided on site	Compliant	Regularly highlighted in the daily briefing. Posters are in changing areas to highlight the actions staff need to take if ensure (pictorial as well as text).		
6.11		all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance, if they or a member of their household displays any of the symptoms	Compliant	Regularly highlighted in the daily briefing spot check audits		
7.1	7. Provide or secure adequate isolation facilities	patients with possible or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	Partial	Within the limits of the estate areas are designated in order of greatest ability to comply with the guidance. F7 the only acute ward with doors to bays and the greatest number of single rooms is the acute Covid ward. G4 furthest away from any other ward area and a stand alone facility is the other Covid affected ward.	As described in RR15 risk assessment	Single rooms are prioritized according to the risk of the infection; this forms the main element of the duty IPN workload. Sideroom lists occupancy lists are completed daily and circulated Sheeting has been installed to provide a barrier to bays
7.2		areas used to cohort patients with possible or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	Compliant	SOP for designated cohorting arrangements		
7.3		patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Compliant	as per trust policies		
8.1	8. Secure adequate access to laboratory	testing is undertaken by competent and trained individuals	Compliant	spot audit / training records		

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

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

11. Integrated quality and performance report

To APPROVE a report

For Approval

Presented by Helen Beck and Susan Wilkinson

Trust Board Report

Agenda Item:	11
Presented By:	Helen Beck & Sue Wilkinson
Prepared By:	Information Team
Date Prepared:	22/07/2020
Subject:	Performance Report

	X	**For Information**	**For Approval**

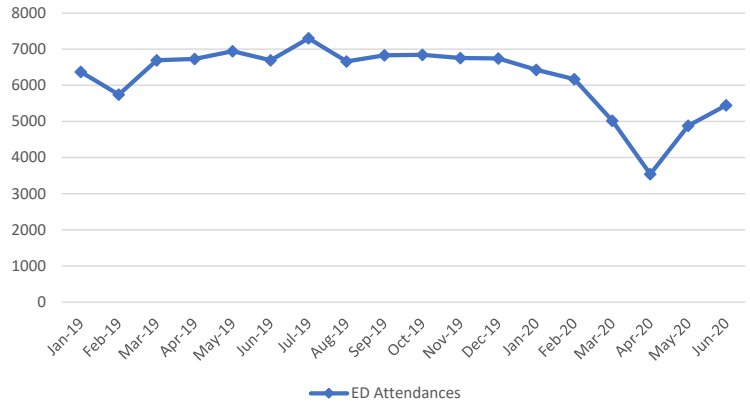
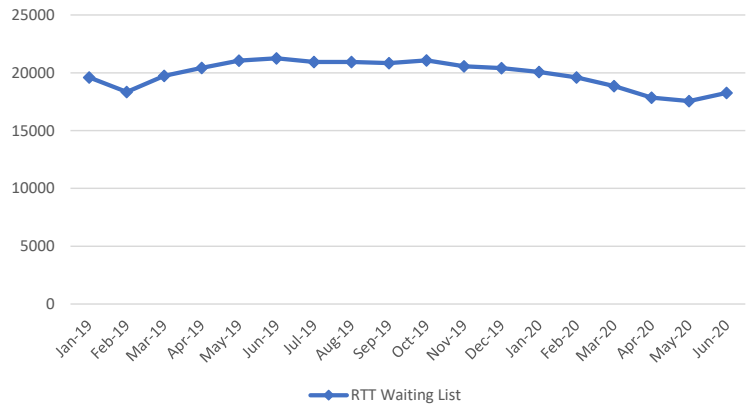
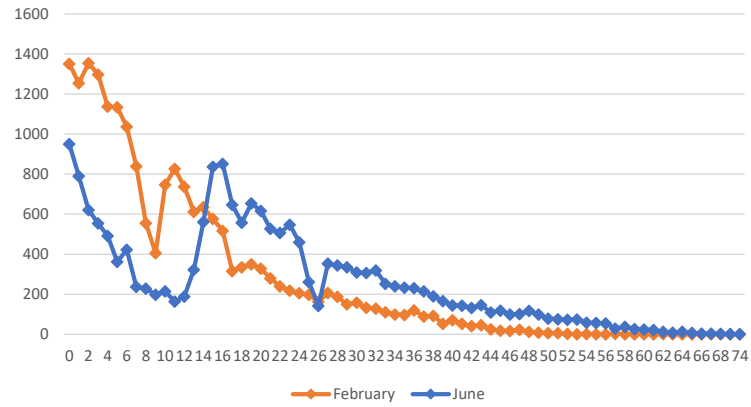
Purpose: [Please indicate Trust priorities relevant to the subject of the report]	**Delivery for Today**	**Invest in Quality, Staff and Clinical Leadership**	**Build a Joined-up Future**
	X		

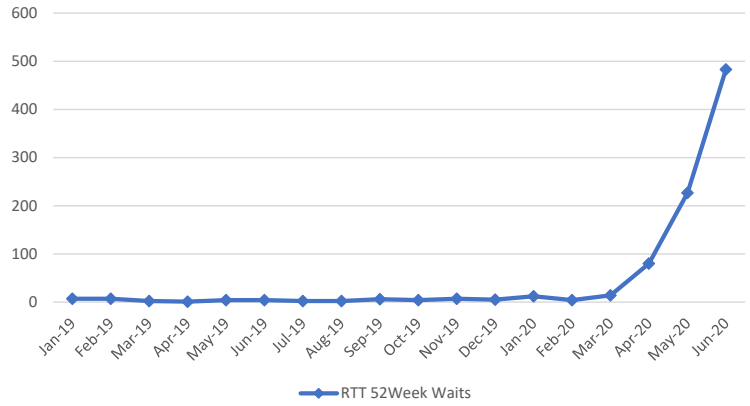
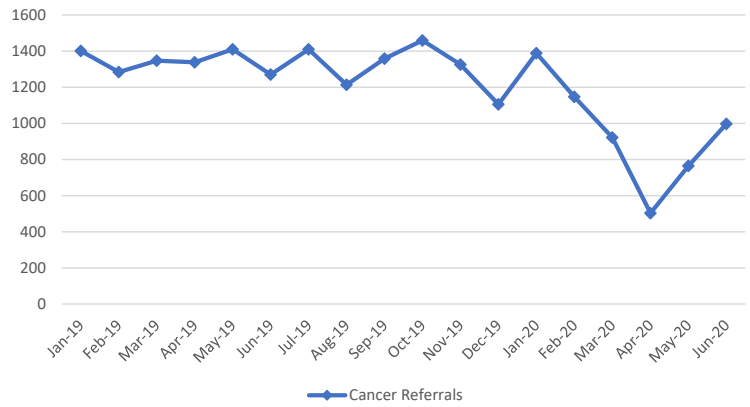
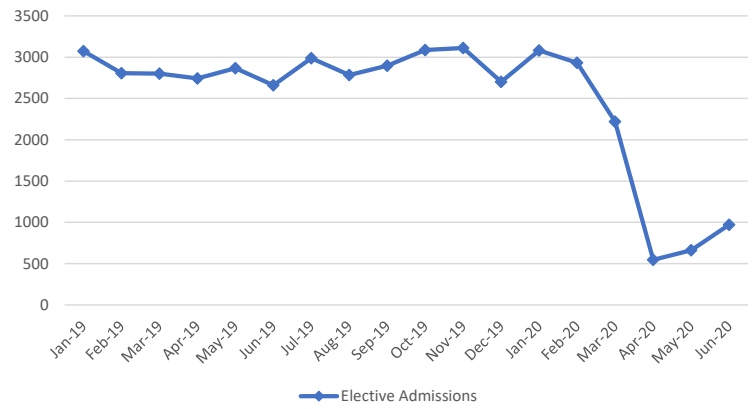
Trust Ambitions [Please indicate ambitions relevant to the subject of the report]	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
		X	X				X

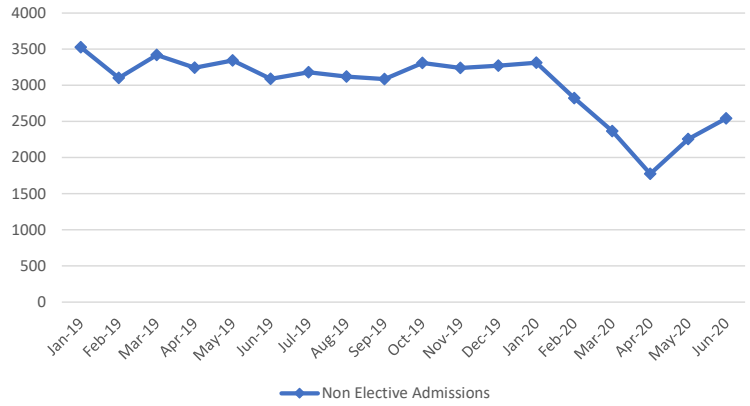
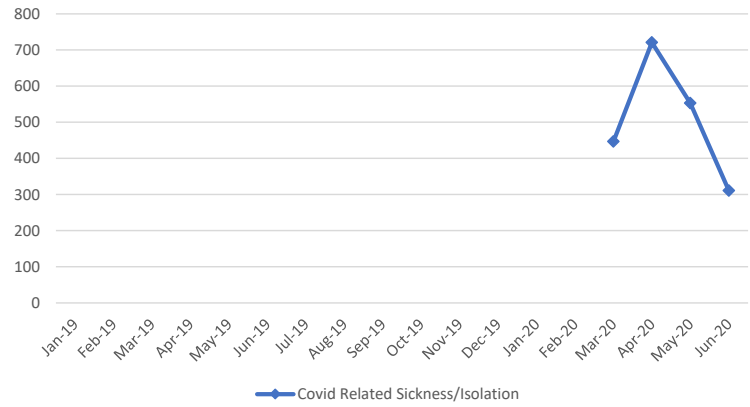
Previously Considered by:	
Risk and Assurance:	
Legislation, Regulatory, Equality, Diversity and Dignity Implications	

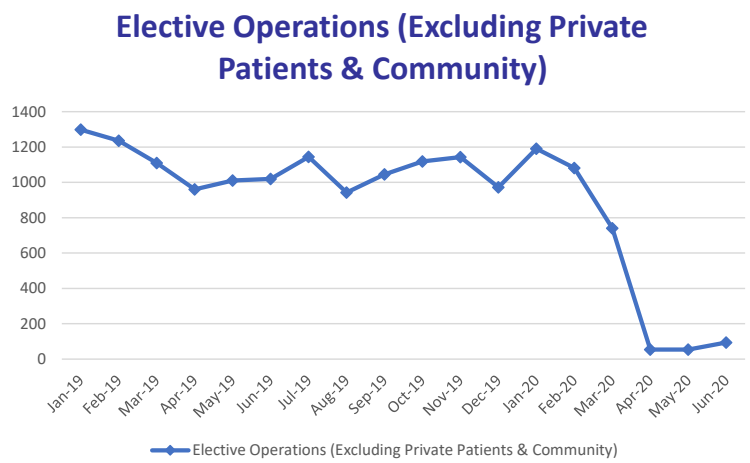
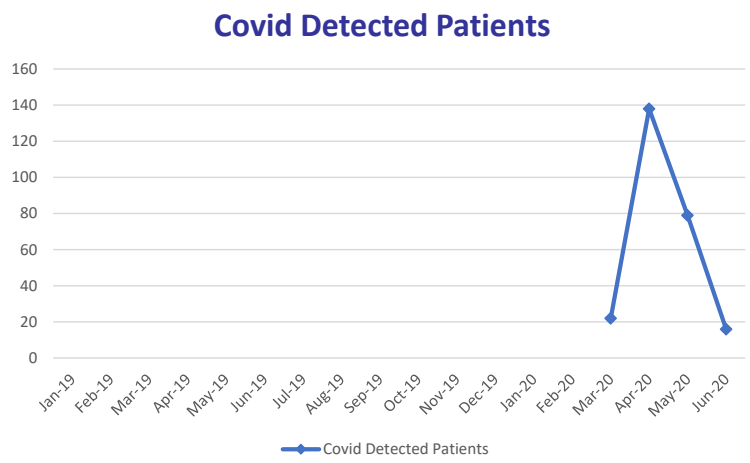
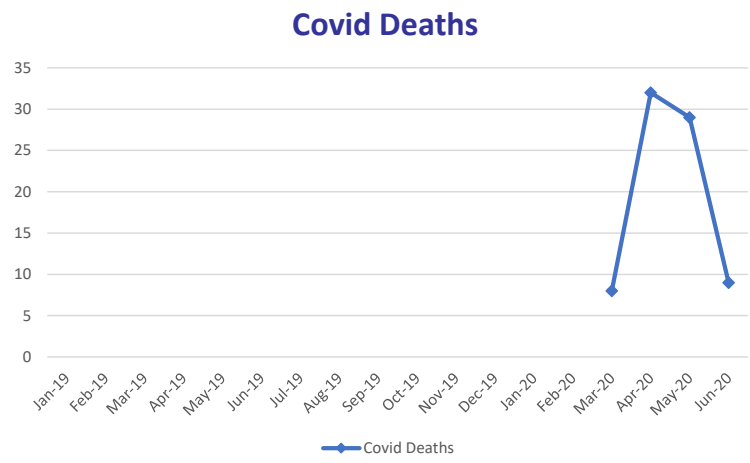
Recommendation:

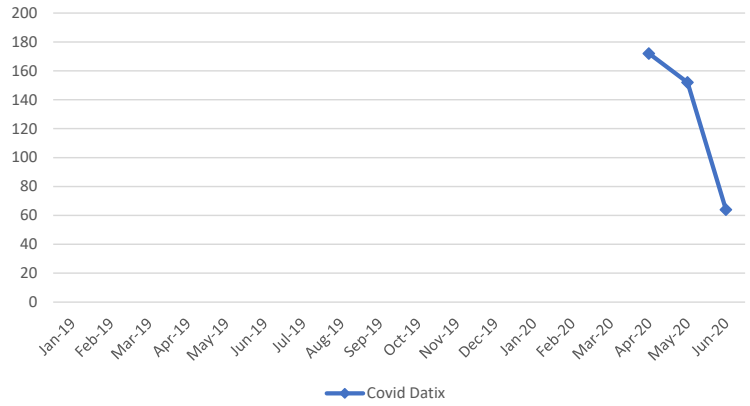
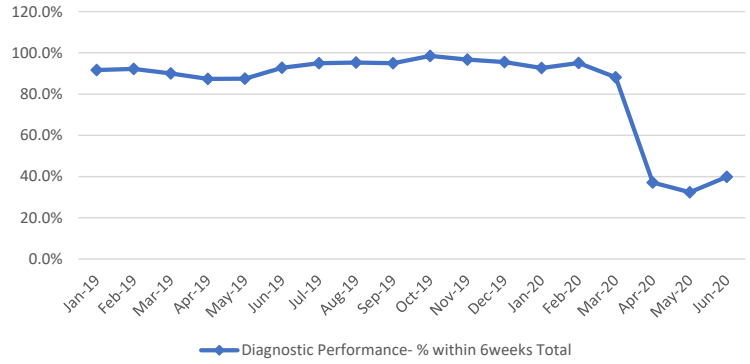
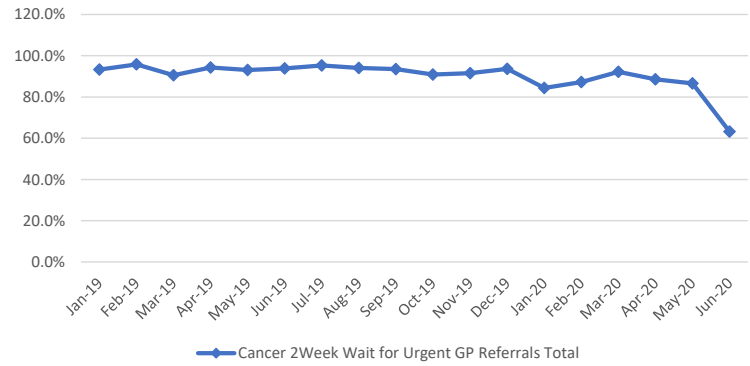
That Board note the report.

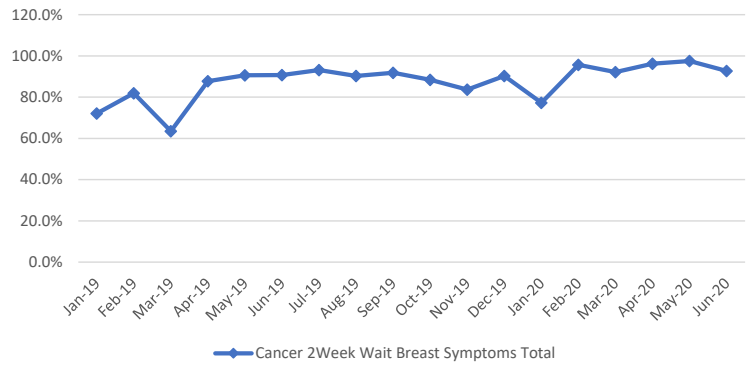
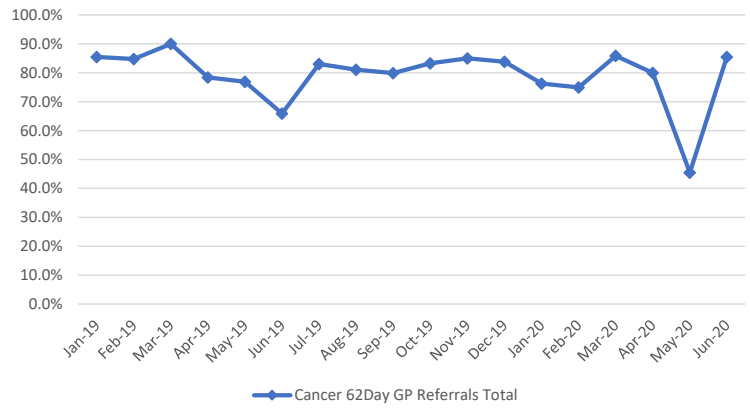
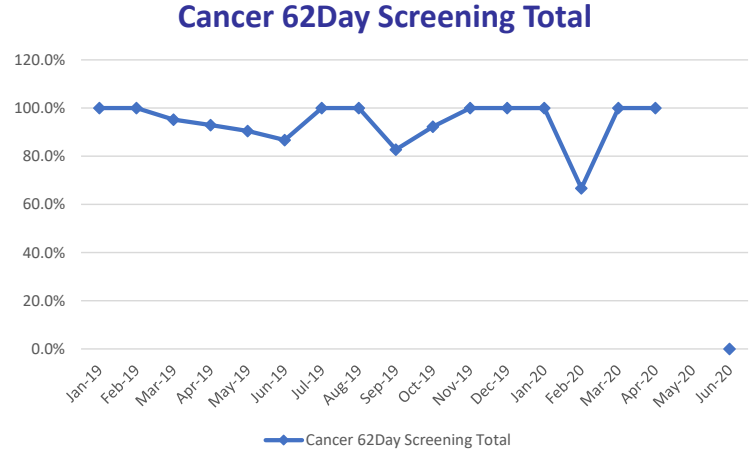
Board Report KPIs	Narratives
ED Attendances 	There were 5449 attendances in ED in June compared to 4880 in May (an increase of 569 patients - 11.7%) although this is still lower than our pre-Covid attendances of 6426 in January, Patients arriving by ambulance increased from 1721 in May to 1771 in June (an increase of 50 patients - 2.9%.) although this is still lower than our pre-Covid ambulance arrivals of 2039 in January, 1587 patients were admitted in June compared to 1453 in May (increase of 134 patients - 9.22%.) although this is still lower than our pre-Covid admitted patients of 1990 in January.
RTT Waiting List 	The overall waiting list size has seen a slight increase in June to 18267, this is mostly due to the referral numbers starting to increase. The waiting list size will likely continue to grow over the next few months as we see the demand increases quicker than the capacity available.
RTT Waiting List Precovid Comparison 	As expected this shows that the waiting list shape has moved along in weeks as it is fairly static, with few referrals than pre-Covid so less patients in the 0-12 week category but a much higher level over patients from 12 weeks onwards in their pathway. As many patients who are waiting in excess of 26 weeks are waiting surgical treatment, this will continue to be the case whilst the elective programme is re-started, as the availability of surgical capacity is much less than pre-Covid.

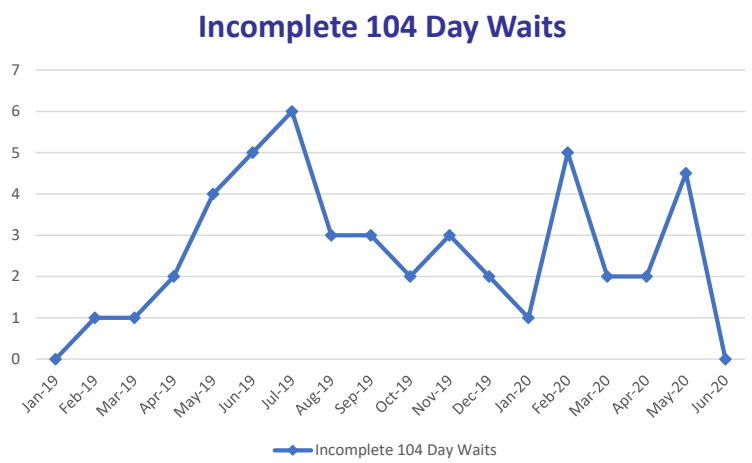
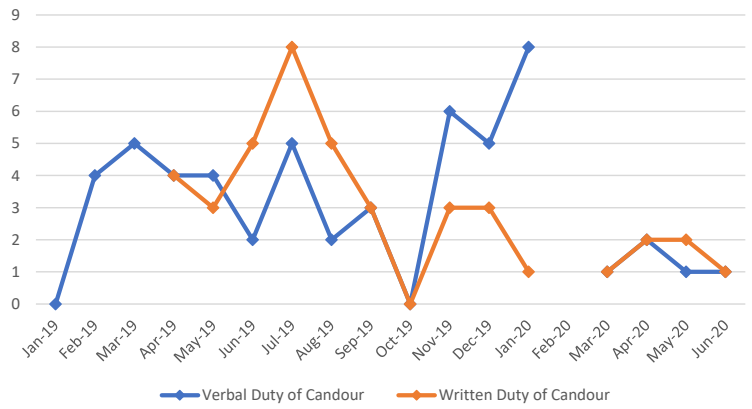
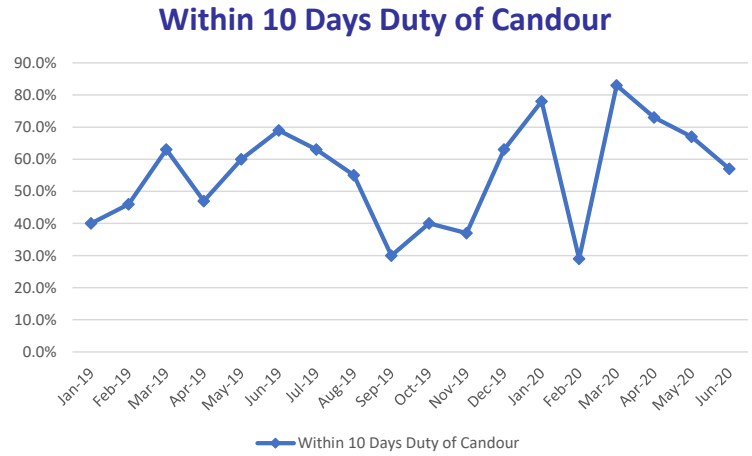
Board Report KPIs	Narratives
RTT 52Week Waits 	The number of 52 week waits continues to grow now at 483, the largest proportion of these are within Orthopaedics, where surgical capacity is limited. Some patients are being treated at the BMI, but Covid restrictions and the lack of an elective surgical ward mean that it is not currently possible to provide a trajectory for the recovery of the 52 Week position. However, patients are being reviewed/written to advise them of wait times, symptom management and who to contact with concerns and a programme of work with primary care to support these patients is on-going.
Cancer Referrals 	Cancer referrals are increasing but have still not reached pre covid levels.
Elective Admissions 	Slight rise in elective admission numbers seen in June risen to 971, this will be a combination of increased Endoscopy capacity, increase in throughput within Theatres, resumption of other day interventions within Radiology.

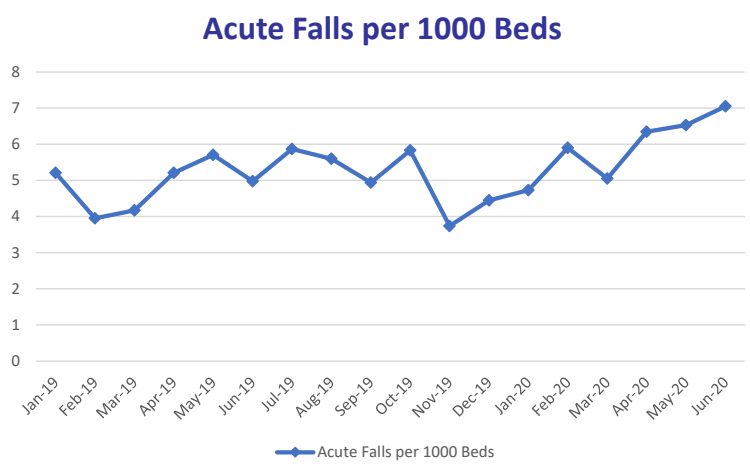
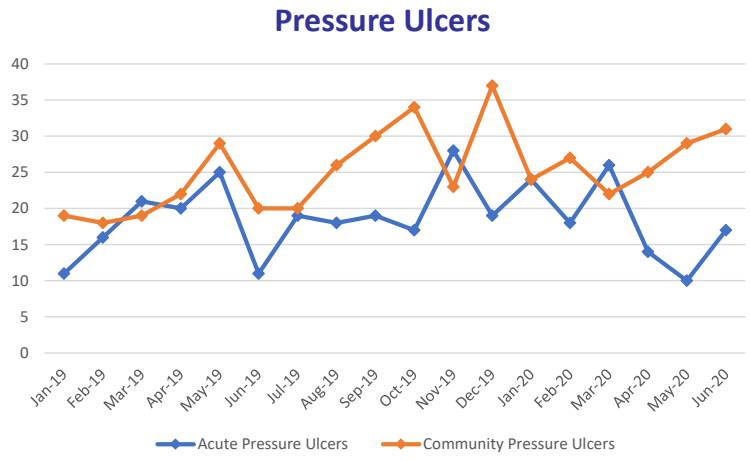
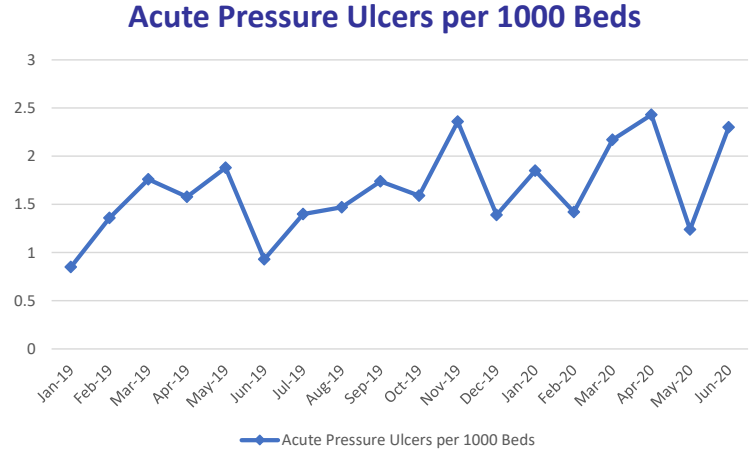
Board Report KPIs	Narratives
Non Elective Admissions 	Non elective admissions were 2543 in June which is an increase from 2255 in May but still significantly lower than pre Covid levels of 3312 in January this is a 23.2% reduction.
Staff Sickness 	The Trust's 12 month cumulative absence as at June 2020 was 3.9%. This has remained stable at 3.9% for April, May and June 2020. At the end of March 2020, prior to COVID-19, the Trust's 12 month cumulative run rate for absence was 3.6%. The increase in the run rate for absence is due to COVID-19 related sickness absence.
Covid Related Sickness/Isolation 	This chart illustrates the number of sickness episodes related to COVID-19 in June 2020. There were 311 episodes reported compared to 553 in May 2020. This is indicative of the reduction in sickness absence levels reported related to COVID-19 in June compared to April and May.

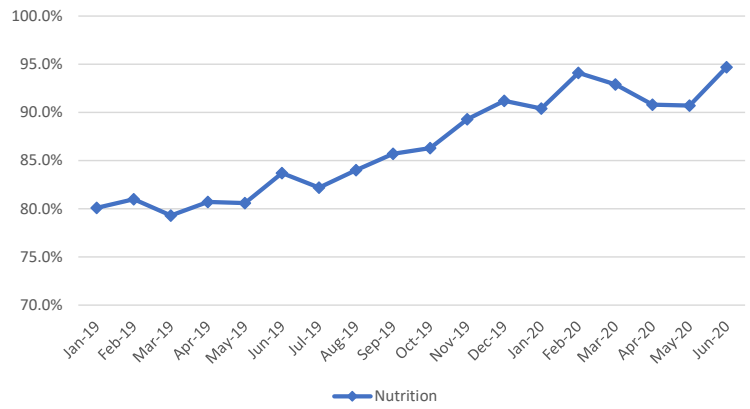
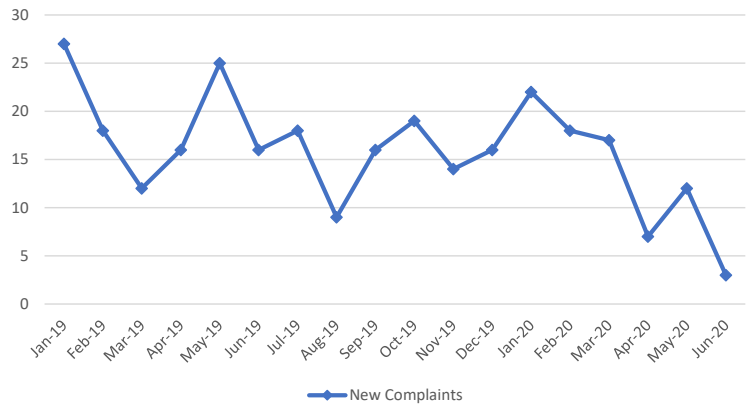
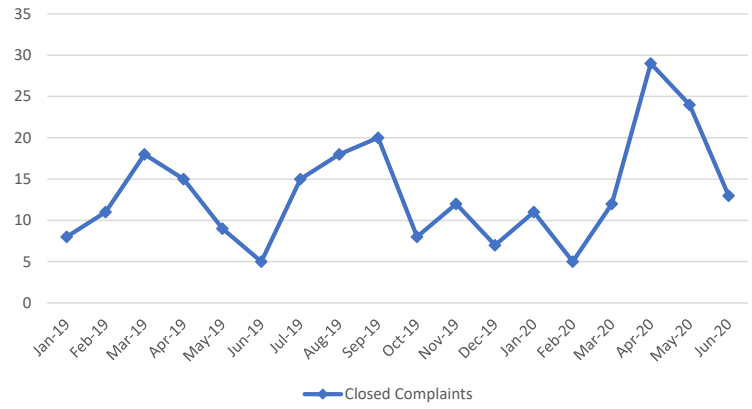
Board Report KPIs	Narratives
	Slight rise in elective admission numbers seen in June to 94 as more theatre capacity was opened. With DSU re-opened 13th July, this will continue to be on plan. However, the lack of surgical elective ward capacity, could inhibit the ability to open more inpatient theatres. Significant work has taken place to reduce the staff impact and zoning within theatres to enable more activity to go through the theatre complex and day surgery.
	For the second consecutive month the number of Covid detected inpatients has fallen and reflects the national picture.
	The number of Covid inpatient deaths has fallen significantly from the May report and reflects the national picture.

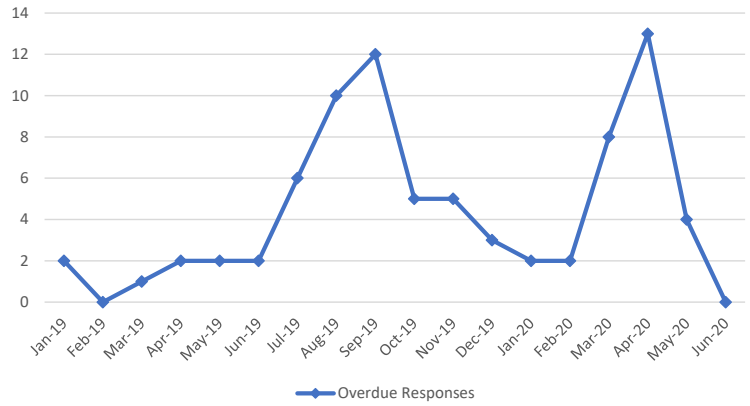
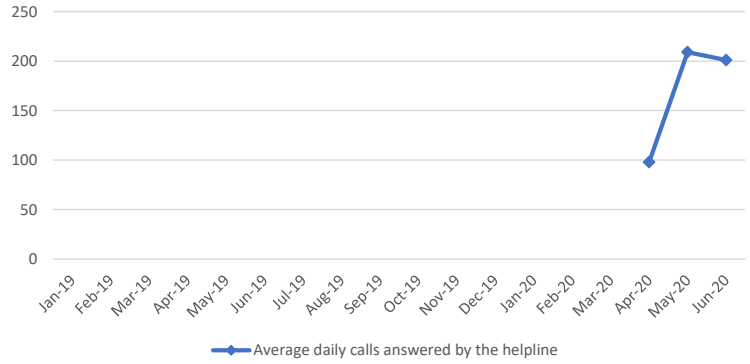
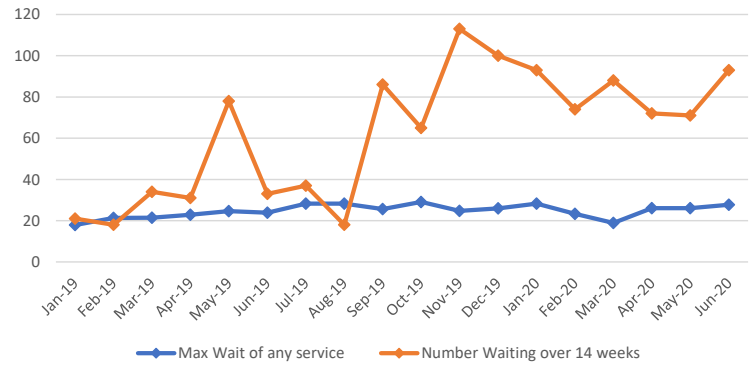
Board Report KPIs	Narratives
Covid Datix 	The Datix incident system captures all incident which relate to the care of a patient or member of staff who has or is suspected to have COVID-19 including incidents which are not related to the management of COVID (e.g. a fall or medication incident) as well as those directly related to the COVID status (e.g. a PPE or patient transfer incident). There was a considerable reduction in the number of these incidents reported in June compared to previous months which reflects the lower number of COVID patients in the hospital. The overall number of incidents reported (regardless of COVID status) in June (694) was in fact higher than in April (621) or May (661)
Diagnostic Performance- % within 6weeks Total 	Diagnostic performance – continues to be directly affected by the measures required to maintain social distancing which has reduced available capacity to around 40% of normal. Endoscopy have increased their capacity to 5-6 outpatient lists per day plus an inpatient list. All nursing staff have returned from deployments elsewhere for Covid. Capacity at BMI is being used but is limited. A review is taking place to ascertain whether it is safe to increase the number of patients per list. Compared to pre-Covid activity, for June CT are working at 79% activity, MRI 57% and non-obstetric ultrasound at 51%. All areas are continuing to work towards maximising their capacity within the available staffing resources. Business cases are progressing for additional CT/MRI capacity and exploring options for endoscopy recovery.
Cancer 2Week Wait for Urgent GP Referrals Total 	We are unable to meet the 2 week waiting time for fast track endoscopy due to the 7 week backlog. Activity is increasing but is still significantly less than pre covid levels.

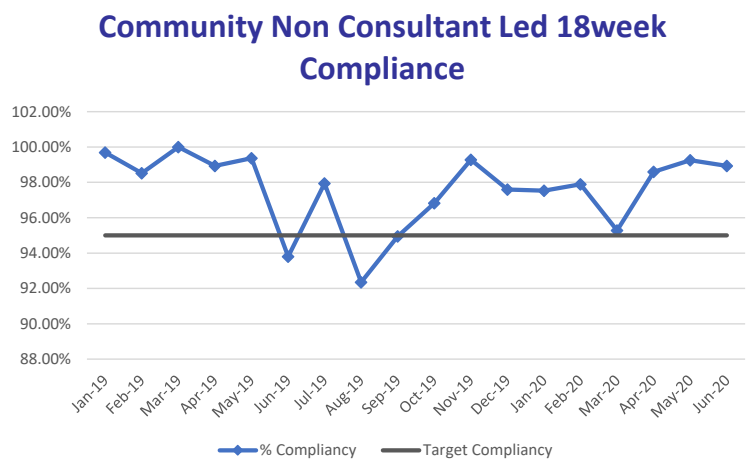
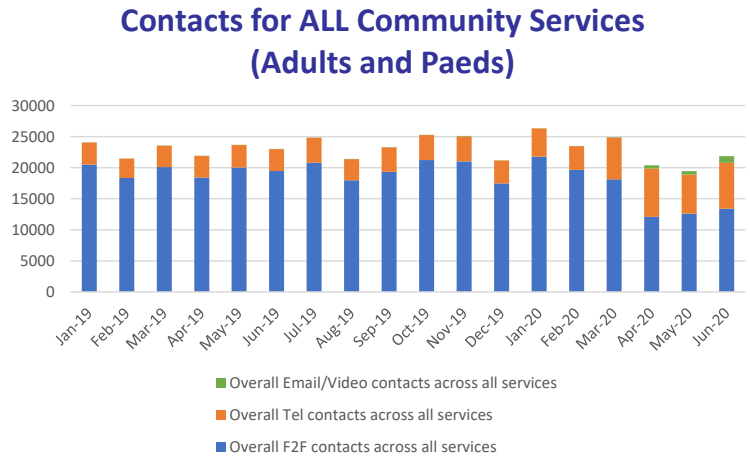
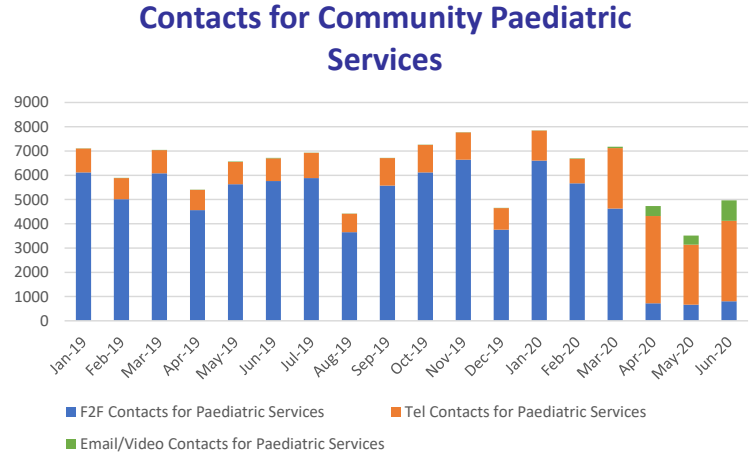
Board Report KPIs	Narratives
Cancer 2Week Wait Breast Symptoms Total 	14 patients waited longer than 14 days for their first appointment, however all of these were due to patient choice to delay initially, but they have now all been seen.
Cancer 62Day GP Referrals Total 	Whilst the performance looks to be much improved, the number of treatments is down by around 50%. This is mostly due to patients still being in the diagnostic phase of their cancer referral pathway, as this standard is measured on date of treatment. There are currently 14 patients on hold for their treatment, this is a mixture of patient choice, those that can be delayed safely and patients who are currently unfit.
Cancer 62Day Screening Total 	We treated only 1 patient who was referred from the screening programmes and this patient was treated over 62 days, due to a late referral from bowel screening.

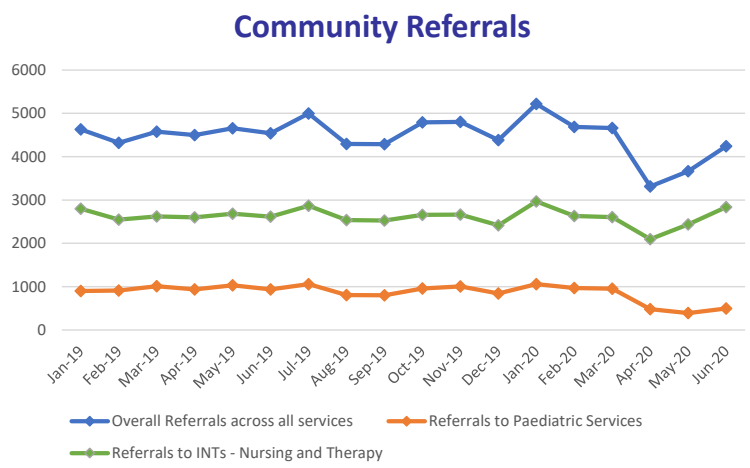
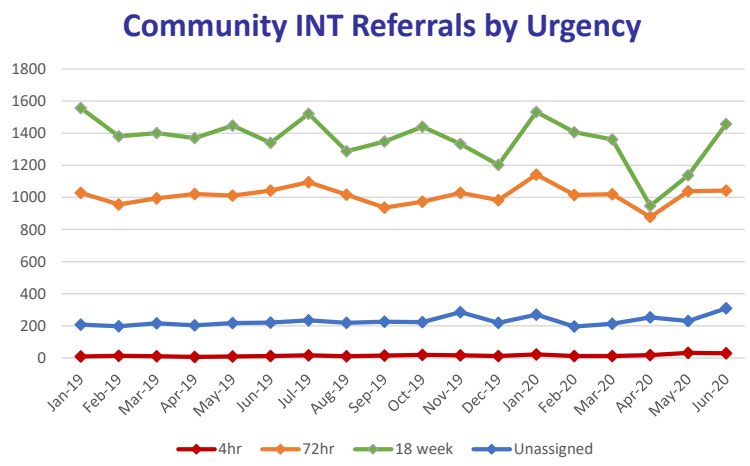
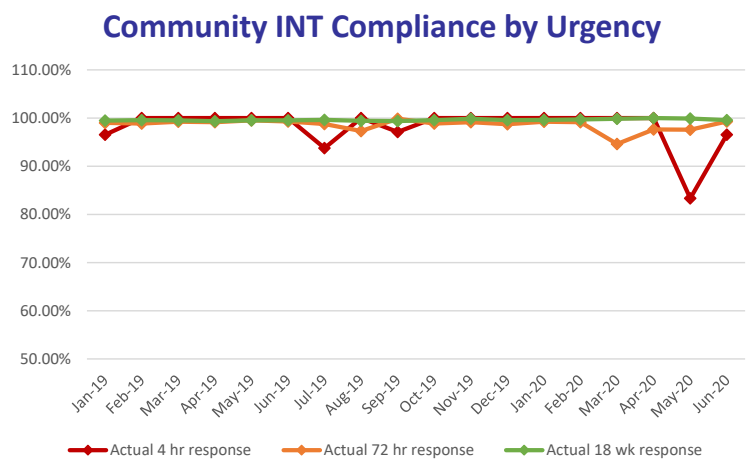
Board Report KPIs	Narratives
	There are 83 patients waiting over 104 days for initial diagnostic test to confirm or exclude cancer and or cancer treatment as at the end of June. Of these 1 patient treated in the trust in June waited over 104 days. The majority of 104 days wait patients are awaiting initial diagnostic test due to endoscopy delays.
	We continue to prioritise and focus on delivering Duty of Candour within the required timeframe and action overdue cases. •Review of the requirement for Duty of Candour is undertaken daily (Monday to Friday) as part of the daily safety brief review and all incidents considered to be graded as amber or above will have a Duty of Candour lead allocated on Datix. This is reviewed weekly by the patient safety admin and escalated where required. •Duty of Candour compliance and overdue encounters are captured in the newly formatted monthly divisional governance reports which are escalated through divisional governance meetings or board meetings. • We are offering training and support for providing Duty of Candour in complex or particularly sensitive cases. •Duty of Candour is part of the patient safety educational syllabus. We are planning to roll out Duty of Candour training as part of RCA training in ward areas for all staff. This will be carried out in the interim period by the patient safety team. •Duty of Candour is part of our PSIRF work stream and it is planned that the PSIRF project team would include champions for Duty of Candour. •We expect to see an improvement in next months' figures as BAU returns.
	We continue to prioritise and focus on delivering Duty of Candour within the required timeframe and action overdue cases. •Review of the requirement for Duty of Candour is undertaken daily (Monday to Friday) as part of the daily safety brief review and all incidents considered to be graded as amber or above will have a Duty of Candour lead allocated on Datix. This is reviewed weekly by the patient safety admin and escalated where required. •Duty of Candour compliance and overdue encounters are captured in the newly formatted monthly divisional governance reports which are escalated through divisional governance meetings or board meetings. • We are offering training and support for providing Duty of Candour in complex or particularly sensitive cases. •Duty of Candour is part of the patient safety educational syllabus. We are planning to roll out Duty of Candour training as part of RCA training in ward areas for all staff. This will be carried out in the interim period by the patient safety team. •Duty of Candour is part of our PSIRF work stream and it is planned that the PSIRF project team would include champions for Duty of Candour. •We expect to see an improvement in next months' figures as BAU returns.

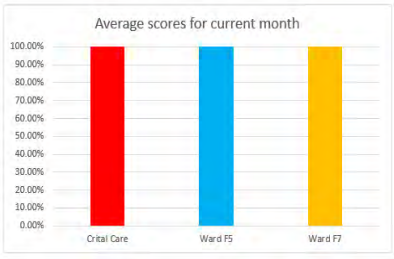
Board Report KPIs	Narratives
	The total number of Trust inpatient falls decreased in June to 52. However there has been an increase in falls per 1000 bed days due to a reduction in bed capacity as a result of the beds being socially distanced. 97.5 % of patients admitted received a falls assessment and of these patients 64% were at risk of falling with 89% receiving a falls care plan. Falls lead appointment has been made (will be in post at the end of August), we have been trialling the new M200 falls equipment on G4/G5 and Rosemary Ward, education for staff on falls prevention continues. The Trust falls group meetings have re-started in June
	There has been an increase in pressure ulcers specifically in the community but also in the acute areas, however when compared to the first six months of 2019 the 2020 data is similar. The tissue viability team, who had been deployed to support community services during the COVID surge are now back within the team. This has resulted in an increase in patient oversight and may account for an increase in reported incidents during the month of June. However the team have worked on, and are delivering a new training package and strategy to address any gaps in knowledge and practice. The tissue viability team are working with the pressure ulcer champions who have volunteered to monitor, investigate themes and promote best practice.
	There has been an increase in pressure ulcers specifically in the community but also in the acute areas, however when compared to the first six months of 2019 the 2020 data is similar. The tissue viability team, who had been deployed to support community services during the COVID surge are now back within the team. This has resulted in an increase in patient oversight and may account for an increase in reported incidents during the month of June. However the team have worked on, and are delivering a new training package and strategy to address any gaps in knowledge and practice. The tissue viability team are working with the pressure ulcer champions who have volunteered to monitor, investigate themes and promote best practice.

Board Report KPIs	Narratives
Nutrition 	Following three months of plateauing of compliance with completion of the Nutrition risk assessments, during the pandemic surge, there has been some improvement in compliance in June 2020. The overall compliance rate was 94.7%, with adult inpatient areas achieving 95.1%. This has been achieved with continued focus and promotion from the Senior Matrons and Ward Managers, ensuring that risk assessments are completed by daily checking of the patient safety dashboard on eCare. There is also ongoing review and audit of the quality of these assessments to gain assurance that the plan of care is in place and being implemented.
New Complaints 	During the month of June 3 formal complaints were received. There has been a reduction in the number of formal complaints over the past 3 months. The reasons for this reduction is likely to be multifactorial. We continue to focus on our patient experience and ensure learning is captured and monitored though all patient and service user feedback.
Closed Complaints 	13 complaints resolved compared to an average of 18 resolved per month, due to focussing the complex cases which are outstanding.

Board Report KPIs	Narratives
Overdue Responses 	All complaints were responded to within the agreed timescale and we no overdue responses for the month of June.
Average daily calls answered by the helpline 	Consistent Avg. volume answered for June. A change in operating hours from 8am-8pm to 10am-6pm due to some clinical staff going back to their normal job roles as we move into BAU following from the peak of Covid.
Community Non Consultant Led 18week Max Wait 	Services covered: Adult SLT, Heart Failure, Neurology Service, Parkinson's Nursing, Wheelchairs, Paed OT, Paed Physio and Paed SLT. In June all services met the 95% target for seen patients but 3 services have patients waiting over 18weeks at the end of June: Heart Failure, Wheelchairs and Paed SLT. The maximum wait for each of these services are 23.9weeks, 27.7weeks and 23.7 weeks respectively. Paed SLT and wheelchairs were both exceeding the wait times prior to COVID, these 2 services have papers and support from the CCG both in understanding demand and increasing resources. Heart Failure patients were in the shielding category so unavailable for assessment for April and May. The number of referrals waiting over 14weeks is in single figures for all services apart from Wheelchairs and Paed SLT, currently 37 and 45 referrals respectively. (Wheelchair data has been included in 18 week Non Cons led services from Sept 19, which resulted in an increase in patients waiting over 14 weeks from that date)

Board Report KPIs	Narratives
	Overall the community services are meeting the 95% threshold for non consultant led services 18 week.
	Overall the contacts for community services have decreased over the COVID months of April, May and June but the services have started using other means of contact rather than face to face and increasing the levels of telephone, video and email. The INTs activity (both Nursing and Therapy) are still primarily face to face.
	Overall the contacts for community services have decreased over the COVID months of April, May and June but the services have started using other means of contact rather than face to face and increasing the levels of telephone, video and email. The INTs activity (both Nursing and Therapy) are still primarily face to face.

Board Report KPIs	Narratives
	Overall the referrals for community services dropped over the COVID months of April and May but these are now increasing as the system starts to stabilise.
	The Integrated Neighbourhood Teams (INTs - Nursing and Therapy) have 3 main response targets, 4hour, 72hr and 18week. From April to May the overall number of Red referrals have increased whereas there were fewer Amber and Green referrals than usual. In June all referrals seem to be levelling out to a more usual rate. Though this is being constantly monitored to check they do not increase exponentially.
	Red response times have a threshold of 98% of referrals to be seen Amber and Green response times have a threshold of 95% of referrals to be seen The May breach of Red referral response rate is due to a small number of patients being seen over the 4hour target.

Board Report KPIs	Narratives
Acuity Measure - To Be Determined	In June an acuity and dependency dashboard were made available on eCare to support decision making regarding safe and appropriate staffing in the inpatient areas. This dashboard takes information from the data in eCare based on 15 different indicators, broken into 3 domains, acuity, dependency and operational need. Currently, this information has only been launched with the Matron Team, however, there are plans to roll this out to all inpatient areas. This data provides a live report to determine areas of greater need on a day to day basis, but overtime it will provide useful information of areas of greater acuity and dependency to guide decisions regarding long term resource need. It is envisaged that next month, this data will be available to report on a monthly basis to provide the organisation with a trend on activity and demand. Anecdotally, for the past month, there has been an increasing demand on services, with many wards needing to breach the social distancing. This increased activity has placed a greater pressure on the teams across the organisation as we have seen pre-Covid levels of activity resume across multiple specialities. Following a decrease in activity initially in June, Critical Care has also seen a rise in non-Covid activity in the later part of the month, and most notably, ED are also seeing an increased level of activity, reaching the level of the pre-Covid era.
Perfect Ward Inspection section | | Category | Score this month | Score last 12 | |---|---|---|---| | 1 | Confirmed or Suspected Cases | 100% (9) | 100% (36) | | 2 | Hand Hygiene | 100% (15) | 88% (59) | | 3 | PPE | 100% (25) | 98% (90) | | 4 | Patient Safety | 0% (0) | 0% (0) | | 5 | Signage | 100% (6) | 82% (22) | | 6 | Staff Awareness | 100% (21) | 98% (84) | *Numbers in brackets show number of questions score is calculated from.* 	During the inspection month there were 3 Covid-19 identified areas, above are the score results, the senior teams have been working with the areas that have scored in the amber region, it is to be noted that this was at the beginning of the pandemic and I would expect it to improve as we continue through this new way of working.

12. Maternity services quality and performance report

To APPROVE a report

For Approval

Presented by Susan Wilkinson

Trust Open Board – 31st July 2020

Agenda item:	12			
Presented by:	Sue Wilkinson, Executive Chief nurse			
Prepared by:	Karen Newbury – Head of Midwifery/Rebecca Gibson Compliance Manager			
Date prepared:	21st			
Subject:	Maternity quality & safety performance report			
Purpose:		For information	X	For approval

Executive summary:

This report presents a new document to enable board scrutiny of Maternity services and receive assurance of ongoing compliance against key quality and safety indicators. As a first edition it may be subject to changes in future iterations. It is proposed initially to present monthly but move to quarterly in future.

This report contains:

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

Also attached as Appendices

1. Perinatal Mortality Tool quarterly report for sign-off (requires formal minuting of receipt**)**
2. Maternity continuity of care paper for information

Maternity dashboard

There are 85 indicators of maternity safety & quality which are regularly reported and reviewed at the monthly Maternity Governance meetings. A sub-set of these which make up the Performance data-set are provided as a board level performance dashboard (see Annex A). It is proposed that these become part of the trust-wide IQPR in future months. Any performance variation requiring action or escalation of the wider data-set will be reported on an exception basis in future maternity performance reports to the board (frequency of reporting tbc but no less than quarterly).

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

Indicators	Narrative
Total Women Delivered Total Number of Babies born at WSH Midwifery Led Birthing Unit (MLBU) Births	The number of births this month is lower than anticipated, however this is variable month by month. The MLBU was our designated COVID area and has now returned to the birthing area for midwifery-led care women. Utilisation is now starting to be embedded with women and staff.
Total Caesarean Sections Total Elective Caesarean Sections Total Emergency Caesarean Sections	This is an isolated variance from previous months. Review to be undertaken and to monitor (update in the next month's report)
Inductions of Labour (ex pre labour & twins)	Although amber the number of inductions is decreasing.
Grade 2 Caesarean Section (Decision to delivery time met)	All non-compliant cases reviewed. Varying reasons for the timeframe not being met. The majority over by a few minutes. No adverse outcomes from the delay.

CNST Maternity incentive scheme

Now in its third year, the maternity incentive scheme supports the delivery of safer maternity care through a '10 steps to safety' framework underpinned by an incentive element to the trust's contributions to the CNST (clinical negligence scheme for trusts). https://resolution.nhs.uk/wp-content/uploads/2019/12/Maternity-Incentive-Scheme-Year-three.pdf

The trust had reported 100% compliance with Year two of this scheme (based on 2018/19 data) prior to the CQC visit in 2019 however concerns were raised into the reliability of this position given the findings of the CQC inspection report and it was agreed that the evidencing required a more robust oversight.

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

As a consequence of this, the trust was required to repay an amount of its previous claimed funds and there is an ongoing risk to future incentive payments.

An action plan has been developed to address the output of the Year two return. This is monitored locally and reported to Women's Health Governance monthly.

The trust is now collating data for the Year three submission and reporting progress through the Maternity highlight report (full document in Annex B). This contains the current performance against the 10 indicators. Two are graded as green (on track) and the first indicator includes a requirement for board sign-off of the quarterly Review of Perinatal deaths using the National Perinatal Mortality Tool. The Board is asked to **minute the receipt** of this document which is attached as Appendix 1.

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

Local audit / monitoring

Currently a report is submitted monthly to the CQC for the indicators highlighted within the Section 29A letter. Compliance has been high and any areas of non-compliance have been addressed and documented within the report. (See Annex C)

Other Maternity indicators including those incorporated elsewhere in board reporting schedule

- Maternity safe staffing reporting

This is currently under development, to be presented next month. It is envisaged that this will be incorporated into the trust-wide staffing report in future months.

- Maternity serious incidents

These are normally reported in the closed board 'serious incidents, complaints, claims and inquests' report on a monthly basis. This includes details of the incident, duty of candour status and whether it is reportable to the HSIB or for local investigation. There were no SIs reported in Maternity in June 2020.

- HSIB

The trust participates in HSIB reviews of care according to the national definitions. There are currently eight WSFT HSIB Maternity investigations. Three final and two draft reports have been received by the trust and the remaining three are within the initial investigation stages. Six of these met the criteria of a serious incident reportable to STEIS. There is currently a working draft of the action plan for the first of these reports (which was received earlier in 2020).

- Participation in national clinical audits

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

- User Group Participation

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

- Maternity and Neonatal Safety Champion relaunch

The new guideline is awaiting ratification. Executive Safety Champion monthly walkabouts are due to commence on the 30th July and the safety champion e-mail address is in place to enable all staff in maternity and neonates to escalate safety issues. Bi-monthly meetings have now commenced.

- Learning from incidents / learning from deaths

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

Maternal deaths and Intrauterine / Perinatal deaths are one of the 'areas of special focus' in the trust's learning from deaths group and in August are due to present their next quarterly summary report.

Trust priorities	**Deliver for today**		**Invest in quality, staff and clinical leadership**		**Build a joined-up future**		
	X		X		X		
Trust ambitions	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
		X	X	X			

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

Recommendation:

The Board to discuss content and format of this report and agree future format and content

The Board to note this report and minute receipt of Perinatal Mortality Tool report

Annex A – Maternity dashboard

	Green	Amber	Red	Apr-20	May-20	Jun-20
Total Women Delivered	>208 or <216	>216 or <208	> 224 or <2 00	178	180	187
Total Number of Babies born at WSH	>208 or <216	>216 or <208	> 224 or <2 00	179	182	190
Twins		No target		1	2	3
Homebirths	2.5%	2% or less	Less than 1%	5 2.8%	7 3.9%	5 2.7%
Midwifery Led Birthing Unit (MLBU) Births	≥20%	19- 15%	14% or less	3 1.7%	12 6.7%	26 13.9%
Labour Suite Births	77.5%	69% - 74%	68% or less	170 95.5%	161 89.5%	154 82.4%
BBAs		No target		4 2.3%	5 2.8%	4 2.2%
Non operative vaginal deliveries	>59%	58% -59%	<58%	144 80.9%	144 80%	131 70.1%
Normal Vaginal deliveries				127	125	118
Vaginal Breech deliveries				1	1	0
Waterbirths		No target		3 1.7%	12 6.7%	17 9.1%
Total Caesarean Sections	<26.%		> 22.6%	34 19.1%	36 20%	56 29.9%
Total Elective Caesarean Sections	11%	>11% -13%	13% or more	14 7.9%	14 7.8%	23 12.3%
Total Emergency Caesarean Sections	14.3%	14.4%-14.9%	15% or more	20 11.2%	22 12.2%	33 17.6%
Second stage caesarean sections				3	5	5
Forceps Deliveries				8 4.5%	6 3.3%	10 5.3%
Ventouse Deliveries				9 5.1%	13 7.2%	3 1.6%
Total Instrumental deliveries	12% - 14%	>14% - 15%	> 15%	9.6%	10.6%	7.0%
Failed Instrumental Delivery				1	0	0
Unsuccessful Trial of Instrumental Delivery				1	2	1
Use of sequential instruments				no data	no data	No data
Inductions of Labour (ex pre labour & twins)	<31%	>31% -32.9%	>33%	39.9%	35%	32.6%
Inductions of labour <37 weeks (% of total inductions)				2.5%	1.30%	6.8%
Grade 1 Caesarean Section (Decision to Delivery Time met)	100%	96 - 99%	95% or less	100%	100%	100%
Grade 2 Caesarean Section (Decision to delivery time met)	80%	76 - 79%	75% or less	57%	81%	67%
Total number of women eligible for Vaginal Birth after Caesarean Section (VBAC)	TBC	TBC	TBC	4	11	17
Number of women presenting in labour for VBAC against number achieved.	TBC	TBC	TBC	2	5	9

List of all 85 Indicators on current WSFT maternity dashboard

Total Women Delivered	Babies assessed as needing BCG vaccine	Post partum Hysterectomies
Total Number of Babies born at WSH	Babies who receive BCG vaccine following assessment	Women requiring a blood transfusion of 4 units or more
Twins	UNICEF Baby Friendly Audits	Critical Care Obstetric Admissions
Homebirths	Breast feeding on discharge from midwife	Eclampsia
Midwifery Led Birthing Unit (MLBU) Births	Number of Women identified as smoking at booking	Shoulders Dystocia
Labour Suite Births	Number of Women identified as smoking at delivery	3rd and 4th degree tears (All vaginal deliveries)
BBAs	Percentage of women smoking at delivery	3rd and 4th degree tears (SVD)
Forceps Deliveries	Percentage of women who gave up smoking	3rd and 4th degree tears (instrumental deliveries)
Ventouse Deliveries	Epidural pain relief	Total women delivered who breastfed babies within first 48 hours
Total Instrumental deliveries	Families from BME communities (Black, Black British, Asian, Asian British	Weekly hours of dedicated consultant cover on Labour Suite
Failed Instrumental Delivery	Women < 18 years	Midwife/birth ratio
Unsuccessful Trial of Instrumental Delivery	Women > 40 years	Consultant Anaesthetists sessions on Labour Suite
Use of sequential instruments	Women referred to postnatal physiotherapy	Anaesthetist response to request for epidural for pain relief within 30 mins
Number of Bookings (1st visit)	Non operative vaginal deliveries	Serious incidents
Women booked before 12+6 weeks	Normal Vaginal deliveries	Never events
Maternal death	Vaginal Breech deliveries	Complaints
Female Genital Mutilation (FGM)	Waterbirths	Proportion of parents receiving a Safer Sleeping Suffolk advice.
Number of babies admitted to Neonatal Unit (>36+6)	Total Caesarean Sections	Preterm births
Number of babies with Apgars of <7 at 5 mins at term (37 weeks or more)	Total Elective Caesarean Sections	Gestational diabetes diagnosed
Number of Babies transferred for therapeutic cooling	Total Emergency Caesarean Sections	Type 1 diabetes
Cases of Meconium aspiration	Second stage caesarean sections	Woman obese at booking appt
Cases of hypoxia	Inductions of Labour (ex pre labour & twins)	Delivery occurred in planned place of birth
Reported Clinical incidents	Inductions of labour <37 weeks (% of total inductions)	Families from Roma and traveller communities
Stillbirth	Grade 1 Caesarean Section (Decision to Delivery Time met)	Families from Eastern Europe communities
Cases of Encephalopathy (grades 2 and 3)	Grade 2 Caesarean Section (Decision to delivery time met)	Mental health issues
1 to 1 Care in Labour	Total number of women eligible for Vaginal Birth after Caesarean Section (VBAC)	Women referred to perinatal mental health teams
Supernumerary Coordinator	Number of women presenting in labour for VBAC against number achieved.	Families referred for pregnancy bereavement counselling?
Unit closures	Postpartum Haemorrhage 1500 mls or more	
Completion of WHO Checklist	Postpartum Haemorrhage 2,500mls+	

Annex B – Maternity Safety Highlight Report (June 2020)

Maternity Safety Highlight Report

Trust: West Suffolk NHS Foundation Trust	Date: 20/07/2020

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

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

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

Number of	
Serious Incidents this month	On-going SI's
0	7
DATIX	Outstanding DATIX
51	10
Out of date guidelines	
3	

Key	
Complete	The Trust has completed the activity with the specified timeframe – No support is required
On Track	The Trust is currently on track to deliver within specified timeframe – No support is required
At Risk	The Trust is currently at risk of not being deliver within specified timeframe – Some support is required
Will not be met	The Trust will currently not deliver within specified timeframe – Support is required

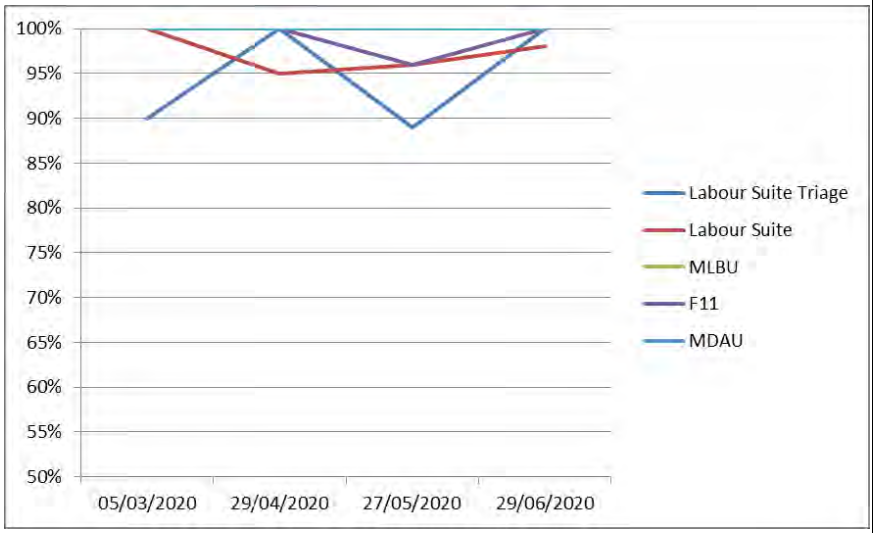
1

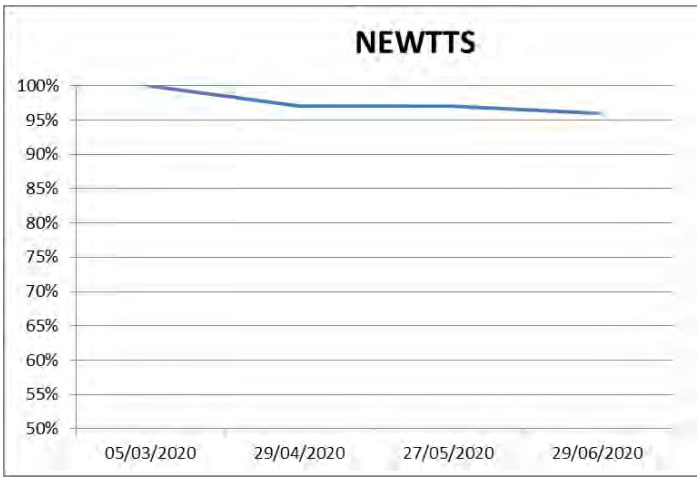
ANNEX C – CQC Section 29A monthly compliance monitoring

Observation recording and MEOWS Scoring (Issues 1 and 2)

1. Due to the length of stay in Labour Suite Triage most women only have one set of observations completed. Following this they are either discharged home or admitted to Labour Suite or F11 (these areas are audited separately)

Observation recording and MEOWS scoring with two areas achieving 100% compliance this month. The exception relates to labour suite where 7 out of 330 observations were incomplete (temperatures, urine output, respiratory rate and 1 score not calculated). This equated to 98% compliance.





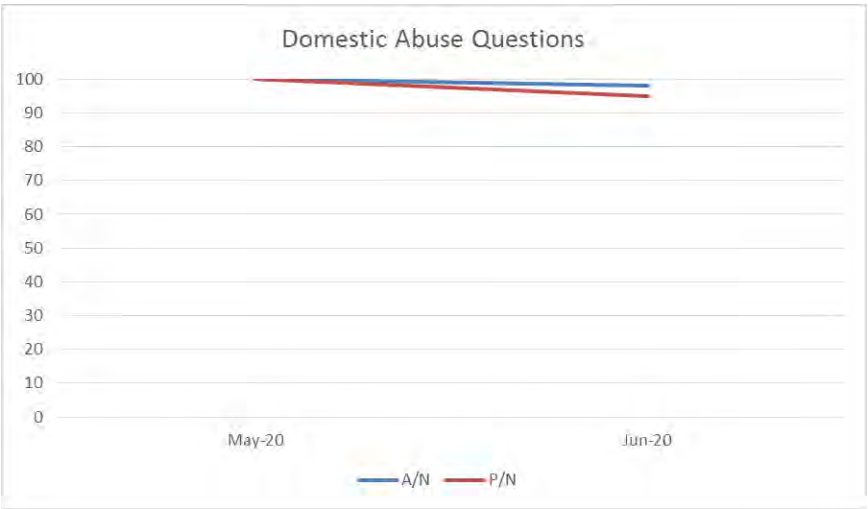
Using a tool to track and score new born babies observations (Issue 3)

Completion of NEWTTS achieved 96% compliance this month, 3 incomplete observations out of 69.

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

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

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



Trust Board Meeting 31st July 2020

Agenda item:	Review of Perinatal deaths using the National Perinatal Mortality Tool			
Presented by:				
Prepared by:	Jane Lovedale Clinical Risk Manager Women and Children's Services			
Date prepared:	July 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 report outlines the details of the perinatal deaths occurring within the Trust and the reviews and actions of these from April 1st 2020 –June 30th 2020 and includes completed investigations and actions of perinatal deaths from the previous report December 20th –March 31st 2020.

This report is submitted after review and approval by the Maternity Safety Champions, WHG and Divisional Governance. It will also be submitted to the Learning for Deaths meeting for information as well.

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:	Quarter 4 submitted to the Trust board. April 24th 2020.
Risk and assurance:	There are no financial or healthcare risks associated with this report which outlines the Trust's position against National reporting frameworks for the review of perinatal losses. The details contained within this may contain sensitive information regarding aspects of care with regard to perinatal losses within the Trust which may cause concern for the Trust and individuals involved in that care. **Assurance is given that these details have been shared with individual mothers and families as part of our duty of candour and with staff as part of individual and team learning.**

Legislation, regulatory, equality, diversity and dignity implications	The information contained within this report has been obtained from the use of regulated National and local reporting platforms. There are no equality and diversity issues related to this report and confidentiality has been maintained by removing patient identifiable information from the report

Recommendation:

The Trust board is asked to receive this report to advise of the details of the findings from all the perinatal deaths and subsequent reviews of these with subsequent recommendations and action plans.

Background

All perinatal losses from 22 +0 weeks of pregnancy and live born babies who subsequently die from 20 weeks of pregnancy to 4 weeks after birth (Neonatal deaths) are reported and recorded within the Trust and to the national Mothers Babies Reducing Risk Audit and Confidential Enquiries (MBRRACE).
There should be a local review of the clinical, social and psychological care given to the mother and the family throughout the pregnancy, labour, birth and postnatal/neonatal period to ascertain if an appropriate standard of care, treatment and management has been given so that lessons can be learned and any findings shared with mother, family and staff.

The perinatal Mortality Review Tool (PMRT) should be used for each case as required.

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.
- Scope for parental input.
- 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.

Completed investigations reported in quarter 4 (2019/20) report.

1.WSH-IR- 54987 December 26th 2019 Intrauterine death at 24 weeks 4 days gestation severe fetal growth restriction from 21 weeks poor prognosis for this pregnancy.

Situation: Patient attended ultrasound scan at 24+3 weeks, no fetal heart beat seen diagnosis intrauterine death at 24+3 days.

Background: Gravida 3 Para 0 history. Smoker – referral to smkoing cessation services. CO monitoring and discussion around smoking undertaken at each appointment. Lupus anticoagulant positive, thrombocytopaenia commenced aspirin from 20 weeks and LMW heparin. folic acid deficiency. Fetal anomaly scan at 20+3 weeks showed all biometry below 3rd centile referred to fetal medicine unit. Potential for developing pre eclampsia risk of severe growth restriction low risk of survival. Further USS at FMU severe growth restriction abnormal uterine dopplers, given option to terminate pregnancy, would like to continue. Seen weekly by midwife for blood pressure monitoring. USS at 24+3.Intrauterine death. Labour Induced progressed vaginal birth of stillborn baby weighing 310gms, birth centile 0.

Assessment:

Root cause Intrauterine growth resriction associated with obstetric antiphospholipid syndrome.

Grading of care of the mother and baby up to the point that the baby was confirmed as having died:

The review group identified care issues which they considered would have made no difference to the outcome for the baby

Grading of care of the mother following confirmation of the death of her baby:

The review group identified care issues which they considered would have made no difference to the outcome for the mother

Recommendations: Post natal follow up with a Consultant obstetrician Advice for success in future pregnancies including stopping smoking and reducing passive smoke. Aspirin pre conception until 36 weeks gestation, low molecular weight heparin from positive pregnancy test to term.

Learning points

- Clarification around thrombophilia on the risk assessment venous thromboembolism.
  Action completed
  Review of the Pregnancy self referral form for women that it contains enough data to flag up issues to ensure women receive a consultant appointment at the time of their early dating scan. **Action completed**

  Investigation Completed 06.02.2020

2. WSH-IR- 56475 15th February 2020 fetal death at 31 weeks gestation. Concealed placental abruption

Situation: Patient 31 weeks pregnant admitted to the Labour Suite (LS) at 0500 hrs with severe abdominal pain, history of no fetal movements, possible concealed placental abruption. On admission tense abdomen suggestive of concealed placental abruption. Immediate ultrasound USS showed fetal bradycardia <60bpm - decision for grade 1 CS. Fetal heart in theatre rechacked with USS no fetal heart, decision to step down CS and transfer back to labour Suite. Patient returned to LS. Labour induced, stillbirth of baby girl 450 mls retroplacental clot following delivery confirming placental abruption. Weight 1520g, birth centile 38.7 (normal weight range for gestation)

Background Second baby. Consultant led care due to risks of smoking in pregnancy and preterm birth. Referral to smoking cessation services, CO monitoring during pregnancy as guidelines, serial scans for growth and cervical length.

Assessment:

Root cause placental abruption, associated risks smoking in pregnancy

Grading of care of the mother and baby up to the point that the baby was confirmed as having died:
The review group identified care issues which they considered would have made no difference to the outcome for the baby
Grading of care of the mother following confirmation of the death of her baby:
The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby

Recommendation:
Postnatal follow up with consultant obstetrician advice around smoking in pregnancy
Support given to maternity and theatre staff following incident.
Learning
Cervical length scanning not in line with national publication Saving Babies due to the current system in the Antenatal clinc, although this did not contribute on the incident. Review the system for booking cervical length scans for previous preterm births
Ensure that all women who have had a preterm birth has an appointment with a consultant before 12 weeks gestation in line with Saving Babies Lives.

Investigation completed 15 May 2020

3. WSH-IR 56761 25th February 2020 Intrauterine death at 36+4 weeks gestation.

Situation: Referred for USS for presentation and growth Attended for ultrasound scan no fetal heart movements seen confirmed intrauterine death.
Background:
Primigravida, given up smoking however CO monitored at each appointment <4ppm (non smoker)
Booked for midwife led care. Routine appointment at 36 weeks gestation, midwife noted patient had not been seen since 28 weeks. Referred patient for USS as unsure of fetal presentation and suspected possible reduced fetal growth. Mother otherwise well and fetal movements noted to be good. Ultrasound scan no fetal heart movements seen confirmed intrauterine death.
Process commenced for induction of labour patient discharged home as trust guidelines to return to labour suite for continuation of induction in 24 hours.
Returned before expected time in early labour, however progressed quickly to vaginal breech birth of stillborn baby weight 1920g Birth centile 1st.
Assessment:
Root cause:The community team did not have a robust system in place which they monitored to ensure women attended routine appointments and therefore did not identify and refer a baby who was growth restricted at an earlier gestation .
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:

The review group identified care issues which they considered may have made a difference to the outcome for the baby.

Grading of care of the mother following confirmation of the death of her baby:
The review group identified care issues which they considered would have made no difference to the outcome for the mother.**Care delivery problems**

Recommendation:
Immediate actions : Community Team lead to conduct a review of scheduled appointments for women on the team's database, In two cases it was identified that women had not been given an appointment at the required gestation. This was immediately rectified, and no harm arose in relation to those cases. **Action completed**

All other community teams leads notified to check their data bases. **Action completed**

Implement one style of database recording, easier and more effective for midwives to ensure women on their caseload do not miss appointments. This must be adopted by all teams and midwives have responsibility to check their own caseload each week.

Support for those community staff involved.

Investigate the possibility of building a further failsafe system into the e-Care system, midwives can be alerted if a woman has missed her window for an antenatal appointment at the recommended gestations, or has not got an appointment scheduled.

Investigation completed May 21st 2020

Summary of Perinatal deaths for Quarter 4

a) **3 cases reported to MBRRACE and suitable for PMRT in reporting period – PMRT started within 4 months of the loss of the baby – standard 95% (WSH compliance 100%)**

b) **MDT review and draft report within 4 months – standard 50% (WSH compliance 100%)**

c) **Parent(s) informed of review and asked for their perspective and any concerns. The service uses a specific feedback form for bereaved parents, deveopled by MBRRACE in conjunction with parents.. – standard 95% (WSH compliance 100%).**

Investigations of deaths for Quarter 1 (2020/21)

1. WSH-IR- 38400 30th April 2020 early neonatal death at 40+1 weeks gestation HSIB investigation.

Situation: Delivery by grade 2 caesarean section very technically difficult birth, body delivered problems delivering baby's head. Baby born in very poor condition, extensive rescusitation required, transferred to the Neonatal Unit.

Background: Second baby, previous CS. Referred to fetal medicine unit for Ultrasound - low placenta ?morbidly adherent found to be not accreta. Placental site reassessed at 34 weeks not anterior not low lying. Booked for vaginal birth, Induction with Dilapan followed by artificaial rupture of membranes after 24 hours. No progress made in labour proceeded for CS grade 2. Dense adhesions, bladder high and adherent to uterine wall, request for consultant to attend, fetal head low in pelvis unable to deliver, second consultant called in from home. Decision to deliver breech and forceps to head, from body to head 6 minutes by in poor condition extensive resucitation .

Assessment: severe hypoxia Following discussion with the neonatalogist at Addenbrookes and in agreement with the parents, blood gas features and neurological activity not compatible with life, decision made to withdraw care.

Recommendations

Immediate actions

- Debrief for staff involved
- Review of case day 1 multidisciplinary team and executive lead.
- Immediate actions support for parents and staff involved.
- Arrange formal debrief with clinical psychologist. For staff involved.
- Duty of candour and notifcation letter with information about HSIB.
- This case meets the criteria for Health Safety Investigation Branch (HSIB)
- Coroner informed of this case and HSIB notified.

Further review of the records following postmortem highlighting sepsis as cause of death

- MDT meeting planned
- Clinical actions: Email to medical and maternity staff regarding prophylactic antibiotics for women undergoing vaginal birth after CS.
- Printed CTG stickers incorrect wording noted.

Ongoing investigation

Summary of Perinatal deaths for Quarter 1

a) 1 case reported to MBRRACE and suitable for PMRT in reporting period – PMRT started within 4 months of the loss of the baby – standard 95% (WSH compliance 100%)

b)MDT review and draft report within 4 months – standard 50% (HSIB investigation)
Achieving the standards for babies investigated by HSIB may be impacted by timeframes beyond the Trust's control. The number of reviews affected, and which component of the standards the number of reviews affected ,and which components of the standard they affect, should be noted in the return to NHS Resolution.

c) Parent(s) informed of review and asked for their perspective and any concerns. The service uses a specific feedback form for bereaved parents, deveopled by MBRRACE in conjunction with parents.. – standard 95% (WSH compliance 100%).

	Action Required	Lead for action	Due to be completed	Date completed	Evidence	Shared Information
WSH-IR-54987	Clarification around thrombophilia on the risk assessment venous thromboembolism.	K Croissant Consultant obstetrician	30/04/2020	01/05/2020	Amendment made to the Risk assessment form.	Information of updated RA and Informative article on thrombophilia included in Risky Buisness -January 2020 edition.
	Review of the Pregnancy self referral form for women that it contains enough data to flag up issues to ensure women receive a consultant appointment at the time of their early dating scan.	Antenatal clinic lead Cathy Adkins	31/03/2020	22/06/2020	Question added to online referral form enquiring whether a woman is under the care of any other hospital department, in order to highlight those women that may need particularly urgent obsetric review	Referral form available on the hospital commuter system.
	Action Required	**Lead for action**	**Due to be completed**	**Date completed**	**Evidence**	**Shared Information**
WSH-IR-56475	Change to the system for booking cervical length scans for previous preterm births	Antenatal clinic lead	31/07/2020	22/06/2020	ANC midwives and Consultants informed that if a consultant requests cervical length scans for a woman then the request form needs to be given	Process for compliance of this system included on the audit programme in relation to Reducing preterm births.

1

					to scan reception rather than ANC reception, this will ensure that the appoinment for the anomaly scan is also amended to incorporate cervical length as well.	
	Ensure that all women who have had a preterm birth has an appointment with a consultant before 12 weeks gestations.	Antenatal clinic lead			Audit compliance September 2020 Included in the local audit plan.	Staff in the ANC aware of this requirement when in receipt of the booking rererral.
	Action Required	**Lead for action**	**Due to be completed**	**Date completed**	**Evidence**	**Shared Information**
WSH IR-56761	**Immediate action** community team leads conduct a thorough review of current scheduled appointments	Outpatient services manager	31/05/2020	31/05/2020	two cases identified that women had not been given an appointment at the required gestation. This was immediately	Email to all team leads from the Outpatient service manager.

2

	for women on the team's database.				rectified, and no harm arose in relation to those cases.	
	Implement one style of database recording, which makes it easier and more effective for midwives to ensure that women on their caseload do not miss appointments. This must be adopted by all teams and checked regularly.	Outpatient services manager	31/05/2020	31/05/2020	All team bases are following the same safe process and are taking responsibility for ensuring that	Community Midwives informed that they must follow the successful method used by castle Hill team for storing records enabling easy monthly checking of their own caseload which they must take full responsibility for.
	Investigate the possibility of building a further failsafe system into the e-care system, whereby midwives can be alerted if a woman has missed her window for an antenatal appointment at the recommended gestations, or has	Outpatient service manager	March 2021	March 2021	Delay in the roll out of maternity eCare. Further discussion with the ECare project lead nearer to Go live date.	Failsafe element incorporated into the Ecare system.

	not got an appointment scheduled.					
WSH IR-56400	Debrief for staff involved	Consultant obstetrician involved	1/05/2020	01/05/2020	Hot debrief at the time of the incident	All multidisciplinary team included
	Review of case multidisciplinary team and executive lead.		01/05/2020	01/05/2020	Executive lead Review of case	Actions identified
	Immediate actions support for parents and staff and staff involved.					Bereavement support for family from bereavement midwife. Cared for in bereavement suite. All staff have had the opportunity to talk with managers or colleagues
	Arrange formal debrief with clinical psychologist	Risk manager Maternity	05/05 2020	05/05 2020		Meeting held 05/05/2020 well attended
	Meets criteria for Health Safety	Risk manager Maternity				Informed via HSIB portal by maternity risk team.

4

	Investigation Branch (HSIB)					
	Coroner informed of this case.					Informed via paediatric team
	Following result of PM reporting cause of death sepsis MDT meeting to review records.	Maternity risk office / consultant obstetrician	07/07/2020	July 2020	Clinical review report of meeting	Planned for July
	Prophylactic antibiotics not received afetr 18 hrs of ARM	Consultant obstetrician	07/07/2020	07/07/2020		Email to medical and maternity staff regarding compliance with prophylactic antibiotics for women undergoing vaginal birth after CS.
	Incorrect printed CTG stickers in circulation which do not mach the fresh eyes stickers in the reocrds.	LS ward manager	06/07/2020			Printers informed new stickers arriving 5/7 days.

This page has been left blank intentionally

Executive Directors – June 2020

Agenda item:				
Presented by:	Darin Geary – Interim Associate Director of Operations, Women & Children and Clinical Support Services			
Prepared by:	Sarah Spall – Better Births Project Lead Matt Larkin – Finance and Performance Manager			
Date prepared:	29th June 2020			
Subject:	**Continuity of Carer**			
Purpose:		For information	✓	For approval

Executive Summary

The aim of this paper is to provide the Executive Directors with information about the implementation of Continuity of Carer and outline the approach West Suffolk NHS Foundation Trust (WSFT) may take to paying midwives working in a Continuity of Carer model for providing intrapartum care in an on-call model.

Implementation of Continuity of Carer is a national policy driven by the National Maternity Review – Better Births (2016) and the NHS Long Term Plan (2016). The evidence base around Continuity of Carer is that it improves health outcomes and saves babies lives because it is expected there will be a reduction in the need for interventions such as instrumental delivery and reduction in admissions to the Neonatal Unit.

Continuity of Carer is part of the NHS Commissioning intentions 2019/2020 and is one of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme 10 safety actions, which if not achieved could potentially have financial implications (missing the opportunity to save £420k). The benchmark is that 51% of women will have received continuity of care by March 2021. Due to Covid-19 there has been a national pause on the transformation programme, but there is still the expectation that trusts will endeavour to meet this target. Providing the programme can be launched on 1st September 2020 we are likely to be at 40% by March 2021 and 51% by next summer.

Continuity of Carer is delivered by midwives working in teams of no more than 8 (headcount) who provide all elements of a woman's care. They work autonomously, organising their own rotas and time ensuring that one of them is available at all times for intrapartum care. In this model a WTE midwife works 37.5 hours but some of that work is carried by working in an on-call fashion.

We are planning to go out to consultation with staff in early July with a view to the first teams rolling out in September 2020. In total we are planning on rolling out 5 community continuity teams plus expanding the scope of the elective caesarean section team in order to meet the national target of providing continuity of care to 51% of women. This can be achieved within the current workforce.

Note - the new on-call payment system will be phased to start on 22nd November 2020.

Trust priorities	Deliver for today		Invest in quality, staff and clinical leadership		Build a joined-up future		
	✓		✓		✓		
Trust ambitions	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	✓	✓	✓				✓
Previously considered by:							
Risk and assurance:							
Legislation, regulatory, equality, diversity and dignity implications:							
Recommendation:	To approve the recommendations outlined in the case						

Continuity of Carer

Background

Current Government maternity policy in England (Better Births, 2016) recommended that Continuity of Carer should become the central model of maternity care over the next five years. Midwifery Continuity of Carer is a model of maternity care that:

- Enables a pregnant woman to build a relationship with a midwife (and a small team of midwives) through her maternity journey;
- Provides a pregnant woman with a primary or named midwife who will give the majority (70%) of her antenatal, intrapartum and postnatal care;
- Enables midwives to build relationships with the women in their care;
- Enables midwives to provide safe and personalised care.

The national target states that by March 2021 most women (at least 51%) should have received continuity of care during their pregnancy, birth and postnatally. It is the aspiration of the Local Maternity System (LMS) that we will offer continuity to all women in due course (subject to additional financial investment) where it is clinically appropriate to do so as part of the National Maternity Transformation Programme Better Births (2016) and the NHS Long Term Plan (2019).

Drivers for Change/Benefits

Implementing Continuity of Carer is a national 'must do' as part of the wider NHSE National Maternity Transformation programme. There is a current, strong, high quality evidence for the positive impact that Continuity of Carer has on a range of health outcomes for women and saves babies lives. The evidence is derived from the large number of randomised controlled trials (15) with more than 17,000 women gathered together in a Cochrane Review (Sandall et al 2016).

This review found the following outcomes for women who received the intervention of midwife-led continuity models, compared to standard care:

More Likely

- To know the midwife that cares for them in labour
- Feel satisfied with their experience of maternity care
- To have a normal birth

Less Likely

- To experience a fetal loss
- To have a premature birth
- To have an instrumental birth
- To have an epidural, amniotomy or episiotomy

Continuity of carer is expected to increase satisfaction amongst women and save money in the long term. This is because it is expected that there will be an increase in normal births on the Midwifery Led Birthing Unit due to the greater emphasis on personalised care, the opportunity for women to develop a

trusting relationship with their midwife throughout their antenatal care and being better prepared for their birth. Consequently, it is expected that there will be a reduction in the need for interventions such as instrumental delivery, and reduction in admissions to Neonatal Unit.

Continuity of Carer – funding on-call payments

As Continuity of Carer is part of the national maternity transformation programme, all trusts senior leaders are currently working their way through all the issues associated with the challenges that this new model presents in terms of the pay system. Consequently, there is no national blueprint of the best way to achieve this. Most trusts are using an on-call system to provide the necessary cover to achieve the standard. Some trusts have local arrangements in place for on-call payments and others are using the terms and conditions from Annex 29 of the Agenda for Change terms and conditions.

Under Annex 29, staff receive a pay enhancement at a flat rate, typically 4.5%, as compensation for being on standby for on-call duties as well as an inflated hourly rate of pay for being called out (between 1.5 and 2 times basic pay depending on whether it is a bank holiday).

The Trust's locally agreed on-call pay arrangement pays standby payments for each on-call shift that is rostered in addition to an inflated hourly rate of pay for being called out (1.5, 1.6 or 2 times basic pay for Monday to Saturday, Sundays and bank holidays respectively).

Following discussion with senior colleagues in Finance and HR the preferred model for WSFT is the current locally agreed on-call system. This is because it is in line with the way other services in the trust are re-numerated for on-call working. This is also considered fairer in that staff will be paid for the additional hours they actually work.

The benchmarking that has been undertaken has established that most trusts are opting to provide continuity of care with the assistance of on call shifts and most are paying for the on-call shifts at the Annex 29 rates of pay. Locally, Cambridge University Hospitals NHS Trust are looking to implement continuity of carer with a locally agreed on-call with their first team starting in July 2020. Whereas, East Suffolk & North Essex NHS Foundation Trust (ESNEFT) are looking to use the Annex 29 framework with a flat rate standby payment of 4.5%.

The WSFT locally agreed on-call pay system has the potential to be 3% more expensive, but the expense can be offset by encouraging staff to take any additional hours worked as Time Off In lieu (TOIL).

Proposed New Working Patterns – What will change

Working in a continuity model will differ from the historical community midwife practice of working a 7.5 hour working day, with 5 on calls per 4-week rota per whole time equivalent post. Continuity midwives will only be part of escalation if deemed necessary by the Manager On-Call in times of high acuity.

For midwives who will join a continuity team, the teams will themselves work out shift and rota patterns. There will be flexibility around this pattern of working, which will be made via agreement from all team members and approved by the Team Leader.

The suggested model will be for each community midwife's hours to consist of:

Flexible community shifts – a 7.5 hour working day
Birth day – to be available to care for women in labour for a 12.5-hour period either in the home or hospital (08.00 – 16:00, on call 16:00 to 20:30)
Birth night – to be available as above overnight (on call 20.00 – 08.30)
Time Off in Lieu (TOIL) will be encouraged to ensure that staff do not work above their contracted hours.

What this means for pay

The pay under the continuity of carer model has the potential to increase for community midwives because of the introduction of birth on-calls on the community rota. The on-call availability pay is paid for 365 days per year and is shared equally amongst team members. However, the on-call callout pay is likely to vary depending on the average birth duration, the proportion of the birth duration that is at night and the number of deliveries per midwife per annum. The pay calculation is based on a 7-hour birth duration that is split equally between shifts, with each whole-time equivalent midwife performing 50 deliveries per year. It is anticipated that, on average, midwives will be called out for 4 hours per week. However, midwives will be encouraged to take Time Off in Lieu (TOIL) to address their work life balance. This reduces the amount of on-call call out pay compared to the maximum estimated call out pay in the table below. It needs to be noted TOIL hours have to be taken back at basic rate of pay.

The new model changes the weekend care offered per team to two four-hour weekend shifts plus the weekend birth day shifts. As a result, the level of enhanced pay received in the continuity of carer model is lower than the current level of enhanced pay.

The following table shows the estimated maximum increase in pay under the continuity of carer model for a Band 6 community midwife:

	Current	**Continuity of Carer**
	***Average* Pay (£)**	**Estimated *Maximum* Pay (£)**
Basic Pay	£35,718	£35,718
Enhanced Pay	£2,284	£1,642
On-call Availability Pay	£594	£1,815
Estimated on-call Callout Pay	£940	£6,699
	£39,535	**£45,874**

The current average pay for a full time Band 6 hospital midwife, working both nights and days, is £42,541. So, a move from the hospital midwifery team to the continuity of carer team is unlikely to adversely impact take home pay.

Financial Implications for the Trust

The maximum estimated cost pressure to achieve a 51% continuity of care level is £255k. However, if many of the midwives take TOIL then the real cost pressure will be much lower than this. The cost pressure calculation, including the Trust's on costs, is shown below:

5	Teams
6	WTE Midwives
30	Total WTE converting to CoC
£8,525	Potential cost pressure per WTE midwife
£255,750	**Total potential pay related cost pressure from 51% CoC**

If half of the eligible midwives choose to take TOIL the cost pressure, for 51% continuity of carer, falls to approximately £135k. No further cost pressures are anticipated as it is assumed that sufficient pool cars have been funded and no other non-pay cost pressures are anticipated.

The maximum total potential pay cost equates to a 4% increase in the agreed 2020/2021 budget for community and hospital midwifery. However, based on the 50% uptake of TOIL, this would equate to a 2% increase in funding required.

Recommendations

1. Accept the principles of the Trust's locally agreed on-call system for financing on-call payments relative to continuity of carer.

2. Take into consideration the decisions made by neighbouring trusts in respect of staff payment with regards to continuity of carer.

3. Allow the 45-day consultation with staff to begin on 9th July 2020 so that the implementation of continuity of carer can start on 1st September 2020 with the introduction of the new payment system on 22nd November 2020.

13. Finance and workforce report

To ACCEPT the report

For Report

Presented by Nick Macdonald

Board of Directors – 31 July 2020

Agenda item:	13			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	24th July 2020			
Subject:	Finance and Workforce Board Report – June 2020			
Purpose:		For information	x	For approval

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

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

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

In particular we are focussing on recurring staffing costs through establishment control and ensuring recurring 2020-21 CIPs are embedded before the end of the financial year.

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

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

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

Recommendation:
The Board is asked to review this report.

FINANCE AND WORKFORCE REPORT
June 2020 (Month 3)

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

Financial Summary

I&E Position YTD	£0m	break-even
Variance against Plan YTD	£0m	on-plan
Movement in month against plan	£0m	on-plan
EBITDA position YTD	£10.2m	adverse
EBITDA margin YTD	16%	adverse
Total PSF Received	£10.2m	accrued
Cash at bank	£26.1m	

Executive Summary

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

Key Risks in 2020-21

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

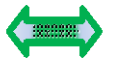
SUMMARY INCOME AND EXPENDITURE ACCOUNT - June 2020	June 2020			Year to date			Year end forecast		
	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)
	£m	£m	£m	£m	£m	£m	£m	£m	£m
NHS Contract Income	19.1	18.1	(1.1)	55.3	54.1	(1.2)	227.2	227.6	0.5
Other Income	2.8	3.0	0.1	8.8	9.0	0.2	36.3	37.1	0.8
Total Income	**22.0**	**21.0**	**(1.0)**	**64.1**	**63.2**	**(1.0)**	**263.4**	**264.8**	**1.3**
Pay Costs	15.5	15.6	(0.0)	48.6	48.1	0.5	201.8	206.1	(4.3)
Non-pay Costs	8.4	7.9	0.4	21.3	22.4	(1.1)	91.3	88.3	3.0
Operating Expenditure	**23.9**	**23.5**	**0.4**	**69.9**	**70.5**	**(0.6)**	**293.1**	**294.4**	**(1.3)**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA excl STF	**(1.9)**	**(2.5)**	**(0.6)**	**(5.8)**	**(7.3)**	**(1.6)**	**(29.7)**	**(29.7)**	**0.0**
Depreciation	0.7	0.6	0.1	2.0	1.8	0.2	8.1	8.1	0.0
Finance costs	0.3	0.3	0.0	1.0	1.0	(0.0)	3.9	4.0	(0.1)
SURPLUS/(DEFICIT)	**(2.9)**	**(3.4)**	**(0.4)**	**(8.8)**	**(10.2)**	**(1.4)**	**(41.7)**	**(41.7)**	**(0.1)**
Provider Sustainability Funding (PSF)									
PSF / FRF/ MRET/ Top Up	2.9	3.4	0.4	8.8	10.2	1.4	41.7	41.7	0.1
SURPLUS/(DEFICIT) incl PSF	**(0.0)**	**(0.0)**	**(0.0)**	**0.0**	**(0.0)**	**(0.0)**	**(0.0)**	**(0.0)**	**0.0**

FINANCE AND WORKFORCE REPORT – June 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 – June 2020

Income and Expenditure Summary as at June 2020

The reported I&E for June is break even, in line with NHSI guidance. Due to COVID-19 we are receiving a top up payment that includes MRET and FRF and ensures we break even. The value of this for June was £3.4m (£10.2m YTD).

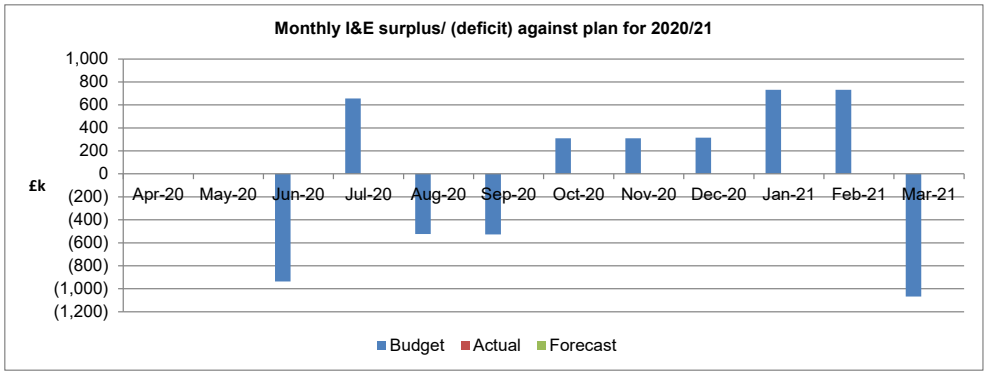
We anticipate this arrangement continuing until at least October 2020.This funding is forecast to increase our income by £10m more than our plan, but we also anticipate expenditure of £10m more than plan. The result is that we forecast to break even, in line with our Financial Improvement Trajectory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

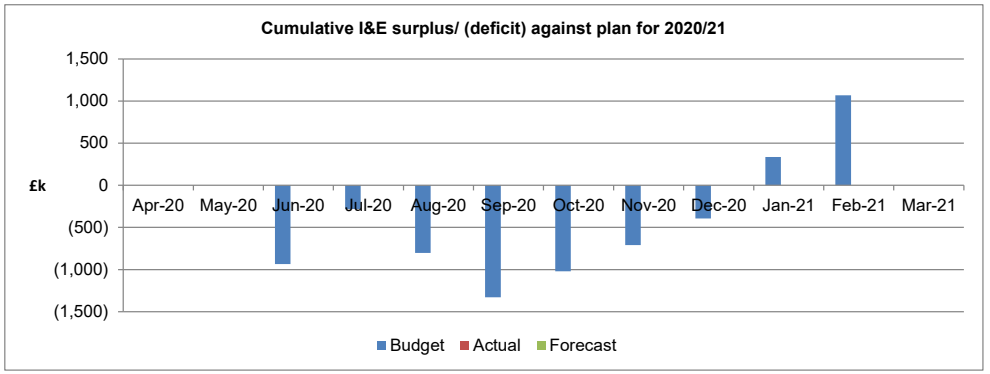
However, the extent to which the overspend on expenditure is recurring will impact on our run rate for 2021-22, (for instance underachieved CIP). We continue to analyse our recurring expenditure in order identify and to take action to improve any pressures that would otherwise arise in 2021-22.

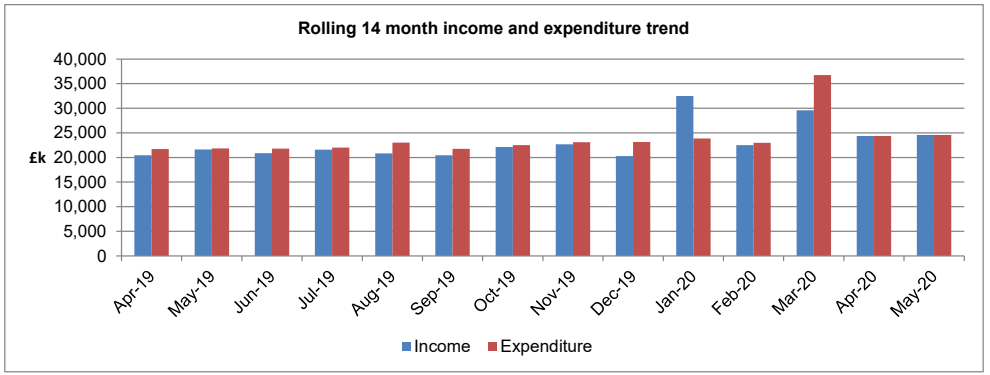
In particular we are focussing on recurring staffing costs through establishment control and ensuring recurring 2020-21 CIPs are embedded before the end of the financial year.

Summary of I&E indicators

Income and Expenditure	Plan/ Target £000'	Actual/ Forecast £000'	Variance to plan (adv)/ fav £000'	Direction of travel (variance)	RAG (report on red)
In month surplus/ (deficit)	(0)	(2)	(2)	⟺	Amber
YTD surplus/ (deficit)	0	(1)	(1)	⟺	Amber
Forecast surplus/ (deficit)	(0)	(0)	0	⟺	Green
EBITDA (excl top-up) YTD	(2,924)	(3,357)	(433)	↓	Amber
EBITDA %	(13.3%)	(16.0%)	(2.7%)	↓	Red
Clinical Income YTD	(115,865)	(113,204)	(2,661)	↑	Red
Non-Clinical Income YTD	(14,609)	(16,512)	1,903	↑	Green
Pay YTD	48,609	48,074	535	↑	Green
Non-Pay YTD	24,298	25,268	(970)	↓	Amber
CIP Target YTD	2,247	1,148	(1,099)	↓	Red





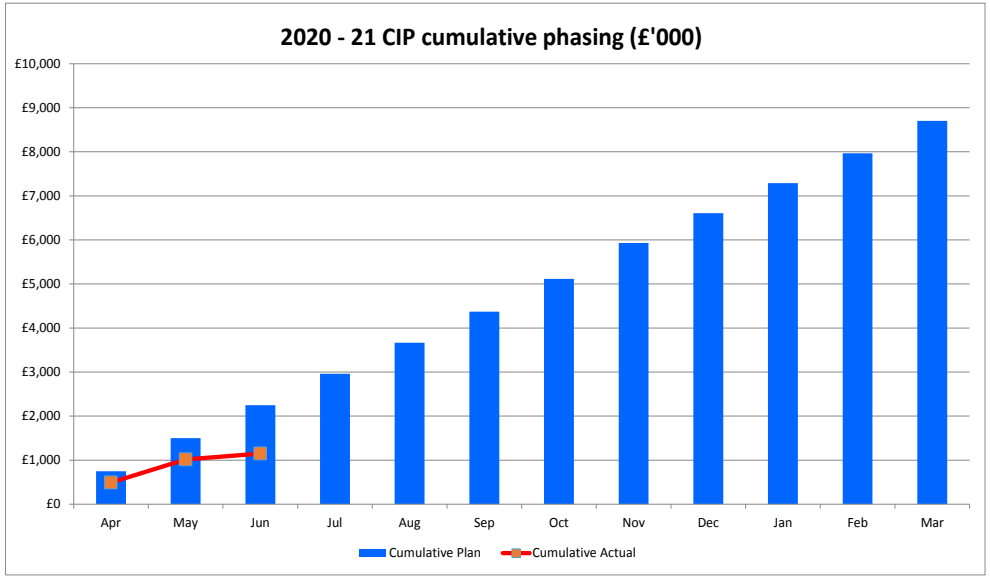


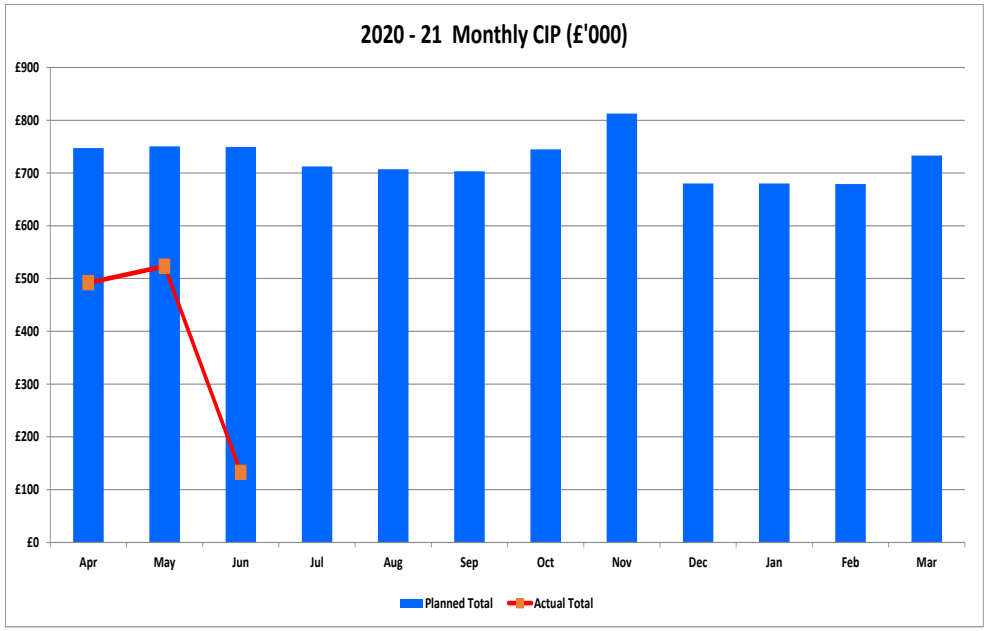
Cost Improvement Programme (CIP) 2020-21

In order to deliver the Trust's control target in 2020-21 we needed to deliver a CIP of £8.7m (3.4%). The plan for the year to June was £2.247m (25.8% of the annual plan) and we achieved £1.148m (13.2%). This represents a shortfall of £1,099k.

Recurring/Non Recurring	2020-21 Annual Plan	Plan YTD	Actual YTD
	£'000	£'000	£'000
Recurring			
Outpatients	254	41	14
Procurement	492	123	126
Activity growth	200	50	50
Additional sessions	363	91	-
Community Equipment Service	510	128	106
Drugs	367	92	64
Estates and Facilities	114	36	22
Other	924	201	210
Other Income	493	123	8
Pay controls	260	65	56
Service Review	16	8	8
Staffing Review	819	178	154
Theatre Efficiency	302	76	-
Contract Review	50	13	-
Workforce	-	-	-
Consultant staffing	-	-	-
Agency	-	-	-
Unidentified CIP	1,079	263	-
Recurring Total	**6,242**	**1,487**	**819**
Non-Recurring			
Pay controls	647	212	198
Other	1,805	545	131
Estates and Facilities	6	3	-
Non-Recurring Total	**2,458**	**760**	**329**
Total CIP	**8,700**	**2,247**	**1,148**

Division	Divisional Target £'000	YTD Var £'000	Unidentified plan £ YTD	Unidentified plan £ year
Medicine	2,555	(589)	64	255
Surgery	2,029	(205)	51	203
W&C/CSS	1,847	(41)	0	0
Community	1,422	(108)	31	125
E&F	516	(106)	62	276
Corporates	331	(52)	55	221
Stretch	0	0	0	0
Total	**8,700**	**(1,099)**	**263**	**1,079**

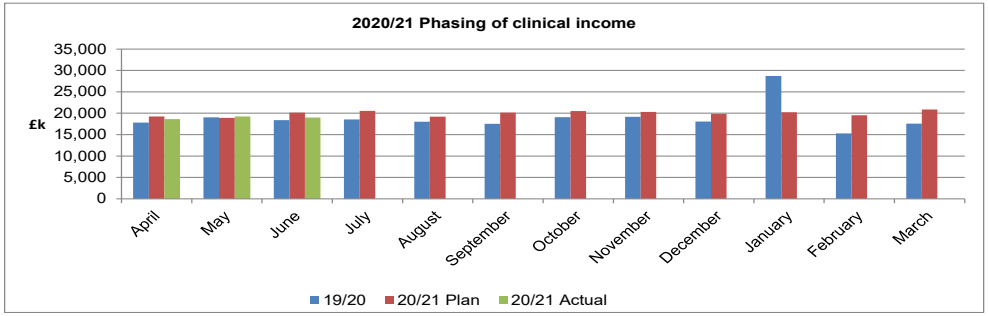




FINANCE AND WORKFORCE REPORT – June 2020

Income Analysis

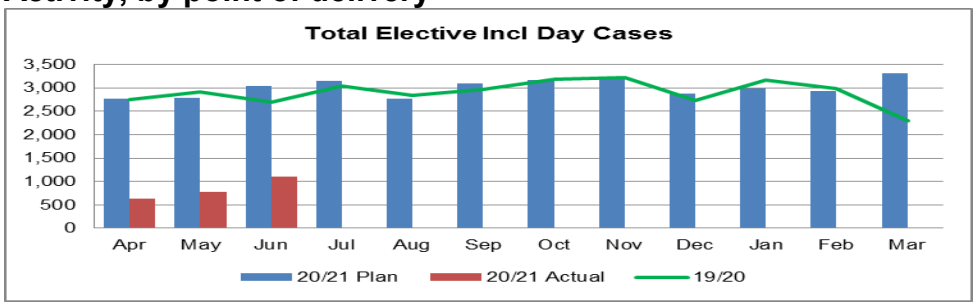
The chart below demonstrates the phasing of all clinical income plan for 2020-21, including Community Services. This phasing is in line with phasing of activity.

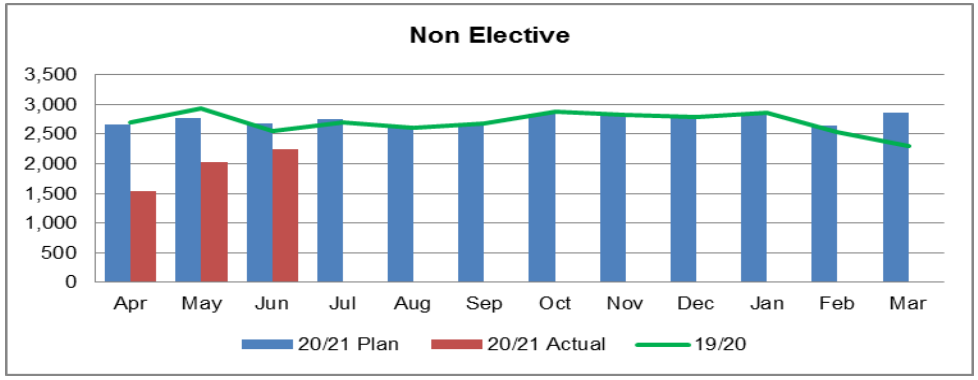


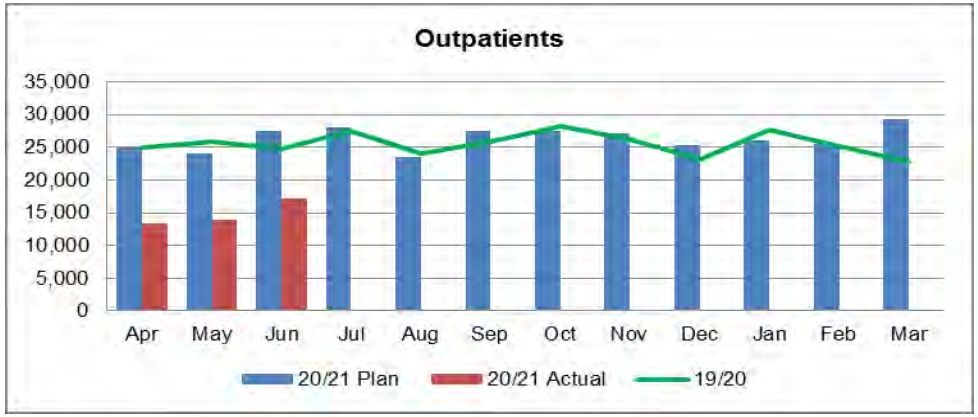
The income position was behind plan for June. The income was based on the national agreed block payments as set out by NHS England, these were put in place to give Providers assured income during the coronavirus period.

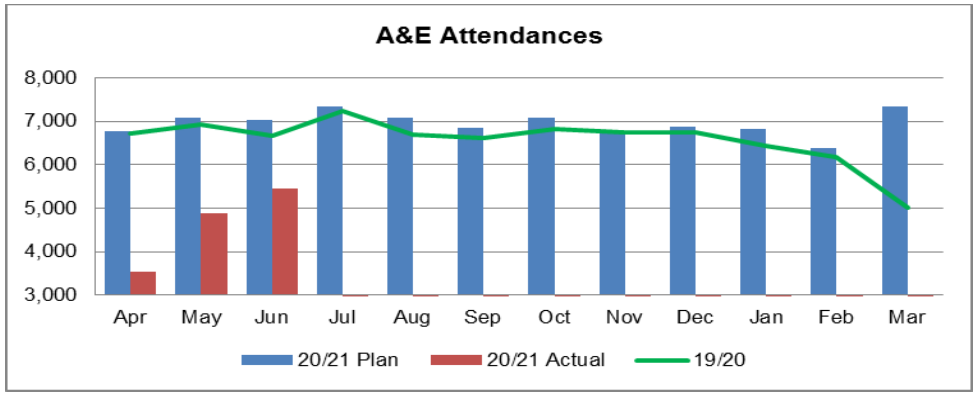
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	1,028	852	(177)	3,058	2,182	(876)
Other Services	3,337	6,508	3,171	8,989	21,766	12,776
CQUIN	182	127	(55)	532	357	(175)
Elective	2,976	702	(2,274)	8,341	1,622	(6,719)
Non Elective	6,374	6,376	2	19,392	18,532	(860)
Emergency Threshold Adjustment	(335)	(335)	0	(1,021)	(1,021)	0
Outpatients	3,342	1,583	(1,758)	9,312	3,974	(5,338)
Community	2,988	2,988	0	8,964	8,964	0
Total	**19,893**	**18,802**	**(1,091)**	**57,567**	**56,376**	**(1,191)**

Activity, by point of delivery



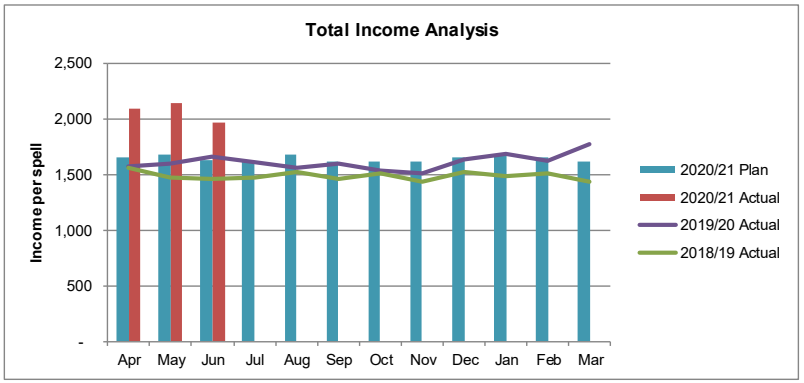


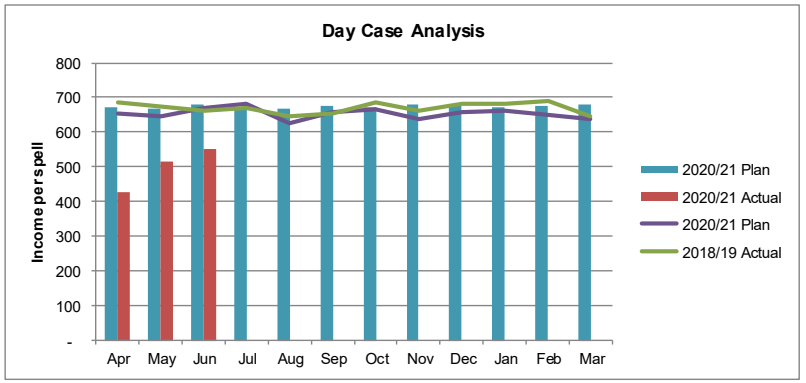


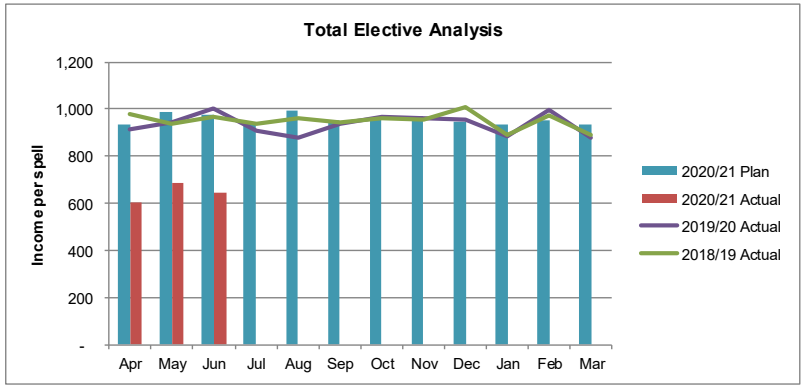


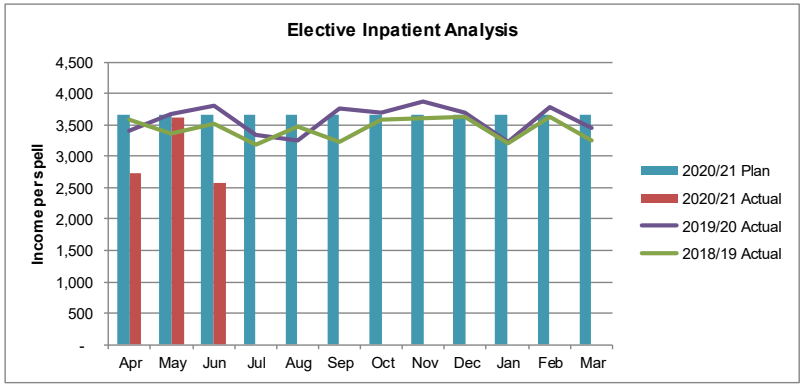
FINANCE AND WORKFORCE REPORT – June 2020

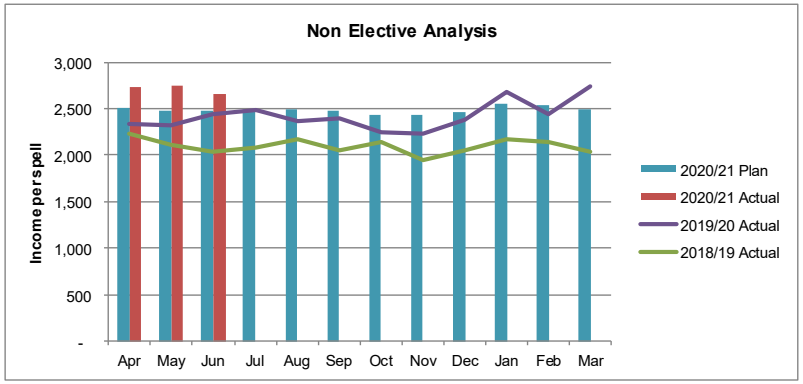
Trends and Analysis

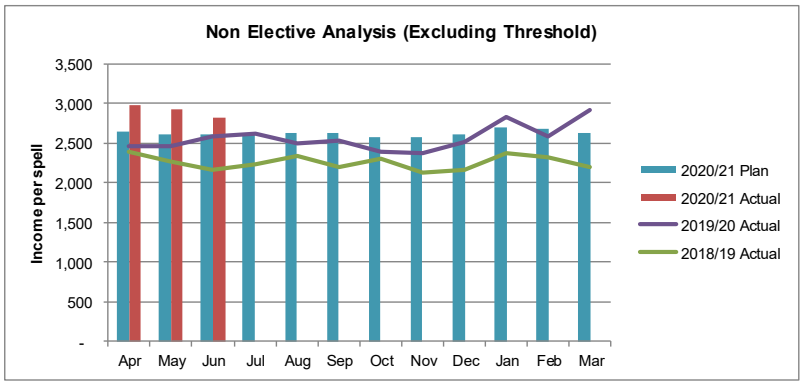












FINANCE AND WORKFORCE REPORT – June 2020

Workforce

Monthly Expenditure (£)				
As at June 2020	Jun-20	May-20	Jun-19	YTD
	£000's	£000's	£000's	£000's
Budgeted Costs in-month	15,541	17,555	13,436	48,609
Substantive Staff	13,762	15,187	12,678	42,653
Medical Agency Staff	130	237	163	519
Medical Locum Staff	320	262	245	871
Additional Medical Sessions	359	378	200	1,001
Nursing Agency Staff	91	69	191	330
Nursing Bank Staff	464	406	324	1,294
Other Agency Staff	41	52	95	154
Other Bank Staff	201	189	138	589
Overtime	132	200	176	445
On Call	87	65	76	218
Total Temporary Expenditure	1,824	1,858	1,607	5,421
Total Expenditure on Pay	15,587	17,046	14,285	48,074
Variance (F/(A))	(46)	509	(849)	535
Temp. Staff Costs as % of Total Pay	11.7%	10.9%	11.2%	11.3%
memo: Total Agency Spend in-month	262	358	448	1,002

Monthly WTE				
As at June 2020	Jun-20	May-20	Jun-19	YTD
	£000's	£000's	£000's	£000's
Budgeted WTE in-month	4,026.9	4,048.1	3,852.3	12,042.0
Substantive Staff	3,811.0	3,751.2	3,433.6	11,275.3
Medical Agency Staff	16.3	18.7	11.8	57.0
Medical Locum Staff	27.7	18.4	18.3	72.5
Additional Medical Sessions	2.7	6.5	9.2	8.8
Nursing Agency Staff	11.7	9.9	27.6	46.0
Nursing Bank Staff	137.6	115.4	93.2	382.3
Other Agency Staff	8.5	10.0	12.3	32.2
Other Bank Staff	77.7	73.2	60.2	230.1
Overtime	36.4	51.4	49.6	117.8
On Call	8.4	5.1	6.9	19.1
Total Temporary WTE	327.0	308.7	289.1	965.7
Total WTE	4,137.9	4,059.9	3,722.7	12,241.0
Variance (F/(A))	(111.0)	(11.8)	129.6	(199.0)
Temp. Staff WTE as % of Total WTE	7.9%	7.6%	7.8%	7.9%
memo: Total Agency WTE in-month	36.5	38.6	51.7	135.2

Page 7

Staffing Numbers (WTE)

The table below reports the increase in our staffing numbers since April 2019 (8.6%), although doesn't take into account changes in activity, capacity or the impact of COVID-19. In June we employed 11.1% more people than in June 2019, being 372 WTE substantive staff (409 WTE including temporary staff).

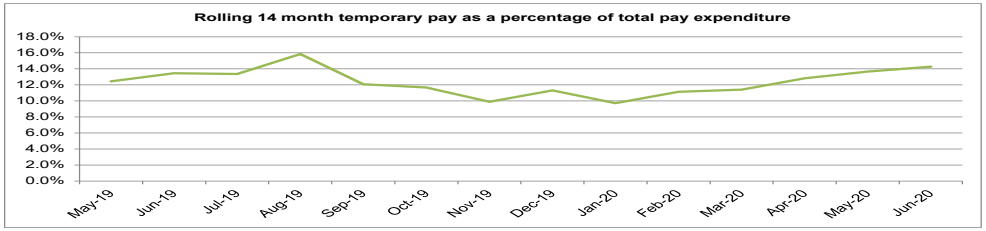
WTES (June 2020)	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals
Staff Group	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Substantive															
Consultant	198.9	199.1	197.2	194.3	196.4	201.3	203.0	203.0	205.3	210.8	209.6	209.5	210.9	214.1	211.8
Dr Higher Non Training	20.1	20.0	20.0	19.8	19.6	20.8	20.1	23.2	23.6	25.3	24.3	29.2	29.2	27.9	27.4
Dr Higher Training	121.6	117.7	119.8	120.1	136.5	131.4	132.7	133.6	128.4	123.9	124.8	126.1	126.7	130.2	124.5
Dr Junior Training	85.9	88.0	88.2	87.2	102.2	96.5	101.3	100.6	100.6	104.1	103.2	104.0	104.0	126.3	126.4
Nursing Registered	984.8	982.2	990.0	1003.0	1010.6	1024.7	1040.2	1066.0	1067.8	1082.0	1085.2	1104.4	1109.8	1132.3	1148.0
Nursing Unregistered	485.1	489.5	498.0	504.2	505.0	512.5	514.3	515.0	526.8	533.5	529.1	531.8	535.1	517.6	539.0
Support Staff	260.5	260.5	261.9	256.3	256.5	265.8	272.2	267.6	265.7	274.8	273.5	267.8	266.8	264.9	260.1
AHP	398.2	399.1	399.8	403.9	407.7	416.2	412.3	417.6	421.7	418.1	425.6	431.9	425.6	426.5	444.9
Sci & Professional	114.9	116.4	118.7	121.4	127.5	126.2	124.2	122.8	124.3	124.7	124.8	124.3	120.8	118.5	122.5
Prof & Tech	39.3	38.0	40.8	40.9	41.0	39.9	38.8	41.8	42.2	42.7	43.7	42.9	44.1	46.8	47.8
A&C	702.7	642.8	645.9	648.0	657.6	663.2	667.9	671.4	665.2	665.2	676.5	678.2	685.8	688.5	699.7
Maintenance Staff	27.3	25.6	24.9	24.9	23.9	24.6	26.3	25.3	22.6	20.9	21.6	21.8	22.6	23.9	25.5
Substantive Total	3439.3	3378.8	3405.3	3423.8	3484.6	3523.1	3553.3	3588.0	3594.2	3626.0	3641.9	3671.8	3681.1	3717.3	3777.6
Temporary															
Bank	158.6	148.6	146.4	158.6	159.5	157.4	146.8	160.9	174.5	159.2	183.6	190.1	204.5	181.8	212.0
Locum	38.6	13.1	18.3	26.9	35.4	29.3	24.8	14.2	30.3	29.7	27.8	28.5	26.4	18.4	27.7
Overtime	63.4	49.4	49.6	43.8	40.6	31.3	7.3	16.3	13.9	11.5	15.9	14.6	30.0	52.2	36.7
Add Sessions	23.3	21.1	16.2	19.6	24.6	16.7	21.6	16.7	16.3	13.6	17.3	22.1	3.5	13.3	6.1
Agency	50.0	42.8	51.7	56.0	65.7	53.1	44.0	39.6	38.7	32.3	66.9	64.9	60.1	38.6	36.5
Temporary Total	333.9	275.0	282.2	304.9	325.7	287.8	244.5	247.7	273.7	246.3	311.5	320.3	324.5	304.3	318.9
Grand Total	3773.2	3653.8	3687.5	3728.7	3810.2	3810.8	3797.8	3835.6	3867.9	3872.3	3953.4	3992.0	4005.6	4021.6	4096.5

However, we have budgeted substantive vacancies of 157.0 WTE in June. These are filled through the use of 255.0 temporary staff as detailed below. In total we are therefore 98.0 WTE over established which is causing the overspend on Pay.

WTES (June 2020)	Substantive Budget	Substantive Actuals	Substantive Vacancies	Bank	Locum	Overtime	Add Sessions	Agency	Total Temp Variance	Net Vacancies / (Over Establishment)
Staff Group	Jun-20	Jun-20	Jun-20	Jun-20	Jun-20	Jun-20	Jun-20	Jun-20	Jun-20	Jun-20
Consultant	227.9	211.8	16.2		(5.5)		1.3	(5.4)	(9.6)	6.5
Dr Higher Non Training	26.9	27.4	(0.6)					(0.3)	(0.3)	(0.9)
Dr Higher Training	138.2	124.5	13.7		(7.0)			(4.1)	(11.0)	2.6
Dr Junior Training	95.8	126.4	(30.5)		(6.6)	(0.3)		(4.0)	(11.0)	(41.5)
Nursing Registered	1191.0	1148.0	43.0	(44.0)		(19.6)	(2.6)	(11.2)	(77.5)	(34.5)
Nursing Unregistered	544.5	539.0	5.5	(84.8)					(84.8)	(79.3)
Support Staff	290.3	260.1	30.2	(30.7)				(2.0)	(32.7)	(2.5)
AHP	478.8	444.9	33.9	(4.1)		(4.1)			(8.2)	25.7
Sci & Professional	148.1	122.5	25.6	(1.0)		(0.7)			(1.7)	23.9
Prof & Tech	49.3	47.8	1.5			(1.1)		(5.1)	(6.2)	(4.7)
A&C	715.2	699.7	15.5	(7.6)		(3.9)		(0.5)	(12.0)	3.5
Maintenance Staff	28.6	25.5	3.1						0.0	3.1
Grand Total	3934.5	3777.6	157.0	(173.3)	(19.1)	(29.8)	(1.3)	(32.6)	(255.9)	(98.9)

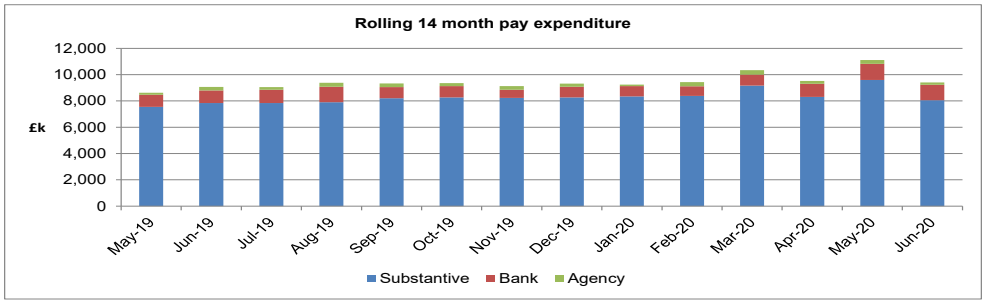
The majority of this over establishment relates to Nursing and includes COVID-19 related increases in staffing. However, we are currently reviewing all nursing establishments and processes for understanding any variances in order to ensure that nursing recruitment and rostering are robust and appropriate.

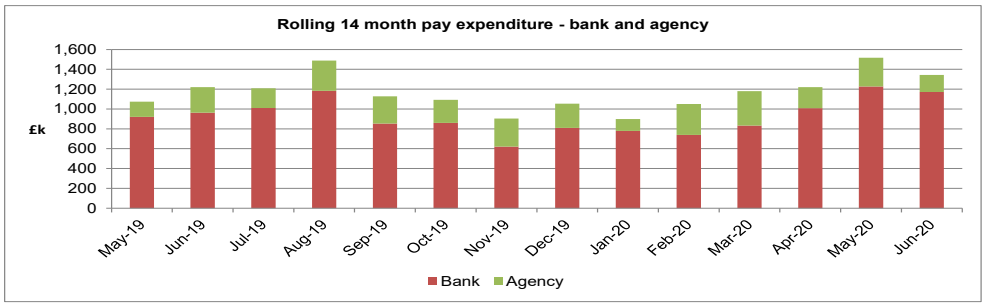
Insofar as the over establishment is driven by the use of temporary staff it should be relatively easy to revert to working within the funded establishment when the additional staffing requirements attributable to COVID-19 subside.

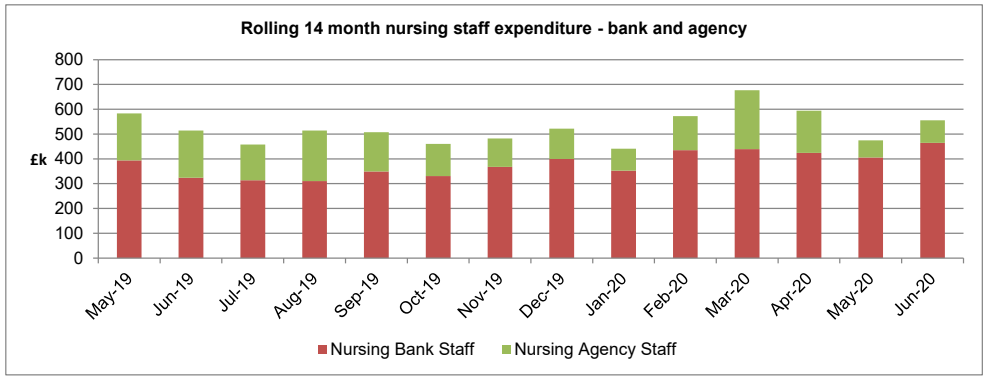


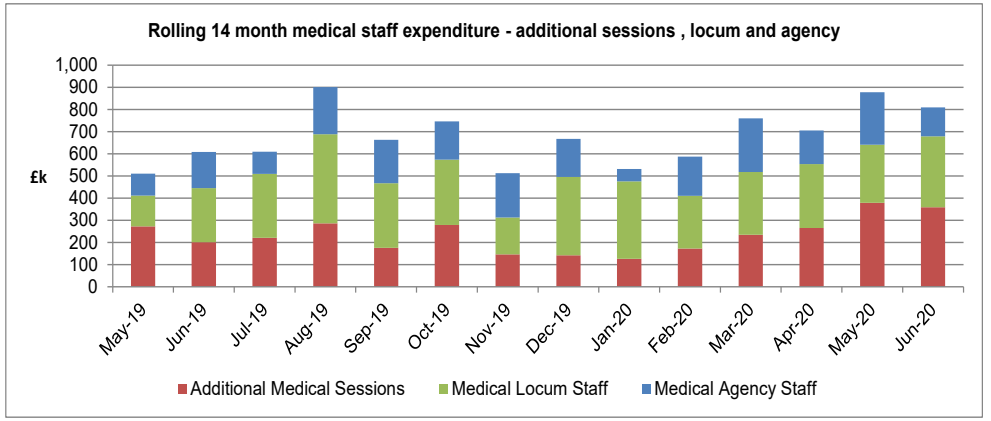
Pay Trends and Analysis

During June the Trust overspent by £46k on pay (£535k underspent YTD).

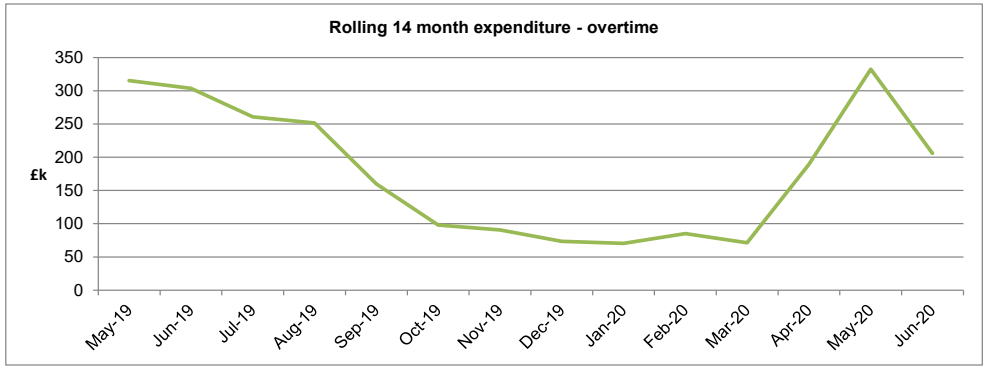








Expenditure on Additional Sessions was £359k in June (£378k in May)



FINANCE AND WORKFORCE REPORT – June 2020

Income and Expenditure Summary by Division

	Current Month			Year to date		
	Budget £k	Actual £k	Variance F/(A) £k	Budget £k	Actual £k	Variance F/(A) £k
MEDICINE						
NHS Contract Income	(7,179)	(5,271)	(1,908)	(21,278)	(14,554)	(6,725)
Other Income	(135)	(237)	102	(759)	(676)	(83)
Total Income	**(7,314)**	**(5,508)**	**(1,806)**	**(22,038)**	**(15,230)**	**(6,808)**
Pay Costs	4,223	3,713	510	12,639	11,151	1,488
Non-pay Costs	1,671	1,614	57	4,454	4,043	411
Operating Expenditure	**5,894**	**5,327**	**567**	**17,093**	**15,194**	**1,899**
SURPLUS / (DEFICIT)	**1,420**	**181**	**(1,239)**	**4,945**	**36**	**(4,909)**
SURGERY						
NHS Contract Income	(5,350)	(2,577)	(2,772)	(15,390)	(6,616)	(8,774)
Other Income	(198)	(172)	(26)	(595)	(549)	(46)
Total Income	**(5,548)**	**(2,749)**	**(2,799)**	**(15,985)**	**(7,166)**	**(8,820)**
Pay Costs	3,351	1,836	1,516	10,041	8,019	2,021
Non-pay Costs	1,105	709	396	3,169	1,839	1,330
Operating Expenditure	**4,456**	**2,545**	**1,912**	**13,210**	**9,858**	**3,352**
SURPLUS / (DEFICIT)	**1,092**	**204**	**(887)**	**2,775**	**(2,693)**	**(5,468)**
WOMENS AND CHILDRENS						
NHS Contract Income	(1,905)	(1,480)	(425)	(5,548)	(4,268)	(1,280)
Other Income	(80)	(75)	(5)	(221)	(165)	(55)
Total Income	**(1,985)**	**(1,555)**	**(430)**	**(5,769)**	**(4,433)**	**(1,336)**
Pay Costs	1,411	1,551	(140)	4,233	4,210	23
Non-pay Costs	187	171	17	528	486	43
Operating Expenditure	**1,598**	**1,722**	**(124)**	**4,761**	**4,695**	**66**
SURPLUS / (DEFICIT)	**387**	**(167)**	**(554)**	**1,007**	**(262)**	**(1,270)**
CLINICAL SUPPORT						
NHS Contract Income	(600)	(317)	(283)	(1,690)	(779)	(910)
Other Income	(270)	(298)	28	(811)	(812)	1
Total Income	**(871)**	**(615)**	**(256)**	**(2,501)**	**(1,591)**	**(910)**
Pay Costs	1,629	1,536	93	4,887	4,533	355
Non-pay Costs	1,111	1,103	7	3,320	3,159	161
Operating Expenditure	**2,740**	**2,639**	**101**	**8,207**	**7,692**	**515**
SURPLUS / (DEFICIT)	**(1,869)**	**(2,024)**	**(155)**	**(5,706)**	**(6,101)**	**(394)**
COMMUNITY SERVICES						
NHS Contract Income	(2,476)	(2,474)	(1)	(7,427)	(7,533)	106
Other Income	(1,029)	(1,082)	53	(3,086)	(3,047)	(40)
Total Income	**(3,505)**	**(3,556)**	**51**	**(10,514)**	**(10,580)**	**66**
Pay Costs	2,522	2,576	(54)	7,565	7,569	(4)
Non-pay Costs	947	791	156	2,808	3,132	(324)
Operating Expenditure	**3,469**	**3,367**	**102**	**10,373**	**10,701**	**(328)**
SURPLUS / (DEFICIT)	**36**	**189**	**153**	**141**	**(121)**	**(262)**
ESTATES AND FACILITIES						
Other Income	(420)	(492)	72	(1,261)	(1,579)	318
Total Income	**(420)**	**(492)**	**72**	**(1,261)**	**(1,579)**	**318**
Pay Costs	901	996	(95)	2,702	2,698	4
Non-pay Costs	612	534	78	1,837	1,545	292
Operating Expenditure	**1,513**	**1,530**	**(17)**	**4,539**	**4,242**	**297**
SURPLUS / (DEFICIT)	**(1,093)**	**(1,038)**	**55**	**(3,278)**	**(2,663)**	**615**
CORPORATE						
NHS Contract Income	(1,635)	(2,212)	577	(47)	(14,671)	14,624
Other Income	(3,611)	(7,667)	4,056	(14,765)	(18,045)	3,280
Total Income	**(5,246)**	**(9,879)**	**4,633**	**(14,813)**	**(32,716)**	**17,904**
Pay Costs	1,504	3,379	(1,875)	6,542	9,894	(3,352)
Non-pay Costs	2,721	3,001	(281)	5,177	8,217	(3,040)
Capital Charges and Financing Costs	993	845	148	2,978	2,802	176
Operating Expenditure	**5,218**	**6,380**	**(1,163)**	**14,697**	**18,111**	**(3,414)**
SURPLUS / (DEFICIT)	**28**	**3,498**	**3,471**	**115**	**14,605**	**14,490**
TOTAL						
NHS Contract Income	(19,144)	(14,331)	(4,813)	(51,381)	(48,421)	(2,960)
Other Income	(5,744)	(10,023)	4,279	(21,499)	(24,874)	3,375
Total Income	**(24,888)**	**(24,354)**	**(534)**	**(72,880)**	**(73,295)**	**415**
Pay Costs	15,541	15,587	(46)	48,609	48,074	535
Non-pay Costs	8,354	7,924	430	21,293	22,420	(1,127)
Capital Charges and Financing Costs	993	845	148	2,978	2,802	176
Operating Expenditure	**24,888**	**24,355**	**532**	**72,880**	**73,296**	**(416)**
SURPLUS / (DEFICIT)	**0**	**(2)**	**(2)**	**0**	**(1)**	**(1)**

Medicine (Sarah Watson)

The division reports an adverse variance of £1.2m in June (£4.9m YTD).

Clinical income is behind plan in month by £1.9m. This is driven by the reduced activity (against plan) as a result of the COVID 19 pandemic. This reduction is witnessed across all types of activity (elective, non-elective & outpatient) within Medicine. In April activity levels were recorded as being 62%, 43% & 31% behind plan for elective, non-elective & outpatient activity respectively. As of June this gap has reduced to 46%, 16% and 23% respectively, with non-elective activity seeing the most significant reduction (from 43% to 16%). It is noted that this loss of divisional income is offset within the Corporate division due to the guarantees over the block contract.

Also as a result of COVID 19, the division is underspent against budget for Pay costs (£510k) in June. During June the following wards were used by the Trust to treat either confirmed or suspected COVID patients: F12, F7, F10 & G4. The cost for these wards in the month will be reclaimed under COVID 19 funding provisions. As such, the costs for these wards have not been met by the division in month, causing the underspend. It should be noted that as long as these (or other) wards are being used for the same purpose, it is anticipated that these underspends will continue.

The division is also recording a £57k underspend on non-pay. This is the net of COVID-19 driven underspends through reduced activity (Drugs and consumable), through reclaiming costs (ward based non-pay) or through unmet CIPS.

Surgery (Simon Taylor)

The division reports an adverse variance of £887k in June (£5.5m YTD).

COVID has had a significant effect on Surgery, with the need to open extra critical care capacity and needing to stop nearly all elective work to support the COVID response.

The underachievement of income based on PbR has resulted in Surgery being £2,799k below plan in month (£8,820k YTD).

Pay was underspent by £1,516k in month (£2,021k YTD) due to less additional sessions being needed for elective work and delays in planned enhancements to certain services.

Non-pay has underspent by £396k in month (£1,330k YTD) due to less patients being in surgical bed's or being treated in theatres and clinics.

Surgery missed its CIP plan in June and has not yet identified a full plan. This is because COVID planning took precedence. Further to this due to the affect COVID is anticipated to have in theatres and clinics some of surgery's' CIP schemes will not be achievable, until normal service is possible.

Women and Children's (Darin Geary)

The division reports an adverse variance of £554k in June (£1.3m YTD)

.

COVID continues to depress activity with elective activity at 20% of the plan, non-elective at 75% of the plan and outpatient activity at 90% of the plan. The lack of inpatient activity is the key reason why income is behind plan by £430k in-month and behind plan by £1,336k YTD.

Pay reported a £140k overspend in-month and an underspend of £23k YTD. In-month the COVID related pay pressures on F1, in NNU and in Hospital Midwifery emerged. They will be transferred to the COVID cost centre in month 4. Year-to-date, the Division has been able to keep within its pay budget as many of the activity related pay spends reduced because of the lower activity levels.

Non-pay costs have been suppressed in-month and year-to-date due to reduced activity levels.

Clinical Support (Darin Geary)

The division reports an adverse variance of £155k in June (£0.4m YTD).

Income for Clinical Support reported £256k behind plan in-month because outpatient activity was at 45% of plan and radiology activity was at 31% of plan. Notably, radiology activity has increased by 10% compared to last month. The Division is behind its income plan by £910k YTD because of the impact of COVID.

Pay reported a £93k underspend in-month (£355k YTD) as many of the activity related pay spends reduced due to the lower activity levels. The Radiology Service has developed plans to increase capacity which are likely to increase pay expenditure going forward.

Non-pay reported a £7k underspend in-month (£161k YTD) as consumable usage reduced in line with activity.

Community Services (Michelle Glass)

The division reports a favourable variance of £153k in June (£262k adverse variance YTD).

Income reported a £51k over recovery in month (£66k YTD) as the Division received additional external 'other income' to recover additional costs incurred. The Division currently expect to achieve income in line with budget in 20-21. Where income is linked to a cost and volume contract, the Division will track and forecast the impact of COVID on the activity levels.

There was an in-month over spend on pay of £54k (£4k underspend, YTD). The Division continue to require agency staff to cover some vacant roles in order to ensure service resilience, support patient flow and manage demand across the services. Through the use of bank and some staff redeployment, the Division is managing the impact of vacancies at this time and is actively recruiting to vacancies.

Non-pay reported a favourable variance of £156k in June (£324k adverse, YTD). The in-month position reflects a recharge of additional costs incurred in April and May out of the Division, including the cost of equipment provided to support End of Life patients and equipment provided for additional external beds, commissioned externally to support the Trust's Covid response. The year to date position primarily reflects an over spend on Community Equipment and associated activity costs, required to support the facilitation of hospital discharge, to enable patients to remain independent at home and to support End of Life patients at home.

We have put in place a number of initiatives, such as providing clinical advisor capacity to ensure utilisation of recycled special equipment and undertake frequent core stock product reviews to ensure the most effective products are available to prescribers and relaunched the 'return, recycle, reuse' campaign. The Division set up super peripheral stores for community equipment to manage the additional cost of supporting same day and urgent equipment delivery, required to support faster discharges from the acute setting. Other one off costs were incurred to further support home and mobile working across our teams and community property costs.

Statement of Financial Position at 30 June 2020

STATEMENT OF FINANCIAL POSITION	As at 1 April 2020	Plan 31 March 2021	Plan YTD 31 May 2020	Actual at 31 May 2020	Variance YTD 31 May 2020
	£000	£000	£000	£000	£000
Intangible assets	40,972	48,993	38,116	42,503	4,387
Property, plant and equipment	110,593	147,050	116,121	115,154	(967)
Trade and other receivables	5,707	5,707	5,707	5,707	0
Total non-current assets	**157,272**	**201,750**	**159,944**	**163,364**	**3,420**
Inventories	2,872	3,000	3,000	2,781	(219)
Trade and other receivables	32,342	20,666	20,666	20,972	306
Cash and cash equivalents	2,441	1,510	18,010	26,071	8,061
Total current assets	**37,655**	**25,176**	**41,676**	**49,824**	**8,148**
Trade and other payables	(33,692)	(23,000)	(23,961)	(28,911)	(4,950)
Borrowing repayable within 1 year	(58,529)	(11,364)	(58,281)	(58,891)	(610)
Current Provisions	(67)	(67)	(67)	(67)	0
Other liabilities	(1,933)	(1,000)	(20,000)	(24,026)	(4,026)
Total current liabilities	**(94,221)**	**(35,431)**	**(102,309)**	**(111,895)**	**(9,586)**
Total assets less current liabilities	**100,706**	**191,495**	**99,311**	**101,293**	**1,982**
Borrowings	(52,538)	(59,241)	(53,676)	(53,098)	578
Provisions	(744)	(744)	(744)	(741)	3
Total non-current liabilities	**(53,282)**	**(59,985)**	**(54,420)**	**(53,839)**	**581**
Total assets employed	**47,424**	**131,510**	**44,891**	**47,454**	**2,563**
Financed by					
Public dividend capital	74,065	160,844	74,225	74,065	(160)
Revaluation reserve	6,942	6,942	6,942	6,942	0
Income and expenditure reserve	(33,583)	(36,276)	(36,276)	(33,553)	2,723
Total taxpayers' and others' equity	**47,424**	**131,510**	**44,891**	**47,454**	**2,563**

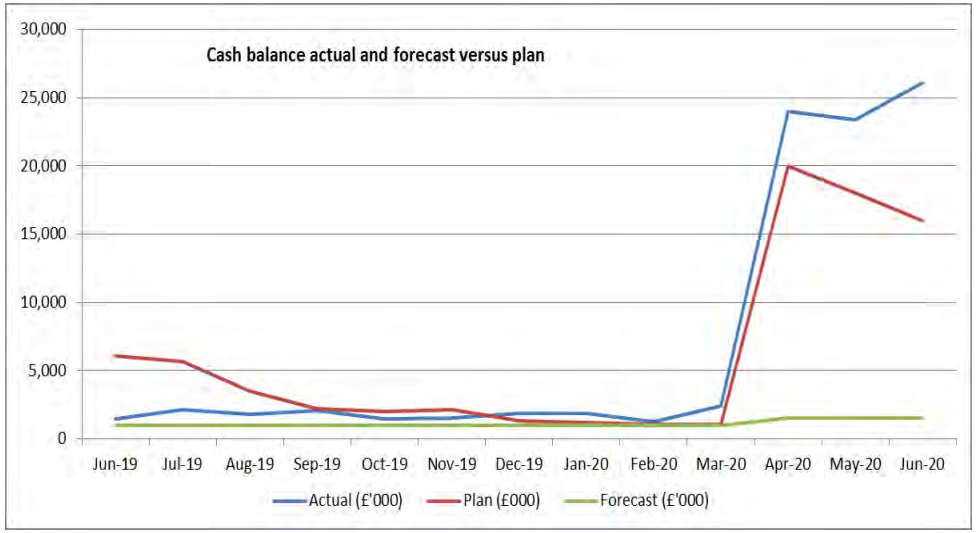
There has been little movement in the balance sheet since the year end. The most notable movements are as follows (cash movement is included separately):

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

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

Cash Balance Forecast for the year

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



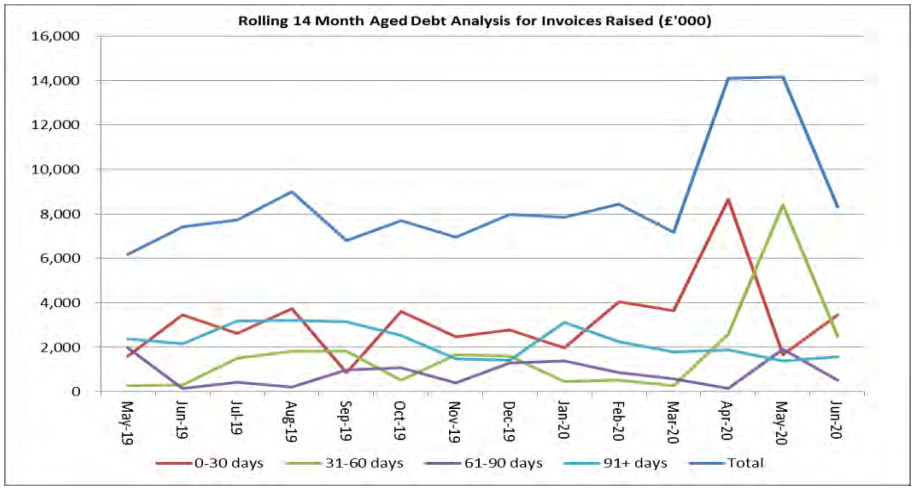
The cash balance has increased significantly and this is due to the current cash regime within the NHS. Contract payments have been paid in advance to ensure that there are adequate cash balances across the NHS and to ensure that payments to suppliers can be made quickly to keep the supply chain in full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

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

FINANCE AND WORKFORCE REPORT – June 2020

Debt Management

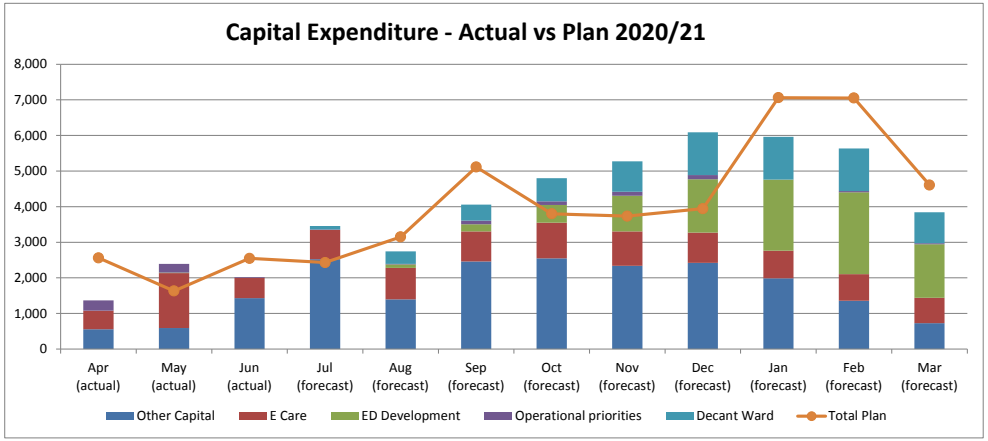
The graph below shows the level of invoiced debt based on age of debt.



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

The overall level of sales invoices raised but not paid has decreased significantly since April due to the fact that a large amount of invoices with NHS Organisations, which were raised at the year-end for over performance, have now been paid. The majority of the debts outstanding are historic debts. Over 84% of these outstanding debts relate to NHS Organisations, with 26% of these NHS debts being greater than 90 days old. We are actively trying to agree a position with the corresponding NHS Organisations for these debtor balances.

Capital Progress Report



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
	Actual	Actual	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	2020-21
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
E Care	520	1,541	568	819	884	845	1,003	968	851	773	745	716	10,233
ED Development	0	16	0	0	100	200	500	1,000	1,500	2,000	2,300	1,500	9,116
Operational priorities	289	243	24	15	15	100	100	115	115	0	35	30	1,081
Decant ward	0	0	0	100	350	450	650	850	1,200	1,200	1,200	871	6,871
Other Schemes	558	590	1,431	2,525	1,394	2,462	2,546	2,338	2,421	1,989	1,357	726	20,337
Total / Forecast	1,367	2,390	2,023	3,459	2,743	4,057	4,799	5,271	6,087	5,962	5,637	3,843	47,638
Total Plan	2,562	1,632	2,546	2,430	3,151	5,113	3,799	3,734	3,945	7,063	7,053	4,608	47,636

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

The Coronavirus pandemic has had a significant impact on the capital programme both in terms of the items on the capital programme and the timing. The ED scheme is to start later in the year and the capital programme reflects this change. The figures shown are as submitted to NHSI. The forecast is currently in line with the plan. Ecare figures have been updated to reflect the latest position following an initial review of the requirements.

10:30 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

14. Nurse staffing report

To ACCEPT the report

For Report

Presented by Susan Wilkinson

Trust Board – 31 July 2020

Agenda item:	14			
Presented by:	Susan Wilkinson, Executive Chief Nurse			
Prepared by:	Susan Wilkinson, Executive Chief Nurse, and Daniel Spooner Deputy Chief Nurse			
Date prepared:	July 2020			
Subject:	Quality and Workforce Report & Dashboard – Nursing June 202			
Purpose:	X	For information		For approval

Executive summary:

The aim of the Quality and Workforce Report and Dashboard is to enhance the understanding ward and theatre staff have on the service they deliver, identify variation in practice, investigate and correct unwarranted variation and lead change to demonstrate value. It also complies with national expectation to show staffing levels within Open Trust Board Papers both inpatient and non-inpatient areas.

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

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

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

Putting you first

Recommendation:
This paper is to provide overview of May's position about nursing staff and actions taken to mitigate, future plans and update on national requirements.
The dashboard provides summary of nursing staffing levels and effect on nurse sensitive indicators
Provides an update on implementation of NHSI Document 'Developing workforce safeguards – October 2018'

1. Introduction

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

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

Since March 2020 the NHS has had to deal with the Coronavirus outbreak. Coronavirus has become a global health emergency. Matrons and Heads of Nursing and Midwifery reviewed staffing on a daily basis to ensure; sufficient ward care capacity, to support the surge in critical care capacity, with appropriate estate, equipment, expertise and support in place to deal with the increase demands that coronavirus has created. This paper will identify the safe staffing and actions taken for the month of June 2020.

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

2. Nursing Fill Rate

The Trust's safer staffing submission has been submitted to NHS Digital for June within the data submission deadline. Table 1 below shows the summary of overall fill % for this month. The full table of fill rates can be seen in Appendix 1. Fill rates are RAG rated to identify areas of concern.

	Day		Night	
	Registered	Care Staff	Registered	Care staff
Average fill rate June 2020	92.3%	85.8%	88.1%	97.3%

Table 1

This data, generated from health roster is reviewed by Heads of Nursing and mitigations and rationale for under or over fill is provided to the executive nurse team. It should be noted that due to the challenges of Covid, including, ward closures, staff redeployment and short-term establishment increases have contributed to some variances in fill rate data. The Deputy Chief Nurse is working with the ward teams to increase the accuracy of eRostering data which will better demonstrate fill rates going forward.

A full list of mitigations and accompanying narrative is provided in Appendix 2 for areas that have fallen below 90% fill rate. Additional narrative has been provided for areas that are above 100% fill rate to ensure use of Nursing resource has been reviewed and challenged appropriately.

3. Care Hours per Patient Day (CHPPD)

CHPPD is a measure of workforce deployment and is reportable to NHS Digital as part of the monthly returns for safe staffing.

CHPPD is the total number of hours worked on the roster by both Registered Nurses & Midwives and Nursing Support Staff divided by the total number of patients on the ward at 23:59 aggregated for the month (lower CHPPD equates to lower staffing numbers available to provide clinical care).

Benchmarking CHPPD with other organisations is difficult as patient mix, establishments and ward environments all contribute the outcome. Ward by ward CHPPD can be found in appendix 1. By itself, CHPPD does not reflect the total amount of care provided on a ward nor does it directly show whether care is safe, effective or responsive. It should therefore be considered alongside measures of quality and safety (NHSI, 2020).

4. Sickness

Sickness levels for Nursing/Midwifery and support staff have been impacted in the initial months of Covid 19, both April and May saw increase in absences in both Nursing and support staff these are demonstrated in chart 2. Sickness peaked in the month of April and further reductions are seen this month (Table 2b).

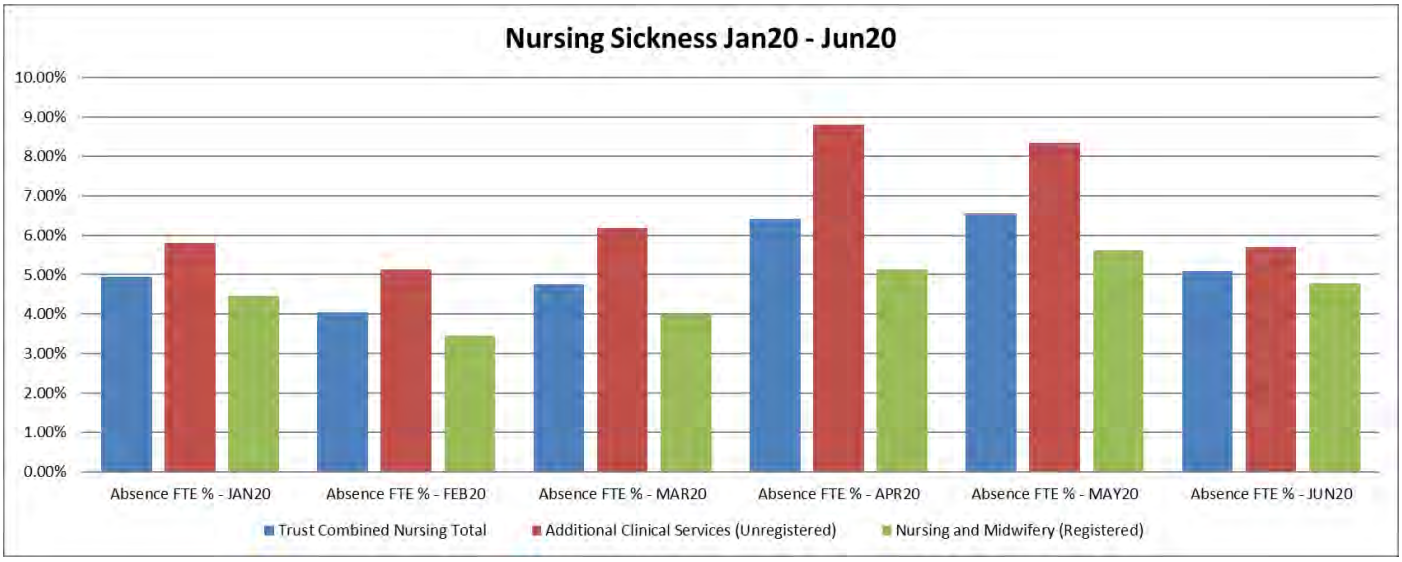


Table 2

	January	February	March	April	May	Jun
Unregistered staff (support workers)	5.81%	5.13%	6.18%	8.81%	8.34%	5.69%
Registered Nurse/Midwives	4.46%	3.45%	3.98&	5.14%	5.61%	4.78%
Combined Registered/Unregistered	4.94%	4.05%	4.76%	6.42%	6.55%	5.10%

Table 2b

Challenges to providing safe staffing have also been exacerbated by staff that are required to self-isolate, either due to exposure to covid 19 or due to a member of their household being symptomatic. This is captured separately to sickness and is demonstrated below (chart 3). The number of nursing staff required to self-isolate has reduced in June. This is positive despite implementation of national test and trace where increasing incidence of self isolation was anticipated.

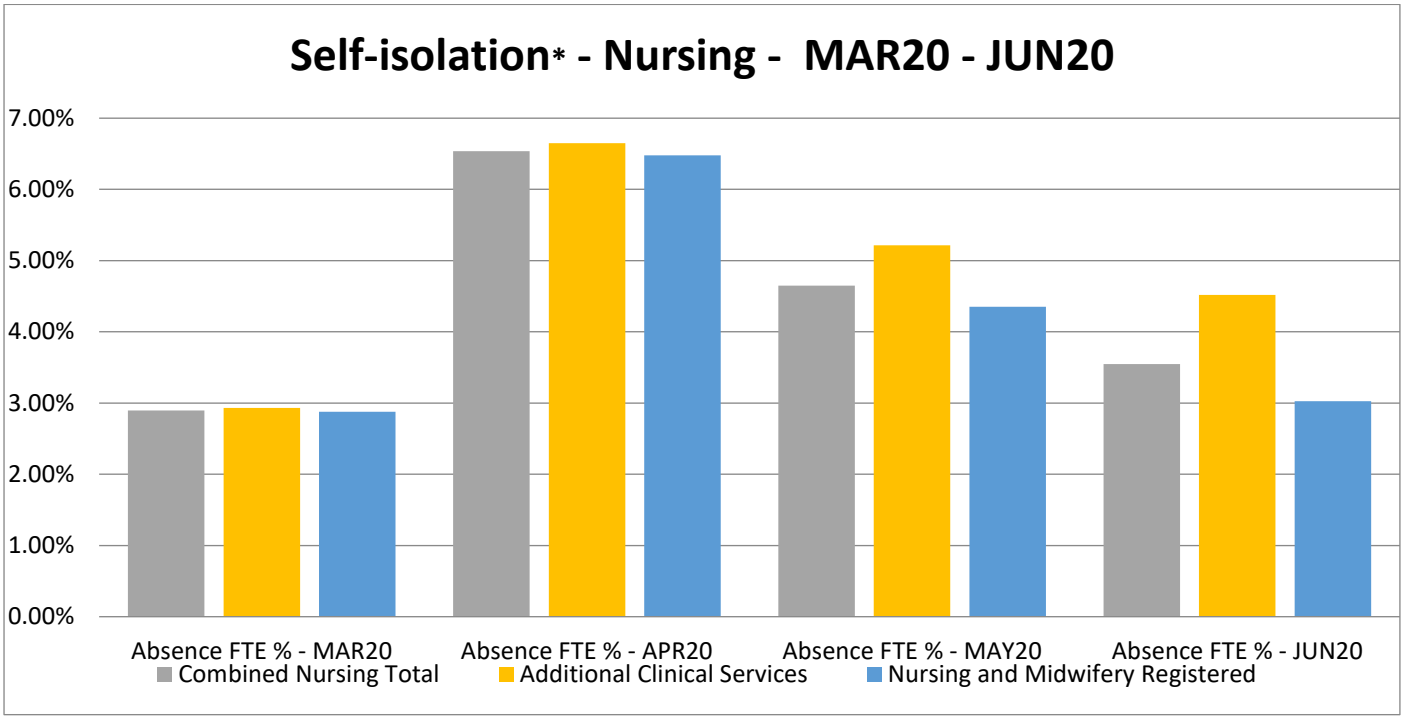


Chart 3

5. Patient Flow and Escalation

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

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

Staffing is reviewed daily across all divisions by the 'Matron of the day'. This role is the escalation point for all wards to raise issues regarding staffing shortfall or concerns. The Matron ensures that all areas are supported and staff are redeployed from areas of low activity or acuity to support where needed.

6. Recruitment and retention

6.1 Vacancies

The incoming Chief Nurse (CN) and Deputy Chief Nurse (DCN) recognise that the difficulty that Covid 19 budgets, ward closures/service redesign and staff redeployments has placed on obtaining an accurate picture of nursing staff vacancies. To address this, throughout July the DCN has held establishment reviews with individual inpatient areas, including representation from finance, HR and eRoster. The intention of the reviews was to ensure that staff were working with the correct budgeted templates and that these matched what the wards are using. Of the meetings that have been held thus far, there are no areas of concern that are carrying significant nursing vacancy. Ward F3 has been identified as having the most RN vacancies as they are yet to recruit into their recent uplift. The team are working with HR to attract candidates to the ward given the opportunities within the speciality.

This exercise has been a positive step forward in understanding the challenges of obtaining accurate data and will form the basis of a formal nurse staffing establishment review which will be completed in the coming months.

Using budgeted versus contracted staff there is a shortfall of 107.7 registered nurses however this is improved by substantive staff that have been reflected in the coronavirus support costs. The net vacancy rate is 33.6 WTE substantive over the budgeted establishment (Table 4)

		Values				
	Ward Nursing	Sum of Budget Period 3	Sum of Actuals Period 1 (April)	Sum of Actuals Period 2 (May)	Sum of Actuals Period 3 (June)	Sum of CURRENT MONTH VARIANCE
Nursing Registered Substantive	Ward	553.8	420.6	453.7	446.1	107.7
	Coronavirus Support Costs	0.0	99.9	82.8	141.3	(141.3)
Total: Nursing Registered Substantive		**553.8**	**520.5**	**536.4**	**587.4**	**(33.6)**

Table 4

This over establishment is driven by a number of factors including fixed term contracts to mitigate future critical care surges, recruiting to posts that are on maternity leave and covering staff that are on secondment or shielding. As the nursing establishment review progresses, any changes to establishment and skill mix will be authorised by the Chief Nursing office to ensure robust control and quality impact assessments.

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

		Values				
Expense Parent Description	Ward Nursing	Sum of Budget Period 3	Sum of Actuals Period 1	Sum of Actuals Period 2	Sum of Actuals Period 3	Sum of CURRENT MONTH VARIANCE
Nursing Unregistered Substantive	Ward	336.7	223.8	238.0	249.3	87.4
	Coronavirus Support Costs	0.0	130.4	103.6	121.2	(121.2)
Nursing Unregistered Substantive Total		**336.7**	**354.1**	**341.6**	**370.5**	**(33.8)**

Table 5

6.2 Overseas Nurse recruitment:
During the pandemic the NMC opened an emergency register in recognition of the value and contribution of staff established within organisations and working towards obtaining their NMC PIN. Of the remaining nurses that our Trust was employing, all joined the temporary register. This can be observed in the increase in substantive registered nurses in May. Recent decisions from the NMC have concluded that these staff will still be expected to complete the OCSE process. The education team have provided further training sessions to facilitate the successful completion of the final exams in August and September.

6.3 Student Nurses:
Of the student cohort that are qualifying in September (n=15) 60% have been offered jobs within WSH. The

education team are working closely with the matrons to identify areas of preference for a further 2 students which will take the retained student cohort to 74%. This will be informed but the vacancy review conducted as described above.

6.4 Recruitment Pipeline

Six Registered Nurses are in the current recruitment pipeline form generic nurse recruitment. These candidates will be interviewed and placed into speciality of preference.

6.5 Staff mental health and emotional wellbeing matters.

The psychological impact of Covid 19 has been managed by providing staff with access to rapid support if needed from experienced clinical psychologists working across the Trust.
They have offered both pre-booked and drop-in 1-2-1 sessions of support as well as group work covering:

- Coping strategies
- Anxiety management
- Trauma-focused interventions
- Mindfulness sessions
- Coaching (including senior staff and leaders across the organisation on how to support the teams they care for)
- Psychological first aid
- Reflective practice/Team reflection sessions
- Interpersonal difficulties in teams

To date the team have offered 340 sessions to over 200 individuals. The team have also offered individual psychological therapies and supported them to access their G.Ps, Suffolk Mind and other organisations to ensure that they are supported.

7. Quality Indicators

7.1 Falls

In patient falls has seen a slight reduction this but falls per occupied bed days has increased. Recruitment to the falls lead practitioner post has been completed and the successful candidate is due to commence in the trust in August. Focused work on falls prevention and risk management can then be accelerated. The falls steering group has also been re-established this month to progress this work

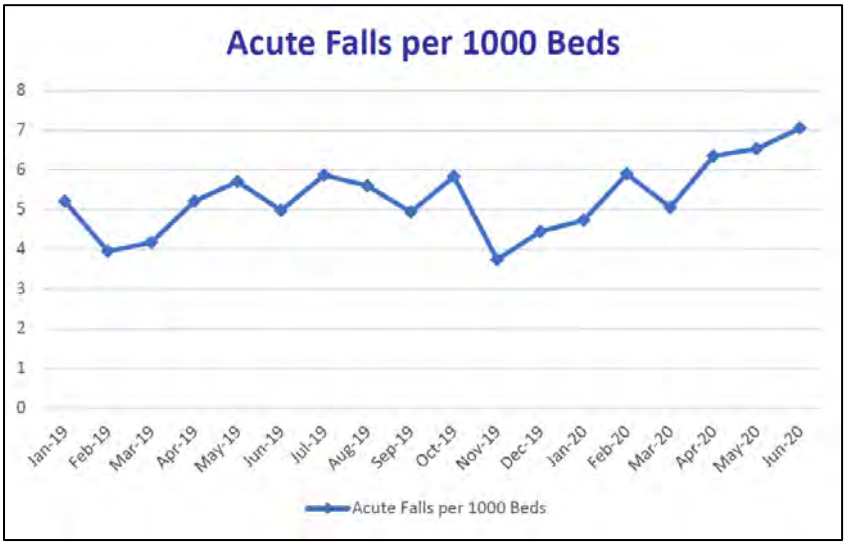


Chart 6

Putting you first

7.2 Pressure Ulcers

June saw an increase in hospital acquired pressure ulcers (HAPU) to 16 from 11 the previous months. This is also demonstrated in HAPU per occupied bed days illustrated below (Chart 2). The Tissue Viability service had been disrupted due to staff absences during peak covid activity. However, the team have now returned to BAU and will be proactively supporting and monitoring high risk patients. A ward by ward list of incidences can be found in Appendix 3.

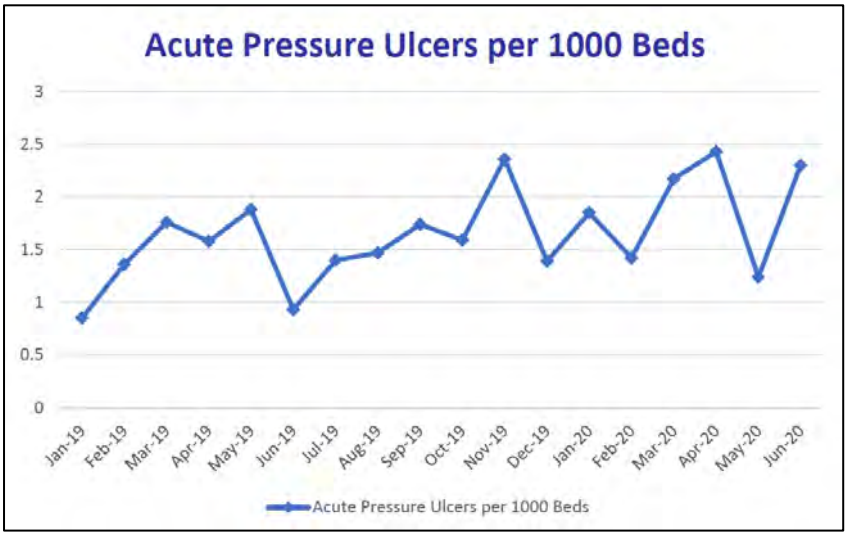


Chart 7

7.3 Compliments and Complaints

There has been a reduced number of complaints received in June 2020 compared with previous months Table 8). Feedback from the patient experience team has advised that the 'keeping in touch 'service has been greatly received from both staff and patients. This service was introduced using staff that had been redeployed or shielded due to Covid 19, to regularly keep in touch with patients and relatives while services had been suspended and trust wide visiting restrictions had been in place. Early indication suggests this service has been very positive and the executive team are exploring how this can continue as service begin to return to business as usual

	Compliments	Complaints
April 2020	14	8
May 2020	14	9
June 2020	8	3

Table 8

8. Maternity Services

NICE Safe midwifery staffing for maternity settings 2015 defines Red Flag events as negative events that are immediate signs that something is wrong and action is needed now to stop the situation getting worse. Action includes escalation to the senior midwife in charge of the service and the response include allocating additional staff to the ward or unit. Appendix 4 illustrates red flag events as described by NICE.
Red Flags are captured on Datix and highlighted and mitigated as required at the daily Maternity Safety Huddle

There were three red flag incidents reported in June – all on the same day.
All three were relating to delay in commencing induction of labour. All three have been investigated and no harm or adverse effect were found to be caused by the delay.

8.1 Midwife to Birth ratio

In June 2020 the Midwife to Birth ratio 1:27, this is within a safe ratio.

8.2 Supernumerary status of the labour suite co-ordinator

This is a requirement for CNST 10 steps to safety and was highlighted as a 'should' from the CQC report Jan 2020. The band 7 labour suite co-ordinator should not have direct responsibility of care **for any** women. This is to enable the co-ordinator to have situational awareness of what is occurring on the unit and is recognised not only as best but safest practice.

In June 2020 we achieved 100% compliance with this however documentational evidence is not available. This has been rectified from the 1st of July with this now being documented on the daily safety huddle sheet. Plans are in place to purchase the Birthrate+ acuity tool and this will capture the supernumerary status of the labour suite co-ordinator 4 hourly.

9. Recommendations and Further Actions:

- Note the information on the nurse and midwifery staffing and the impact on quality and patient safety
- Note the content of the report and that mitigation is put in place where staffing levels are below planned.
- Note the content of the report is undertaken following national guidelines using research and evidence based tools and professional judgement to ensure staffing is linked to patient safety and quality outcomes.
- Note the work commenced with the clinical teams to ensure accuracy of eRosters to illustrate accurate fill rates and robust management of nursing resource
- Trust wide nursing establishment review has commenced starting with inpatient wards to ensure we have the right staff in the right place at the right time.

Appendix 1. Fill rates and CHPPD

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59	RNS/RMs	Non registered (care staff)	Overall
Cardiac Centre	2,887.50	2,721.77	1,322.50	1,215.33	1,725.00	1,644.50	690	678.5	94.3%	91.9%	95.3%	98.3%	536	8.1	3.5	11.7
F8	1,380.00	1,334.00	1,380.00	888.00	1,380.00	1,069.50	1,035.00	960.50	96.7%	64.3%	77.5%	92.8%	435	5.50	4.20	9.80
F12	682	608.5	341.5	363.5	690	675.5	345	363	89.2%	106.4%	97.9%	105.2%	203	6.3	3.6	9.9
F9	1,380.00	1,339.00	2,059.50	1,817.50	1,035.00	1,047.50	1,376.50	1,615.00	97.0%	88.2%	101.2%	117.3%	911	2.60	3.80	6.40
G1	2,722.40	2,244.67	1,042.50	1013.017	690	679	345	352.5	82.5%	97.2%	98.4%	102.2%	274	10.7	5	15.7
G3	1,375.00	1,392.00	2,060.00	2,236.00	1023.5	1,001.50	1,035.00	1,618.00	101.2%	108.5%	97.9%	156.3%	882	2.70	4.40	7.10
G4	1,388.00	1,200.75	2,031.50	2,055.25	1,032.50	910	1,380.00	1,463.00	86.5%	101.2%	88.1%	106.0%	536	3.9	6.6	10.5
G5	1,376.00	1,383.75	2,033.00	2,094.58	1,035.00	1026.083	1,032.50	1,494.25	100.6%	103.0%	99.1%	144.7%	543	4.40	6.60	11.00
G8	2,064.50	1,976.33	1,729.00	1,898.50	1,380.00	1,333.00	1,030.50	1,339.33	95.7%	109.8%	96.6%	130.0%	587	5.6	5.5	11.2
F7	1,380.00	1,410.00	2,044.75	1,745.33	1,380.00	1,381.00	1,721.00	1,662.50	102.2%	85.4%	100.1%	96.6%	302	9.20	11.30	20.50
AAU	1,708.00	1,816.33	2,950.50	1,943.00	1,725.00	1,635.50	1,035.00	931.50	106.3%	65.9%	94.8%	90.0%	238	14.5	12.1	26.6
A&E	5,792.25	5,225.00	2,056.50	2,284.25	2,377.25	2,607.50	675	1,042.75	90.2%	111.1%	109.7%	154.5%				
Rosemary Wd	669	977.25	978.00	1,083.75	667	689.5	525	719.75	146.1%	110.8%	103.4%	137.1%	453	3.7	4	7.7
Glastonbury Ct	693.5	694	1,008.50	1,015.50	678	670.25	526	527.5	100.1%	100.7%	98.9%	100.3%	496	2.8	3.1	5.9
CCS	5,451.50	2,820.00	583	539	5,639.00	2,163.75	253.00	88	51.7%	92.5%	38.4%	34.8%	153	32.6	4.1	36.7
F3	1,357.00	1,403.00	2,058.50	2,085.50	977.50	1,059.00	1,311.00	1,167.00	103.4%	101.3%	108.3%	89.0%	619	4	5.3	9.2
F4	990.00	759.5	1,373.50	771.65	690	485	345	442.5167	76.7%	56.2%	70.3%	128.3%	476	2.6	2.6	5.2
F5	1,380.00	1,445.50	1,368.50	1,350.50	1,035.00	1012.5	685.5	649	104.7%	98.7%	97.8%	94.7%	550	4.5	3.6	8.1
F6	1,616.50	1,734.50	1,601.00	1,599.50	1,012.00	1,035.00	678.5	678.5	107.3%	99.9%	102.3%	100.0%	619	4.5	3.7	8.2
Recovery Unit	6,840.00	1,884.75	6,840	0	6,840	839	6,840	0	27.6%	0.0%	12.3%	0.0%				
F11	3,682.75	3,910.17	1,368.75	1,554.75	2,876.50	2,726.75	1,062.00	841.5	106.2%	113.6%	94.8%	79.2%	47	141.2	51	192.2
F1	1,196.00	1,462.00	690	772.75	1,035.00	1,265.00	0	195.5	122.2%	112.0%	122.2%	N/A	95	28.7	10.2	38.9
F14	708	743	168	132	720	718.5	0	0	104.9%	78.6%	99.8%	N/A	95	15.4	1.4	16.8
NNU	1,080.00	1,063.50	360	96	1,080.00	900	360	204	98.5%	26.7%	83.3%	56.7%	49	40.1	6.1	46.2
F10	1380	1335	1377.5	1275.75	1035	981	1028	1117.5	96.7%	92.6%	94.8%	108.7%	422	5.5	5.7	11.2
G9	1380	138	2050	313.5	1035	69	1380	161	10.0%	15.3%	6.7%	11.7%	40	5.2	11.9	17

Appendix 2: Fill rate narrative and mitigations

Purple	>100%
Green	90% - 100%
Amber	85% - 89% & 101% - 105%
Red	<85% or >105%

Name	Day Reg Fill Rate	Day Un-Reg Fill Rate	Night Reg Fill Rate	Night Un-Reg Fill Rate	Fill Rate Rationale / Comments
A&E Department W531	90%	111%	110%	154%	Change in budget to increase establishment which will be shown on August 2020 Health Roster Template: x1 extra Un- Reg on night shift. Creation of an extra ENP shift for Fri/Sat/Sun/Mon working until 11pm. Twilight un-reg x1 6pm-2 am.
Acute Assessment Unit W560	106%	66%	95%	90%	Day rate RN increased due to unavailability of Un- Reg due to x3 on A/L, x1 on external placement, x2 house isolation, x1 study.
Newmarket Hospital Rosemary Ward	146%	111%	103%	137%	Staff redeployed from OPD were still in staffing numbers for first two weeks in June, we were also redeployed an RN from COPD community team for the whole of June, these staff had set hours and working patterns which we were unable to change Due to the new layout of the ward and extra beds we are booking an extra RN during the day and an extra NA at night, when not covered by redeployed staff which is currently not in our budgeted establishment.
Critical Care Services	52%	92%	38%	35%	The low fill rates are due to optional shifts which have been left open to allow for the additional support which was required during the COVID surge in demand. Predominately this increased support was from registered staff, however, some non-registered assistance was also provided by supporting teams and the healthroster shifts were opened up to support this. During the increased surge, 2 areas for Critical Care provision were required to support patients affected with COVID and those who were not, staffing 2 areas required additional staff, however this decreased in June and many of the staff who had been supporting the team have returned to their normal practice and roles. The healthroster is being reviewed to reflect this.
F10	97%	93%	95%	109%	High acuity. Staffing flexed due to not hitting 100 % fill rate for reg staff, increasing non-reg to meet shortfall.
Medical Treatment Unit	88%	79%	N/A	N/A	X1 RN on retire and return. Pain list and biopsy list work reduced due to Covid.
Midwifery Services	106%	114%	95%	79%	Creation of 519 bleep holder shift to enable Labour Suite co-ordinator to be supernumerary. Template updated from September 2020

Neonatal Unit	98%	27%	83%	57%	High sickness at present, unable to fill shifts
Recovery Unit	28%	0%	12%	0%	The low fill rates are due to a decrease in demand on the service during the current pandemic. Although emergency and rapid access surgery has continued, this is a reduction in the normal level of service. Currently the Recovery roster is accommodating teams from Day Surgery, hence additional optional shifts have been added to allow for staff to be rostered. The non-registered fill is 0% as the nursing assistants are either shielding or been redeployed during the pandemic, however, this has not affected the current staffing demand. This roster has needed to be flexible to address the challenges in changing demand of service daily.
Respiratory Ward (F8)	97%	64%	78%	93%	N/A
Ward F1	122%	112%	122%	195%	Staffing 2 separate areas due to COVID
Ward F12	89%	106%	98%	105%	F12 has been a Covid Ward with high acuity. Registered nurses- staff sickness, isolating and shielding- Skill mix flexed to ensure ward cover. There was a requirement to boost staffing at night due to high acuity and level of patient specials/ increased observations required.
Ward F14 Gynae	105%	79%	100%	N/A	New member of staff started - supernumerary
Ward F3	103%	101%	108%	89%	There has been a slight over establishment of some shifts on F3 due to the team accommodating team members from Ward F4 when their ward was closed mid June. Team members on Ward F4 have joined the team to support the team and gain experience of the care and management of Trauma patients and those requiring more urgent care. Underfill of the non-registered night shift, is partly due to overfill of the night shift by registered staff to accommodate the F4 team.
Ward F4	77%	56%	70%	128%	Ward F4 was closed mid June to allow for the decant of Ward G5. Prior to this, some shifts were not filled as there was a significant reduction in patients to allow for the closure of the ward. There is overfill of the non-registered night shift to allow for an increased number of staff to accommodate the emergency flow, as opposed to the elective ward, the template is designed for.
Ward F5	105%	99%	98%	95%	There is a slight overfill of Registered staff on the day shift to accommodate team members from the closed Ward, F4. This has allowed team members from F4 to have the opportunity to gain skills and experience in managing Urology patients in the future.
Ward F6	107%	100%	102%	100%	There is a slight overfill of Registered staff on the day and night shift to accommodate team members from the closed Ward, F4. This has allowed team members from F4 to have the opportunity to gain skills and experience in managing acute situations and emergency surgical patients in the future.

Ward F7	102%	85%	100%	97%	F7- Covid Ward High acuity and patients requiring NIV and chest drains; therefore, registered nurses increased. Staff shielding (NR)
Ward F9	97%	88%	101%	117%	Gastro Ward. Specials required for detox patients.
Ward G1	82%	97%	98%	102%	Day Reg: 3.14 RN's on MAT leave/shielding. Night time skill mix balanced with 2% increase in Un-Reg to meet shortfall of 2% RN.
Ward G3	101%	109%	98%	156%	High acuity. Specials required.
Ward G4	87%	101%	88%	106%	G4 – Covid Ward with EOL care. High acuity requiring increased staffing at night. RN's sickness and A/L which needed to be taken for staff well-being.
Ward G5	101%	103%	99%	145%	High acuity. High number of confused patients and high risk of falls. Increase in observation/specials levels required.
Ward G8	96%	110%	97%	130%	High acuity. Patients at risk of falls. Increase in observations/specials required.
Ward G9 (Winter Escalation)	10%	15%	7%	12%	Ward closed. Short term contracted staff on G9 have been working flexibly across organisation. G9 is base ward and therefore cannot be moved on health roster as would impact pay.

Appendix 3: Ward by Ward breakdown of Falls and Pressure ulcers

HAPU

	Cat 2 (Minor)	Cat 3 (Moderate)	Unstageable (Moderate)	Total
Cardiac Centre - Ward	2	0	0	2
Critical Care Unit	0	0	1	1
F10 Winter Escalation	2	0	0	2
F5 - ward	1	0	0	1
F9 - ward	1	0	0	1
G1 - ward	1	0	0	1
G3 - Endocrine & General	1	0	0	1
G4 - ward	1	0	0	1
G5 - Ward	1	0	0	1
Respiratory Ward	1	0	0	1
F7	3	1	0	4
No value	0	0	0	0
Total	14	1	1	16

Falls

	None (no harm caused)	Negligible (minimal injury requiring no treatment)	Minor (injury requiring minor treatment)	Moderate	Total
Cardiac Centre - Catheter Lab	1	0	0	0	1
Emergency Department	1	0	1	0	2
F1 - Ward	1	0	0	0	1
F10 Winter Escalation	5	0	0	0	5
F12 Isolation Ward	2	0	0	0	2
F3 - ward	2	0	0	0	2
F5 - ward	1	0	0	0	1
F9 - ward	2	0	0	0	2
G1 - ward	0	1	0	0	1
G3 - Endocrine & General Medicine	3	0	0	0	3
G4 - ward	4	0	0	0	4
G5 - Ward	4	1	3	0	8
G8 - ward	9	0	2	0	11
Glastonbury Court	4	1	0	0	5
Radiology Department	1	0	0	0	1
Rosemary Ward	2	0	0	1	3
F7	2	0	0	0	2
Acute Assessment unit (AAU)	1	0	1	0	2
Integrated Therapies	0	0	1	0	1
Total	45	3	8	1	57

Appendix 4: Maternity Red Flag Events

Missed medication during an admission
Delay of more than 30 minutes in providing pain relief
Delay of 30 minutes or more between presentation and triage
Delay of 60 minutes or more between delivery and commencing suturing
Full clinical examination not carried out when presenting in labour
Delay of two hours or more between admission for IOL and commencing the IOL process
Delayed recognition/ action of abnormal observations as per MEOWS
1:1 care in established labour not provided to a woman

15. Safe staffing guardian report – Q1

To ACCEPT the report

For Report

Presented by Nick Jenkins

Trust Board – 31st July 2020

Agenda item:	15			
Presented by:	Dr Nick Jenkins, Executive Medical Director			
Prepared by:	Francesca Crawley, Gardian of Safe Working			
Date prepared:	23rd July 2020			
Subject:	Safe Staffing Guardian Report – Quarterly Report April – June 2020			
Purpose:	x	For information		For approval

Executive summary:

The report is compiled by the Guardian of Safe Working Hours (GOSW), a role appointed as part of the new contract. The purpose of the report is to provide evidence of safe rostering and compliance with the TCS, to highlight any difficulties which have arisen, and to explain how they are being addressed.

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:	
Risk and assurance:	
Legislation,regulatory, equality, diversity and dignity implications	

Recommendation: For the board to endorse the quarterly report

QUARTERLY REPORT ON SAFE WORKING HOURS

DOCTORS AND DENTISTS IN TRAINING

1st April 2020 – 30th June 2020 Executive Summary

Introduction

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

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

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

Summary data

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

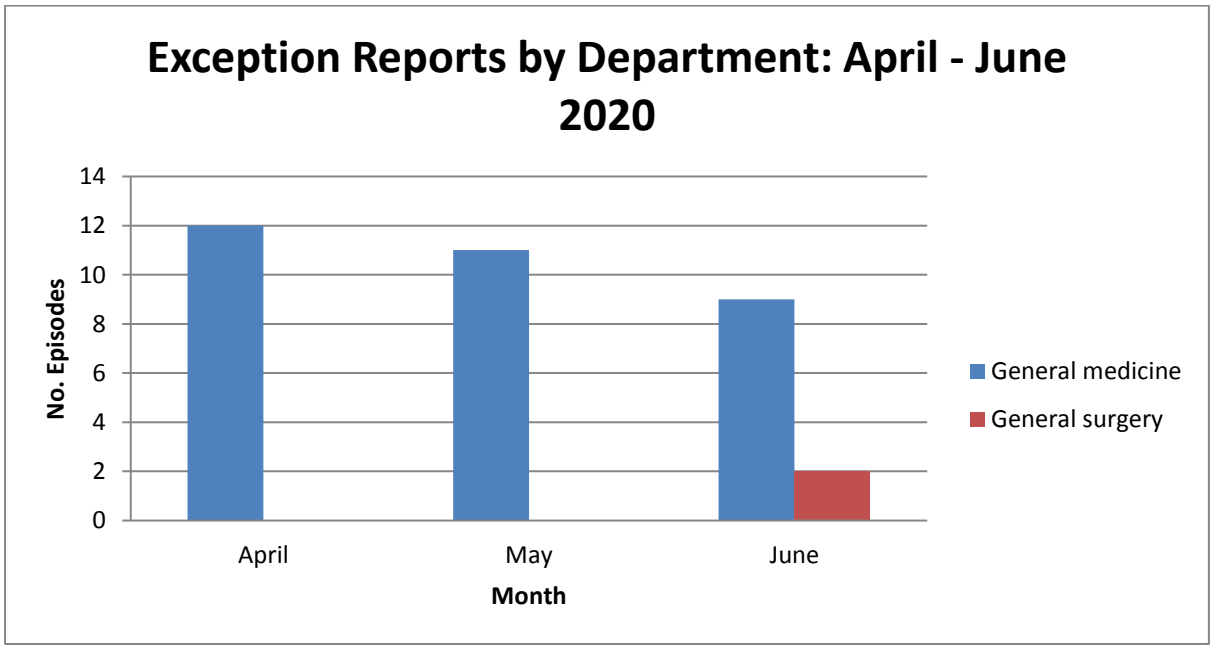
1. Exception reporting: 1st April – 30th June 2020

a) Exception reports (with regard to working hours)

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

Exception Reports by EXCEPTION TYPE						
Department	Grade	Pattern of Hours worked	Educational Opportunities or available Support	Support available during Service Commitments	Hours of Work	Total overtime hours claimed
Medicine	F1	0	0	0	24	38.30
	F2	0	0	0	2	4
	GP/ST/CT	0	0	0	6	7.30
Surgery	F1	0	0	0	1	2
	F2	0	0	0	1	1.45
Total		**0**	**0**	**0**	**34**	**53.45**

Exceptions reports by month and department



b) Work schedule reviews for period 1st April – 30th June 2020

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

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

2) <u>Immediate Safety Concerns: 1st April – 30th June 2020</u>

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

There have been no ISC in this period.

3) Locum Bookings: 1st April – 30th June 2020

TABLE 1: Shifts requested between 1st April – 30th June 2020 by 'reason requested'

Locum Bookings by REASON REQUESTED										
Department	**Rota Compliance and Induction Cover**	**Leave (Annual, Carers, Study and Interview, bereavement)**	**Maternity and Paternity Leave**	**Sickness and Reduced Duties**	**Extra**	**COVID-19 Additional Dependency**	**COVID-19 Sickness**	**COVID-19 Self-Isolation**	**Vacancy**	**Grand Total**
Anaesthetics		2		1						3
Emergency Medicine		100		4	99	23	4	16	239	485
ENT				1		22				23
General Medicine	10	36	2	9	40	103	4	44	27	275
General Surgery	6	7		19		17		12	30	91
Haematology			4							4
Obs & Gynae				1			4	1	13	19
Ophthalmology	1							11	13	25
Paediatrics	1	2	7	60				1	28	99
T&O				1				3		4
Urology					3					3
TOTAL	18	147	13	96	142	165	12	88	350	1031

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

Filled by NHS / Agency		
Department	**NHS**	**Agency**
Anaesthetics	3	
Emergency Medicine	364	121
ENT	23	
General Medicine	275	
General Surgery	91	
Haematology		4
Obs & Gynae	19	
Ophthalmology	25	
Paediatrics	71	28
T&O	4	
Urology	3	
Grand Total	878	153

4) Vacancies – 1st April – 30th June 2020

During this period, the Trust ran on COVID rota's which utilised the doctors available.

5) Fines – 1st April – 31st June 2020

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

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

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

Matters Arising

- Covid-19 has meant new rotas with more juniors and consultants on the wards. This has had impact at the weekends and evenings. Probably partly because of this and partly as there have been fewer in-patients, exception reports in the last 3 months have been minimal.
- We have recently returned to pre covid rotas and there have been a few ER which I am monitoring. There is no pattern as yet
- The have been no 'immediate safety concern' ER this academic year.
- The Junior Doctor Forum has had agreement from the Finance Director to move the mess back to the original location near MRI. I am unclear of the timeframe for this, but on behalf of the juniors, very grateful.
- We still have a considerable amount of money to spend (GOSW fund, 'Fight Fatigue' money) and this will be the focus of the GOSW meeting on July 29th.
- I have a session at the main trust induction to introduce myself and encourage safe working and will meet the new F1 in September when they have settled in.

16. Improvement programme board report

To RECEIVE the report, including the Trust improvement plan

For Report

Presented by Susan Wilkinson and Stephen Dunn

Trust Open Board – 31 July 2020

Agenda item:	17			
Presented by:	Steve Dunn, Chief Executive Sue Wilkinson, Executive Chief Nurse			
Prepared by:	Richard Jones, Trust Secretary John Connelly, Head of PMO			
Date prepared:	24 July 2020			
Subject:	Improvement programme board report			
Purpose:		For information	X	For approval

Following consideration and approval by the Board at its meeting in June two meetings of the Improvement programme board (IPB) were held during July.

The first meeting, held on **1 July**, was used to engage with senior staff within the organisation and review the proposed framework for managing the Trust's quality improvement plan. This included detailed consideration of the framework, consideration of the current improvement plan, review of a sample cluster group slide deck and review of the draft terms of reference. This provided a good insight into how the framework would operate including the flow of information and assurance from subject leads, to cluster groups, to the programme board, the Board of Directors and our regulators.

The second meeting, held on **13 July**, reviewed and updated terms of reference (**Annex A**). Included among the changes was the requirement to appoint a second non-executive director (NED) to the committee to provide the appropriate level of Board oversight. The Board is asked to consider and nominate a NED to this role. Healthwatch Suffolk will also be invited to attend future meetings.

The meeting then worked in a more business as usual ways to consider:

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

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

- No plans were submitted for business as usual approval (Blue rating) - as this was the first meeting of the IPB this was not unexpected
- A maternity deep dive will be undertaken and presented at the next IPB with evidence for embedded delivery. This will test an approach for using deep dives reviews, supported by the CCG, as a standard part of the IPB work approach for testing improvements are embedded. If successful planned deep dives will be selected according to risk and as part of the process to review and signed off embedded delivery
- Specific changes to plans will be submitted to the IPB for approval on an going basis

- Monitoring Blue rated plans would be ongoing with reviews to test sustained improvements on a frequency as determined by the IPB
- A focus on benefits and outcomes will be maintained as part of the testing of embeddedness
- Membership of the IPB and the cluster groups will be reviewed to ensure the right size groups for effectiveness and appropriate medical, clinical and other representation. It was felt that cluster group membership should be widened rather than increasing the size of the IPB as an assurance board. This will be reviewed and confirmed at the next meeting
- Areas for future focus included: the Trust's patient safety & quality framework and the CQC's "Should" findings. Additions to the Trust's improvement plan to be manageably within resourcing constraints into the improvement review process at cluster group going forward
- A timetable will be prepared to provide a clear and transparent reporting process for all stakeholders
- An IPB risk log will be developed and maintained
- Programme management office (PMO) support for the programme was recognised

Reflections at the end of the meeting included recognition of the amount of work undertaken to prepare the meeting pack and thanks from the CCG for being invited.

Trust priorities	**Deliver for today**		**Invest in quality, staff and clinical leadership**		**Build a joined-up future**		
	X		X		X		
Trust ambitions	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X	X	X	X	X	X	X
Previously considered by:	Executive Directors meeting 8th April 2020						
Risk and assurance:							
Legislation, regulatory, equality, diversity and dignity implications	See individual references throughout the document						

Recommendation:

1. Note the report and contents
2. Approve a second NED to become a member of the improvement programme board and approve the draft terms of reference (Annex A)
3. Approve the updated Trust improvement plan (Annex B)

Improvement programme board

Terms of Reference

1. Constitution

1.1 The Board of Directors hereby resolves to establish a Committee of the Board to be known as the improvement programme board (the Committee). The Committee is a sub-committee of the Board of Directors and has no executive powers, other than those specifically delegated in these Terms of Reference

1.2 The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Programme Board. The Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary

1.3 The Committee will, when required and appropriate, establish subcommittees and delegate certain responsibilities and decisions to subcommittees

1.4 The Committee has the authority to approve relevant strategies, policies and procedures

1.5 The Committee will work closely with the Audit Committee and Quality and Risk Committee, avoiding duplication

1.6 Significant risks reported to or identified by the Committee will be reviewed to consider the implementation of additional controls. Where these additional controls cannot be implemented in a timely manner the matter will be referred to the Trust Executive Group (TEG) for consideration of resource implication. At the Chair's discretion the Committee may refer significant risks directly to the Trust Board

1.7 The Board approved a governance framework (Annex A) to support the improvement processes and governance at the Trust to operate across three interdependent workstreams:

- Key Trust improvements, including internal priorities and findings of regulatory bodies
- Covid-19 recovery
- Quality improvement (QI) methods

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

1.8 The emphasis in formatting the agenda of the committee will be to review and share improvement use externally and internally, promoting a systematic improvement methods across the Trust.

2. Membership

2.1 Membership will comprise those set out below:

- Chief Executive (Chair)
- Two non-executive directors, including the Chair of the Board of Directors
- Executive Chief Nurse

- Executive Director of Resources
- Executive Chief Operating Officer
- Executive Director of Human Resources and Communications
- Executive Medical Director

- West Suffolk CCG chief executive
- West Suffolk CCG chief nurse
- Clinical Advisor, NHS East of England
- Healthwatch Suffolk

2.2. Other attendees:

- Deputy COO
- Head of PMO
- Trust Secretary
- Compliance manager
- Subject experts for specific items on the agenda

2.3 Attendees are only required to attend the meeting for specific items relevant to them, but can attend for the whole meeting should they wish

2.4 A **quorum** will be four members which must include a WSFT non-executive director and WSFT executive director.

3. Attendance at Meetings

3.1 With the exception of the Chief Executive, members should have an identified deputy who will attend in their place when they are unable to.

4. Frequency of Meetings

4.1 Meetings will normally be held monthly but no less often than four times in a year.

5. Duties and Responsibilities

5.1 Regularly (at least six-monthly) review and approve the **Trust's improvement plan** to ensure it appropriately reflects the priorities of the Board, divisions and specialists as well as the external operating environment and regulators. All aspects of the plan to be allocated to an appropriate SRO cluster for delivery.

5.2 Receive, consider and approve any **in-year additions** to the improvement plan and allocate to an appropriate SRO cluster group.

5.3 Ensure appropriate **resource** is available to support delivery, oversight and assurance of the improvement plan.

5.4 Receive **SRO cluster reports**, which support the following:

5.4.1 Monitoring and review of progress with the agreed improvement plan. This includes improvements which are service/division specific and those that cross divisions
5.4.2 Review of issues for escalation, including adverse progress status of "red" (action beyond due date) or "Amber" (action at risk of missing due date)
5.4.3 Receive and approve recommendations to change action plans, including changes to delivery dates and delivery plans
5.4.4 Receive evidence and approve recommendations to change action status to "Black" (action implemented, assurance testing ongoing). This will need to include evidence of delivery across all relevant divisions
5.4.5 Receive evidence and approve recommendations to change action status to "Blue" (action implemented and assurance evidence that action is embedded with agreed

cycle of ongoing assurance). This will need to include evidence of delivery across all relevant divisions

5.4.6 Approve the assurance cycle for actions with an agreed “Blue” status and receive evidence that this assurance model is being delivered

5.4.7 Approve changes to the assurance cycle for individual actions based on the assurance findings. This includes the ability to move an action back to active to further mitigate and improve delivery.

5.5 Approve the programme for **quality assurance visits** with the CCG and receive the results of this either direct or through the relevant SRO cluster group.

5.6 Promote **learning and sharing** for improvement activity, both from within and outside of the Trust.

5.7 Review and approve the annually **work plan** for the committee and review the forward plan.

5.8 To contribute to the Trust’s **Annual Governance Statement (AGS) and Internal Audit** programme.

6. Reporting, Accountability and Review of Effectiveness

6.1 The minutes of Committee meetings shall be formally recorded and a **report provided to the** Board of each meeting.

6.2 The Committee shall review its **terms of reference annually** (but after three months of first establishment).

6.3 The Committee will agree on an annual basis a **reporting schedule** for all areas of its terms of reference. This will determine standing items for the agenda and items for regular reporting.

6.4 The Committee shall carry out a **self-assessment** in relation to its own performance no less than once every two years.

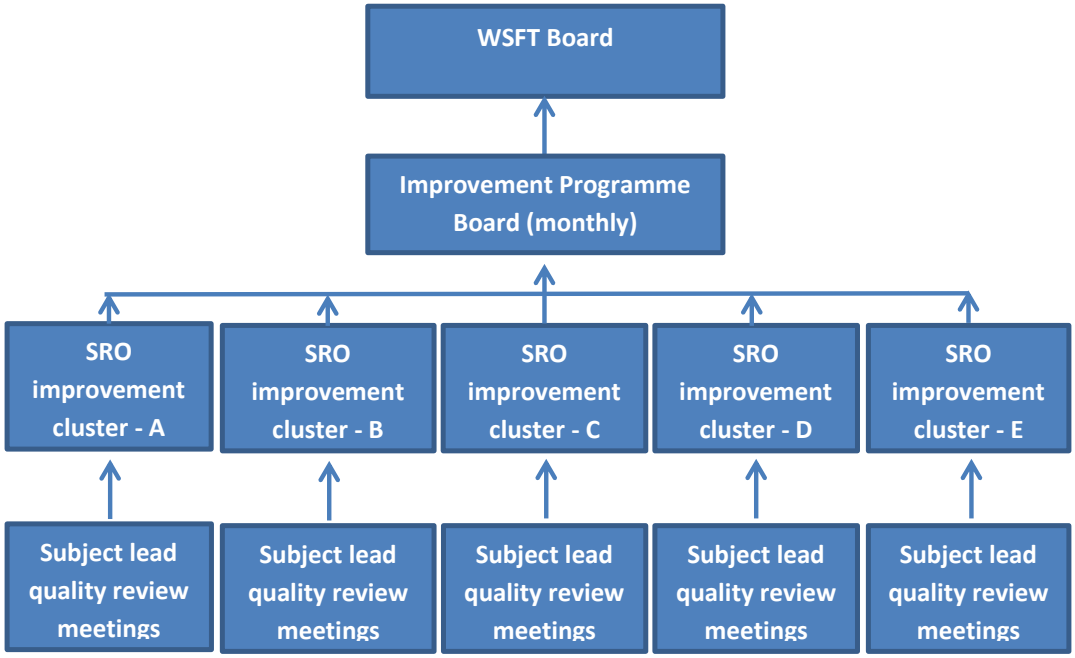
6.5 An **annual report** of the activities of the Committee shall be presented to the Board of Directors, identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken.

Annex A: Improvement governance framework

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

- ***Subject lead quality review meetings with the SRO Cluster Project Manager*** – these meetings are operational and provide review and challenge with an opportunity to update on progress
- ***Senior responsible office (SRO executive) cluster meetings*** – these meetings are operational and provide senior oversight and challenge as well as an appropriate escalation forum
- ***Improvement programme board*** – a Board-committee whose membership includes non-executives, executives and senior leaders from across the Trust as well as representation from the CCG.

The oversight and quality assurance framework ensures effective delivery of the agreed improvement actions to the defined timescales.



- All plans are held centrally and updated by the PMO to ensure effective version control
- Any changes to plans are subject to Improvement Board approval. There are no unilateral changes to plans outside of this change control process

Annex A: WSFT Improvement Plan - Status Summary Report

Version date: 24th July 2020

Finding no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status	Project end date	Current status / overall RAG rationale
1	The trust must take definitive steps to improve the culture, openness and transparency throughout the organisation and reduce inconsistencies in culture and leadership. To include working relationships and engagement of consultant staff across all services.	1. Implement Trust-wide staff engagement project to elicit feedback to inform decision-making, including establishment of a BAME Staff Network. 2. Establish an executive team development programme, including 360. 3. Utilise the medical engagement scale to better understand and support improvement for the factors underpinning clinical engagement. 4. Establish a staff psychological support service to enhance well-being support for our teams. 5. Provide an organisational development update to the Board.	Stephen Dunn	Jeremy Over	Green	30.11.20	On track for completion Nov 20 based on QA Meeting with Jeremy Over. Update 29.06: - "What Matters to You" survey 1400 had over 1,400 responses in terms of learning from our staff's experience of Covid-19 - Beter Working Lives survey being undertaken by Paul Molyneux - BAME staff network established and first meeting held - A review policies is happening to ensure a more compassionate approach reflecting a just and learning culture - Investment in Staff Psychology services agreed and led by Emily Baker to support staff through Covid-19 - Freedom to Speak Up Guardian position out to recruitment -Link also with relevant items in related plans eg Duty of Candour (Plan 10) **Update 13.07.20: Additionally re-instated daily executive and senior nurse and doctor walkabouts and feeding back to staff more regularly in comunications.** **- JO to plan feedback process from IPB Membership to achieve consensus in terms of 'what does assurance and evidence of embedding mean' for Plans 1 & 2 given measuring outcomes / culture improvements ref culture**
2	The trust must ensure the culture supports the delivery of high quality sustainable care, where staff are actively encouraged to speak up raise concerns and clinicians are engaged and encouraged to collaborate in improving the quality of care.	1. Recruitment a new Lead Freedom to Speak Up Guardian, who in turn will develop a network of Speak Up ambassadors. 2. Implement lessons learned from external review of whistle blowing matters	Stephen Dunn	Jeremy Over	Green	30.11.20	On track for completion Nov 20 based on QA Meeting with Jeremy Over. Update 29.06: See 1 above. - Freedom to Speak Up Guardian position out to recruitment **Update 13.07.20:** **- Interim FTSU Guardian in place whilst recriutment process completes. Important right person recruited and supported to lead developments hence Nov end date.** **- Additional actions to be added to plan to ensure required improvement happens**
3	The trust must ensure that processes for incident reporting, investigation, actions and learning improve are embedded across all services and that risks are swiftly identified, mitigated and managed. The trust must ensure that incident investigations and root cause analysis are robust and that there are processes for review, analysis and identification of themes and shared learning.	1. Review of current incident pathways and their compliance to highlight areas for improvement. Include the outcome of this review in the design of new pathways as an integral element of the implementation of the Patient safety & improvement framework (PSIRF) 2. Ensure all divisions are supported to achieve these outcomes through the central patient safety / clinical governance team	Susan Wilkinson	Lucy Winstanley	Red	31.10.20	Overall RAG progression Amber subject to PSIRF implementation which has now recommenced. Trust is an early adopter of national PSIRF programme. **Update 09.07.20:** Overall RAG moved to Red. Plan's 3 and 4.3 will be re-drafted for submission and review at the next SRO Improvement Cluster meeting to ensure that specific actions in the plans can be progressed and deivered within the constraints of: 1) The national PSIRF programme 2) Trust review of Patient Safety and Quality **Update 13.07.20: Trust is an eary adopter of national PSIRF Programme which has been paused due to the pandemic. Progressing the work internally and not depending on national PSIRF programme for completion but moved to Red due to Covid-19 delays**

Finding no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status	Project end date	Current status / overall RAG rationale
4.1	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - clinical audit is monitored and reviewed to drive service improvement.	1. Review and define opportunities to improve the current organisational pathways for recording and reporting on local and national audit participation including consideration of a new bespoke audit information system. 2. Working with divisions, develop a structure to enable the inclusion of audit actions within wider divisional improvement plans 3. Widen the scope of clinical effectiveness to address all elements of national best practice including but not limited to NICE guidance, Royal college publications, HSIB and other national best practice publications	Nick Jenkins	Lucy Winstanley	Red	31.10.20	**Update 25.06.20**: See Plan 4.1 for line for line updates. Plan moved to Red RAG. - Assigned leader of actions on secondment. Update will be provided at next SRO Cluster re backfill arrangements - One audit software package to be selected in July. -Divisional national audit participation meeting cancelled in June (CSEC) -Defining Clinical Governance Manager role is part of Trusts Patient Safety & Quality Work. Definitions around central and divisional governance functions required. -Interim divisional clinical audit requirement – escalated as an agenda item **Update 13.07.20: Resource available to provide backfill and actions should progress quickly when post filled and so end date 31.10.20 stands.**
4.2	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - mortality reviews are monitored and reviewed to drive service improvement.	1. Set up the National Medical Examiners service which will review all deaths and agree a reporting pathway into the trust for any cases requiring further review. 2. Supported by the appointment of a Learning from deaths (LfD) caseload manager; implement the LfD strategy including the specific action to streamline and centrally capture learning from local M&M reviews	Nick Jenkins	Jane Sturgess	Green	31.10.20	All ME Officers in post. MEs all recruited, some start dates have been delayed and plans are in place to manage service pending all being in post. **Update 13.07: Plan 4.2 will be reviewed in detail at the next cluster which has been arranged in line with project lead's availability. Overal green with some actions complete but will need further assurance and a forensic examination.**
4.3	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - incidents are monitored and reviewed to drive service improvement.	1. Through participation in the national pilot for the implementation of the Patient safety & improvement framework (PSIRF) design pathway for monitoring, investigation and review of outcomes from incident reporting 2. Implement the trust patient safety & learning strategy developed in 2019	Susan Wilkinson	Lucy Winstanley	Red	31.10.20	See No 3
4.4	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - complaints are monitored and reviewed to drive service improvement.	1. Undertake NHSE&I patient experience framework assessments across the whole Trust 2. Review of divisional reporting of actions and learning from complaints, including accurate recording of service improvement linked directly to changes as a result of feedback	Susan Wilkinson	Cassia Nice	Complete	31.10.20	Project Status Amber as audit of improvement actions required. Patient Experience Managers for Complaints and PALS in post together with Patient Experience Administrator. Update 23.06.20: 5/6 points in the plan ready for submission and approval at Implementation Board to move from Black (complete) to Blue (BAU. All these actions complete with no further monitoring required. - Business case for patient experience and PALS roles approved. - All postholders in place and positions are permanent. Point 6 should remain Black (complete) to allow time to evidence attendance and outcomes from divisional Board meetings. **Update 13.07.20: Actions complete but not yet BAU ready. Continued monitoring required. Complaints are reducing but the team needs to be in place to continue to monitor to ensure KPI's are still being met.**
5	The trust must ensure that effective process for the management of human resources (HR) processes, including staff grievances and complaints, are maintained in line with trust policy. To include responding to concerns raised in an appropriate and timely manner and ensuring support mechanisms in place for those involved.	The management of HR processes, including investigations, will be strengthened by embedding the following in practice: 1. Monitoring time lines for each case 2. Reviewing cases that are not progressing in a timely fashion, taking action where possible. 3. Actions to be recorded on the database and effectiveness reviewed at subsequent fortnightly Case Review meetings. 4. Escalate cases where there is a significant delay to the Executive Director of Workforce for review in regular meeting with Deputy Director of Workforce 5. Consider use of external investigators where there is a lack of internal investigatory resources 6. HR Policies will be reviewed to ensure a more kind and compassionate approach that is aligned to a 'just' culture.	Jeremy Over	Claire Sorenson	Green	31.10.20	Status green as work on track for completion by October 2020. Elements of work are complete i.e. Just Culture training carried out by Trust solicitors. Further tasks to embed a just and learning culture in the Trust are now starting up (post Covid-19). **Update 29.06:** -Review Mersey Care re Just and Learning model. - Mersey Care HRD booked for a 5 o'clock club - Reviewing investi+S15gation toolkit undertaken by project team / linclude investigation recording system updates in plan. October completion date reflects time to complete the investigation toolkit. Update plan with PMO before next SRO Cluster **Update 13.07.20:** **- Slot to review plan with PMO agreed** **- Merseycare NHS HR Director presenting at next 5 O' clock Club**

Finding no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status	Project end date	Current status / overall RAG rationale
6	The trust must ensure that robust processes are embedded for patient follow up appointments and those on surveillance pathways. To include systems and process for regular oversight and assurance that patients are not being lost to follow up across all specialties within the organisation.	1. Design process for follow up booking 2. Recruit two new members of staff in TAC for all ward booking follow ups. Write SOP for Endoscopy. 2. Update all relevant Standard Operating Practices for Follow Ups and Surveillance. Write SOP for Endoscopy. 3. Identify and deliver any training needs within each specialty and Endoscopy 4. Design process for virtual surveillance booking of patients 5. Clinic Patients Missing Follow Ups - e-Care work 6. Prepare Communications piece for Green Sheet/Staff Briefing 7. Agree Go-Live date and communicate to all relevant parties	Helen Beck	Angela Price	Red	31.3.21	Processes in place. QA review also ascertained that Covid-19 holding statement and clear plan are also in place to pause safely. Actions are therefore essentially complete. Update 25.06: Overall status RAG moved to Red as plan needs to be re-focussed. Agreed action AP/CA to meet PMO to update. Update 09.07: Action completed. Revised plan prepared with Holding Statement for review at July SRO Improvement Cluster. **Update 13.07.20: Most of actions were done but now a different landscape with Covid-19 and the number of patient appointment cancellations. HB meeting with teams regularly and is obtaining frequent reassurance but further assurance required. The team is pulling together a status report of supporting evidence re: lists and actions as part of move back to business as usual operational process. Key issue is size of backlogs and capacity is less than previous to undertake the work. Surveillance programmes have been paused. Pathways still in place.** **- HB to provide assurance (detailed information) at next IPB 10.08.20**
7	The trust must take definitive steps to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant.	The main themes from the actions plans are: 1. RTT Reporting – update to the reporting solutions to remove as many as possible of the manual workarounds within RTT reporting. Requires support from Cerner on technical fixes and testing by the WSFT Information Team. 2. RTT Training – working with users of the system and patient pathway trackers to ensure accurate information recorded relating to RTT pathways. 3. Data Quality – work to ensure there is a programme in the organisation to focus specifically on DQ. 4. Theatres Information – development of the initial theatres dashboard after end user pilot to version 2.	Craig Black	Nickie Yates	Amber	31.12.20	Overall RAG iAmber. Is clear plan but are resourcing issues and some of face to face actions cannot be completed during pandemic. - RTT Reporting workstream mainly complete. - Theatres Information workstream has continued and is on track. - RTT Training and Data Quality work streams paused due to resourcing issues and pandemic given requirement to be on site **Update 23.06:** - RTT Reporting – Mainly complete but cannot turn Blue as embedded before Trusts October update complete with testing evidence, which should resolve issues of remaining manual work arounds. - RTT Training – Looking to provide remote training for staff working from home. NY / HK are working to see how can be done electronically. This is an action to add to the plan. For administration staff it may be as simple as running same meetings via Teams. For Clinical Forums may record, demonstrate and provide PowerPoint online learning quiz. - Data Quality - DQ actions will be further progressed subject to resources and needs further discussion with SRO Theatres Information – Dashboard in place but cannot turn Blue as embedded until the dashboard can be used and tested under more normal circumstances post Covid-19 as not all theatres are open presently. **- Update 13.07.20: Outstanding workarounds do not present significant risk and will be resolved over next quarter. Out to advert for DQ Manager and so plan should turn green at next cluster**
8	The trust must continue to develop information technology systems and integration across the community services	1. Submit Business case for approval at Trust Board 2. Appoint Project Manager 3. Establish programme reporting governance to Digital Board 4. Undertake technical reviews at Community Sites 5. Undertake infrastructure upgrades including service migration, provision of laptops and remote access solution 6. Monitor programme delivery	Craig Black	Mike Bone	Green	31.12.20	**Update 23.06:** Overall RAG green. Whilst Community project implementation heavily impacted by pandemic, IT been able to facilitate other postive developments including remote working, which were not planned prior to Covid-19. Work recommenced on community integtation from June 20 and on track for December 20 completion. RAG may move to Amber subject to level of co-operation with NELCSU regarding migration around which there is a significant risk. Mike Bone to inform group if RAG needs to change.

Finding no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status	Project end date	Current status / overall RAG rationale
9	The trust must continue to take action to improve performance against national standards such as the 18 week referral to treatment (RTT) standard, six week diagnostic standard ad access standards related to suspected and confirmed cancer management	1. Develop business cases for Orthopaedics, Ophthalmology, General Surgery and Gynaecology 2. Business Cases to include up to date demand and capacity models, outline plans and costings to reduce current backlog, whilst balancing demand to enable the services to meet the national standard. 3. Continue to update Action Plans for all other specialities on a monthly basis 4. Review and monitor plans at new RTT steering group meeting with the ADO's, Weekly Access Meeting and Cancer PTL Meeting 5. Develop comprehensive action plan for Endoscopy now demand and capacity exercise complete for review at new bi-weekly Endoscopy oversight meeting	Helen Beck	Hannah Knights	Red	31.3.21	The Overall RAG is green as there is a clear plan and a realistic completion date but the work has been impacted by Covid-19. Clear plans being developed as part of Corvid recovery phase 3. Update 25.06: Overall RAG status moved to Red. Plan needs to be re-focussed. HK/AB to update plan. HK to prepare Covid-19 Holding Statement **Update 09.07.20: Covid-19 Holding Statement prepared. Revised Plan pending for review at next SRO Improvement Cluster.** **Update 13.07.20: The demand and capacity work was initially completed but since then capacity has reduced and there is uncertainty regarding future demand. Recovery of elective activity post Covid-19 is likely to take 2 - 3 years. The priority is diagnostics and cancer first and then 18 week waits.**
10	The trust must ensure that the duty of candour is carried out as soon as reasonably practicable, in line with national guidance	1. Continue to highlight key areas of non (or late) compliance via the IQPR and divisional performance reporting pathways. 2. Seek staff feedback on reasons for non (or late) compliance with DoC to identify opportunities for improvement using QI methods 3. Enable staff to fully achieve the remit of the Being Open framework through provision of training and support recognising that the patient / family conversations can be emotive and distressing both for the families but also the clinicians providing that message on behalf of the organisation	Susan Wilkinson	Lucy Winstanley	Red	31.10.20	Overall RAG is Amber as Duty of Candour work is integral to PSIRF Implementation (see No 3). All actions therefore switched to Amber with end date 31.10.20. The Trust Board has maintained oversight of compliance and addressed performance issues as part of ongoing incident review process. The revised plan will be presented at the Quality Group in July to agree the next steps with a key group of stakeholders. **Update 23.06.20:** Overall RAG moved to Red. Plan will be recalibrated for submission at the next SRO Improvement Cluster. The revised plan will be presented at July Quality Group to agree next steps with a key group of stakeholders. Similar with Plan 3 and 4.3, Plan 10 is subject to the development of the Trusts Patient Safety and Quality Agenda which is reporting at TEG 20th July. **Update 13.07.20: Another plan wrapped up in PSIRF and again not taking eye off the ball. More updates to follow next month.**
11	The trust must ensure effective processes are in place to meet all the requirements of the fit and proper persons regulation	1. Put in place clear procedures that ensure full compliance with all FPP requirements and record keeping, including recruitment, ongoing declarations and appraisal. 2. Implement structured reporting and audit of compliance through the audit committee.	Jeremy Over	Angie Manning	Green	31.7.20	Assurance testing being undertaken for most recent executive (acting) and NED appointments. **Update 29.06:** No. items in plan to be increased to reflect delivery. **Update 09.07.20:** HR met with PMO. Plan has been updated **Update 13.07.20: The small number of identified gaps within personal files have been of senior appointments have been rectified. Adequate processes are now in place.**
12	The trust must ensure that mandatory training attendance, including training on safeguarding of vulnerable children and adults, improves to ensure that all staff are aware of current practices and are trained to the appropriate level	1. Build, review and implement the mandatory training recovery plan with tracking to ensure 90% compliance	Jeremy Over	Denise Pora	Amber	31.05.21	Overall RAG Amber as mandatory training has continued for new starters but not for existing staff for duration of pandemic. Through a risk based approach the current Mandatory Training Recovery Plan is presently being reviewed as work is being restarted. **Update 29.06:** Plans will be updated re Covid-19 and second recovery plan for Mandatory Training. - Revised Plan will be presented at TEG July 20. - Mandatory training to be reviewed with W&C division - Issue is that PROMPT training needs to be mandated **Update 13.07.20: Long date (31.05.21) due primarily to capacity with limited access to education centre due to pandemic. Requires e-learning development. End date will be reviewed and may come forward but dont want to over promise.** **- Plan to mandate PROMPT Training is in place.**

Finding no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status	Project end date	Current status / overall RAG rationale
13	The trust must ensure staff complete patient risk assessment to identify patients at risk of deterioration and risk assessments for day to day care activities.	Put eCare change requests in place to amend: 1) Changes to triage form, mandate safeguarding concerns yes/no box 2) Changes to triage form, mandate falls history/risk of yes/no box, to then generate ED falls assessment if yes ticked 3) Changes to ED safety checklist, to mandate all fields, to add n/a column, to move pressure area assessment from 2nd hr to 1st hr, to add drop down box on pressure area assessment to choose from skin intact, DTI, category 1-4 (to be able to choose more than one) 4) To mandate observation, pain score fields on triage form for both adult & paediatrics 5) To communicate changes to staff 6) To complete weekly audits to monitor compliance 7) To request compliance data from the information team 8) To have 1-1 with staff which are non-compliant 9) Add to perfect ward 10) Monitor through weekly compliance audits and regular communications with ED staff re changes and be proactive with feedback re further changes	Susan Wilkinson	Ian Pridding	Amber	31.8.20	Overall RAG is green and on track. Patient safety checks being included on perfect ward app. Overall RAG moved to Amber. Awaiting compliance data report from Information Team (expected Mid July) regarding Patient Safety Checklist compliance as technical issues now resolved. Accurate compliance data will provide the levers to drive improvement through 1:1's or via the line managememt structure as it will be clear who is / not completing the Patient Safety Checklist. All relevant aspects of compliance will be added to the Perfect Ward App - A poster will be produced for the ED department for patients to view which presents the idealogy behind the Patient Safety Checklist and the Trusts commitment to it. - The first five parts of the plan are complete and are ready for submission to the IB for approval in July. **Update 13.07.20: Key actions due to complete in July including accurate compliance reports from the information team so may turn green at next cluster**
14	The trust must ensure staff record medication temperatures and escalate any concerns in line with its medications policy.	1) Pharmacy to audit all fridge temperatures in Emergency Department. Actions to address issues resulting from temperature audit: - Introduction of trays into the fridge to keep stock together to minimise time looking for drugs - Pharmacy Assistant responsible for stock replenishment to return all excess fridge stock to pharmacy to improve airflow within the unit - Assess requirement of rigid cold blocks in fridge and remove if unnecessary - Installation of more accurate external fridge thermometers on advice of pharmacy - Request monthly audits from pharmacy to ensure continued compliance 2) Ambient temperature monitoring Ensure appropriate systems and processes are in place to monitor ambient room temperatures in areas where drugs are stored and appropriate escalation processes where required. Actions to address issue: - Installation of thermometers in all rooms used for storage of drugs. - Introduction of ambient room temperature checking on to existing fridge temperature checks - Compliance to be audited within monthly perfect ward assessments 3) Escalation of increased temperatures Ensure appropriate escalation of increased temperatures to Unit Manager to ensure appropriate action taken	Susan Wilkinson	Dona Bowd	Green	31.08.20	Overall RAG green. Daily recording in place on wards with matron rounds then checking completion through Perfect Ward App. **Update 08.07.20:** Plan essentially complete with 7/8 items immediately ready for approval at IB to move to Blue (BAU) as room and fridger temperature planned improvements are embedded and monitored. Item 8 on the plan is to add room and fridge temperatures to the Perfect Ward App **Update 13.07.20: Findings related principally to ED and Maternity but this is an area again where the Trust has taken the opportunity to review organisation wide. 7/8 actions complete and internal checks confirm compliance but still need ongoing assurance to 31.08.20.** **- Also, central temperature recording system maybe something to look at in new building. Central collation system required and so monitoring assurance needs development.**
15	The trust must ensure that staff records in relation to equipment and medication checks are completed.	1) Review of documentation for equipment and medication checks Departmental review of existing documentation with a view to simplifying checklists and improve compliance. 2) Review of online checking duplication of paper and online checking was causing confusion and impact on compliance. 3) Long term strategy to replicate improved paper checklist on to the online system. 4) All changes communicated to staff via email and hot topic	Susan Wilkinson	Dona Bowd	Green	31.07.20	Paper format - Infection prevention to revisit plan to meet with IT re replicating updated electronic forms on to the online checking system. **Update 08.07.20:** Plan essentially complete with 5/6 actions to review and improve resuscitation equipment and medication checklists ready for submission to IB for approval. The last remaining item on the plan is to customise the online checklist template on e-Care for all ED areas for individual resus trolleys. This work has been impacted by Covid-19 and the ED Matron will pick up again with IT to complete this action. **Update 13.07.20: Similar to plan 14, majority of actions complete with one key item to complete in July 20 and again to work on centralised log for monitoring.**

Finding no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status	Project end date	Current status / overall RAG rationale
16	The trust must improve medicines management, particular in respect of management of controlled drugs, storage of patients' own medications and monitoring ambient room temperatures in drugs rooms.	<u>Controlled drugs and storage of patients own mediciation</u> 1. Review of existing policiies (confirmed as fit for purpose) 2. Ensure staff awareness of procedures and put in place systematic review of compliance 3. Ensure effective action is taken to address individual or themes of non-compliance <u>Ambient room temperatures</u> 1. Email communication to all staff to remind to escalate high temperatures to Unit Manager (regular escalations since communication.) 2. Issue included in weekly hot topics discussed at all handovers. 3. Unit manager informs pharmacy of any escalations to ensure appropriate actions if required. 4. Long term strategy: Trust wide consideration of centralised temperature monitoring	Susan Wilkinson	Simon Whitworth	Amber	31.10.20	Overall RAG green. Actions mainly complete - wards reported broken lockers repairs made by facilities. Audit of compliance being implemented through PerfectWard App to embed practice through leadership of Heads of Nursing Update 08.05.20: Overall plan moved to Amber. Actions complete with exception of mock inspection re medicines management (medicines storage). However, holding statement prepared re actions that need to be added to the plan for delivery so that plan be embedded: Holding statement 08.07.20: No guarantee actions in plan mean that problems around the safe storage of medications will not recur: - Further communications required to ensure message is getting across to relevant ward staff, including managers and matrons, to ensure the actions are being implemented consistently across the organisation. - Appropriate monitoring arrangements will also need to be in place if the plan is to move to Blue (BAU). - Consideration should be given as to whether any of these processes could be automated. These actions should be added to the revised baseline plan before the next SRO Improvement Cluster meeting **Update 13.07.20: Additional items added to plan. SW meeting with SWh to review actions in plan to achieve BAU.**
18	The trust must ensure that all bank and agency staff have documented local inductions.	West Suffolk Professionals 1. A generic trust induction checklist is to be enhanced and re-implemented for all new agency and bank workers. This will be followed up with a local area induction to be completed during first worked shift. 2. Agency and Bank workers will complete local area induction on the commencement of their first shift. 3. If additional shifts are undertaken in different areas, it is the expectation of the trust that a local induction will be conducted for each new area worked. 4. All bank staff training is to be reviewed and recorded on OLM. Medical Staffing 1. All Agency staff are given induction booklets before their first day, which they are required to sign and return a statement confirming they have read and understood this on their first day. 2. Bank medical staff are formed by current training and trust doctors, therefore are covered by local induction process. Ad hoc audits will be undertaken by WSG and MS with findings reported to HRD on a quarterly basis	Jeremy Over	Holly Randall / Helen Beard	Green	31.12.20	Overall RAG green with one remaining amber action: HR to check with CDS what is focus on OLM. Assurance process to be agreed. Update 29.06: New WSP Manager starts 1st July '20. Status of plan reviewed and updated with new actions assigned given departure of manager. **Update 13.07.20: New WSP Manager in post with detailed updated action plan for implementation.**
19	The trust must ensure that medicines are stored securely within the main and day surgery theatre department.	1. Identify storage requirement and purchase cupboards 2. Local audits planned whilst areas accessible re Covid-19 3. Identify cupboard locations and estates to hang cupboards 4. Risk assessments can then take place 5. Perfect Ward App to be introduced to ensure compliance	Helen Beck	Irene Fretwell	Green	31.10.20	Overall RAG green. Weekly QA call through June with Project Lead. Update 25.06: Project progressing and on track. **Update 13.07.20: On track and has progressed despite Covid-19 and could potentially bring end date forward and present to Board for approval / BAU once the audit reports are presented by the team.**

Finding no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status	Project end date	Current status / overall RAG rationale
20	The trust must improve monitoring ambient room temperatures in drugs rooms.	1. MDT meeting to access temperature monitoring options available 2. Prepare baseline assessment of ambient temperatures in Clinical Area 3. Investigation cost associated with automated temperature monitoring equipment and Air conditioning 4. Ordering of Max/Min room temperature thermometers 5. Creation of Ambient temperature monitoring record book for clinical areas 6. Creation of Ambient temperature monitoring email address for wards to use to report temperature exclusions 7. Distribution of max/min room temperature thermometers to inpatient clinical areas 8. Ordering of second batch of Max/Min room temperature thermometers 9. Distribution of second batch of max/min room temperature thermometers to inpatient clinical areas 10. Creation of MedicBleep ambient temperature reporting message group 11. Creation of Perfect Ward monitoring tool for Ambient temperature monitoring 12. Completion of Risk Assessment of actions if high ambient temperatures recorded	Susan Wilkinson	Simon Whitworth	Complete	28.2.20	Overall RAG Black Complete. Trust Guidance now in place for managing adverse ambient temperatures - this is also a risk assessment tool. As an additional action, Perfect Ward App will be introduced to ensure compliance with requirement around recording temperature monitoring. Action implemented, assurance testing ongoing. **Update 08.07.20:** Plan 20 is Black (complete) only in context of implementing all actions in current plan. However, there remains a monitoring and reporting risk around ambient temperatures as the actions in the plan are manual. - The Implementation Board may therefore need to consider the introduction of a centrally monitored, continuously recording Ambient room temperature, fridge and freezer monitoring system for the Trust at a potential cost in excess of £100k, to switch the plan to Blue (BAU), for which a business case will be required. - This initiative would need to form part of the Buildings Management Systems strategy with Estates & Facilities monitoring and maintaining the alarms and to ensure that batteries do not expire. - Existing analysis suggests that other options, including air conditioning, are unrealistic given the associated cost and the current fabric of the building. **Update 13.07.20: Planned actions complete but need to understand from Board how much monitoring is required to move to BAU and adjust end date.** **- SW restated that compliance and action will not be dependent on centralised alarm system for maintaining temperatures.**
21	The trust must improve monitoring of women's records and ensure that a greater number of records are audited monthly.	Audit programme to be put into place including sampling methods and timescales	Susan Wilkinson	Karen Newbury	Complete	28.2.20	appropriate audit sample size. **Update 08.07.20**: The recommendation is that Plan's 21, 23, 24, 25 are submitted to the Improvement Board for approval to move the RAG from Black (Complete) to Blue (BAU) as a Clinical Quality Midwife has been appointed with responsibility for undertaking monthly audits. Sample sizes and audit dates are agreed and the findings are presented monthly at the Women's Health Governance Board and the Women & Children's Divisional Board going forward. **Update 13.07.20: Actions are complete. Midwife appointed to undertake audits. Need to see assurance results to progress through Board to move to BAU.** **- A maternity deep dive will be undertaken by KN, SW, LN, JR reporting back at next IPB with 3 months data as evidence**
22	The trust must ensure that carbon monoxide monitoring assessments and records are in line with trust policy..	Monitor compliance through audit and (when required) action to address non-compliance	Susan Wilkinson	Karen Newbury	Complete	28.2.20	Action implemented, assurance testing ongoing. Recognised that pandemic has impacted on our ability to deliver this monitoring - this is mitigated through appropriate referral to the smoking cessation advisor. **Update 08.07.20: The RAG for Plan 22 cannot move from Black to Blue (BAU) given national stop on carbon monoxide monitoring assessments through pandemic.**
23	The trust must ensure that women are asked about domestic violence in line with trust policy.	Monitor compliance through audit and (when required) action to address non-compliance	Susan Wilkinson	Karen Newbury	Complete	28.2.20	Action implemented, assurance testing ongoing. **Update 13.07.20: See 21**
24	The trust must ensure that they implement a nationally recognised monitoring vital observations tool for women attending triage on labour suite and the maternity day assessment.	1. Project plan for the implementation of MEOWS first in the maternity areas (complete) and then in the wider hospital for peripartum ladies (including the wider group of miscarriage, termination and ectopic pregnancies) 2. Continue to monitor compliance through audit and (when required) action to address non-compliance	Susan Wilkinson	Karen Newbury	Complete	28.2.20	Action implemented, assurance testing ongoing **Update 13.07.20: See 21**
25	The trust must ensure they implement a national recognised monitoring vital observations tool for new born babies on the labour suite and F11 ward.	1. Project plan for the implementation of NEWTTS (complete) 2. Continue to monitor compliance through audit and (when required) action to address non-compliance	Susan Wilkinson	Karen Newbury	Complete	28.2.20	Action implemented, assurance testing ongoing **Update 13.07.20: See 21**

Finding no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status	Project end date	Current status / overall RAG rationale
26	The trust must ensure they carry out daily checks of resuscitation equipment.	1. Key actions are to remove paper checking of resuscitation equipment and replace with electronic checking	Susan Wilkinson	Karen Newbury	Complete	31.1.20	Action implemented, assurance testing ongoing **Update 07.07.20:** Plan No 26 can be submitted for approval at IB to move the RAG from Black to Blue (BAU). - Paper checking is no longer used in the department. The following checks were originally put in place: - F11 Ward Manager check daily - Labour suite co-ordinators to check daily - Service Manager to check weekly compliance in all areas A Clinical Quality Midwife has also been appointed with responsibility for overseeing checks **Update 13.07.20: Again actions virtually complete (31/34 guidelines prepared) and midwife in place to complete audit checks.**
27	The trust must ensure clinical guidelines are up to date.	1. Through the divisional leadership review and update all clinical guidelines and issue through the approval pathway 2. Put in place systematic system to support the management, reporting and monitoring of clinical guidelines across the Trust to ensure they are kept up to date	Susan Wilkinson	Divisional Triumvirate	Amber	31.10.20	Update 23.06.20: 29/36 guidelines updated in maternity. Project plan being prepared to roll-out new technology to support management of clinical guidelines. **Update 23.06.20: Clarity needed re divisional engagment via Tri**
28	The trust must ensure patients can access the service when they need it and receive the right care promptly in line with national targets.	See No 9	Helen Beck	Helen Beck with ADOs	Red	31.3.21	See No 9
29	The trust must ensure diagnostic test results are available in a timely manner.	Review reporting arrangements for relevant diagnostics services. Ensure appropriate escalation procedures are in place for delays. Address the negative impact of COVID on diagnostic testing and reporting.	Helen Beck	Helen Beck	Red	31.12.20	Through the Board reports and divisional PRMs performance is monitored against 6-week diagnostics standards. Compliance was being delivered for all diagnostics other than endoscopy. The monthly PRMs also include radiology reporting times and prior to COVID the Trust was achieving good performance. There is an SOP in place to escalate imminent OPD appointments for which results are not available to prioritise them on reporting queue prior to the patients appointment. Monitoring systems are effective and in place. The diagnostic testing and reporting forms part of the phase 3 recovery plan for COVID -availability of additional resource will impact on timescale for delivery. Update 25.06.20: Covid has had a significant negative impact on diagnostic timeframes. A recovery plan is in development. Reporting times have improved due to reduced numbers of tests and is monitored through divisional PRMs. Covid-19 holding statement required as diagnostic timeframes have extended significantly under Covid-19 **Update 13.07.20: The Trust could have evidenced at the time of the CQC inspection that tests were available in a timely manner but the information was not requested. The landscape has now changed and Covid-19 has had a significant negative impact on diagnostic performance. Whilst reporting times have improved due to reduced numbers of tests which are monitored through divisional PRM's, a recovery plan is in place as diagnostic timeframes have extended significantly.**
30	The trust must ensure there is an effective process in place for monitoring patients requiring a follow up appointment and for those on surveillance pathways.	See No 6	Helen Beck	Angela Price	Red	31.03.21	25.06.20 Overall status Red pending collation of new documentation re COVID backlogs

Finding no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status	Project end date	Current status / overall RAG rationale
31	The trust must ensure staff complete and record patient pain assessments in patient records.	1. Issue reminder to teams regarding the importance of undertaking pain assessments for end of life patients 2. Review of core template on SystmOne to ensure that it is fit for purpose 3. Written guidance on completion of core assessment template on SysmOne 4. Share written guidance with clinical teams 5. Identify SuperUsers to support training on the correct use of the core template and embedding within teams 6. Update staff via CREWS divisional quality report 7. Include audit of completion of Pain Assessment via Perfect Ward App	Helen Beck	Michelle Glass	Green	31.12.20	Overall RAG is Green with one Red item re Crews divisional quality report / Newsletter which has been reintroduced as part of Covid-19 recovery. Also one Green item is regarding providing evidence re use of Perfect ward App. Update 25.06: Should be at BAU embedded point. NSH action to provide update at next SRO Cluster. **Update 13.07.20: HB and MG seen early audits and should be able to give a recommendation by the next Board. Assurance that all available care plans will be completed and a huge amount of work has been done. MG confident would be embedded and progressed to BAU (Blue).** **- HB to present update at nexr IPB 10.08.20**
32	The trust must ensure all staff complete mandatory training including safeguarding training.	See No 12	Jeremy Over	Denise Pora	Amber	31.5.21	See No. 12

17. Mandatory training and appraisal report

To APPROVE a report

For Approval

Presented by Jeremy Over

Board of Directors 31 July 2020

Agenda item:	17			
Presented by:	Jeremy Over, Executive Director of Workforce & Communications			
Prepared by:	Denise Pora, Deputy Director of Workforce (Learning and OD) and Emma Bell, Education and Training Co-ordinator, Lorna Lambert, Medical Education Manager			
Date prepared:	13th July 2020			
Subject:	Workforce information reporting – appraisal and mandatory training			
Purpose:	☑	For information		For approval

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

Appraisal

- The Trust appraisal participation target is set at 90%; the June 2020 completion figure is 73.18%, a fall of 6.42% since March 2020. See Appendix A.

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

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

- An action plan is in place to support an increase in appraisal completion. See Appendix B. The plan has been reviewed in light of the impact of COVID-19.

Mandatory training

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

- The latest compliance figure is 86%. This is a reduction of 3% from the previous Board report in April. See Appendix C.

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

- New ways of delivering mandatory training are being developed. The Postgraduate Medical Education Team have had good success with Microsoft Teams to provide fire training for both

junior doctors and consultant medical staff and are exploring using it for blood transfusion awareness. Conflict resolution training has also been provided virtually for 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**		
			☑				
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:	Mandatory Training Steering Group for mandatory training, and monthly IPQR board report for appraisal and mandatory training.						
Risk and assurance:	Risk to patient and staff safety due to gaps in knowledge, awareness and support. Mandatory Training recovery plan and impact assessments included.						
Legislation, regulatory, equality, diversity and dignity implications	Legislation, regulatory, equality, diversity all included.						
Recommendation: Trust board members are invited to note this report.							

Appendix A

Appraisal compliance June 2020 – Trust target 90%

Division	Total Assignments	Total Applicable Staff	Total Applicable Staff Expired	Total appraisals due within 3 months	Total New Starters	Total Maternity	Divisional Compliance Rate	Movement (on last month)
Clinical Support Division	471	405	76	94	54	12	**81.23%**	1.14%
Community Division	912	719	187	180	159	34	**73.99%**	-1.67%
Corporate Services Division	436	342	109	78	83	11	**68.13%**	-1.58%
Estates & Facilities Division	402	359	50	90	41	2	**86.07%**	-7.11%
Medical Division	1142	865	256	176	256	21	**70.40%**	-4.07%
Surgical Division	805	663	228	133	125	17	**65.61%**	-4.07%
Women and Child Division	349	282	69	54	52	15	**75.53%**	-0.17%
Trust total	**4517**	**3635**	**975**	**805**	**770**	**112**	**73.18%**	**-2.77%**

Appendix B – Appraisal Action Plan

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

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

Row Labels	Match	No Match	Grand Total	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	May-20	Jun-20	Jul-20	% Difference from June-July
179|LOCAL|Basic Life Support - Adult|	1766	1022	2788	81%	81%	81%	82%	83%	87%	86%	85%	84%	74%	71%	63%	-7%
179|LOCAL|Blood Bourn Viruses/Inoculation Incidents|	2172	293	2465	85%	85%	88%	88%	89%	89%	88%	88%	89%	89%	89%	88%	-1%
179|LOCAL|Blood Products & Transfusion Processes (Refresher)|	1225	487	1712	78%	76%	77%	75%	78%	78%	76%	77%	77%	75%	74%	72%	-2%
179|LOCAL|Conflict Resolution - elearning|	914	139	1053	81%	81%	85%	88%	88%	90%	90%	89%	89%	87%	86%	87%	1%
179|LOCAL|Conflict Resolution|	1377	505	1882	76%	75%	75%	76%	78%	77%	77%	76%	76%	76%	75%	73%	-2%
179|LOCAL|Equality and Diversity|	4075	294	4369	90%	90%	93%	92%	93%	94%	94%	94%	94%	93%	93%	93%	0%
179|LOCAL|Fire Safety Training - Classroom|	3695	674	4369	90%	88%	91%	90%	89%	90%	90%	90%	88%	86%	85%	85%	-1%
179|LOCAL|Fire Safety Training - eLearning|	3387	982	4369	84%	83%	87%	87%	87%	89%	89%	88%	88%	81%	80%	78%	-2%
179|LOCAL|Health & Safety / Risk Management|	3895	474	4369	91%	90%	92%	91%	91%	92%	91%	91%	92%	90%	90%	89%	0%
179|LOCAL|Infection Control - Classroom|	1986	116	2102	95%	95%	96%	96%	96%	97%	98%	98%	97%	96%	96%	94%	-1%
179|LOCAL|Infection Control - eLearning|	2097	281	2378	90%	88%	91%	91%	90%	91%	90%	90%	91%	88%	88%	88%	0%
179|LOCAL|Information Governance|	3732	637	4369	86%	87%	91%	90%	91%	92%	93%	91%	91%	83%	84%	85%	1%
179|LOCAL|Major Incident|	4001	368	4369	85%	85%	88%	87%	92%	92%	92%	92%	92%	92%	92%	92%	0%
179|LOCAL|Medicine Management (Refresher)|	1550	253	1803	86%	85%	86%	86%	87%	87%	86%	87%	87%	87%	86%	86%	0%
179|LOCAL|Moving & Handling - elearning|	985	176	1161	80%	79%	82%	81%	86%	86%	86%	85%	86%	84%	84%	85%	1%
179|LOCAL|Moving and Handling - Clinical|	1535	905	2440	79%	82%	82%	83%	84%	87%	87%	84%	84%	75%	72%	63%	-9%
179|LOCAL|Moving and Handling Non Clinical Load Handler|	323	51	374	61%	65%	70%	73%	91%	94%	93%	93%	94%	90%	90%	86%	-4%
179|LOCAL|Safeguarding Adults|	3870	499	4369	89%	88%	89%	90%	89%	90%	90%	89%	90%	89%	88%	89%	0%
179|LOCAL|Safeguarding Children Level 2|	1901	200	2101	90%	89%	91%	92%	92%	91%	91%	92%	93%	90%	90%	90%	0%
179|LOCAL|Security Awareness|	4107	262	4369	89%	88%	91%	92%	96%	96%	96%	95%	95%	95%	94%	94%	0%
179|LOCAL|Slips Trips Falls|	2544	319	2863	82%	81%	84%	86%	86%	89%	87%	88%	88%	88%	89%	89%	0%

NHS|CSTF|Preventing Radicalisation - Basic Prevent Awareness - 3 Years|	3880	489	4369	92%	90%	91%	90%	90%	91%	90%	90%	91%	89%	89%	89%	0%
NHS|CSTF|Preventing Radicalisation - Prevent Awareness - No Specified Renewal|	2630	395	3025	82%	82%	83%	83%	84%	87%	86%	85%	87%	87%	87%	87%	0%
NHS|MAND|Safeguarding Children Level 1 - 3 Years|	3912	457	4369	93%	95%	93%	93%	93%	93%	92%	92%	92%	90%	89%	90%	0%
NHS|MAND|Safeguarding Children Level 3 - 1 Year|	499	52	551	80%	79%	84%	83%	84%	84%	84%	87%	90%	89%	88%	91%	3%

Appendix D – Mandatory Training Recovery Plan

Item	Requirement	Action	Update	Completion date	Responsibility
1	Review of Mandatory Training Subjects	Address increase of mandatory training compliance.	A full review of all mandatory training courses has taken place to ensure appropriateness and renewal period. All changes were managed in a safe, auditable way, placing patient and employee safety as the top priority.	Complete	Mandatory Training Steering Committee
2	Update OLM following Mandatory Training Review	Update ESR and staff records to reflect requirements	Education & Training Team are currently inputting the amendments made following the full mandatory training review (see item above). Implement changes identified in action 1.	Date under review due to COVID	Mandatory Training Team
3	Improve access to e-learning modules	Implement necessary changes to server to improve access and usability of e-learning system.	IT completed all relevant sever updates. The mandatory training team have transferred the majority of their e-learning packages onto the Articulate software. There are still some issues with Articulate as some community staff have reported issues, and the education and training team are currently unable to have any audio clips within the presentation. The Education and Training team are liaising with IT regarding this.	Date under review due to COVID	Rob Smith Rob Howorth
4	Support streamlining for junior doctors	Continue to engage with streamlining projects Provide opportunities for mitigation where streamlining is not currently in place	Revision of induction timetables to include West-Suffolk specific mandatory training courses Work with Trusts across region to achieve best possible data transfer through ESR system.	Complete	Lorna Lambert, Rota co-ordinators
5	Managers to have direct access to staffs performance information including mandatory training	To implement ESR (Electronic Staff Record) Supervisor Self Service	Implementation plan agreed with full roll out planned by March 2020. Roll out put on hold due to COVID-19 impact. New implementation date to be agreed.	Paused	Workforce Team HR

Item	Requirement	Action	Update	Completion date	Responsibility
6	Community training data to be reviewed	It has been raised that some community data does not seem to be accurate within the ESR system and does not match local records, specifically from Paediatrics	Community Leads to provide the Education & Training Team with details of those records/individuals which do not match or are inaccurate in OLM. The Education & training Team to investigate and then update as appropriate.	Date under review due to COVID On-going	Education & Training team
7	COVID-19 recovery plan – new starters (all staff excluding junior doctors)	Non-medical clinical induction including mandatory training elements continued during pandemic with shift to e-learning where possible	Changes have resulted in significant increase in workload for E&T team, rescheduling training and increased enrolment in e-learning, this will be on-going for the foreseeable future. Risk to approach caused by lack of capacity of facilitators and education centre capacity with social distancing result in significant reduction in numbers trained at workshops. Proposal to allow for increased numbers through 1m+ distancing with mitigating PPE declined by Strategic Group. Process being put in place to monitor e-learning completion by staff.	Date under review due to COVID	
		Trust induction elements of mandatory training – all converted to e-learning, except fire delivered as a face-to-face standalone session.	Trust induction to be set up as single certificated course – this will reduce administrative workload. Member of staff redeployed from Volunteers Service to be trained to support this. eLearning package to be put together by the education and training team.	September 2020	Education and Training Team
8	COVID-19 recovery plan – refresher training for non-medical clinical staff	Refresher training reduced to subjects requiring annual refresher for period August to December 2020 due to constraints of facilitator availability and social distancing requirements.	Face-to-face update mandatory training paused from 26 March to 31 July 2020 for all non-medical staff groups, excluding midwives. Refresher training for midwives recommenced in July 2020. Refresher training for other non-medical clinical staff recommences in August 2020.	August 2020	Education and Training Team Departmental Managers
9	COVID-19 recovery plan – refresher training for non-clinical staff	Majority of training is e-learning. Face-to-face sessions will recommence in August 2020.		August 2020	Education and Training Team Departmental managers

Item	Requirement	Action	Update	Completion date	Responsibility
10	COVID-19 recovery plan senior medical staff	To review the consultant slide set	The consultants slide set needs to be reviewed and updated by the Education and Training Team.	December 2020	Education and Training Team with Deputy Medical Director
11	Review model of provision of non-medical clinical mandatory training to ensure staff remain compliant but are not undertaking training more frequently than required.	Develop new model for non-medical clinical mandatory training updates	To be signed off by the Mandatory Training Steering Committee in September 2020.	January 2021	Education and Training Team with Mandatory Training Steering Committee
12	Increase bank staff mandatory training compliance	To continue with monthly reporting and ensure action plans are agreed.	Following the bank mandatory training reports meetings will be held with all relevant department leads to discuss their action plans and identify any support needed.	January 2021	Education and Training Team with West Suffolk Professionals Manager and Medical Staffing Manager
13	The trust will look to develop a tracking process to alert managers to those staff who are falling behind in compliance levels (i.e. 90%).	Cover; staff groups, i.e. trust doctor and midwifery compliance, subjects, i.e. safeguarding children L3, as well as departments and directorates, i.e. community 7 women and children.	Action to be reviewed in the light of impact of ESR Manager self-service	March 2021	Education and Training Team

18. Consultant appointment report

To ACCEPT the report

For Report

Presented by Jeremy Over

Board of Directors – 31 July 2020

Agenda item:	18			
Presented by:	Jeremy Over, Executive Director of Workforce and Communications			
Prepared by:	Medical Staffing, HR and Communications Directorate			
Date prepared:	20th July 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**	

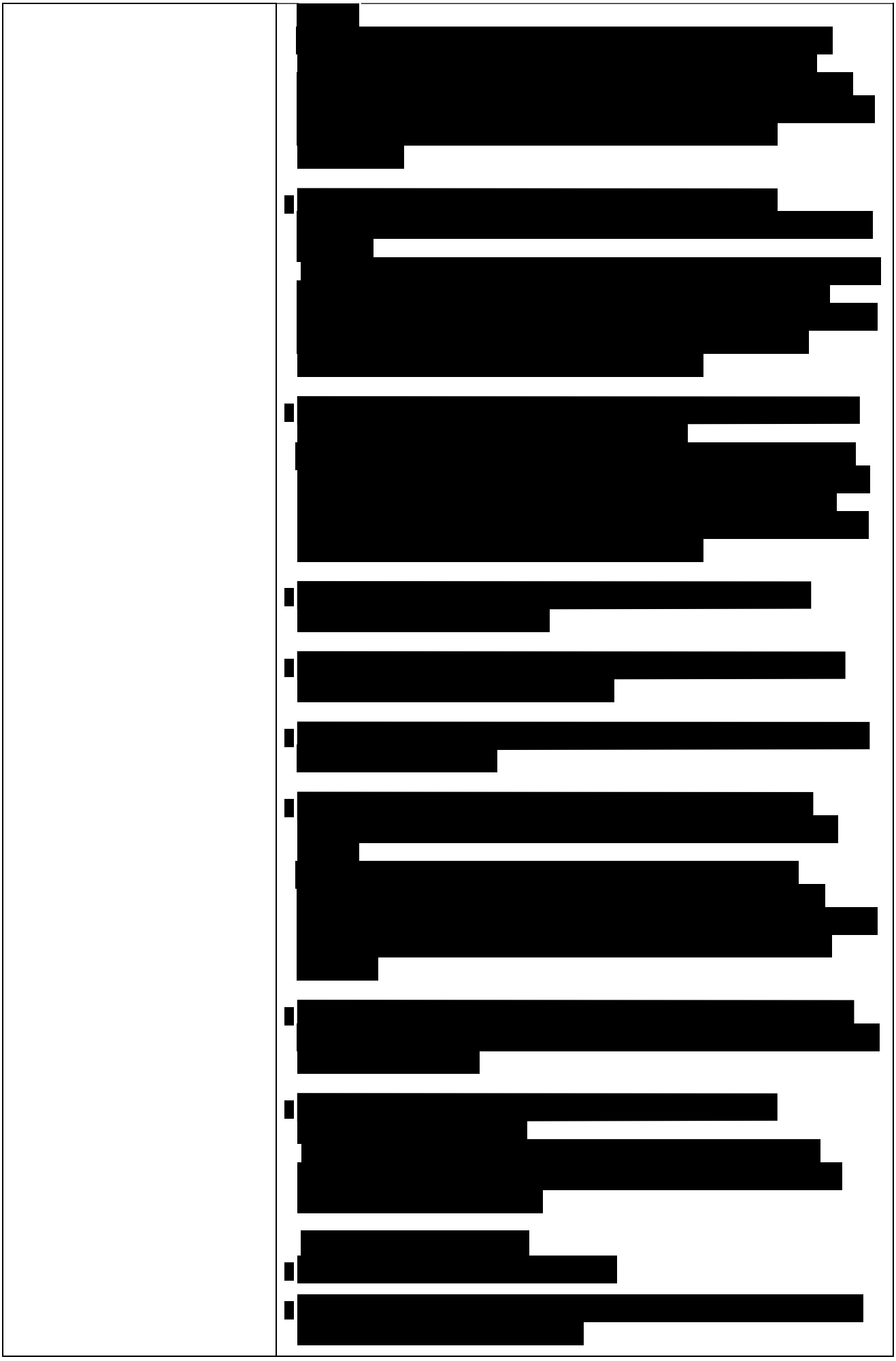
Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	x	x	x	x	x	x	x

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

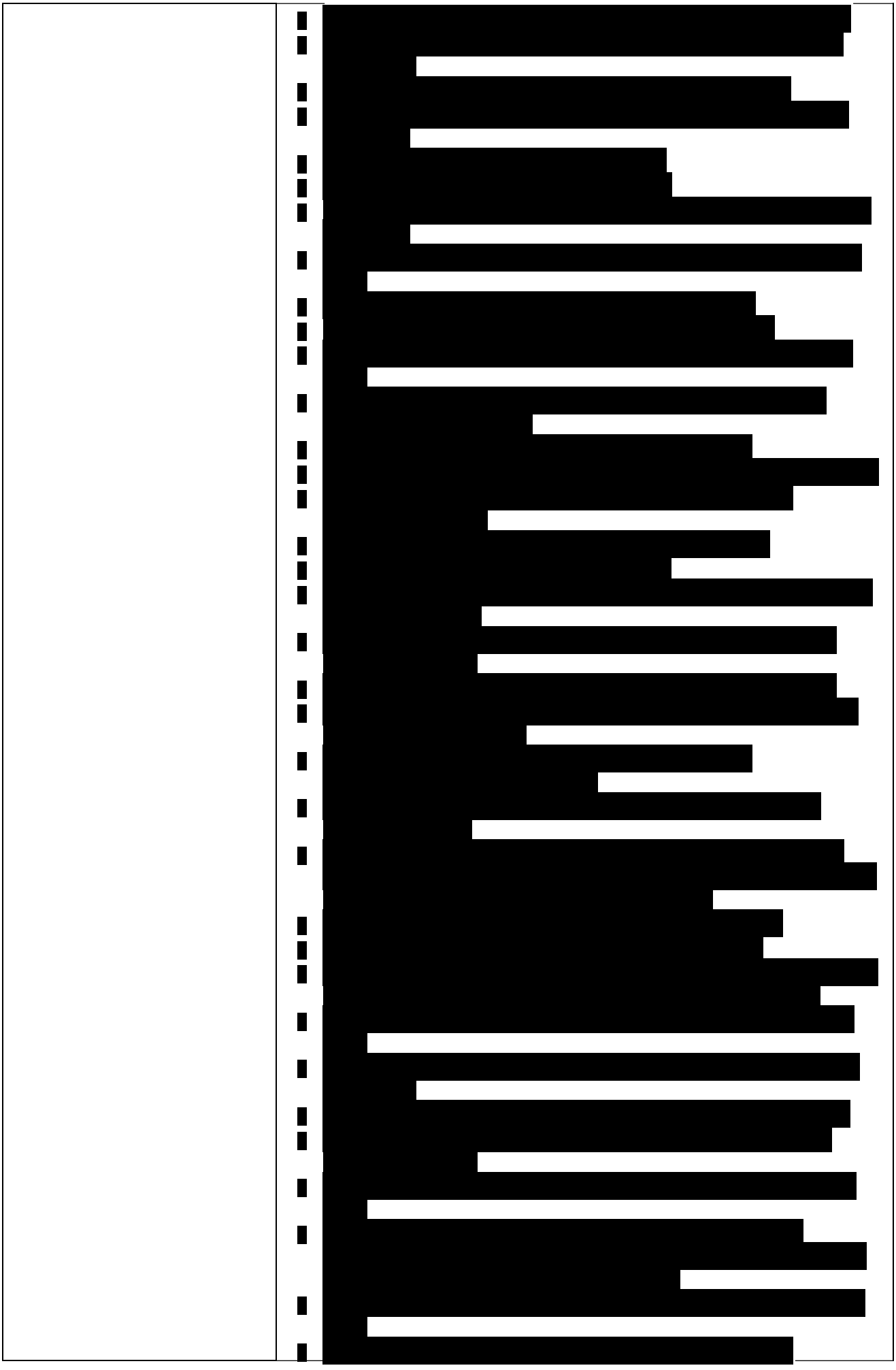
Recommendation:

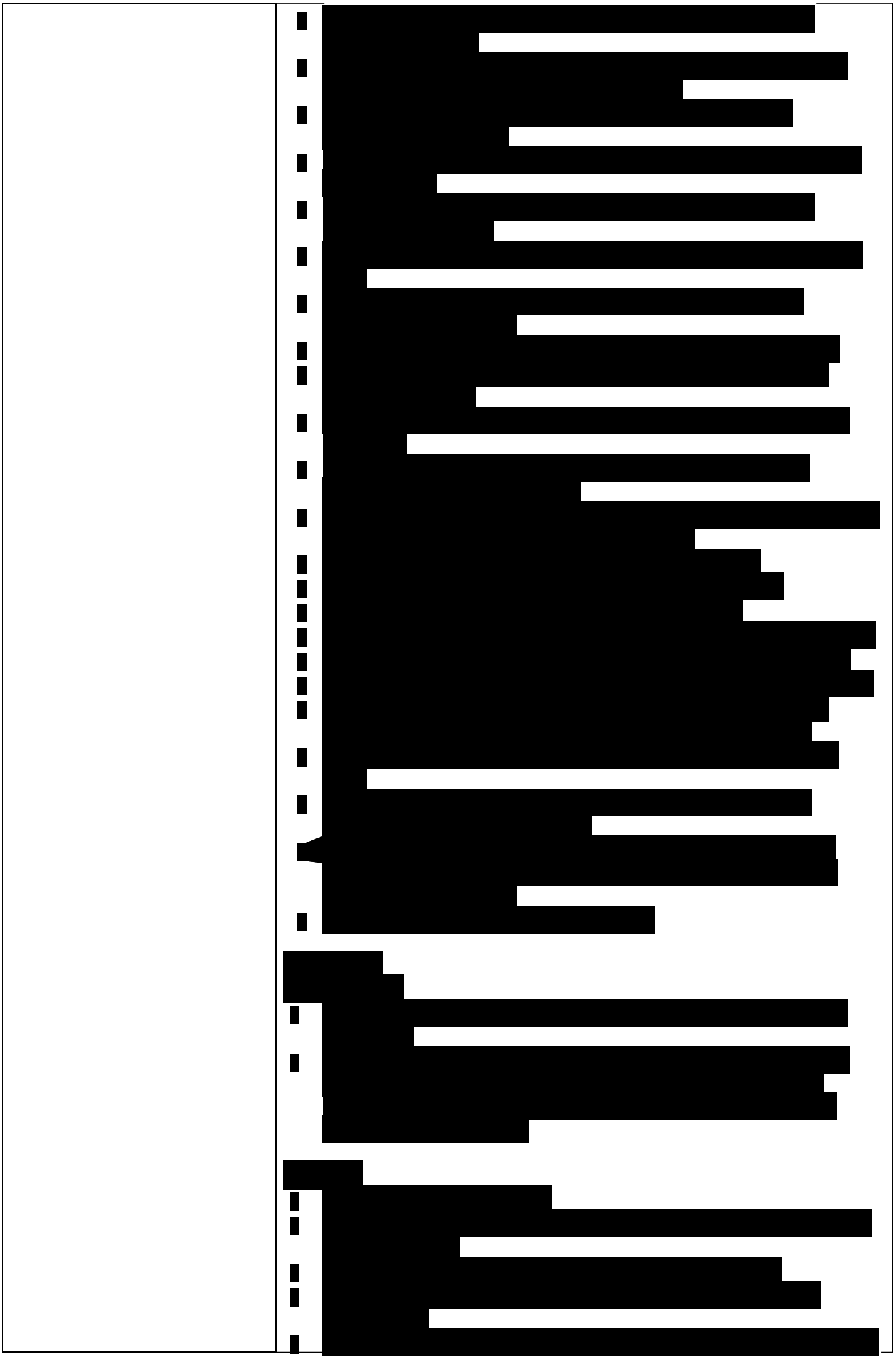
For information only

POST:	Acute Consultant in Obstetrics and Gynaecology - Maternal Medicine
DATE OF INTERVIEW:	Thursday, 25th June 2020
REASON FOR VACANCY:	Replacement
CANDIDATE APPOINTED:	[redacted]
START DATE:	TBC
PREVIOUS EMPLOYMENT:	[redacted]



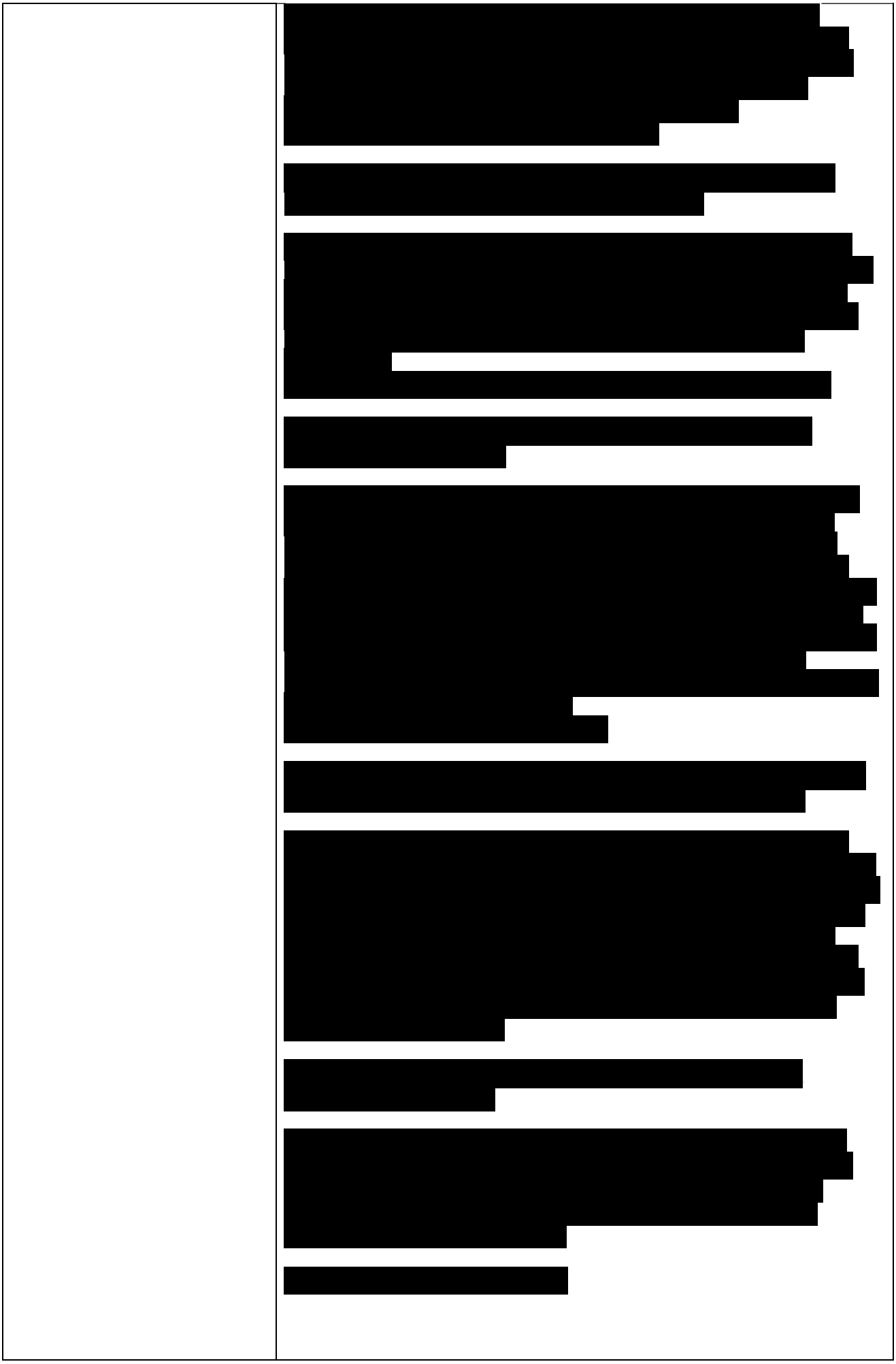
	[redacted]
QUALIFICATIONS:	**QUALIFICATIONS** [redacted]





	[redacted]
NO OF APPLICANTS: **NO OF INTERVIEWED:** **NO OF SHORTLISTED:**	5 2 1

POST:	Acute Consultant in Obstetrics and Gynaecology - Urogynaecology
DATE OF INTERVIEW:	Thursday, 25th June 2020
REASON FOR VACANCY:	Replacement
CANDIDATE APPOINTED:	[redacted]
START DATE:	TBC
PREVIOUS EMPLOYMENT:	**Present Job: Obs & Gynae, West Suffolk Hospital** [redacted]



	[redacted]
QUALIFICATIONS:	[redacted]

	[redacted]
NO OF APPLICANTS: **NO OF INTERVIEWED:** **NO OF SHORTLISTED:**	4 1 1

19. Putting you first award

To NOTE a verbal report of this months winner

For Reference

Presented by Jeremy Over

11:00 BUILD A JOINED-UP FUTURE

20. Integration report – Q1

To APPROVE the report

For Approval

Presented by Kate Vaughton and Helen Beck

West Suffolk NHS Foundation Trust Board Meeting

Friday 31st July 2020

Agenda item:	20			
Presented by:	Kate Vaughton, Director of Integration			
Prepared by:	Jo Cowley, Senior Alliance Development Lead, WSCCG Dawn Godbold, Associate Director, Integration and Partnership, WSFT Sandie Robinson, Associate Director of Transformation, WSCCG Lesley Standring, Head of Operational Improvement, WSFT			
Date prepared:	23/07/2020			
Subject:	West Suffolk Integration Update			
Purpose:	X	For information		For approval

Executive summary: This paper provides an update on the progress being made with integration in the West Suffolk system including specific transformation projects. This is a combined paper on Alliance development and transformation.

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

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

Previously considered by:	*WSCCG Govering Body*
Risk and assurance:	
Legislation, regulatory, equality, diversity and dignity implications:	

Recommendation:
The Board are asked to note the progress being made on individual initiatives and collaborative working across the system.

West Suffolk Integration Update

West Suffolk NHS Foundation Trust Board Meeting

31st July 2020

1.0 Introduction

1.1. This paper provides a quarterly update for the Board about activity to transform services and outcomes for people within the West Suffolk Alliance area. A number of different teams contribute to the report, from across the CCG, the hospital and Alliance partners.

1.2. The paper covers some key Alliance developments in the past period, and highlights some examples of changes that have taken place over the period of the pandemic that may be of interest to the Governing Body.

2.0 How the Alliance adapted over the last few months as a response to COVID-19.

2.1. The Alliance quickly adapted to the pandemic crisis in a number of ways, many of which come through in the examples listed below. Key features of this included:

- Fast, collaborative decision making
- Sharing of resources and information
- Partners able to flex services to meet current need.

2.2. Initially a West Alliance Tactical Cell was established, in which all system partners met twice a week to share intelligence, discuss issues and to ask for help. This enabled partners to start to support each other through new ways of working and provide support both operationally as well as on a more personal level during what was a very difficult time for all organisations. To enable this change, the Alliance Steering Group was stood down, with the understanding that the decisions would need to be more tactical and fast paced, and the West Cell effectively took over the functions of the Steering Group. In the last month the frequency of these meetings has been reduced and the group now meets fortnightly.

2.3. A number of subgroups were also stood up to co-ordinate activity across key areas of work, for instance homelessness, end of life and clinical decision making. A key new group is the Senior Operational Leadership Forum, which has operational leaders across community health, adult social care, mental health and the hospital working together. They meet weekly and the aim is for this group to be able to manage the developing integrated system together. The new governance is likely to be adopted by the Alliance now, at least in the short to medium term. A diagram is attached to this paper at **Appendix 1**.

3.0 Examples of rapid decisions about changes to services

3.1. The Suffolk GP Federation worked with the CCG to enhance two critical areas of support for our communities and service. The first of these was around symptom management and palliation of patients with COVID-19, which aimed to provide palliative clinical care to people at the end of life who wanted to die at home. Clinicians were able to provide a one touch plan for the palliative pathway, using medication that was readily available from community pharmacy, to a set of guidelines that had been designed by hospice palliative care specialists.

3.2. The GP Federation are in the process of collecting feedback from clinicians via a survey to understand how often the protocols put in place were used and how helpful they were for both themselves and patient care.

3.3. As part of the GP out of hours service the Federation set up support for Community Hospitals, Care Homes, Community Nursing and the Ambulance Service so that they could call into a clinical hub and speak to a local GP or ANP with access to the full GP record via telephone and/or video, resulting in better outcomes for the patient.

3.4. The arrangements in both service areas remain in place and in use with have no plans to remove them in the short term.

3.5. Other groups came together to share information, make tactical decisions and agree joint action. One of these was a daily meeting with Practice Managers, led by the CCG Primary Care Lead. These meetings were particularly helpful for reviewing and implementing new guidance and ensuring a consistent approach to problem solving and service changes. Another area of close collaboration was around care homes, where a county approach included relevant partners to share information and ensure appropriate actions taken. Technology was provided for care homes to support communication, both professionally and with relatives and carers, during the lockdown period. Additional infection control training and support was also put in place for all homes, with a buddy system established resulting in stronger links between Primary, Community Care and the Care Home teams.

3.6. Future working will continue to include opportunities to change services in a way that works better for patients and practitioners. For example, there is an ICS wide urgent care workshop in July aiming to develop direct booking from NHS 111 into Same Day Emergency Care and the Emergency Department which NHS England are seeking to be operational by November. Dr Dan Boden, Emergency Medicine Consultant and ECIST Clinical Associate leading on direct booking work, is keen to visit West Suffolk to support developments. ECIST is the Emergency Care Intensive Support Team - a clinically led national NHS team.

3.7. Data obtained during the pandemic is being used to take forward demand and capacity modelling in the community. The West Suffolk Foundation Trust public health deep dive into community COVID-19 discharge data highlighted a number of pathways not presenting as would be expected. Deep dive into the cellulitis pathway in progress and currently scoping an out of hospital pathway to build resilience. Several key actions have been taken forward following a subgroup community modelling meeting with mental health, acute and community health and social care on 10th July:

- Agreement to bring a focus on demand data and waiting lists to look at how better partnership working can improve the collective support to specific pathways. This builds on the virtual multi-disciplinary teamwork in Newmarket looking at how health and social care support their green RAG rated waiting list through a trusted assessment ‘mutual aid’ approach – there are currently 80 people being supported through this approach.
- Agreement to look at some of the pathways identified in the public health deep dive across community health and care.
- Agreement to map the discharge pathways 0,1,2 and 3 to better understand the increase in demand particularly for pathway 1 and the out of hospital resources required.
- Targeted focus on dementia starting with Dementia Intensive Support Team where referrals have tripled this month and likely to increase further.
- The Orthopaedic/MSK information will be mapped through the MSK Operational Board and Jo Douglas from Allied Health Professionals Suffolk will feed back to the Senior System Operational Leadership Forum.

4.0 Examples of sharing resources

4.1. Allied Health Professional Suffolk are a key Alliance partner and found during COVID-19 that they were unable to delivery their services as normal. They used the Mutual Aid principles to transfer staff to work within Integrated Neighbourhood Teams (INTs), in particular to provide

additional therapy for people needing rehabilitation. This supported a faster discharge from hospital for people with and muscular-skeletal conditions that require physiotherapy.

4.2. Furloughed staff volunteer to help integrated teams – this is the message we used in our staffing bulletins to let colleagues know about Abbeycroft Leisure supporting the INTs.

Since the start of Coronavirus people have overwhelmingly wanted to get involved, help and make a difference in whatever way they can, especially in their local community. A great example of help on the ground in West Suffolk is between Alliance partners where local furloughed staff from Abbeycroft Leisure have been providing help and support to community health and care teams.

It's been really successful and appreciated too! Health, Adult and Community Services, the voluntary sector have worked with the multi-agency 'Home But Not Alone' service, which was set up to help vulnerable people in the community through COVID. The partners have collaborated to manage the work across the Integrated Neighbourhood Teams (INTs) and find tasks for the Abbeycroft volunteers.

So, how does it actually work and what is the added value from volunteers?

A local customer, with a care package, had support pre-COVID with shopping and other basic needs. During a phone call with the Community Matron she said that she enjoyed visiting the gym to exercise and stay fit, something she couldn't do through with her existing carers.

The Community Matron contacted the Abbeycroft Leisure volunteers who are helping in the Newmarket Team to see what they could do. It turns out there's a volunteer who works at a gym in Newmarket and has offered to meet and help the lady at the gym when it re-opens with some appropriate exercises.

This is just one example, the volunteers have also been doing tasks like putting together dressing packs and patient record packs, reception duties (in premises closed due to COVID) and delivering PPE and equipment.

It has been a really positive experience so far for everyone and the Alliance partners are keen to look at how to build both the support and goodwill of volunteers and the successful partnership working that we've seen across different organisations over the past three months.

4.3. The project team is working with the leads at the West Suffolk Foundation Trust to broaden their volunteering scheme, so that volunteers can continue to be linked to the INTs. We are also working with the District Council Communities and Families team to work on some of the benefits we see of having volunteers in the INTs. For example, should we have a volunteer passport with training provided across Alliance partners, and how do we make sure that when volunteers are linked through to the INTs they are able to use all of their skills.

5.0 Examples of flexing resources to meet need

5.1. **Home But Not Alone:** The Home But Not Alone (HBNA) helpline was established at short notice by Suffolk County and District Councils to provide advice and support to people who are shielding. The service was 7 days a week, 8 until 8, initially. Now it is open Monday to Friday and options are being developed about the future of the service going forward, particularly with the uncertainty about potential future need. The service has received over 11,000 calls to date across Suffolk, with the majority of calls about food. Delivery of medication was the second highest reason for calling noted.

5.2. In many cases HBNA call handlers were able to help people by finding a community or voluntary group to support the request. After a few weeks they were finding though that there was a need for additional capacity to support the delivery of medication, where people had exhausted all local options. In response the CCGs across West and Ipswich and East Suffolk worked with community transport providers to deliver medication to people who had no other

way of getting hold of the pills they need. In the West Suffolk Alliance area over 80 deliveries were made.

Tania Farrow, Chief Officer for the Suffolk Local Pharmaceutical Committee said: ***"It became clear from the beginning of the pandemic that many people in our communities would need to be supported to stay at home and the response from local volunteers was amazing."***

5.3. However, in order to ensure that vital medicines could be safely delivered to patients when they were needed, everyone had to work together to make sure that the process was clear, well managed and followed all the guidance that pharmacies are required to follow."

5.4. The demand for this service has now decreased considerably as more people feel able to collect prescriptions themselves or have made arrangements with friends or neighbours. It is likely that the CCG arranged service will cease at the same time as any changes made to the HBNA helpline.

5.5. **End of Life:** The West Suffolk Alliance multi-agency End of Life Strategic Programme Board changed the way it worked during the pandemic increasing the frequency of its meetings, broadening its membership and creating specific task/finish groups for workforce planning and clinical issues. The group met twice weekly and had formal links into the newly created ICS-wide End of Life group for COVID-19. The group's main focus was to plan for the expected increase in end of life care and deaths due to COVID-19, and to develop new ways of working to help meet that demand to ensure that, where possible, people and their family's needs were met.

5.6. Although the high levels of demand that were predicted did not materialise, the planning and new ways of working have definitely enhanced services for those people who did become unwell and die, not just those who had COVID-19, but also for those who had other end of life conditions.

5.7. By working together in a collaborative manner, the group were able to achieve both new ways of working and improvements to existing ways of working. The changes have all had positive direct impact on either: patient/family experiences, clinical time/ resource efficiencies, staff experience/satisfaction and system working. These changes will benefit all patients/families in the future.

Recent feedback from hospice specialist nurses have praised the Newmarket community team and the Early Intervention Team for their person centred and compassionate care. They said, ***"both teams have worked tirelessly in the past months to support complex and challenging cases along with the day to day management of their workloads."*** And ***"During this time of COVID we are all facing unprecedented challenges; however we believe the majority of the patients and their families continue to receive high quality and compassionate care."***

5.8. The End of Life Group did benefit from some additional funding that enabled the purchase of additional equipment and staff resources, whilst some of the new ways of working will also reduce costs of service delivery. The main initiatives are set out below:

- Joint working between hospice nurses and community health teams - jointly caring for patients at home, sharing expertise, supporting one another, improved continuity of care for patient/family
- Extra turning equipment and delivery vans - more patients able to stay at home, faster delivery times for urgent EOL equipment
- Improved online training package for Verification of Expected Death – less delays for families, less delays for funeral directors, improved staff satisfaction, more efficient use of GP time, collaboration between community health/GP Federation/coroner/hospice and University of Suffolk (county wide)

- Changes to process for signing medication charts – reduced delays for patients/families in receiving treatment, increased staffing efficiencies, improved staff satisfaction
- Hospice advice line changes – improved access to expert advice 24/7 for whole system including care homes, improved patient/family experience, improved staff learning
- Changes to recording of people's resuscitation wishes – improved continuity of care for patient/family, improved numbers of people having their wishes recorded and adhered to, staff efficiencies
- Implementation of Family Administered Medication – empowerment of family, improved patient/family experience
- Marie Curie Nurse seconded to Early Intervention Team (EIT) – shared learning and expertise, overnight Marie Curie sitting service and EIT now share caseloads and provide support visits to overnight sitters. Ability for resources to be 'pooled' to enable a staff member to stay with a patient/family If death is imminent rather than having to leave to move to next patient
- Stocking of end of life drugs in Community Pharmacies – improved patient/family experience, reduction in delay of treatments, reduction in staff time wasted to source drugs
- Toolkit for people on how to talk about death – empowerment of patients, families and wider community
- Bereavement model of resources and support as part of ICS wide approach – improved bereavement experience for families and carers
- Increased support and training for care and learning disability homes – collaborative approach to support care home staff and patients
- Additional Consultant support for West Suffolk hospital – supported clinicians, ethical decision making and training

5.9. The group has now reduced the frequency of its meetings to monthly, it has reviewed its membership in light of the excellent joint work that has been achieved and will continue to have a broad membership. The group will continue with the initiatives above and seek to identify further ways to improve services for patients and families. It will continue to develop the end of life plan in line with the Alliance strategy and is just about to embark on a public survey with Healthwatch to capture people's experiences of end of life care and death during COVID-19.

6.0 Hospital transformation

6.1. The hospital operational improvement team were shifted to support the core resilience team in March. This included responding to new guidance as it was released and ensuring it was implemented across the organisation. In addition to national guidance changes the team have developed the 'keeping in touch service' this enables family and friends to keep in touch with patients during the period of no visitors and ongoing for patients on COVID-19 wards where visiting is not open.

6.2. The team have also given additional support to the community division. This has involved reviewing what has worked well and ensuring the new ways of working with community healthcare teams and care homes continues. Planning for recovery is now underway, with a more collective system focus on winter and the out of hospital operational model.

7.0 System Executive Group

7.1. The System Executive Group (SEG) moved to monthly one-hour meetings during the COVID-19 period to allow a system wide CEO forum to input into the pandemic response. The meeting in July focused on the plans for the new hospital, which is very much being seen

as a system project. The project team are taking a co-production approach to the development of their plans, supported by Healthwatch and other partners.

7.2. Independent Chair: SEG agreed at their meeting in March to appoint an independent chair for the Alliance. A small group of lay and elected members helped to shape the role and the interview process. The Independent Chair is a one-day a week paid appointment and will provide leadership and focus for the Alliance working closely with their counterparts in North East Essex and the Integrated Care System (ICS). Successful interviews and a stakeholder panel were held on the 9th and 10th July. This was led by William Pope, the Independent Chair for the Suffolk and North East Essex ICS Board leading the interview panel, supported by a range of partners who were involved in both the interview and stakeholder panels.

8.0 Delivery planning

8.1. A small group from across Alliance partners are working on the next iteration of the Alliance Delivery Plan. The starting point has been the experiences during the pandemic, which were captured in a SWOT analysis across all Alliance partners. The Plan will show priorities for Alliance for 20/21. Action against these priority themes will help us to achieve the four ambitions set out in the Alliance Strategy – All About People and Places. The five themes (along with their sponsors) are:

- Collaborative Communities (Davina Howes)
- Children and Young People (Allan Cadzow)
- Integrated Neighbourhood Teams (Senior System Operational Leadership Forum)
- Responsive Support (Bernadette Lawrence)
- Working together (Kate Vaughton)

8.2. The theme leads will be working with workforce, digital and other colleagues to make sure that plans in our enabler areas are supporting our Alliance themes.

8.3. The development of the plan is supported by the Quality Improvement Team, hosted at West Suffolk Foundation Trust and headed up by Anne Whiteside. Anne's team are providing detailed direction to ensure that our Alliance aims, and actions are specific and measurable, and they will be alongside us throughout delivery as part of the system quality improvement approach that the Alliance has signed up to.

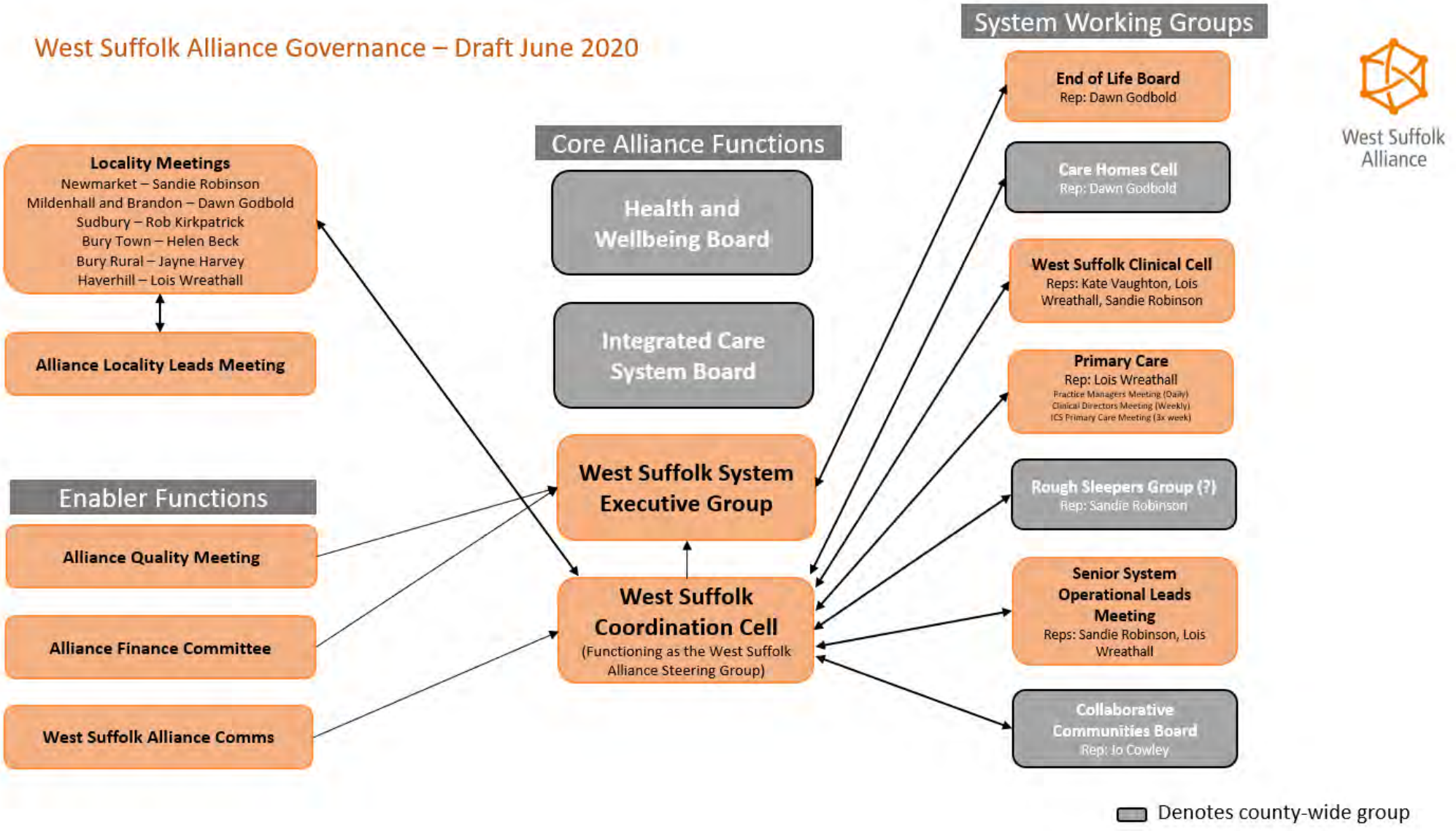
8.4. Going forward the Quality Improvement Team will be providing comprehensive training, practical support, data analysis, plus they are bringing in the support of the Institute of Healthcare Improvement, whose model for improvement we will be working to. Further information and opportunities for system partners to be involved will be made available as soon as possible.

8.5. A new feature of our planning this time round is the creation of an Involvement Plan. The team are working with a small group from Healthwatch, Suffolk Mind and with the CCG Lay Member for Patient and Public Involvement to agree our plan for involvement, with the ambition to move to a fully co-produced model over time. As a first step all theme leads are looking at what people have said about services during the pandemic and ensuring their plans reflect what has worked well for people. They are also each developing an involvement plan for their theme, with help from the ICS engagement lead, Katie Sargeant.

9.0 Recommendation

9.1. The Trust is asked to note the progress being made through the West Suffolk Alliance and the Trust's wider partnership working.

Appendix 1


West Suffolk Alliance Governance – Draft June 2020
West Suffolk Alliance
Locality Meetings
Newmarket – Sandie Robinson
Mildenhall and Brandon – Dawn Godbold
Sudbury – Rob Kirkpatrick
Bury Town – Helen Beck
Bury Rural – Jayne Harvey
Haverhill – Lois Wreathall
Alliance Locality Leads Meeting
Enabler Functions
Alliance Quality Meeting
Alliance Finance Committee
West Suffolk Alliance Comms
Core Alliance Functions
Health and Wellbeing Board
Integrated Care System Board
West Suffolk System Executive Group
West Suffolk Coordination Cell
(Functioning as the West Suffolk Alliance Steering Group)
System Working Groups
End of Life Board
Rep: Dawn Godbold
Care Homes Cell
Rep: Dawn Godbold
West Suffolk Clinical Cell
Reps: Kate Vaughton, Lois Wreathall, Sandie Robinson
Primary Care
Rep: Lois Wreathall
Practice Managers Meeting (Daily)
Clinical Directors Meeting (Weekly)
ICS Primary Care Meeting (3x week)
Rough Sleepers Group (?)
Rep: Sandie Robinson
Senior System Operational Leads Meeting
Reps: Sandie Robinson, Lois Wreathall
Collaborative Communities Board
Rep: Jo Cowley
Denotes county-wide group

11:10 GOVERNANCE

21. Trust Executive Group report

To ACCEPT the report

For Report

Presented by Stephen Dunn

Board of Directors – 31 July 2020

Agenda item:	21			
Presented by:	Steve Dunn, Chief Executive			
Prepared by:	Richard Jones, Trust Secretary			
Date prepared:	19 June 2020			
Subject:	Trust Executive Group (TEG) report			
Purpose:	X	For information		For approval

6 July 2020

During Steve Dunn's **introduction** to the meeting, it was emphasised that with activity starting to increase as part of the next phase of COVID there was a local and national focus on patient access, including cancer and elective care. It was recognised that this remains challenging and forms the significant focus of recovery and winter planning. Discussion took place on the progress with pathology disaggregation from ESNEFT and the clinical and managerial leads for this were recognised and thanked.

Feedback from the workshop held in June was considered regarding the structure and roles to **support patients' safety and quality**. The summary of the workshop sessions was welcomed by the group and considered good reflection of the discussion and feedback. Further conversation took place on a number of points including how to structure the senior leadership and executive accountability. It was agreed that based on the feedback, further discussion options for the structure will be developed.

A detailed report was received on **COVID recovery plans and winter planning**. It was recognised that a significant amount of work has been undertaken in preparation of the plans, including working with external partners. With the limited elective care provided since lockdown the number of patients now waiting more than 18 and 52 weeks has increased significantly. The focus remains to mitigate harm to patients waiting for treatment. Plans to open the day surgery unit to undertake lower risk procedures were noted. The impact of social distancing on our ability to step up clinical services and activity was discussed.

The **COVID infection prevention and control assurance framework** was received and key issues reviewed. Discussion included the timely reporting of swab results and the ability to effectively isolate patients.

The new format **quality and performance report** was reviewed. It was recognised that this was evolving in terms of its content as part of COVID recovery. Additional detail would be developed for maternity and community services. Discussion also took place on the finance and workforce report. This included sustained reduction in nursing agency spend and a number of ongoing capital projects.

The **red risk report** was received, this included 'top risks' for staff engagement and raising concerns; COVID response and recovery; building structure and provision of suitable estate; and pathology services. There were no additional red risks and three red risks were downgraded/closed as a result of mitigating action taken (undertaking births in theatre; paediatric cardiac echo's; and neonatal unit staffing).

The Trust's **improvement plan** was received. It was recognised that this is a working document and was subject to review through the senior responsible office cluster group meetings. Comments were requested on the draft terms of reference of the new improvement programme board and volunteers sought to contribute to a task and finish group to prepare for the Trust's participation in national pilot of the patient safety incident response framework (PSIRF).

An update was received on progress with **pathology disaggregation** and the future options for networking with service providers. This included discussion on the provision of future GP pathology activity.

An update was received from the programme director on the plans and next steps for the **new health and care facility** development. It was confirmed that the expectation was to complete the strategic outline case by the end of December 2020. This would lead into a significant piece of work on clinical and wider engagement on the facility's design. An update was received on the structure issues within the Trust which have contributed to the impetus on the planning for the new facility.

Reports were received and noted on: Allocate implementation; Health & Wellbeing group; Emergency planning; losses and special payments; review of waivers; and executive directors meetings.

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

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

Previously considered by:	The Board receives a monthly report from TEG
Risk and assurance:	Failure to effectively communicate or escalate operational concerns.
Legislation, regulatory, equality, diversity and dignity implications	None

Recommendation:

The Board to note the report

22. Emergency preparedness, resilience and response strategy

To approve the strategy document

For Approval

Presented by Helen Beck

Trust Open Board Meeting – 31 July 2020

Agenda item:	22			
Presented by:	Helen Beck, Chief Operating Officer			
Prepared by:	Barry Moss, Head of EPRR			
Date prepared:	24/7/20			
Subject:	EPRR Strategy			
Purpose:		For information	X	For approval

Executive summary:

This retrospective approval is necessary to meet audit requirements and the policy will be under review again post-COVID de-briefs with a further revision likely at that time. The strategy sets the principles and process to develop and maintain the Trust business continuity, critical and major incident response and recovery capability. It sets out the expectations, outcomes, roles and responsibilities laid against the Trust to allow successful delivery of Emergency Preparedness, Resilience and Recovery (EPRR) outputs against national core standards, policies and guidance. It is to be utilised as the authoritative document by all Trust staff, taking precedence over all other internal documentation where appropriate, and provides the background and directive to ensure that the Trust Resilience capability can be delivered.

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

Trust ambitions	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X	X	X		X		X

Previously considered by:	Emergency Planning Team, DCOO, COO
Risk and assurance:	Reduces residual risk held for emergency response.
Legislation, regulatory, equality, diversity and dignity implications	Meets NHS EPRR Core Standards

Recommendation:
Approval of the Strategy is sought.

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) STRATEGY

For use in:	**West Suffolk NHS Foundation Trust**
For use by:	**All staff Members**
For use for:	**Trust Emergency Management and Resilience**
Document owner:	**Head of Emergency Preparedness, Response and Resilience**
Status:	**Final**

1 INTRODUCTION

This strategy sets out the expectations, outcomes, roles and responsibilities laid against the West Suffolk NHS Foundation Trust (WSFT) to allow successful delivery of Emergency Preparedness, Resilience and Recovery (EPRR) outputs against national core standards, policies and guidance. It is to be utilised as the authoritative document by all Trust staff, taking precedence over all other internal documentation where appropriate, and provides the background and directive to ensure that the Trust Resilience capability can be delivered.

2 BACKGROUND AND CONTEXT

2.1 The NHS plans for and responds to a wide range of incidents and emergencies that could impact business continuity and affect health or patient care. Within the health service this work is generally referred to as 'Emergency Preparedness, Resilience and Response' (EPRR).

2.2 As an acute Trust and Category 1 Responder under the Civil Contingencies Act, WSFT is mandated to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care.

2.3 WSFT maintains consistent levels in key services when faced with disruption in order to retain public confidence and reduce the impact on service delivery. In line with NHS guidelines and core standards for EPRR, WSFT utilises this EPRR strategy to deliver along a continuum of severity: Business Continuity Incidents, Critical Incidents and Major Incidents.

3 SCOPE & PURPOSE

3.1 **Scope:** At the national level this strategy is underpinned by legislation and guidance contained in:

- 3.1.1. CCA (2004).
- 3.1.2 NHS Act (2006 - as amended).
- 3.1.3 Health & Social Care Act 2012 (Section 46)
- 3.1.4 NHS Constitution.
- 3.1.5 Requirements for EPRR as set out in the NHS Standard Contract(s).
- 3.1.6 NHS England EPRR guidance and supporting materials including:
  - (a) NHS England Core Standards for EPRR
  - (b) NHS England Business Continuity Management Framework (service resilience)
  - (c) Other appropriate NHSE guidance
- 3.1.7 National Occupational Standards for Civil Contingencies
- 3.1.8 ISO22301 Societal security – Business Continuity Management Systems

3.2 **Purpose:** The EPRR Strategy articulates WSFT's approach to, and management of, incidents in order to mitigate identified increased risk to patient safety, and to deliver the Trust's business as usual (BAU) service offering to maintain patient flow. Consequently, whilst Trust Command, Control and Coordination (C3) is always the basis for addressing any incident, detailed management of such events will be bespoke and will be conducted on a case by case basis by the Operational, Tactical and Strategic managers (dependant on the level of risk identified) and, if required, other Trust and external specialists. All will draw upon this EPRR Strategy, the Trust C3 Plan, bespoke Incident or Business Continuity Plans (BCPs) as appropriate, as well as their experience, in order to manage developing situations requiring escalation. It should be noted that EPRR is a varied portfolio and can be separated into 7 work/threat groups:

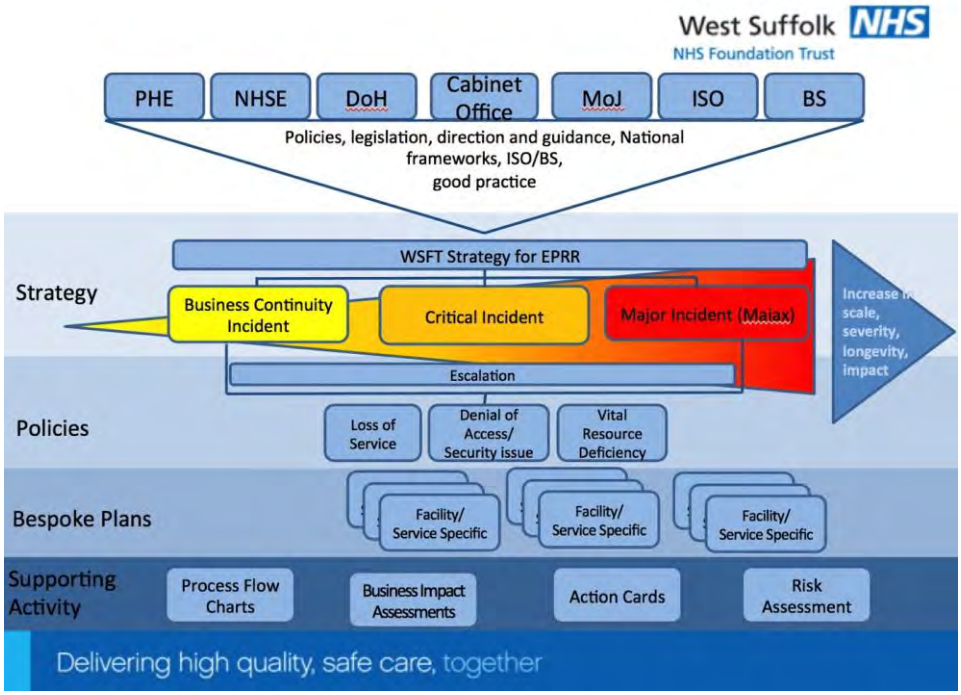
3.2.1 **Special Operations** – Local or National Events which will impact on BAU (Demonstrations, Public Disorder, Large Scale events or Mass Gatherings).
3.2.2 **Acute Major Incidents** – Generic, Specialty, Mass Casualty and CBRN (Chemical Biological Radiological and Nuclear) where the Trust is an initial responder.
3.2.3 **Threats to Public Health** – Outbreaks which threaten normal operating arrangements or require the implementation of special measures or preparations such as pandemic flu or Ebola.
3.2.4 **Seasonal Variation** – Planning and responding to cold and hot seasonal issues.
3.2.5 **Public Infrastructure Failures** – National Fuel disruption arrangements, Utilities Failures and Counter Terrorism Initiatives within the Health Service and as part of a Multi-agency Response.
3.2.6 **Business Continuity Arrangements** – Loss of Site and Evacuation planning, Management of Bomb Threats and Security incidents, Service-specific Business Continuity Arrangements and System-wide resilience plans.
3.2.7 **Surge and Escalation Planning** – Planning and responding to "Significant Incidents" whether internal or the result of another agency.

3.3 **Types of incident**. As an overview, commonly used classifications of types of incident[1] include:

3.3.1 **Business continuity/internal incidents** – incidents that deny access to the Trust infrastructure, that limit the services may offer, or that are the consequence of denial of a vital resource.
3.3.2 '**Rapid On-set'** – an incident that has a very short time from occurrence to impact.
3.3.3 '**Rising tide'** – an incident that has an identifiable duration from occurrence to impact.
3.3.4 **Cyber-attacks** – attacks on systems to cause disruption and reputational and financial damage. Attacks may be on infrastructure or data confidentiality.
3.3.5 **Mass casualty** – typically events with overall casualties in the 10s or 100s (although the Trust may only see a small % of the total figure) where the normal major incident response must be augmented with enhanced or extraordinary measures.

3.4 It is not an exhaustive list and other classifications may be used as appropriate and the nature and scale of an incident will determine the appropriate Incident Level. Therefore, successful business continuity is seen as the collective corporate responsibility of everyone at WSFT - it is an essential tool in establishing organisational resilience. These incidents are articulated under the methodology at Figure 1.

Figure 1: Management of EPRR at WSFT



[1] NHS England Emergency Preparedness, Resilience and Response Unit. *NHS England Emergency Preparedness, Resilience and Response Framework*. 10 November 2015. P10.

4 STRATEGY AIM

4.1 To facilitate a co-ordinated response to incidents to ensure the safety of patients, visitors and staff within the Trust.

4.2 This Strategy provides the necessary high-level direction and guidance to return the Trust to a BAU status through the proactive management of an incident or events and, where necessary, to inform the wider area and regional health care structures of the challenges that the Trust is facing which threaten disruption to its service offering.

4.3 The strategy is not an incident response delivery plan; that is articulated in the C3 Plan and other bespoke response plans. The strategy is the definition of how the Trust ensures it is prepared to enact the C3 plan.

5 STRATEGY OBJECTIVES & OUTCOMES

5.1 WSFT EPRR Strategic Objectives are:

5.1.1 All Trust EPRR outcomes will be based on assessed risk, with any residual risk articulated in Trust Risk management systems.
5.1.2 WSFT will deliver a proactive approach to the management of all EPRR outputs by defining roles and responsibilities and, consequently, all staff will fully understand their role and responsibilities in the event of an incident or events.
5.1.3 Clear intra- and inter-Trust EPRR information management, situational awareness and associated communication routes will be established and maintained.
5.1.4 The Trust will retain agility, flexibility and dynamism and be optimised to anticipate, prepare for, prevent, respond to and recover from disruptions, whatever their source and whatever part of the organisation they affect.
5.1.5 Embed a culture of EPRR within WSFT supported by plans, resources, training and validation.
5.1.6 Identify and implement preventative actions that reduce the risk of disruption to key services.
5.1.7 Ensure continuity of essential services when faced with a range of disruptive challenges.
5.1.8 Ensure the recovery of critical functions and return to normal working as quickly as possible following a major incident or service disruption.
5.1.9 Ensure that plans are aligned with those of partner organisations including the identification of triggers and protocols for activation of EPRR procedures and arrangements.

5.2 EPRR Strategic Outcomes are:

5.2.1 The relevant legal and regulatory requirements for emergency planning and business continuity management will be complied with.
5.2.2 Clear and concise Tactical and Operational plans to meet the defined risk.
5.2.3 Robust arrangements to respond to an incident or service.
5.2.4 Operational, financial and reputational risks to the Trust will be recorded, managed and, ultimately, reduced.
5.2.5 To ensure that hazards, risk and threats are identified, recorded, assessed and control measures developed.
5.2.6 A forum where EPRR and Business Continuity (BC) matters can be addressed.
5.2.7 A system of regular reporting and review across the organisation, which aligns with the Trust internal wider governance arrangements and specific risk management.
5.2.8 A training and exercising programme for all levels of the organisation, which will link to multi-agency training through the Local Health Resilience Partnership (LHRP) and the Local Resilience Forum (LRF).
5.2.9 Positive EPRR assurance to the Trust Board, commissioners, NHS England, healthcare partners and other Responders.

All of the above will be assessed by both Internal Audit, and by the NHS England annual EPRR Core Standards audit.

5.3 **Method:** The strategy is focused on ensuring that response and recovery management is optimised, and that information is shared in a timely manner to allow informed decision making and activity generation; all of this whilst enabling and supporting escalation to more senior elements of the organisation where necessary and required. This will be delivered through the methodology described in the Trust C3 Plan. This will be supported by continuous capability development to improve response, BC, and recovery outcomes, plus enhancements to

the command structure and delivery, and finally a training and exercising schedule that incrementally builds capability.

5.4 **Underpinning:** As illustrated at Figure 1, the EPRR Strategy is underpinned by Trust bespoke policies and nested plans which can be broadly categorised as: Loss of service, Denial of access / Security related incidents or vital resource deficiency. Whether in response to a business continuity incident at one end of the spectrum, or a major incident at the other, the Trust's response will be bespoke, focussed and dynamic, for which preparation and proven competency will be necessary.

5.5 **Supporting Plans:** Whilst broad implementation guidelines are contained within this strategy, they are to be considered in support of the overarching Trust C3 Plan, and its supporting capability, facility and service-specific plans and departmental BCPs which address the bespoke requirements of specific incidents where it has been identified that further direction and guidance will assist the dynamic management of the incident.

5.6 Events are dynamic, as they evolve so their severity may increase or decline and, during external reporting, the Strategic Commander will describe events externally in terms of the Incident Levels; the associated NHS descriptions are shown in Table 1.

Table 1 NHS England Incident Levels

Level 1	An incident that can be responded to and managed by a local health provider organisation within their respective business as usual capabilities and business continuity plans in liaison with local commissioners.
Level 2	An incident that requires the response of a number of health providers within a defined health economy and will require NHS coordination by the local commissioner(s) in liaison with the NHS England local office.
Level 3	An incident that requires the response of a number of health organisations across geographical areas within an NHS England region. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.
Level 4	An incident that requires NHS England National Command and Control to support the NHS response. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.

5.7 **Capability Development:** In order to deliver the EPRR process at WSFT, it is necessary to conduct capability development activity as detailed at Annex A. This is an integrated management process to assess and manage risk, and therefore to provide realism and proportionality to the emergency response and recovery process before defining residual risk for treatment. In real terms, the Trust will integrate and coordinate all practices that provide outputs that impact on the provision of EPRR through the Trust Resilience Group, the Site Management Team, the Operational team, the Core Risk Team and the Trust Executive Group. The EPRR Non-Executive Director (NED) will provide 'mentorship' of the process, and act in an advisory capacity to the Executive Directors and the Board.

5.8 **Managing Risk:** Internally, the Trust will assess and manage the risk to patients according to the C3 Plan, and use the C3 Plan to: record and communicate operational pressure; to assist with the operational management of resources; and to articulate the perceived level of risk to patients. All established and on-going EPRR Risk will be managed in the Trust Risk Register. The Trust EPRR planning process, including Risk, is articulated at Annex B. The Trust Risk process can be found in PP (15)093 – WSFT Strategy & Policy for Risk Management.

6 TRAINING

6.1 In order for the Trust to manage the impacts of business continuity, critical or major incident, all levels of management and all responders must conduct regular training. The formal training for the Trust C3 roles and organisational groupings is currently in design and will be added as an annex to this document in due course. In the interim, operationally-focussed training occurs in its place to generate competency.

7 EXERCISING

7.1 NHS Organisations and providers of NHS funded care must exercise their plans in order to prove that they have appropriately trained, competent staff and suitable facilities permanently available to effectively manage business continuity, critical and major incidents. The Trust's programme of training, exercising and validation is at Appendix 1 of Annex A.

8 ROLES & RESPONSIBILITIES

8.1 The following is a summary of the Trust EPRR roles and responsibilities, with a greater expansion on these duties at Annex C:

8.1.1 **Chief Executive** (CE) has responsibility for compliance with the CCA 2004.
8.1.2 **Executive Chief Operating Officer** (ECOO) is the senior staff member with responsibility for the delivery of the Trust's EPRR capability, through the Trust Executive Group (TEG), and is the designated Accountable Emergency Officer (AEO).
8.1.3 **Deputy Chief Operating Officer** (DCOO) is the appointed senior staff member with direct responsibility to the ECOO for EPRR.
8.1.4 **Head of EPRR** is responsible to the DCOO for the day-to-day planning and deliver of EPRR across the Trust.
8.1.5 **Executive Directors** will ensure the implementation of this strategy across their directorate.
8.1.6 **Associate Directors of Operations** will conduct all tactical and operational implementation of EPRR plans and procedures.
8.1.7 **All Staff** will be familiar with the arrangements, their roles and responsibilities detailed in the C3 Plan and Business Continuity plans.
8.1.9 **EPRR Non-Executive Director** formally holds the EPRR portfolio for the Trust and acts as the senior compliance officer for the Trust.

9 GOVERNANCE

9.1 **Assurance and Compliance with Legislative Duties:** The national core standards for Emergency Preparedness Resilience and Response (EPRR) as defined by NHS England (NHSE) indicate that, as an acute healthcare provider, WSFT is expected to fulfil certain responsibilities[2]. These core standards will be met, where applicable, in full by the Trust and reported on annually. Since 2016, the EPRR Organisational Assurance Process was adopted to ensure that providers of NHS funded care were working towards meeting the requirements for EPRR, particularly as set out in the NHS England Core Standards Matrix. The provision of this assurance gives confidence that Category 1 and 2 Responders are compliant with the requirements for EPRR within the new structures of the NHS. There are 92 standards assigned to the revised EPRR assurance process divided into three main sections: Core Standards; Hazmat/CBRN Standards; Hazmat/CBRN Equipment.

9.2 These are the minimum standards that the Trust must meet and the AEO is responsible for ensuring that these standards are achieved utilising audits and the Trust EPRR training and exercising strategy. The AEO will therefore manage the delivery of the following activities to ensure the Trust complies with national requirements where appropriate:

9.2.1 Undertake an annual self-assessment against core standards identifying a level of compliance for each. For Acute Trusts these standards clarify the existing and on-going EPRR requirements, they are not additional. It is expected that the level of preparedness will be proportionate to the role of each organisation as well as the range of services they provide;
9.2.2 Review divisional improvements plans and develop action plans to meet extant core standards; monitor action plan achievement;
9.2.3 Complete an annual statement of compliance to be approved by the Trust Board before submission to the LHRP and present it to the Executive Board for public approval before submission.
9.2.4 Ensure that the approved annual statement of compliance is published in the Trust Annual Report and is available on-line.
9.2.5 Ensure that the Non-Executive Director who formally holds the EPRR portfolio for the organisation is publicly identified via the Trust website and annual report, and that there is a formal and established process for briefing the incumbent on the progress of the EPRR work plan outside of Board/Governing Body meetings.

[2] an overview of the key areas is at https://www.england.nhs.uk/ourwork/eprr/gf/#core

9.2.6 Delegates the management of the Trust Resilience Group to the DCOO and attends Trust Resilience Group (TRG[3]) and attends the Strategic Local Health Resilience Partnership (LHRP) meetings or, where that is not possible, delegates that responsibility to the DCOO or Head EPRR.

9.3 As detailed at Annex C & D, the Head of EPRR manages the Trust EPRR capability development and delivery on a daily basis on behalf of the AEO and is assisted by the TRG. Risk reporting is through the Core Risk Committee (CRC), and all approval is delivered by submission to the Trust Executive Group (TEG) and the Board as necessary.

[3] The TRG leads and undertakes all EPRR capability development activity for WSFT.

10 GLOSSARY OF TERMS AND ACRONYMS AND TITLES

Battle Rhythm	The meetings and activity profile to be used under specified circumstances.
BAU	Business as Usual
BCM	Business Continuity Management
BCP	Business Continuity Plan
BIA	Business Impact Assessment
Bronze / Operational	The '*gold–silver–bronze*' command structure previously used at WSFT was a hierarchical framework for the command and control of incidents which related to the '*strategic-tactical-operational*' levels of command now formally adopted. An Operational / Bronze commander directly controls an organisation's resources for/at the incident in the delivery of the tactical plan, and will potentially be found with their staff working at the scene; there may be many Operational / Bronze commanders operating in their own functional and command areas during BAU or an incident, but all will be reporting to the Tactical Commander. At WSFT during BAU the designated Trust Site Coordinator / Clinical Site Coordinator is the operational level manager responsible for the oversight of the day-to-day management of the hospital. Incident Commanders may be deployed to an incident as the Tactical Commanders on-scene commander and inter-organisation and external agency liaison.
Business Continuity incident	An event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level. (This could be a surge in demand to requiring resources to be temporarily redeployed)
CBC	Clinical Bed Coordinator. Responsible for the daily management and tracking of patient flow.
CEO	Chief Executive Officer
Clinical Site Coordinator	Out of hours manager responsible for Patient Flow; previously termed #888
Critical incident	Any localised incident where the level of disruption results in the organization temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions.
DCOO	Deputy Chief Operating Officer
ECOO	Executive Chief Operating Officer
EPRR	Emergency Planning, Resilience and Response
FSC	Families Support Centre: Trust location where relatives and friends of mass casualty patients may receive information and support.
Gold / Strategic	See '*Bronze / Operational*' above. The strategic-level manager (referred to hereafter as the Strategic Commander) has executive command and control over the deployment and management of WSFT's resources and will have responsibility for the response and recovery strategy to be employed; this be realised by setting SMART objectives. The role will be filled by an on-call member of the Trust Executive and they will be unlikely to be co-located with operational and tactical staff. The Strategic Commander may have supporting staff available to them (Loggist, Comms, Finance, HR, H&S, Legal etc) and they will be located by default in the Northside Conference Room in Quince House.
HCC	Hospital Control Centre previously termed the Hospital at Night (H@N) room located just off the F5/F6 Wards corridor. It is the default management location for Site Coordinator and the CBC. It may also be used as the Hospital's Tactical Control Centre (TCC) – commanded by the Tactical Commander – during the initial phase of an incident or for a solely clinical issue but, for the former, the TCC is more likely to be located in the Ops Directorate Conference Room, the Education Centre, Quince House, or another ad hoc location.
Incident	Incidents are classed as either:

	(a) Business Continuity Incident (b) Critical Incident (c) Major Incident
Incident Commander	Deployed to an incident as the Tactical Commanders on-scene commander and inter-organisation and external agency liaison. The role may be filled by a volunteer resilience professional (Head of Portering/Security, Chargehand Porter, Head of EPRR, Fire Officer), or by the Site Coordinator and the CBC, or any available manager.
Major Incident	Previously referred to as a 'MAJAX' and is any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require specific arrangements to be implemented.
Operational command	The hierarchical incident-facing element of the chain of command which oversees the activity at the site of an incident, or in addressing the consequences of an incident, and was previously referred to as Bronze.
Patient Capacity Management Meetings	Formally termed 'Bed Meetings'.
RCG	Recovery Coordinating Group; multi-agency forum usually based at a Local Authority headquarters tasked with planning and implementing the recovery of the incident to reach a pre-determined end-condition.
Recovery	The process of rebuilding, restoring and rehabilitating the community following an emergency.
Resilience	Ability of the community, services, area or infrastructure to detect, prevent and, if necessary, to withstand, handle and recover from disruptive challenges.
Response	Decisions and actions taken in accordance with the strategic objectives, tactical plans and operational activity as defined by emergency responders.
SCC	Strategic Control Centre; Trust capability likely to be located in Quince House.
SCG	Strategic Coordination Group; multi-agency forum located usually at a senior police headquarters, which takes overall responsibility for the multi-agency management of an incident and establish a strategic framework within which lower levels of command and co-ordinating groups will work
Silver / Tactical	See '*Bronze / Operational'* above. A Tactical / Silver commander manages tactical implementation following the strategic direction given by Strategic / Gold and makes it into a plan that is delivered by Operational / Bronze. They are on-call managers who may, depending on the nature of the incident, decide to co-locate with Site Coordinator / Clinical Site Coordinator at WSH.
SIRI	Serious Incidents Requiring Investigation (SIRI) are defined as incidents that occurred in relation to NHS-funded services and care resulting in one of the following: a. Unexpected or avoidable death of one or more patients, staff, visitors or members of the public, and up to six months from discharge from services; a scenario that prevents or threatens to prevent the Trust's ability to continue to deliver healthcare services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, or IT failure; b. Acts or allegations of abuse (sexual, physical, psychological, theft, misuse or misappropriation of money or property and neglect or acts of omission which cause harm or place at risk of harm) of a service user; c. Adverse media coverage or public concern about the Trust or the wider NHS. d. One of the core set of "Never Events" as updated on an annual basis, for example, inpatient suicide using non collapsible rails; The admission of a child of 17 years, or under, to an adult psychiatric ward; significant healthcare associated infections (as defined by Health Protection Agency) i.e. an outbreak of infection, failure in decontamination or infected healthcare worker; The Anglia Health Protection Team should also be advised. e. Information Governance events. IG SIs are defined as "Any incident involving the actual or potential loss of personal information that could lead to identity fraud or have other significant impact on individuals should be considered as serious"

	f. Maternity, infant and child incidents as described in the NPSA National Framework for Reporting and Learning from Serious Incidents Requiring Investigation
Site Coordinator	In hours manager responsible for Patient Flow; previously termed Bronze Manager
SITREP	Situation Report
Strategic command	The hierarchical top of the chain of command where strategy – the linking of Ends, Ways and Means is set - and policy decisions are made and responsibility for objective setting and the Organisation's vision resides. Strategic / Gold also delivers outward facing interactions and provides support to Tactical / Silver. Previously referred to as Gold.
Tactical command	The interface between the operational and strategic levels of command where objectives are transposed into a plan and resultant tasks in order to deliver the Organisation's vision. Previously referred to as Silver.
TCC	Tactical Control Centre. Trust capability located in the Education Centre Room 4a.
TCG	Tactical Coordinating Group; multi-agency forum usually located at a Local Authority or Police headquarters. Interprets SCG direction, develops a tactical plan, and coordinates activities and assets.
TCI	To come in.

Old Role Title	New Title	Role
Clinical Bed Coordinator / #358	No Change	As before
Bronze Manager / #888	Site Coordinator (in hours), Clinical Site Coordinator (OOO)	Operational Patient Coordinator
None	Operational Incident Response Commander	Command of incident scene on Trust premises, and any allocated staff
Area Controller	Operational ED Commander	Command capability, coord with other Op Commanders
Area Controller	Operational Surgical/Anaesthetics Commander	Command capability, coord with other Op Commanders
Area Controller	Operational Medical Commander	Command capability, coord with other Op Commanders
Area Controller	Operational Discharges Commander	Command capability, coord with other Op Commanders
None	Operational Families Support Centre (FSC) Commander	Command capability, coord with other Op Commanders
Silver Manager	Tactical Commander	Responsible for planning and commanding cross-Trust response
Medical Incident Controller (MIC)	Tactical Clinical Lead	Advisor to Tactical Commander (as required dependent on incident)
CRT	Tactical Estates & Facilities Lead	Advisor to Tactical Commander, commands supporting E&F assets (as required dependent on incident)
CRT	Tactical Portering & Security Lead	Advisor to Tactical Commander, commands supporting P&S assets (as required dependent on incident)
None	Tactical FSC Lead	Advisor to Tactical Commander (as required dependent on incident)
None	Tactical Surgical & Anaesthetics (Directorate) Lead	Advisor to Tactical Commander (as required dependent on incident)
None	Tactical Discharge Lead	Advisor to Tactical Commander (as required dependent on incident)
None	Tactical Medical (Directorate) Lead	Advisor to Tactical Commander (as required dependent on incident)

Old Role Title	New Title	Role
Senior Manager on Call (SMoC - Community)	Tactical Community SMoC	Advisor to Tactical Commander, commands uninvolved community assets (as required dependent on incident)
Runners	Tactical Support staff	Provides support to running of TCC, and delivery of C3 (as required dependent on incident)
Loggists	Tactical Information Management (IM) staff	Manages all TCC information, reports and returns
Gold	Strategic Commander	Responsible for directing cross-Trust response
None	Strategic Recovery Lead	Responsible for planning and commanding cross-Trust recovery
None	Strategic Finance Lead	Advisor to Strategic Commander, commands supporting Finance assets (as required dependent on incident)
None	Strategic HR Lead	Advisor to Strategic Commander, commands supporting HR assets (as required dependent on incident)
None	Strategic Legal Lead	Advisor to Strategic Commander, commands supporting Legal assets (as required dependent on incident)
None	Strategic Health & Safety Lead	Advisor to Strategic Commander, commands supporting H&S assets (as required dependent on incident)
None	Strategic Comms Lead	Advisor to Strategic Commander, commands supporting Comms assets (as required dependent on incident)
Runners	Strategic Support staff	Provides support to running of SCC, and delivery of C3 (as required dependent on incident)
Loggists	Strategic IM staff	Manages all SCC information, reports and returns
Hospital at Night Room (H@N)	Patient Coordination Centre (PCC)	As before
Hospital Control Centre (HCC)	Tactical Control Centre (TCC)	Delivers tactical planning/tasking/tracking/reporting, and Controls and Coordinates operational delivery
None	Strategic Command Centre (SCC)	Provides strategic direction/tracking/reporting and approves and directs resource support.
None	Families Support Centre (FSC)	Provides life support, comfort, clinical linkage, pastoral support to families and relatives of incident victims

DOCUMENT CONTROL

Author(s):	Head of Emergency Preparedness, Resilience & Response
Other contributors:	Deputy Chief Operating Officer
Approvals and endorsements:	Trust Resilience Group Executive Directors Trust Executive Group
Consultation:	Trust Resilience Group DCOO
Issue no:	2.0
File name:	EPRR Strategy v1.0
Supersedes:	Internal Escalation
Equality Assessed	Yes
Implementation	EPRR Manager will check plans; plan will not be issued or approved unless approved by TRG.
Monitoring: (give brief details how this will be done)	As Required review by Operational Team, Site Management Meeting, Trust Resilience Group.
Other relevant policies/documents & references:	Trust C3 Plan Specific Resilience, Incident and Business Continuity Plans
Additional Information:	• The Civil Contingencies Act (2004) (CCA). • The NHS Act (2006 - as amended). • Health & Social Care Act 2012 • The NHS Constitution. • The requirements for EPRR as set out in the NHS Standard Contract(s). • NHS England EPRR guidance and supporting materials including: o NHS England Core Standards for Emergency Preparedness, Resilience and Response o NHS England Business Continuity Management Framework (service resilience) o NHS Commissioning Board Business Continuity Management Framework (service resilience) • National Occupational Standards for Civil Contingencies • BS ISO 22301 Societal security – Business continuity management systems PAS 2015 – Framework for Health Services Resilience.

ANNEX A - EPRR CAPABILITY DEVELOPMENT PROCESS

1. The development of Trust EPRR capability consists of 4 phases and is under the purview of the DCOO with delivery delegated to the Head of EPRR:

a. Phase 1 – Programme Management.
b. Phase 2 – Analysis & Planning.
c. Phase 3 – Implementation, Resourcing & Training.
d. Phase 4 – Evaluation & Improvement.

Phase 1 – EPRR Programme Management.

2. **EPRR Programme Management**. On behalf of the ECOO, the DCOO will lead on the coordination of EPRR programme management activities, which are:

a. Developing Trust C3 capability.
b. Producing Major Incident (MI), Emergency Management (EM including Recovery), Emergency Communications (EC), Information management (IM), Situational Awareness (SA), and BC Policies, Strategies, Guidance and Templates.
c. Establishing the scope of the above subservient development programmes.
d. Developing a timetable for implementation with timescales for completion.
e. Achieving 'top down' buy in.
f. Confirming how the EPRR Programme will be financed and resourced.
g. Commencing a programme of awareness raising.

Phase 2 – Analysis & Planning

3. **Analysis.** The aim of this phase is to conduct organisational and threat/issue analysis to allow the Trust to thoroughly understand the potential problems that may occur, how they will affect the Trust outcomes, and what can be done to prevent, mitigate, or react to such problems. The result will be appropriate response and recovery plans, or documented Risk Assessments (RA) for residual risk to be fed into the Trust risk process; both will include an analysis that will identify the key services, products, inter-dependencies, and threats/issues. It will also seek to identify the business-critical activities, Single Points of Failure (SPOF) and how these can be affected by perceived threats, risks and hazards, internally or externally. Analysis will be conducted by Trust staff under EPRR sub-element work areas through the TRG, and will be coordinated by the Head of EPRR in liaison with the Trust Risk Management staff. This will include:

a. No less than annually reviewing the Trust (and partner) Risk Register and supporting assessments through the Trust Risk Strategy process and evidencing this through version control.
b. Consulting widely with relevant internal and external stakeholders during risk evaluation and analysis stages
c. On engagement of suppliers, receiving assurances of commitment to BC, through appropriate accreditation or business continuity plans.
d. Sharing risk assessment(s) appropriately with partners according to the scope and scale of the identified risk, once completed.

4. **Planning.** The analysis phase will provide the foundation for subsequent integrated planning. In the planning phase, the single subject (MI, EM, BC, Security, Health & Safety, Fire, specialist areas) planning phases are brought together by the Head of EPRR through the TRG– although they should have been cognisant of each other as they progress – to provide an integrated threat analysis and to inform the resultant capability development and planning.

Phase 3 – Implementation, Resourcing & Training

5. **Implementation.** Once the threat analysis is complete and has informed the drafting of plans, the transition into the implementation phase under the ECOOs purview will occur; this will be managed by the DCOO under an approved and funded implementation plan (drafted by Head EPRR).

6. **Resourcing.** If required, the TEG will recommend the resourcing funding plan, provided by the DCOO, to the Executive Board for funding approval. Once this is gained, a plan to deploy any new resources will be developed and then implemented in conjunction with the training plan. The latter will be written by Head of EPRR for TEG approval.

7. **Training**. Training is to be designed, developed and delivered against specified standards of achievement, to be designed by relevant Trust and external staff, managed by Head of EPRR; training achievement is the responsibility of direct line management. Due to the wide range of skill sets identified to meet the implementation plan, training is likely to be delivered by both internal and external suppliers, and the delivery is to be captured in individual staff training records, and captured centrally by Head of EPRR so that there is Trust overview of the capability inherent in the organisation. To be effective, the training programme requires clear leadership and an integrated management process, driven by the Chief Executive and the Executive and Quality Boards, and promoted by the principal managers and executives. It should be managed at both the operational and organisational levels. To achieve this, the Trust will, through the AEO, appoint the DCOO to be responsible for training programme management, in that the DCOO will:

a. Identify and approve training funding.
b. Identify key members of staff to be responsible for training within their respective departments and areas.
c. Implement effective communication regarding the importance of EPRR training and conformance with its requirements.

Phase 4 – Evaluation & Improvement

8. **Evaluation.** No improvement programme can be proven as worthy of the investment required without evaluation. Such an evaluation will assure that staff, processes, plans and resources have met a specified standard. The evaluation plan and process are to be designed by Head of EPRR against the EPRR Core Standards and relevant national guidance, managed by the DCOO, and approved by the ECOO. Reporting of achievement is to be made to the Executive Board by the ECOO, against the Trust annual plan, which is to include EPRR key performance indicators. The Trust has an annual training and exercise programme designed by Head of EPRR (see Appendix 1) that facilitates the on-going development of all staff, promoting an understanding of their roles and responsibilities, whilst testing the effectiveness of the EPRR capability. Exercising develops teamwork, competence and confidence in a safe environment. The findings from the exercises will be used to improve plans and supporting business arrangements. It should be noted that EPRR core standards state that the exercise profile should be, at a minimum:

a. 1 x Live Ex every 3 years;
b. Table top annually;
c. Internal activation exercise twice yearly.

WSFT sees this requirement as insufficient to provide appropriate assurance and will therefore instigate a more frequent yet relevant programme thereby absorbing the above elements.

9. Core standards for EPRR provide a standardised internal assessment framework, and are linked to the frequency of self-assessment; the requirement is for the AEO to provide assurances to the Health Community via the LHRP and to the CCGs as contractors of the Trust's services; this occurs through the audit process and by attendance at the LHRP meetings. The plan for this assurance is included in the strategy delivery timeline when the rest of the development stream has been agreed and will be further articulated in future iterations of Appendix 1. One option under consideration to improve the quality of the assessment is to either bring in an external independent verifier or a peer Trust.

10. There are several methods of exercising plans and infrastructure, each dependent on the objective of the exercise. However, for the purpose of this programme, a series of workshop and walkthrough exercises will be initially and then subsequently undertaken across the organisation to test new plans and supporting arrangements. Further exercises (including other types such as 'activation', 'command post', 'table top' and 'practical') may be carried out if major failings are identified, or within the following 12 months as the EPRR capability matures.

11. Lessons learnt from incidents, training and exercises will be included in post event reports including areas for potential improvement. The reports will include an action plan and recommendations for any further updates to the EPRR capability and this will feed back into the strategies, action plans, and DATIX risk management as appropriate.

Supporting Activities

12. **New Build or Works Programmes**. With any new build or works programmes, the Trust will consider the potential risks, impacts and opportunities on existing and future business, activities and processes. Close engagement between the EPRR Programme and these capital programmes at the TRG and the Framework Group meeting will help to ensure that Trust EPRR is cognisant and matures commensurate within local and regional environments.

13. **Communications**. In order to cascade periodic updates through management tiers, the Trust EPRR intranet page will include all current plans and procedures, as well as Lessons Identified. This may also include articles on recent disruptions, the response, successes, etc. The focus will be to raise awareness of the Trust EPRR Programme and improve confidence between all parties.

14. **Delivery Risks**. EPRR analysis, planning and implementation is integrated into the existing Trust Risk governance framework through the Trust Risk Manager to mitigate the following:

a. Prolonged EPRR Programme delivery.
b. Failure to deliver the EPRR Programme.
c. Failure to improve and mature the EPRR capability following completion of the Programme.
d. Incoherent, ineffective and 'silo' plans.
e. Inappropriate response to a service interruption.
f. Inappropriate financial spending.
g. Damage to reputation and brand.

15. **Health & Safety, Fire, Environmental and Security**. It is essential that the EPRR arrangements do not compromise the health and safety of any persons within the confines of, or conducting activities or processes relative to, the Trust including lone working. Trust Health & Safety and Security are integrated in the development of the EPRR arrangements and when invocation of EPRR plans occurs. It is important that EPRR is linked – at least in the plans - to security procedures (lockdown etc) and training (CCTV; SIA qualified staff; conflict management and resolution), and escalation reflecting national threat levels and CONTEST. Additionally, the Trust will consider the potential impacts upon the environment when developing the EPRR arrangements, utilising Best Available Techniques (BAT) during any service disruption including those related to emerging and high-profile threats and solutions such as cyber security, detection, investigation and information protection.

16. **Audits**. Internal audits will be used to assess the maturity of the Trust EPRR plans, associated plans and supporting arrangements and delivery. The audits will reveal where non-conformities and corrective actions are required. The results of audits will be communicated to Board level so that appropriate actions can be authorised and directed to improve Trust EPRR. The audits have 5 key functions:

a. To validate compliance with the Trust EPRR policy and standards.
b. To review the Trust EPRR solutions and to validate the Trust EPRR Plans.
c. To verify that appropriate EPRR exercise activities are taking place.
d. To gain appropriate confidence in the competence of Trust staff in delivering EPRR solutions.
e. To highlight deficiencies and issues, with a view to resolution.

17. An on-going programme of internal first party audits of the EPRR capability is planned at Appendix 1, and the results are to be documented by Head of EPRR. Identified nonconformity will be recorded within the audit report, and any required corrective actions implemented. Personnel undertaking internal audits of the EPRR capability will be judged as: qualified and experienced in EPRR; experienced and competent in auditing techniques; if relevant, have a good understanding of the structure and application of ISO standards; and shall be independent from the day-to-day operations of

the EPRR to ensure impartiality. The Trust will employ a 2nd party audit annually[4], as well as submitting internal self-assessment to the LHRP and NHS England also annually. On occasion, a third-party audit may be requested by, or imposed upon, the Trust.

18. **Improvement**. Through the setting and monitoring of objectives and continual development of the Trust EPRR capability by the Head of EPRR, through the TRG, and acting upon problems and outcomes of exercises and incidents, the Trust shall continually improve the effectiveness of EPRR. The EPRR solution is to be routinely reviewed as at Appendix 1, to ensure its continuing suitability, adequacy and effectiveness. Reviews will include assessing opportunities for improvement and the need for changes to the EPRR, including the EPRR plans and objectives. Records of any management reviews will be retained, including any decisions and actions related to possible changes to EPRR plans, objectives, targets and other elements of EPRR, consistent with the commitment to continual improvement. Input to management reviews will include:

a. Results of internal audits and evaluations of compliance with legal requirements.
b. Communication(s) from external interested parties, including complaints.
c. Incident preparedness and operational EPRR performance.
d. Extent to which Trust objectives have been met.
e. Status of corrective and preventive actions.
f. Follow-up actions from previous management reviews.
g. Changing threats and hazards, circumstances, including developments in legal and other requirements related to its risks, threats and hazards.
h. Recommendations for improvement.

19. **Lessons Learnt**. Lessons identified from training, exercises and incidents will be captured in after-action reports, which will be presented to the Board by the ECOO. Such lessons will be subject to analysis and converted to Lessons Learnt, which will be used to determine any amendments or inclusions required when plans are updated, and will be held in a working database constructed and maintained by Head of EPRR. These lessons will be presented at reviews of the EPRR capability, or any of the elements thereof, and at management reviews. The ECOO will hold the responsibility for the successful resolution of Lessons Learnt in accordance with Trust policy and procedures. This process will be integrated with, and support, the Trust DATIX methodology. This process will include:

a. **Preventative Actions**. The Trust will act through the TRG to address issues associated with Trust EPRR to prevent occurrence. All preventative actions will be recorded on an Action Tracker by Head of EPRR, including:
   i. Non-conformity and the cause.
   ii. Action taken and reviewing results of action taken.
   iii. Identifying a change to risks (focusing upon significant risks).
   iv. The priority of preventative actions based upon the results of analysis.

b. **Corrective Actions**. The Trust will act through the TRG to eliminate the cause of non–conformities associated with the implementation of EPRR in order to prevent re-occurrence. All non-conformities will be recorded on an Action Tracker by Head of EPRR, including:
   i. Identifying the nonconformity.
   ii. Determining the cause of the nonconformity.
   iii. Determining and implementing the corrective action.
   iv. Recording the results of action taken.
   v. Reviewing the corrective action taken.

To achieve this, the TRG will utilise after-action reporting, de-briefs, Lessons Learnt and DATIX to provide a consolidated report on all significant incidents through the Head of EPRR to the ECOO for discussion at executive level meetings.

20. **Management Reviews**. The outputs from management reviews, be they departmental, directorate, divisional or Trust level, should include any decisions and actions related to possible changes to EPRR policy, objectives, targets and other elements of the EPRR, consistent with the

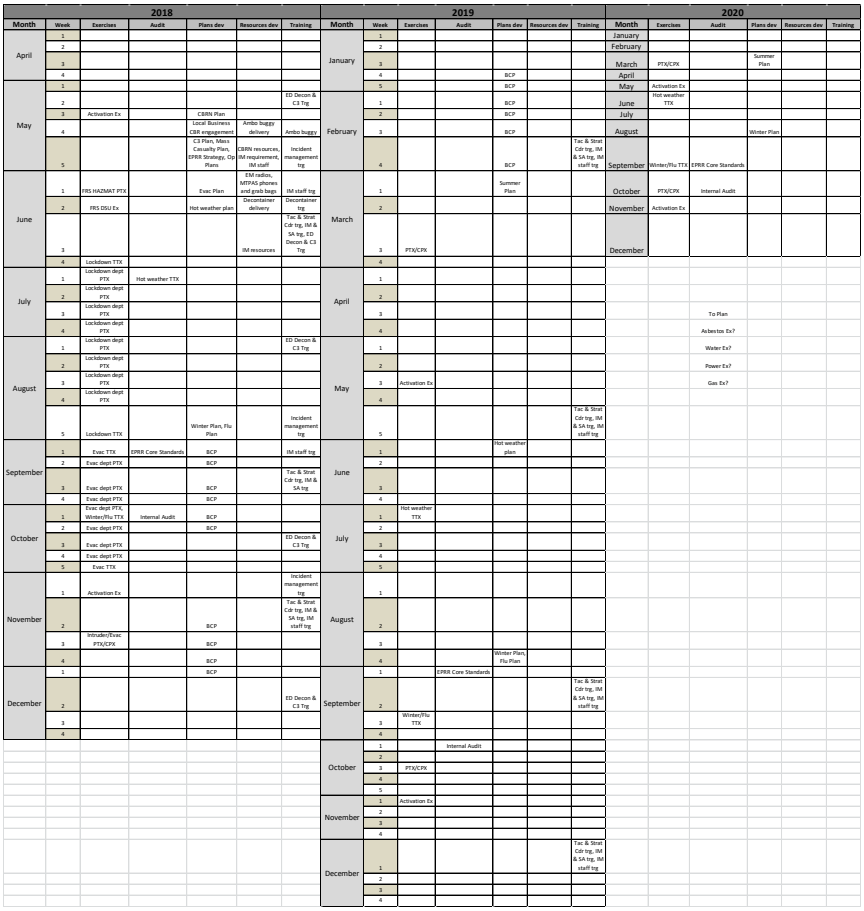
[4] Whose auditors will meet the same criteria as for Trust first party auditors.

commitment to continual improvement. Such outcomes will be fed by the Head of EPRR through the TRG for resolution and reporting.

Summary

It is important for the Trust to understand how the 'critical path' that maintains everyday health care operations is enabled by EPRR. This requires a detailed understanding of what activities are taken and when, what processes and equipment are utilised and by whom. This knowledge, extrapolated by the EPRR Programme will help to identify business critical activities and processes, assess inherent risks and pinpoint weaknesses. The EPRR Programme, supported by this strategy will provide the framework from which to develop robust and effective EPRR arrangements, whilst improving and adapting organisational resilience.

Figure 2: WSFT EPRR Capability Development Plan @1st May 2018 (subject to change)
[screen shot below - see attached excel spread sheet]



2018

Month	Week	Exercises	Audit	Plans dev	Resources dev	Training
April	1					
	2					
	3					
	4					
May	1					
	2					ED Decon & C3 Trg
	3	Activation Ex		CBRN Plan		
	4			Local Business CBR engagement	Ambo buggy delivery	Ambo buggy
	5			C3 Plan, Mass Casualty Plan, EPRR Strategy, Op Plans	CBRN resources, IM requirement, IM staff	Incident management trg
June	1	FRS HAZMAT PTX		Evac Plan	EM radios, MTPAS phones and grab bags	IM staff trg
	2	FRS DSU Ex		Hot weather plan	Decontainer delivery	Decontainer trg
	3				IM resources	Tac & Strat Cdr trg, IM & SA trg, ED Decon & C3 Trg
	4	Lockdown TTX				
July	1	Lockdown dept PTX	Hot weather TTX			
	2	Lockdown dept PTX				
	3	Lockdown dept PTX				
	4	Lockdown dept PTX				
August	1	Lockdown dept PTX				ED Decon & C3 Trg
	2	Lockdown dept PTX				
	3	Lockdown dept PTX				
	4	Lockdown dept PTX				
	5	Lockdown TTX		Winter Plan, Flu Plan		Incident management trg
September	1	Evac TTX	EPRR Core Standards	BCP		IM staff trg
	2	Evac dept PTX		BCP		
	3	Evac dept PTX		BCP		Tac & Strat Cdr trg, IM & SA trg
	4	Evac dept PTX		BCP		
October	1	Evac dept PTX, Winter/Flu TTX	Internal Audit	BCP		
	2	Evac dept PTX		BCP		
	3	Evac dept PTX				ED Decon & C3 Trg
	4	Evac dept PTX				
	5	Evac TTX				
November	1	Activation Ex				Incident management trg
	2			BCP		Tac & Strat Cdr trg, IM & SA trg, IM staff trg
	3	Intruder/Evac PTX/CPX		BCP		
	4			BCP		
December	1			BCP		
	2					ED Decon & C3 Trg
	3					
	4					

2019

Month	Week	Exercises	Audit	Plans dev	Resources dev	Training
January	1					
	2					
	3					
	4			BCP		
	5			BCP		
February	1			BCP		
	2			BCP		
	3			BCP		
	4			BCP		Tac & Strat Cdr trg, IM & SA trg, IM staff trg
March	1			Summer Plan		
	2					
	3	PTX/CPX				
	4					
April	1					
	2					
	3					
	4					
May	1					
	2					
	3	Activation Ex				
	4					
	5					Tac & Strat Cdr trg, IM & SA trg, IM staff trg
June	1			Hot weather plan		
	2					
	3					
July	1	Hot weather TTX				
	2					
	3					
	4					
August	1					
	2					
	3					
	4			Winter Plan, Flu Plan		
September	1		EPRR Core Standards			
	2	Winter/Flu TTX				Tac & Strat Cdr trg, IM & SA trg, IM staff trg
	3					
	4					
October	1		Internal Audit			
	2					
	3	PTX/CPX				
	4					
	5					
November	1	Activation Ex				
	2					
	3					
	4					
December	1					Tac & Strat Cdr trg, IM & SA trg, IM staff trg
	2					
	3					
	4					

2020

Month	Exercises	Audit	Plans dev	Resources dev	Training
January					
February					
March	PTX/CPX		Summer Plan		
April					
May	Activation Ex				
June	Hot weather TTX				
July					
August			Winter Plan		
September	Winter/Flu TTX	EPRR Core Standards			
October	PTX/CPX	Internal Audit			
November	Activation Ex				
December					

To Plan
Asbestos Ex?
Water Ex?
Power Ex?
Gas Ex?

ANNEX B - EPRR PLANNING PROCESS

1. **Overarching EPRR Planning Framework:** EPRR is managed through the integrated emergency management (IEM) lifecycle. This consists of the steps shown in Table 2 below and these are to be followed by the Trust.

Step	Name	Purpose
Anticipation Assessment / Prevention	Impact Analysis	Identifies a priority order for the recovery of services / processes
	Risk Register	Identified the types of incident that may occur, and the potential impact if they do occur. The results of this will be used to identify when a contingency plan is required
Preparation / Responding / Recovery	Command and Control Framework	To ensure effective management of any event requiring invocation of an emergency plan
	On call staff	Arrangements for ensuring the Trust has access to sufficiently senior staff 24x7
	Resource Escalation Action Plans	Structured sets of arrangements are implemented when 'normal' operating functions are challenged, for example through loss of staff, resources or periods of high demand.
	Mass Casualty Plan	Used when the hospital receives so many casualties that special measures are necessary to deal with them
	Business Continuity Plans	Detail the response to interruptions of critical services and the action required to maintain services at an acceptable level and return them to normal operations as soon as possible.
	Specialty plan	The response when a response to a specific incident or threat is required and not contained within a generic incident plan previously mentioned

Table 2: IEM

2. **Emergency Planning Overview.** There are a number of interrelated planning levels, which the Trust will integrate with:

2.1 **Requirements within the NHS:** The Civil Contingencies Act requires Category 1 Responders to maintain plans for preventing emergencies; reducing, controlling or mitigating the effects of emergencies; and taking other action in the event of emergencies; this is the responsibility of the ECOO as AEO. To do this, the Trust is to draw on national, regional and local risk assessments and is to have regard for the arrangements to warn, inform and advise the public at the time of an emergency. Trust plans will contain procedures for determining whether an emergency has occurred; the provision for training key staff; and provision for exercising the plan to ensure it is effective. Procedures are also be put in place to ensure that the plan is reviewed periodically and kept up to date. All of the above will be checked annually for compliance by the Non-Executive Director with responsibility for EPRR. Specifically, the Trust, through Head of EPRR, is to:

2.1.1 Involve Category 2 Responders - and other organisations which are not subject to the Act's requirements - as appropriate throughout the planning process.

2.1.2 Have regard to the activities of relevant voluntary organisations when developing plans. The Regulations permit Category 1 Responders to collaborate with other organisations in delivering the emergency planning duty.

2.1.3 Have a statutory duty to publish their emergency plans, to the extent necessary or desirable for the purpose of dealing with an emergency.

2.2 **Emergency planning at the sub-national level**: Planning at a multi-LRF level is different from planning at the local (Trust) level. Cooperation at the sub-national level in England is a key element of the UK's civil protection framework. The sub-national tier is not a judgement on the local level; rather, it is a mechanism for improving co-ordination and communication into and out from the centre of government. Co-operation at the sub-national level involves the representatives of local Responders and central government bodies working together to address larger-scale civil protection issues. Co-operation may take place within a multi-agency setting or directly between 2

or more Responders. The Trust will be represented at this planning level by the DCOO and Head EPRR.

2.3 **Emergency planning at the UK Government level:** The UK government capabilities programme is the core framework through which the government is seeking to build resilience across all parts of the UK. The programme uses risk assessment over a 5-year period to identify the generic capabilities that underpin the UK's resilience to disruptive challenges and ensures that each of these is developed. These capabilities include dealing with mass casualties and fatalities, response to chemical, biological, radiological or nuclear (CBRN) incidents, provision of essential services and warning and informing the public. The government has in place a coordinated cross-governmental exercise programme covering a comprehensive range of domestic disruptive challenges, including accidents, natural disasters and acts of terrorism. The programme is designed to test rigorously the concept of operations from the coordinated central response through the range of lead government department responsibilities, and the involvement of the devolved administrations, to the sub-national tier and local Responders. These national processes feed into the devolved administrations, sub-national and local levels to ensure fully integrated emergency planning at all levels throughout the UK. The DCOO is responsible for Trust integration into this level of planning.

2.4 **The role of the voluntary sector in emergency planning and response:** Where appropriate, The Trust is to consider, at an early stage in planning, whether voluntary organisations may have capabilities which could assist in responding to an emergency. The voluntary sector can provide a wide range of skills and services in responding to an emergency. These include: practical support (such as first aid, transportation, or provisions for Responders); psycho-social support (such as counseling and help lines); equipment (radios, medical equipment); and information services (such as public training and communications). The Head of EPRR will consult with voluntary organisations on the Trust's behalf.

3. **Emergency Plans.** The Trust will have operational, tactical, and strategic plans dependent on the type of incident, and on the scope and scale of response required. Emergency planning should aim to prevent emergencies occurring, and when they do occur, proactive and tested contingency plans, coupled with sound planning to address the peculiarities of the particular incident, should reduce, control or mitigate the effects of the emergency. It is a systematic and ongoing process which should evolve as lessons are learnt and circumstances change. Emergency planning should be viewed as part of a cycle of activities beginning with establishing a risk profile to help determine what should be the priorities for developing plans, and ending with review and revision, which then re-starts the whole cycle - see Figure 4 for an overview of linkages. The Trust will maintain plans which cover 3 different areas:

3.1 **Plans for preventing an emergency:** In some circumstances there will be a short period before an emergency occurs when it might be possible to prevent the incident occurring by proactive prompt or decisive action. This will require departmental, directorate, divisional or Trust contingency plans and procedures, headed by the Trust C3 Plan.

3.2 **Plans for reducing, controlling or mitigating the effects of an emergency:** The main bulk of planning should consider how to minimise the effects of an emergency, starting with the impact of the event (i.e. alerting procedures) and looking at remedial actions that can be taken to reduce effects. Recovery plans are also to be developed to reduce the effects of the emergency and ensure long term recovery. This will include internal and external Major Incident plans, and Business Continuity Plans which will be drafted and coordinated by Head of EPRR.

3.3 **Plans for taking other action in connection with an emergency -** Not all actions to be taken in preparing for an emergency are directly concerned with controlling, reducing or mitigating its effects. Emergency planning should look beyond the immediate response and long-term recovery issues and look also at secondary impacts. For example, the wave of reaction to an emergency can be quite overwhelming in terms of media attention and public response. The Trust C3 Plan and supporting emergency plans consider how to handle this increased interest. This will require a Trust Recovery Plan to be coordinated and drafted by the Trust Recovery Lead[5].

[5] Executive Director appointed by the Trust Strategic Commander (see C3 Plan)

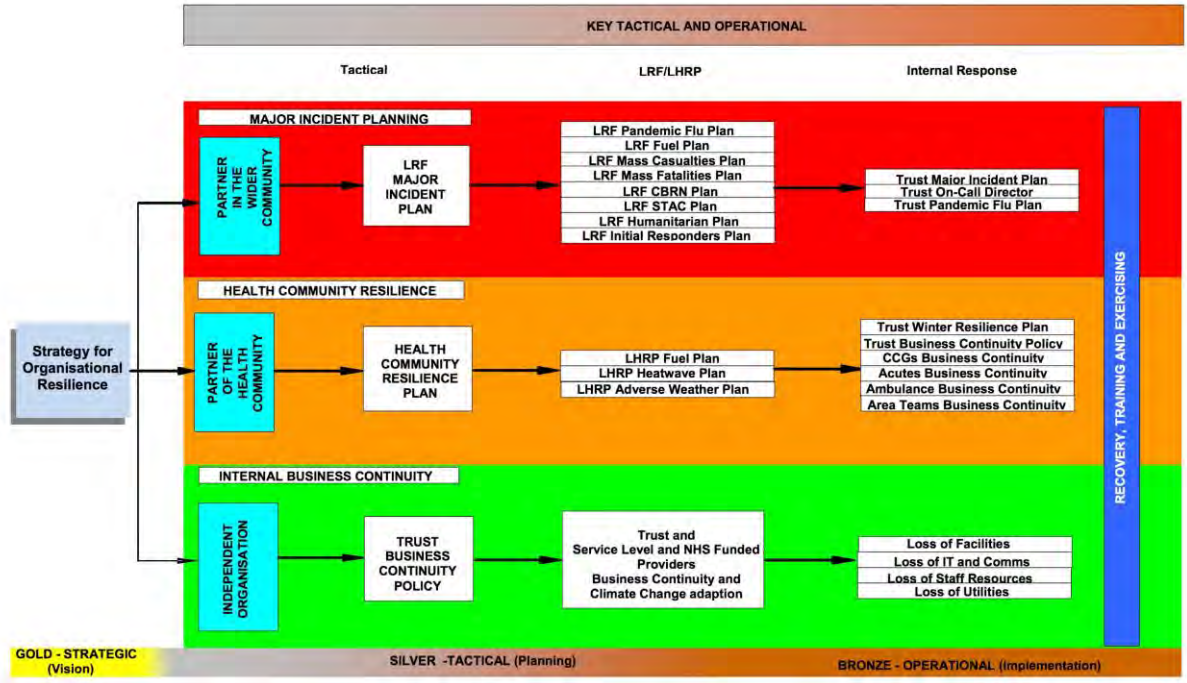


Figure 3: EPRR Organisational Activities

4. **Activation and Maintenance of Plans.** The Trust C3 Plan includes procedures for determining whether an emergency has occurred, and when to activate the plan in response to an emergency. This should include identifying an appropriately trained person who will take the decision, in consultation with others, on when an emergency has occurred. The maintenance of plans involves more than just their preparation. Once a plan has been prepared, it must be maintained systematically to ensure it remains up-to-date and fit for purpose at any time if an emergency occurs. It may be that multiple organisations develop a joint emergency plan where the partners agree that, for a successful combined response, they need a formal set of procedures governing them all. For example, in the event that evacuation is required, the police would need carefully pre-planned co-operation from various other organisations such as fire and ambulance services and the local authority, as well as involvement of others such as transport organisations.

5. **Exercising Plans and Training Staff.** Head EPRR will design an on-going training system (Appendix 1 to Annex A) to provide opportunities for staff involved in the planning for, or response to, an emergency, to receive appropriate training. Executive Directors are responsible for ensuring staff have conducted the required training and are suitable capable to perform their duties. The Trust will test the effectiveness of all emergency plans by carrying out exercises at varying levels, to a plan drawn up and managed by Head of EPRR, against standards drafted by Head of EPRR and approved by the DCOO.

6. **Training & Exercising Strategy.** The trust EPRR training and exercising programme at Appendix 1 to Annex A is drafted annually by Head of EPRR for DCOO approval. The programme includes those non-Trust staff who have a role in the emergency plans such as contractors and civil protection partners. The plans themselves explicitly identify the nature and frequency of training and exercising required articulated as; a detailed 12-month strategy for the current FY; an approved strategy in outline for the following FY; and an unapproved draft strategy for the 3rd FY.

7. In particular, Head of EPRR is to ensure that National Occupational Standards are adopted for the training of commanders at all levels of response as part of the training and exercising strategy. This, as part of the core standards assurance process, proves “competency” in responding to incidents and emergencies and leads toward a level of professional development.

ANNEX C - TRUST EPRR ROLES & RESPONSIBILITIES

1. **Chief Executive** has overall responsibility for compliance with the CCA 2004 and will:

- Ensure that the Trust complies with all statutory requirements of the Act.
- Ensure the provision of sufficient resources to meet the requirements of CCA.
- Assign an executive lead for EPRR, and a non-executive Director with oversight of the EPRR portfolio.
- Ensure effective BC and MI plans (generic and specific) are in place to correspond with the major risks identified within the Trust and for those identified on local community and national risk registers.
- Oversee command and control in line with the Trust C3 Plan to include, if appropriate, identifying an Executive Director to lead on recovery.
- Promote EPRR across the Trust and allocate it sufficient status and priority to ensure achievement.

2. **Non-Executive Director responsible for EPRR** will maintain oversight of the Trust EPRR capability and annually will check Trust compliance with CCA requirements. The EPRR Non-Executive Director (NED) will provide 'mentorship' of the process, and act in an EPRR advisory capacity to the Executive Directors and the Board.

3. **Executive Chief Operating Officer** (ECOO) is the senior staff member with responsibility for the delivery of the Trust's EPRR capability, through the Board, to the correct and realistic standard of competency, and is the designated Accountable Emergency Officer (AEO), and will

- Provide clear leadership and facilitate an integrated management process for EPRR.
- Set the EPRR strategic direction, and approve the EPRR Analysis, Risk, Planning, Funding, Resourcing, Implementation, Training and Validation documentation.
- Oversees the development of the EPRR capability and in particular the delivery of the implementation phase.
- Appoint the DCOO to manage the routine delivery of EPRR.
- Approves the EPRR capability implementation and evaluation activity presented by the DCOO.
- Manages the successful resolution of Lessons Learnt.
- Reports achievement of the EPRR programme to the Executive Board as required, including the presentation of 'after action' reports to the Board.
- Liaise with the Quality Committee to ensure the EPRR strategic direction is assured.
- Presents the EPRR Strategy to the Executive Board for approval.
- Ensure the Trust undertakes an annual self-assessment against core standards identifying a level of compliance for each.
- Review the divisional improvements plans and manage the development of action plans to meet extant core standards, and monitor action plan achievement;
- Complete an annual statement of compliance to be approved by the Trust Board before submission to the LHRP and present it to the Executive Board for public approval before submission.
- Ensure that the approved annual statement of compliance is published in the Trust Annual Report and is available on-line.
- Ensure that the Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation is publicly identified via the Trust website and annual report, and that there is a formal and established process for briefing the incumbent on the progress of the EPRR work plan outside of Board/Governing Body meetings.
- Regularly attend the Trust Resilience Group (TRG) and Local Health Resilience Partnership (LHRP) meetings or, where that is not possible, delegates that responsibility to the DCOO or Head EPRR.

4. **Deputy Chief Operating Officer (DCOO)** is the appointed senior manager with responsibility for EPRR and will:

- Coordinates all EPRR programme management and capability development activity across the Trust.

- Manages the EPRR capability implementation and evaluation activity for the ECOO.
- Identify and approve training funding.
- Identify key members of staff to be responsible for training within their respective departments and areas.
- Implement effective communication regarding the importance of EPRR training and conformance with its requirements.
- Provide a resource-funding plan to the Executive Board for approval at least annually.
- Ensure the Ops Board receives regular, at least annually, on EPRR, including on exercises, training and tests undertaken.
- Provide executive support to the emergency planning programme.
- Represent the Trust at the UK Government, and the sub-national level, of emergency planning.
- Identify if further support is required from the Board (whether from a second executive Director or Non-Executive Director) to provide assurance to the Board of Directors that the Trust is meeting its legal obligations.
- Ensure that the Trust is compliant with the EPRR requirements as set out in the Civil Contingencies Act 2004, The Health and Social Care Act 2012, the NHS planning framework and the NHS Standard Contract.
- Ensure that the Trust is properly prepared and resourced for dealing with a major incident or emergency event;
- Ensure the Trust and any providers they commission, have robust EPRR arrangements (including BC) in place
- Attend Local Health Resilience Partnerships (LHRP) meetings on behalf of the ECOO (or ensure the trust has appropriate representation at the meeting) and that the Trust is appropriately represented at any relevant governance meetings, sub groups or working groups of the LHRP or Local Resilience Forum (LRF).

5. **Head of EPRR** will:

- Manage the Trust EPRR capability development and delivery on a daily basis on behalf of the AEO assisted by the TRG.
- Coordinate and capture EPRR analysis, in liaison with Trust Risk Management staff.
- Draft all EPRR contingency plans and contribute to other related Trust plans as required.
- Involve external Cat 2 responders and voluntary organisations when planning, training and exercising.
- Coordinate all EPRR integrated management planning and draft the EPRR Implementation, Resourcing, Training and Evaluation Plans.
- Set and monitor objectives and continual development of the Trust EPRR capability.
- Design and manage the EPRR Training and Evaluation Programmes (including audit), capturing progress for upward reporting.
- Design and deliver the Trust EPRR 'Lessons Learnt' process, including preventative and corrective actions.
- Implement a system of regular reporting and review across WSFT that aligns with the Trusts risk management and governance arrangements.
- Support the AEO in implementing the Trusts EPRR Framework.
- Represent the Trust at the sub-national level of emergency planning.
- Develop, disseminate and maintain the Trusts corporate EPRR arrangements.
- Attend appropriate local and regional planning meetings.
- Support Executive Directors, Clinical Directors, Directorate Managers, Ward Managers and Senior Nursing Staff in the development of BC and MI Plans.
- Retain archived version of BC and MI plans to ensure an audit trail of changes is available.
- Ensure that hazards, risk and threats are identified, recorded, assessed and control measures developed, where appropriate.
- Establish and maintain a forum (TRG) where EPRR and BC matters can be discussed.
- Provide regular updates from the TRG to the DCOO & ECOO.
- Develop, deliver and maintain a training strategy for the Trust and facilitate delivery.
- Arrange, deliver and coordinate exercises as required.
- Maintain training records and records of attendance in relation to all EPRR and BC activities.

- Produce an EOY annual report for the Trust Board summarising the current state of the Trusts EPRR arrangements.
- Contribute to NHS England Situation and EPRR report.
- With External Agencies:
  - Agree risk profiles and maintain a Community Risk Register.
  - Develop and participate in multi-agency plans and other documents, including protocols and agreements
  - Co-ordinating multi-agency exercises and other training events.
  - Participate in multi-agency debriefs
  - Provide expert advice and share knowledge, experience and best practice.

6. **Executive Directors** will;

- Ensure their staff are competent in the delivery of EPRR outcomes.
- Oversee the effective implementation of this EPRR policy and related plans within their areas of responsibility.
- Effectively delegate emergency planning responsibilities within their areas of responsibility, including nominating a BC lead (ideally service leads/operational managers), and a clinical flow planning lead.
- Effectively support their managers' decisions and recommendations in terms of the provision of appropriate resources for emergency planning.
- Ensure that managers have adequate training to participate effectively in the preparation for and response to major incidents.
- Ensure the provision of appropriate resources including equipment and facilities to enable an effective response to a MI.
- Cascade Communications messages and BC and MI plans (generic and specific) to staff within their areas.

7. **Associate Directors of Operations, Clinical Directors and Senior Nursing Staff** will:

- Periodically review and update action cards for the department or ward;
- Support divisional BC leads to ensure local BCP are maintained and developed.
- Participate in the development of emergency plans
- Ensure the development and maintenance of BC and MI plans (generic and specific) and submit these to the appropriate committee for ratification.
- Maintain an emergency contact list for all staff in the department or ward
- Ensure that critical services and support systems (including IT) have been identified within their areas of responsibility
- Ensure that appropriate equipment is available and regularly maintained in order to respond to major incidents
- Implement all aspects of this policy, the BC and MI Plans (generic and specific) within their area of control.
- Ensure that staff receive training appropriate to their role in responding to MI.
- Maintain a local record of staff attendance and training in relation to all EPRR and BC activities.
- Brief staff on the situation, any new developments and Trust actions.
- Ensure that there is a departmental debrief following all major incidents and the recommendations of these are fed in to a Trust-wide debrief.
- Provide appropriate representation at the TRG.
- Utilise the Lessons Learnt and DATIX system.

8. **Risk Officer** will:

- Receive and record hazards, risks and threats that emerge from EPRR programme.

9. **Head of Comms** will:

- Support the TRG with tactical and operational comms planning and delivery.
- Support the C3 Plan as the lead for strategic comms planning and delivery.

10. **All Staff** will:

- Be familiar with the arrangements, their roles and responsibilities detailed in the MI and BC plans
- Undergo training and participate in exercises that test response, recovery and continuity plans.

ANNEX D - EPRR GOVERNANCE

1. Process for Monitoring Effective Compliance. The EPRR Governance process is encapsulated in Figure 5. All of the EPRR designated elements feed through the same governance system, and are coordinated at the tactical level by the DCOO as the AEO. The TEG sets the strategic EPRR direction, and this is assured by the Quality Committee, and ultimately by the Board. The latter also approves the EPRR Policy, whilst the TEG approves this strategy, and both are drafted by Head EPRR for the DCOO to present. All meetings are to focus on the Risk Management linkage, and the recording of decisions. Importantly, the Board must approve the EPRR Statement of Compliance, which is to be presented to NHS England in September annually.

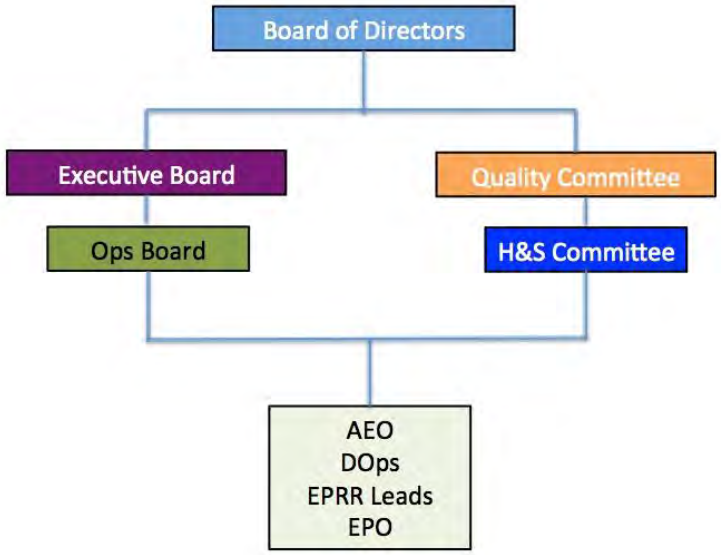


Figure 4: Governance Framework [placeholder]

Standard to be monitored	**Process for monitoring** e.g. audit, on-going evaluation etc.	**Frequency** e.g. annually 3 yearly	**Person responsible for:** undertaking monitoring & developing action plans	**Committee responsible for:** review of results, monitoring action plan & implementation
Review & update all response plan	Review of plans	At least annually	Head EPRR and nominated divisional leads.	Quality Committee
Review and update Business Continuity Plans	Review of plans	At least annually	Departmental BC Leads supported by Head EPRR	Divisional Boards or equivalent.
Communications Exercise	Exercise and report	Quarterly	AEO supported by Head EPRR	Quality Committee
Implement testing of Incident Control Centre set-up	Exercise and report	Quarterly	AEO supported by Head EPRR	Quality Committee

Standard to be monitored	**Process for monitoring** e.g. audit, on-going evaluation etc.	**Frequency** e.g. annually 3 yearly	**Person responsible for:** undertaking monitoring & developing action plans	**Committee responsible for:** review of results, monitoring action plan & implementation
Desktop tests of emergency plans	Exercise and report	Monthly	AEO supported by Head EPRR	Quality Committee
Live test of Major incident plan	Exercise and report	Bi-annually	AEO supported by Head EPRR	Quality Committee
Annual report	Annual report	Annually	AEO supported by Head EPRR	Executive Board Trust Board

23. Agenda items for next meeting

To APPROVE the scheduled items for the next meeting

For Approval

Presented by Sheila Childerhouse

Board of Directors – 31 July 2020

Agenda item:	23			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	24 July 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 – 2 October 2020

Description	Open	Closed	Type	Source	Director
Declaration of interests	✓	✓	Verbal	Matrix	All
Deliver for today					
Patient story	✓	✓	Verbal	Matrix	Exec.
Chief Executive's report	✓		Written	Matrix	SD
COVID-19 report	✓		Written	Action	HB
Integrated quality & performance report	✓		Written	Matrix	HB/SW
Finance & workforce performance report, including staff recommender and spend on COVID	✓		Written	Matrix	CB
Risk and governance report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
Invest in quality, staff and clinical leadership					
'What matters to you' engagement report and recommendations	✓		Written	Matrix	JO
Nurse staffing report	✓		Written	Matrix	SW
Quality and learning report, including quality priorities and learning from deaths	✓		Written	Matrix	SW/NJ
WSFT digital board report	✓		Written	Matrix	CB
Improvement programme board report	✓		Written	Standing item	SD/SW
Annual reports: - Equality, diversity and inclusion - Infection prevention and control - Safeguarding children - Research and development	✓		Written	Matrix	 JO SW SW NJ
Education report, including undergraduate training	✓		Written	Matrix	JO
National patient survey report	✓		Written	Matrix	SW
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	SW
Car parking report	✓		Written	Matrix	CB
Consultant appointment report	✓		Written	Matrix – by exception	JO
"Putting you first award"	✓		Verbal	Matrix	JO
Build a joined-up future					
Pathology services report	✓	✓	Written	Matrix	CB/NJ
Strategic update, including Alliance, System Executive Group and Integrated Care System (ICS). Including timetable for strategy review.	✓	✓	Written	Matrix	SD
Governance					
Trust Executive Group report	✓		Written	Matrix	SD
Audit committee report, including annual report	✓		Written	Matrix	AE

Nurse strategy	✓		Written	Matrix	SW
Estates strategy	✓		Written	Matrix	CB
Risk management strategy	✓		Written	Matrix	RJ
Scrutiny Committee report		✓	Written	Matrix	LP
Review of COVID governance arrangements	✓		Written	Matrix	RJ
Board assurance framework		✓	Written	Matrix	GN
Confidential staffing matters		✓	Written	Matrix – by exception	JO
Council of Governors report	✓		Written	Matrix	SC
Board development programme	✓		Written	Matrix	SC/JO/RJ
Use of Trust seal	✓		Written	Matrix – by exception	RJ
Agenda items for next meeting	✓		Written	Matrix	RJ
Reflections on the meetings (open and closed meetings)		✓	Verbal	Matrix	SC

11:20 ITEMS FOR INFORMATION

24. 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

25. Date of next meeting

To NOTE that the next meeting will be held on Friday, 2 October 2020 at 9:15am in West Suffolk Hospital

For Reference

Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

26. 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