Board of Directors (In Public)

Schedule	Friday 4 December 2020, 9:15 AM — 11:30 AM GMT
Venue	Via video conferencing
Description	A meeting of the Board of Directors will take place on Friday, 4 December 2020 at 9:15. The meeting will be held virtually via video conferencing
Organiser	Karen McHugh

Agenda

AGENDA
Presented by Sheila Childerhouse

Agenda Open Board 2020 12 04 Dec.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 6 November 2020
   For Approval - Presented by Sheila Childerhouse

   Item 6 - Open Board Minutes 2020 11 06 Nov 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 an introduction on current issues
   For Report - Presented by Stephen Dunn

   Item 8 - Chief Exec Report Dec '20 v2.doc

9:40 DELIVER FOR TODAY

9. Operational report
   To APPROVE the report
   Helen will be joined by Jenny McCrory (Sudbury Team Lead)
   For Report - Presented by Helen Beck

   Item 9 - Operational Trust Board report Nov 2020.doc

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

    Item 10 - Integrated quality and performance report - Novemner 2020.pdf

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

- Item 11 - Board report Cover sheet - M07.docx
- Item 11 - Finance Report- October 2020 FINAL.docx

10:20 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

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

- Item 12 - People OD highlight report.docx.doc

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13. Quality, safety and improvement reports
To APPROVE the reports
Presented by Susan Wilkinson and Nick Jenkins

13.1. Maternity services quality & performance report
For Approval

- Item 13.1 - Maternity services quality and performance report - Nov 20.docx
- Item 13.1 Annex C - Saving babies lives.pdf
- Item 13.1 Annex D - Monthly OandG report.docx

13.2. Quality and learning report, including learning from deaths
For Approval

- Item 13.2 - Quality and Learning report - Nov 2020.docx

13.3. Infection prevention and control assurance framework
For Approval

- Item 13.3 - COVID IPC assurance framework - Nov 2020.docx

13.4. Quality improvement programme board report
For Approval

- Item 13.4 - Improvement programme board report Nov 2020.docx

Item 13.4 - 201109 Status Summary Action Plans IPB Out.xlsx

13.5. Nursing staffing report
For Approval

Item 13.5 - Staffing Review October Final.docx

11:00 BUILD A JOINED-UP FUTURE

14. Future system board report
To APPROVE the report
For Approval - Presented by Craig Black

Item 14 - Future system board report - Nov 2020.docx

15. Digital board report
To APPROVE report
For Approval - Presented by Craig Black

Item 15 - Trust board - digital update - November 2020.doc

11:20 GOVERNANCE

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

Item 16 - Governance report.doc

11:25 ITEMS FOR INFORMATION

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

18. Date of next meeting
To NOTE that the next meeting will be held on Friday, 29 January 2021 at 9:15am

in West Suffolk Hospital
For Reference - Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

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

AGENDA

Presented by Sheila Childerhouse

Board of Directors

A meeting of the Board of Directors will take place on **Friday, 4 December 2020 at 9:15**.
The meeting will be held virtually via video conferencing.

Sheila Childerhouse
Chair

Agenda (in Public)

9:15 GENERAL BUSINESS		
1.	**Resolution** The Trust Board is invited to adopt the following resolution: "That representatives of the press, and other members of the public, be excluded from the meeting having regard to the guidance from the Government regarding public gatherings."	Sheila Childerhouse
2.	**Apologies for absence** To note any apologies for the meeting and request that mobile phones are set to silent.	Sheila Childerhouse
3.	**Declaration of interests for items on the agenda** To note any declarations of interest for items on the agenda	Sheila Childerhouse
4.	**Questions from the public relating to matters on the agenda** (verbal) To receive questions from members of the public of information or clarification relating only to matters on the agenda	Sheila Childerhouse
5.	**Review of agenda** To agree any alterations to the timing of the agenda.	Sheila Childerhouse
6.	**Minutes of the previous meeting (attached)** To approve the minutes of the meeting held on 6 November 2020	Sheila Childerhouse
7.	**Matters arising action sheet (attached)** To accept updates on actions not covered elsewhere on the agenda	Sheila Childerhouse
8.	**CEO report (attached)** To receive an introduction on current issues	Steve Dunn
9:40 DELIVER FOR TODAY		
9.	**Operational report (attached)** To approve the report	Helen Beck / Jenny McCrory (Sudbury Team lead)
10.	**Integrated quality and performance report (attached)** To approve a report	Sue Wilkinson / Helen Beck
11.	**Finance and workforce report (attached)** To approve report	Craig Black
10:20 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP		
12.	**People and OD highlight report (attached)** To approve report	Jeremy Over

13.	**Quality, safety and improvement report** To approve reports: 13.1 Maternity services quality and performance report 13.2 Quality and learning report, including learning from deaths 13.3 Infection prevention and control assurance framework 13.4 Quality improvement programme board report 13.5 Nurse staffing report	Sue Wilkinson / Nick Jenkins
11:00 BUILD A JOINED-UP FUTURE		
14.	**Future system board report (attached)** To approve report	Craig Black
15.	**Digital board report (attached)** To approve report	Craig Black
11:20 GOVERNANCE		
16.	**Governance report (attached)** To approve report, including subcommittee activities	Richard Jones
11:25 ITEMS FOR INFORMATION		
17.	**Any other business** To consider any matters which, in the opinion of the Chair, should be considered as a matter of urgency	Sheila Childerhouse
18.	**Date of next meeting** To note that the next meeting will be held on Friday, 29 January 2021 at 9:15 am in West Suffolk Hospital	Sheila Childerhouse
RESOLUTION TO MOVE TO CLOSED SESSION		
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To AGREE any alterations to the timing of the agenda.

For Reference

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6. Minutes of the previous meeting

To APPROVE the minutes of the meeting held on 6 November 2020

For Approval

Presented by Sheila Childerhouse

DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 6 NOVEMBER 2020 AT WEST SUFFOLK HOSPITAL
Via Microsoft Teams

COMMITTEE MEMBERS			
		Attendance	**Apologies**
Sheila Childerhouse	Chair	•	
Helen Beck	Chief Operating Officer	•	
Craig Black	Executive Director of Resources	•	
Richard Davies	Non Executive Director	•	
Steve Dunn	Chief Executive	•	
Angus Eaton	Non Executive Director	•	
Nick Jenkins	Executive Medical Director	•	
Rosemary Mason	Associate Non Executive Director	•	
Jeremy Over	Executive Director of Workforce and Communications	•	
Louisa Pepper	Non Executive Director	•	
Alan Rose	Non Executive Director	•	
David Wilkes	Non Executive Director	•	
Sue Wilkinson	Interim Executive Chief Nurse	•	
In attendance			
Helen Davies	Head of Communications		
Georgina Holmes	Trust Office Manager *(minutes)*		
Richard Jones	Trust Secretary		
Kate Vaughton	Director of Integration and Partnerships		
Governors in attendance (observation only)			
Peter Alder, Florence Bevan, Judy Cory, Jayne Gilbert, Gordon McKay, Jane Skinner, Liz Steele,			

Action

GENERAL BUSINESS

20/215 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."

The Chair welcomed everyone to the meeting and introduced Helen Davies, Head of Communications, who had recently joined the Trust. She also explained that this was the last board meeting for the current governing body and thanked them all for the contribution that they had made during their term of office.

20/216 APOLOGIES FOR ABSENCE

There were no apologies for absence.

20/217 DECLARATION OF INTERESTS FOR ITEMS ON THE AGENDA

No declarations of interest were received.

20/218 QUESTIONS FROM THE PUBLIC RELATING TO MATTERS ON THE AGENDA

Q With the uncertainty of the effect that an increase in Covid cases would have on the Trust could assurance be provided that people would be kept up to date on the changes to the dates of their appointments and that the public would be kept informed about what was happening?

A The Trust was very conscious of the importance of this and would try to maintain as much of its elective programme as possible during the winter period. However, there was uncertainty about the effect that Covid demand would have during the next few months. The public would be kept informed and further details were provided in the papers for this meeting. There was an elective care plan and individual letters had been sent out to 21,000 patients who were waiting for procedures/appointments to assure them that they had not been forgotten. Social media was also being used for this purpose and information was available on the GP website.

20/219 REVIEW OF AGENDA

The agenda was reviewed and there were no issues. Feedback was requested on the changes in format of some of the reports for this meeting.

20/220 MINUTES OF MEETING HELD ON 2 OCTOBER 2020

The minutes of the previous meeting were approved as a true and accurate record subject to the following:

Page 8, item 195; first question to be amended to read; “The balance sheet showed borrowing for the year of £50m that was unplanned.”

Page 13, item 204; answer to first question, final sentence to be amended to read; “Cellular pathology would be the first laboratory to apply for accreditation and others would take longer to be ready”.

Page 15, item 206; first question to be amended to read; “It was important that a bottom up piece of work was undertaken, but was the board considering a top down piece of work to ensure that these aligned?”

20/221 MATTERS ARISING ACTION SHEET

The ongoing actions were reviewed and the following update provided:

Item 1880; consider options to open access to the virtual board meeting to the public and press. It was proposed to use a similar approach to the AMM ie Microsoft Live, if it was possible to make this technology work.

Item 1886; consider approach and support regarding people who are older returning to work, including volunteers. The Trust had a very clear risk assessment process in place which still applied; people should work from home if possible.

The completed actions were reviewed and there were no issues.

Q Re the elective care communications plan which was appended to this report, was one of the desired outcomes to build trust in WSFT as an organisation; did this apply to the community as well elective patients?

A It was confirmed that the plan should also apply to community care and that this needed to be reflected in the plan.

20/222 PATIENT/STAFF STORY

Two letters complimenting staff were read out.

- The first was from a patient who had attended ED following an accident. On arrival they were dealt with quickly and efficiently and given clear instructions. They had to return a few days later as their wound was swelling and very painful. They were quickly booked in and saw the triage nurse. Following a wait they were then seen by a young lady doctor who was extremely efficient, kind and carried out the necessary treatment to the wound, again giving clear instructions. The patient also complimented the receptionist on the desk, who although really pushed with the numbers arriving dealt with it all calmly, including finding wheelchairs etc.
- The second was from a gentleman in appreciation of the Keeping in Touch service. His elderly mother had spent two extended stays in WSFT over a three-month period and being able to see and speak to each other via the Keeping in Touch service every day has been very important to both of them. It also enabled him to feed back to the medical team invaluable information about how his mother was actually feeling and coping on both a physical and a psychological level. He felt it was important to underline the importance and relevance of that aspect of the service. He complimented all of the Keeping in Touch team for their compassion and professionalism and said that they were a credit to the NHS and the caring professions.
- These stories were an example of compassion and care provided to patients, even when staff had been working very hard over a long period of time.

20/223 CHIEF EXECUTIVE'S REPORT

- The country was now in a second lockdown due to the increase in Covid cases. However, it was hoped that the experience for WSFT would be slightly different this time as there was better PPE, better/increased testing and better treatment options. There was also the desire to maintain services for as long as possible during winter.
- The importance of everyone having a flu jab was stressed.
- There would be a real focus on supporting staff through this period.
- The Trust was working with Attain to looked at options to create capacity on the site to enable it to progress the necessary remedial work in the hospital to address the RAC plank issue. Governors would be updated on the findings of this work.
- WSFT's purchase of Hardwick Manor was excellent news, however it was reiterated that no formal decision had been made about the site for a new health and care campus. The board and governors would continue to be updated on this.
- The team involved in bringing pathology services back in-house were thanked. Feedback from pathology staff was very positive and morale had greatly improved.
- A member of staff in the emergency department had been the subject of racism last Friday which was unacceptable. The local police had been very supportive and were thanked for their actions in addressing this.
- There had been a national issue three weeks ago where Roche, who supplied 40% of laboratory products to the NHS, had supply issues. All of the biochemistry in WSFT's labs were Roche analytics. The laboratory team had worked very hard to predict how quickly they would run out of some products and were able to work across the ICS to deliver mutual aid and exchange products between sites in the east of England, including collaboration with primary care, which meant that WSFT never got to the point of being unable to do any single tests. This had been nationally recognised as one of the best ICS responses to this

Roche had now resolved the issue and although the supply chain was not back to normal the decision had been taken as an ICS that business should return to normal but this would continue to be monitored.

This was a good trial run for other supply issues that might occur as a result of Eu Exit.

- The Trust was focussing on Mersey Care and Civility Saves Lives which reflected the culture change it was trying to deliver.

Q Was the co-production work on the new system design, eg workshops etc, continuing during lockdown?

A Yes, the plan was for business as usual during this period. However, if the Trust became overwhelmed by the Covid situation this would be reconsidered.

Q As better treatments became available for Covid how did WSFT capture national learning and ensure that it implemented this in a timely manner, as this was critical for patient recovery?

A Every doctor was obliged to keep up to date with new developments/treatments etc and specialist societies and royal colleges disseminated information to their members. Also, where there were very important or fast moving developments, eg with Covid, NHSEI cascaded this information.

This week the Trust had received the first doses of the antibody mixture that was given to Donald Trump. In addition, all of the Trust's Covid patients had been given the opportunity to take part in research studies for treatments that had not yet been proven, but could be of benefit to them and others in the future.

DELIVER FOR TODAY

20/224 OPERATIONAL REPORT

Phase 3 recovery

- It was not intended that the Trust would do anything differently as a result of the country being in lockdown again. There were no plans to stop any services and it would continue to try to increase the level of activity. Therefore, the communication plan would not change apart from messages put out on social media to tell people that they should continue to attend their appointments.
- The level of Covid in the local population meant that the Trust could continue with as much elective activity as possible. There was a real regional and national focus on recovering activity.
- A lot of the issues and challenges were around social distancing within the estate. However, ward F4, surgical elective, was now back in full operation which would assist with the recovery plan.

Winter planning and Covid

- In addition to national lockdown, yesterday morning it was announced that the NHS was now back in level four incident status. Therefore, Trusts would be under national rather than regional control, which meant that they had to be prepared to react very quickly to any national guidance.

- As a result, WSFT was stepping up its command and control activities but would continue to maintain normal divisional communication routes. To reflect the feedback received in the What Matters to You (WMTY) survey.
- Currently (as at this morning) the Trust had 13 patients who had tested positive for Covid and one patient who was being treated as positive although their swab was negative. These numbers had been relatively steady for the past couple of weeks although numbers coming into the Trust with potential Covid were increasing.
- In order to manage this increase, an additional area had been designated for potential Covid patients as they arrived. Preparations were also being made to open an additional critical area in order to support cohorts of Covid and non-Covid patients.

Q What was the Trust doing to address the lack of rapid testing which could result in potential to delay discharge?

A The Trust had tested and validated Samba machines. However, this was not quite point of care testing as each test took approximately 90 minutes. These machines were placed in clinical areas but required staff to operate them; they were currently operational during working hours but the Trust was working hard to recruit staff to operate these 24/7. This would mean that as people came through emergency pathways they could have a rapid test with a result in two hours rather than 24 hours.

Q If critical care capacity was increased, would this have an impact on the elective care programme and RTT recovery? If this was the case would there be a need for additional internal and external communication?

A The leadership of the anaesthetic body had worked together to create a more flexible rota to enable the increase in critical care capacity. They would be able to increase resource as demand increased and only when this reached tipping point would the elective care programme be affected. The concern was more around nursing support but this was being looked at.

Q Re endoscopy; was there any evidence of increased harm as a result of late diagnosis and was there anything that the Trust could do to increase the number of endoscopies per day?

A This was more that could be done and the new Assistant Director of Operations (ADO) was working hard with the team to maximise capacity and implement seven day working as well as insourcing from an external company. The Trust was monitoring these patients and there was a mechanism to enable any harm to be identified, reported and investigated. Considering the number of patients whose procedures had been delayed a very small number were being seen who there was a problem with. Each of these were fully investigated to make sure that there was not anything that the Trust could have done differently.

WSFT was doing more detailed investigations than some other organisations for each of these cases as they arose. To date there had not been one related to endoscopy but for one patient whose CT scan was delayed this had resulted in harm. There would be a small number of patients who suffered as a result of the impact of Covid but one of the challenges was the unwillingness of people to attend hospital. Next week a virtual clinic was taking place try to persuade people to come into hospital and assure them about the safety precautions that were in place. Governors could also perform an important role in encouraging and reassuring people about coming into the hospital for appointments or treatment.

- Most of the detail relating to winter planning had been through the scrutiny committee. Winter was always a difficult time to plan for due to the number of unknowns, eg activity levels, flu etc, but this year the number of variables was unprecedented.
- Currently the assumption was that Covid demand could take up to 13% of beds and there was a plan that would enable the Trust to maintain the elective recovery programme, manage Covid cases and manage normal emergency admissions. The numbers and future projections would be monitored and the organisation would work flexibly to respond to the situation as it evolved.

<u>EU exit planning</u>

- WSFT had now received a list of suppliers who were being centrally assured and the team would be working through this to see which were local and the Trust may need to do more work with.
- Details of logistic routes that did not go via normal routes for NHS purchasing had also been received.
- There had also been information on recognition of overseas staff qualifications in relation to UK staff qualifications. Similar agreements had also been made regarding medical devices and consumables.
- The team was continuing to validate supply routes and cross check information and the Trust would need to assess the situation by the end of next week.

Q What assumption had been made for staff absence in the winter and recovery plans; currently staff sickness appeared to be at a fairly high level? Was it anticipated that there would be any issues with staffing levels as a result of the forthcoming EU exit?

A WSFT currently had more EU staff than when Brexit first started so there was no indication that staff from EU countries were leaving as a result of this. It was very important that these staff felt supported, welcomed and wanted by WSFT and the local population. The Trust had recently written to each of these members of staff to make sure that they were aware of the settlement scheme and offering the support of the HR team to help them through this process if necessary. The letter had included a very personal message from the Chief Executive about their place in the organisation and its support for them.

The sickness data in the IQPR remained steady and not at too high a level, ie just below 4% which was slightly higher than the Trust would like but not as high as in other areas of the country. Regular (daily) reviews were undertaken to ensure that staffing levels were safe and move staff into areas where there were gaps. There was also a well documented escalation process if staffing numbers became short or critical and actions would be taken in order to maintain front line services.

- A number of initiatives had been put in place to support the community teams and put in additional resources to the teams to assist them over the winter period.
- The impact of Covid on the care home sector and visiting restrictions had meant that fewer people were going into care homes. This has resulted in additional pressures on the community teams to provide care for people in their own homes.

20/225 INTEGRATED QUALITY AND PERFORMANCE REPORT

- Emergency department attendances were slightly lower than in August.
- The referral to treatment (RTT) waiting list continued to increase but the rate of this increase had slowed down. 52 week waits also continued to increase but at a slower rate. Work continued to address this.

Q The cancer referral rate appeared to be increasing but was not yet back to the normal rate. This suggested that people in the community were not accessing the treatment they needed, therefore there was likely to be a backlog of people in the advanced stage of cancer. Had the Trust planned for this in the future, as this was a concern?

A This was a concern and there was likely to be a backlog in terms of late presentations in the future. There was a major social media campaign to try to persuade cancer patients not to ignore symptoms.

Q What was the perfect ward App trying to deliver as data for October was not available; was this something that the board should be concerned about?

A The perfect ward App had been adapted to try an assist during Covid. The information in this table may not add any value and would be reviewed for next month.

ACTION: review value of perfect ward KPI table. **S Wilkinson**

- Duty of candour had improved this month which was a result of the hard work of the team.
- Focussed work continued on falls and pressure ulcer prevention.
- The outcome of an investigation into a grade four pressure ulcer was being used as learning for collaborative working and a collaborative approach to concordance and understanding; this should have a positive impact on patients in the community
- The patient safety incidents reported (total resulting in harm and 'related to Covid') were not related to Covid specifically. This information had been included to identify if Covid was having an impact on incidents. This would be reviewed.

ACTION: review patient safety incidents stated as 'related to COVID'. **S Wilkinson**

20/226 FINANCE AND WORKFORCE REPORT

- Financial performance continued to be consistent throughout the year. Overall the Trust was breaking even and was forecast to break even at the year end. This was as a result of expenses relating to Covid being recovered.
- The caveat was that there was a lot of uncertainty around activity that would take place over the next six months, mainly around the Trust's ability to deliver elective activity.
- The extent to which the Trust would have to go outside the organisation for activity would incur additional expense and there was currently a debate about the reimbursement that would be received for this. There was also an issue around the ability of external organisations to deliver this activity.
- The finance team continued to focus on what normal looked like and what the underlying position would be as the organisation moved forward.
- The recent update to the finance report related the capital programme. All of the uncertainty around capacity fed into this, ie the structure and the way in which this was responded to. Attain was doing a piece of work on the options around capacity to facilitate the remedial programme.
- Bringing theatre one back into use had been approved as part of the capital programme. However, as this work was progressing the Trust was seeking to add additional items to this scheme in order to address some of the structural concerns and improve storage within theatres, which would improve the efficiency of the whole theatre suite. Therefore, there was a request in the finance paper to increase the capital for this scheme by £600k.

- The second element of the update to this report related to the work on the emergency department. The Trust had received national funding to develop a Covid area within the emergency department. This was a £2.7m scheme which was due to be completed in January, however as this had progressed the Trust had come up with another additional potential scheme to expand the current work into the medical records space. This would create a further eight beds and would be an effective use of money as the same contractors could be used who were working on the current scheme. Details of the additional work and costs, ie £1.6m, were provided in the update to the finance report. It was intended to constrain the overall capital scheme within the current capital programme by delivering this in different ways.

Q Re the capital for the future system programme; was it envisaged that there would be any call on capital this year or in the next financial year and if so were there dedicated loans relating to this?

A There was dedicated funding for the future system programme and it was not possible to move money between this income stream and any other expense lines.

Q Was the Trust still intending to achieve its CIP target and was it anticipated that there would be any consequences if it didn't apart from rolling forward into next year?

A It was not anticipated that the CIP would be achieved as there was currently not the flexibility to manage Covid and still achieve the CIP. The consequences would not be on this year as expenditure was covered through Covid funding, therefore the overall result this year would not be affected. However, there would be a consequence in terms of the underlying position as the organisation moved into next year and this was the focus of the finance department and the PMO (project management office) who were also working on the CIP for next year.

Q How long did the Trust expect to continue to receive Covid funding?

A It was difficult to know but the Trust was currently forecasting to break even for this year subject to continuation of the current funding mechanism. The department of health were very keen to regain some control over the level of expenditure within the entire NHS but recognised that with the second wave of Covid expenditure levels would vary due to the disparate levels of Covid across the country. Currently the ICS was assuming that for the remainder of the year expenditure would be covered by income related to Covid but there was no guarantee.

Q The financial position of the Trust was currently a false situation, which was a concern. Was this being considered when looking at the position for next year?

A This was being taken into account; the teams were trying to ensure that in businesses cases etc where expenditure was incurred this was non-recurrent, although this could be a challenge, eg recruitment of additional staff versus use of temporary staff.

The executive team were very mindful of staffing issues and had to make decisions based on this. The finance and operational teams were currently undertaking a review of what the new normal baseline costs would look like as a result of the changes in the ways of working so that this could be used as a basis for future CIPs. Benefits and opportunities were also being looked at, as well as additional costs, and the teams would focus on what this meant for next year's CIP programme.

ACTION: show outcome of not delivering recurring CIPs for this year as part of CIP programme for next year. **C Black**

Q Was the Trust taking into consideration the fact that a new facility was being planned when considering any capital investment and would this change any decisions that were made?

A This had recently been taken into account when making decisions and these discussions would continue to take place at the board over the next years. There was a need to always be aware that the Trust was spending public money and this must be done in the best way possible.

- The board approved the proposal to delegate authority to the scrutiny committee to approve the revised capital programme.

ACTION: delegate authority to the scrutiny committee to approve the revised capital programme. **C Black**

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

20/227 PEOPLE AND ORGANISATIONAL DEVELOPMENT (OD) HIGHLIGHT REPORT

- The board received the following papers which were appended to this report:

  - West Suffolk People Plan
  - Freedom to Speak Up Guardian report (Q2)
  - Freedom to Speak Up policy
  - Staff Health and Well-being annual report
  - Guardian of Safe Working Hours quarterly report (Q2)
  - Mandatory training and appraisal quarterly report (Q2)

- There were many different drivers behind the **West Suffolk People Plan**, including What Matters to You, the national people plan and growing a just and learning culture within WSFT. Behaviours and leadership were very important and the proposed plans to focus on this were detailed in this report.
- The board received and noted the nominations for Putting You First Awards for the month and congratulated the two recipients; Jill Bunch, senior occupational therapist, ENT and Tracey McGavin, midwife.
- Amanda Bennett who, with Dr James Barrett, had recently been appointed as the two new **Freedom to Speak Up Guardians**, presented the report for this item. She explained that everyone had been very enthusiastic and committed to promoting a culture in which staff felt safe to report their concerns and confident that action would be taken as a result. The planned actions to assist in implementing this were detailed in the report.
- The board approved the revised Trust policy and procedure for **Freedom to Speak Up, Whistleblowing, Staff Concerns about Patient Care and Other Healthcare Related Matters**.

Q How could the board be assured in the future that the people plan had been delivered and embedded throughout the organisation and how would this be reviewed, taking into account feedback and the perception of top down?

A This would depend on the divisions and teams adopting this and deciding what they were going to work on with the support of the organisation. There would be a more detailed plan under this with responses and time scales. This plan would identify how to capture and record the impact that this was having.

ACTION: develop method of reviewing/monitoring progress and embedding of the people plan. **J Over**

Q The Mersey Care assertion that a just and learning culture helped with patient care was not mentioned in this report, ie happy staff equals happy patients. What should the board be looking for in the future to provide assurance that this work would also lead to improved patient care, as had been demonstrated with Mersey Care?

A The Mersey Care just and learning culture approach was about how an organisation responded when something went wrong. If it was perceived that the immediate response would be one of fault finding and blame, this may deter people from reporting incidents. However, if people felt confident that the priority was to learn lessons and support them to make things safer this would result in more people feeling confident to speak up.

The Trust was keen to find out more about how Mersey Care reported on management of investigations and how this linked to incidents. The revised Freedom to Speak up policy needed to consider how this operated, ie what was a speak up event and how these were classed and understood and how they related to individual employment grievances.

The speaker at the 5 o'clock club on Thursday 19 November would be Dr Chris Turner who led the Civility Saves Lives (CSL) movement. If health professionals were not civil to each other this could be a patient safety risk, therefore if people were polite and respectful this would result in better outcomes for patients.

Q There were a lot of actions that needed to be undertaken by the whole organisation. What changes, if any, needed to be implemented or supported by the board to demonstrate its commitment to the change programme?

A The board would be considering its own development and this was very important for leadership and cultural change as an organisation. Ultimately the culture of the organisation was driven by leadership and the board and its words, actions and behaviours. The board development plan needed to be rooted in the development of the people plan.

This was a plan for the whole of WSFT based on a bottom up approach from what staff had to say, but if it the plan was only owned corporately it would fail. One of the priorities was about line managers; from the staff survey on the whole there had been very good feedback but it was also apparent that some mangers required more support and development.

- The board received and noted the annual **Staff Health and Wellbeing** report.

Q Was the 20.3% of sickness absence time lost due to anxiety, stress, depression, other psychiatric illness, as expected or worse than expected?

A This figure was not a surprise and was commensurate with the breakdown of similar absence reasons in other hospitals. This was one of the reasons that the Trust had doubled its investment in psychological support for staff and recruitment to this team was now complete.

- The board received and noted the **Guardian of Safe Working Hours** quarterly report (Q2)
- The board received and noted the **Mandatory training and appraisal** quarterly report (Q2)

Q Appraisal performance had reduced due to the Covid situation; could the board be assured that the Trust had a robust appraisal process in place?

A The Trust did have a process in place and this would be reviewed as more was understood about how appraisals could benefit from the just and learning culture approach. Appraisal rates were regularly focussed on at monthly meetings with the divisions and they were supported with actions to increase appraisal participation.

- It was noted that the appraisal rate for surgery had increased by 10% from 66% to 76% which was good news and there was an ongoing focus on this.

Q What was the Trust's average appraisal rate?

A The rate had been previously been in the high 80s% but the target was 90% and the aim was to get back to this.

Q Appraisals were a key tool in terms of driving culture change and improving employee engagement. Currently compliance for corporate services was 61%; how could this be improved as this was about setting a good example to the organisation?

A This was the personal responsibility of the executive team to ensure that appraisals were completed for their staff. Due to Covid ways of working in corporate services had been disrupted in different ways to clinical services with people working from home but this needed to be addressed over the next month or two.

ACTION: Increase appraisal compliance for corporate services. **J Over**

- The board noted the following consultant appointments:
  Mr Saif Al Azzawi; Consultant in Plastic Surgery
  Mr Elamurugan Arumugam; Consultant in Plastic Surgery

227.1 MATERNITY SERVICES QUALITY AND PERFORMANCE REPORT

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

- Maternity was working towards the development of a quality and safety approach by looking at the whole governance approach and developing a quality dashboard which would be shared with the board.
- The maternity dashboard was appended to this report (Appendix A)
- The board received and noted the **Staffing report** (Appendix C) which was a CNST requirement. This looked at the whole establishment and would be presented to the board every six months.
- WSFT met the nationally recognised birth rate plus tool. However, there were areas that needed to be improved upon ie labour suite co-ordinator supernumerary status. External assistance was being provided by Mai Buckley to develop documented evidence.
- The 100% target of one to one care of women in labour was not achieved last month due to one patient going into labour very quickly whilst in the ante natal ward.
- Due to the number of births and staffing shortages relating to COVID the midwife to birth ratio of 1:27.7 was not achieved in September
- Red flag incidents for the last six months were highlighted. Due to staff shortages, acuity and the high number of patients the unit had to close for 24 hours in September which meant that four patients were diverted to the Norfolk and Norwich.

- No serious incidents or Healthcare Safety Investigation Branch (HSIB) cases were reported in September. However, the draft reports for two ongoing HSIB investigations had been received and meetings had taken place to consider these and any actions required
- The board received and noted **Evidence of the Maternity services methods of gathering user feedback and working with service users (**Annex D). This gave an overview of the standards and the evidence to show that these had been met. Nearly all been met with the exception of a few actions which were being addressed.
- The board received and noted **Perinatal Mortality Review Tool (PMRT) Report** (Annex E). This report outlined the details of perinatal deaths that had occurred within the Trust in July to September. There had been one intrauterine death at 32 weeks; a local investigation had been undertaken to see if there was any learning from this. Initial findings identified two actions, however neither of these would have changed the outcome.
- A draft report had been received from the HSIB relating to a case that occurred in April; this was an early neonatal death following a very difficult caesarean section. It had been a surprise that the coroner's report gave sepsis as the cause of death, rather than a difficult delivery. Work was being undertaken as a result of this report.
- The CCG/NHSIE report had been received with recommendations that had been met and an action plan was in place which linked in with the overarching CQC action plan. NHSEI's improvement officer, Mai Buckley, was supporting the team to put in place the actions recommended by the CQC. She would be visiting WSFT again with an observer, as engaging obstetricians was an outstanding action.

Q The maternity dashboard showed a number of red indicators, including the total number of babies born in the midwifery led birthing unit which was due to the increased number of induced labours. As this was a national change, did this target need to be changed?

A Changes did need to be made as these parameters were set two years ago. Ideally a national dashboard was required so that this could be benchmarked against. It was hoped to that a regional benchmark could be developed so that assurance could be provided that a Trust was not an outlier.

Q As a senior leader, how did Karen Newbury feel about the culture of the Trust, did she feel listened to and supported?

A Karen Newbury confirmed that she felt supported and listened to. There had been a culture shift within the maternity department but it was very difficult for staff who had worked very hard over a long period of time not take things personally and this was a challenge relating to the Trust's culture. Governance was extremely important in maternity services and the culture relating to this needed to change, ie support rather than blame,

227.2 INFECTION PREVENTION AND CONTROL ASSURANCE FRAMEWORK

- The Trust was picking up a lot of learning that had come through both regionally and nationally. This was related to patient moves and focussing on how to minimise the number of patient moves.
- E-care was now able to capture patient moves and the Trust continued to work on this.

Q Item 5.5 stated that all patients with suspected Covid were tested promptly and the Trust was compliant. However, the narrative on page two of the report stated that a

further review needed to be undertaken for those patients who did not have a swab taken to understand the reasons for this. What was the reason for this anomaly?

A The narrative was about understanding why the swab wasn't taken; it was not about the Trust's ability to take swabs and this would be reviewed.

227.3 QUALITY IMPROVEMENT PROGRAMME BOARD REPORT

- Positive feedback had been received from the CCG following their medication and equipment assurance visit/review. This would be reported to the improvement programme board (IPB) on Monday.
- An audit had been undertaken on how the Trust was managing the improvement action plan. The outcome of this was that the auditors had reported the highest level of "substantial assurance"
- The board approved the updated Trust improvement plan.

227.4 NURSE STAFFING REPORT

- Fill rates continued to be monitored and more data was now available, with a clearer idea of actual vacancies
- During September there had still been a number of wards not in their usual areas.
- F10 was now permanently open and the establishment of this was still being worked through.
- The establishment review had been completed and would be presented to the board in December or January.

BUILD A JOINED-UP FUTURE

20/228 INTEGRATION REPORT – Q2

- This report gave details of the very good initiatives that were being implemented as a system. These would assist in managing some of the challenges around recovery and winter planning etc.
- The case studies and powerful feedback from patients on the virtual ward and virtual clinics were highlighted.
- The action and work being undertaken following the What are we Missing sessions to link more directly with communities was highlighted. Development of joint working within the alliance system also continued to be developed, ie with Abbeygate leisure.
- One of the positive outcomes of the Covid situation was the Covid Cell that had been set up to respond to Covid. This was working well and had resulted in putting actions in place which meant that the whole system was also better prepared for winter.
- It was proposed that the board should spend more time on this report in the future.

ACTION: schedule agenda to allow sufficient time for integration report. **R Jones**

GOVERNANCE

20/229 GOVERNANCE REPORT

- The board approved the dissolution of The pathology partnership limited. It was confirmed that this company had been dormant since the Trust bought it.

- The board approved the update of the quality and risk committee's terms of reference pending implementation of the new committee structure.
- The board noted the incorporation of the risk appetite statement in the risk management strategy and that this would be kept under regular review (Annex B).

Q Could the board have a more detailed discussion around the risk appetite statement?

A This would be considered in greater detail so that the board could explain to people within the organisation the change in the decisions relating to the risk rating.

ACTION: Risk appetite statement to be discussed by the audit or quality and risk committee and brought back to the board in January. **R Jones**

20/230 AGENDA ITEMS FOR NEXT MEETING

The board received and noted the content of this report.

ITEMS FOR INFORMATION

20/231 ANY OTHER BUSINESS

There was no further business.

20/232 DATE OF NEXT MEETING

Friday 4 December 2020, 9.15am

232.1 The dates of board meetings for 2021 were received and noted.

RESOLUTION TO MOVE TO CLOSED SESSION

20/233 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 – 4 December 2020

Agenda item:	7			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	27/11/2020			
Subject:	Matters arising action sheet			
Purpose:		For information	X	For approval

The attached details action agreed at previous Board meetings and includes ongoing and completed action points with a narrative description of the action taken and/or future plans as appropriate.

- Verbal updates will be provided for ongoing action as required.
- Where an action is reported as complete the action is assessed by the lead as finished and will be removed from future reports.

Actions are RAG rating as follows:

Red	Due date passed and action not complete
Amber	Off trajectory - The action is behind schedule and may not be delivered
Green	On trajectory - The action is expected to be completed by the due date
Complete	Action completed

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

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

Previously considered by:	The Board received a monthly report of new, ongoing and closed actions.
Risk and assurance:	Failure effectively implement action agreed by the Board
Legislation, regulatory, equality, diversity and dignity implications	None

Recommendation:
The Board approves the action identified as complete to be removed from the report and notes plans for ongoing action.

Ongoing actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1875	Open	31/7/20	20/170	Outcome of nursing staff establishment review (including community) to be presented to the board when available in December	2/10/20 - confirmed that this information will be available before January	SW	29/01/21	Green
1880	Open	2/10/20	Item 1	Consider options to open access to the virtual board meeting to the public and press	Testing ability to extend the MS Live events model used for annual members meeting - plan to pilot at meeting on 4/12.	RJ	04/12/20	Green
1888	Open	2/10/20	Item 27	Schedule review of COVID governance arrangements in December	Scheduled for January meeting	RJ	29/01/21	Green
1896	Open	6/11/20	Item 12	In preparing the CIP programme for 2021/22 provide visibility that start in a negative position based on not delivering the 2020/21 recurring CIPs		CB	29/01/21	Green
1897	Open	6/11/20	Item 13	Develop arrangements which over time will provide assurance of progress with people plan - action timeline and deliverables (outcomes)	Action plan in development. Interim progress report in People & OD highlight report.	JMO	29/01/21	Green
1898	Open	6/11/20	Item 13	Provide improvement plan and trajectory for corporate appraisal performance	In development	JMO	29/01/21	Green
1899	Open	6/11/20	Item 16	Undertake further engagement and review of the risk appetite statement and bring back to Board	Statement being reviewed	RJ	29/01/21	Green
1900	Open	6/11/20	Item 16	Action through Companies House the dissolution of The Pathology Partnership Ltd	In progress	RJ	29/01/21	Green

Closed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1885	Open	2/10/20	Item 14	Invite Ayush Sinha, chair of Trust's BAME group to talk to the Board	Dr Sinha has kindly agreed to attend the 04/12/20 meeting of the Board.	JMO	06/11/20	Complete
1893	Open	6/11/20	Item 11	IQPR - clarify the Perfect ward reporting arrangements	AGENDA ITEM	SW	04/12/20	Complete
1894	Open	6/11/20	Item 11	IQPR - review patient safety incidents which states “related to COVID”	AGENDA ITEM	SW	04/12/20	Complete
1895	Open	6/11/20	Item 12	Delegated authority to Scrutiny Committee to consider and approve additional potential capital expenditure for ED development (£2.7M) to create a COVID area. An additional potential scheme has been identified to extend into medical records space to create a further 8 beds.	Business case approved at Scrutiny Committee on 11 November	CB	04/12/20	Complete

8. Chief Executive’s report

To RECEIVE an introduction on current issues

For Report

Presented by Stephen Dunn

Board of Directors – 4 December 2020

Agenda item:	8			
Presented by:	Steve Dunn, Chief Executive Officer			
Prepared by:	Steve Dunn, Chief Executive Officer			
Date prepared:	30 November 2020			
Subject:	Chief Executive's Report			
Purpose:	X	For information		For approval

Executive summary:

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

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

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

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

Recommendation:

To receive the report for information

Chief Executive's Report

Although the country might have been in lockdown, in the NHS its been an extremely busy month. First, it seems, there is light at the end of the tunnel. The effectiveness of the three vaccines by Pfizer-BionNTech, Moderna and Oxford/AstraZeneca, which have been purchased by the Government, appear extremely encouraging and hopefully will allow us to remerge next spring to some sort of new normal. However, this will require one of the biggest vaccination programmes the country has ever seen and we are doing our bit to support this.

Although all the vaccines have been developed relatively quickly, all will have undergone the usual three phase trials, involving around 40,000 people, and a rigorous approval process. No vaccine will be used unless it has been approved by the Medicines and Healthcare products Regulatory Agency, and we will share more details when they become available. The current Joint Committee on Vaccination and Immunisation advice to the Government is that health and care workers, alongside care home residents and staff and those aged 80 or over, should get the vaccine before anyone else.

Colleagues across the Trust are now working on how to quickly and safely get this vital protection to our staff. Can I thank the more than 100 staff who have volunteered to help protect colleagues as part of our **COVID-19 vaccination programme**. We are working across the Trust to put together our biggest ever vaccination programme, offering all our staff the chance to be among the first to receive a jab alongside colleagues from our partner health and social care organisations.

The first vaccines likely to be available will have very complex temperature storing or 'cold supply chain' requirements, and will need to be given within a few hours of packs being opened to avoid wasting doses. This means – unlike for flu vaccines for which we offer peer vaccinations at many community sites - we will have to operate from a single location in Bury St Edmunds so we can vaccinate staff as safely and efficiently as possible. To help staff based in the east of the county, we have agreed with East Suffolk and North Essex NHS Foundation Trust that our staff will be able to access their vaccinators in Ipswich.

The earliest we will receive the vaccine will be 7 December - although that date could change. The exact date will depend on the final approval of vaccines and the manufacturing and delivery process. The vaccine needs to be given in two doses, 28 days apart. We are putting in place an online booking system for vaccine appointments and we will let staff know the details of this as soon as possible.

In the meantime, we continue with our focus on providing health and care services to our local community through the winter. It is worth highlighting how more complex and difficult it is to provide health and care services at the moment. In essence, we are managing three groups of patients, those with or suspected of having Covid-19, those who need routine elective care and those emergency non Covid patients who need treatment. The infection control requirements and workforce impact of Covid-19 makes juggling this workload a major patient logistical undertaking for our operational and clinical teams and I would like to convey my thanks to them for all they are doing.

For example, as a leadership team we have been focused on trying to do everything we can to minimise **nosocomial infections, or infections acquired in hospital**. This is not just to protect patients and staff, but also to give confidence to our community that its safe to come into hospital if they need treatment. The detailed infection prevention assurance report, which is on the Board agenda, details the various steps and high impact actions we are seeking to do to minimise these infections across the Trust**.**

I would like to say a big thank you to all our staff for everything they are doing to respond to these fast evolving and complex requirements. Nevertheless, we all have a role to play, and infection

prevention and control is everybody's business. This means practising good hand hygiene and maintaining social distancing in and away from the workplace. It also means wearing the right personnel protective equipment (PPE) when in clinical settings, and using face masks in non-clinical settings. I also want to acknowledge the problems created by our ageing estate and the lack of space, by modern healthcare standards, which does impact on our ability to minimise nosocomial infections**.**

For similar reasons, and due to the increasing prevalence of COVID-19 both within the community and the Trust, we have also made some changes to **inpatient visiting arrangements:**

- For most areas, visiting arrangements will continue as at present: inpatients can have a one-hour visit, once a day. This must be booked in advance with the ward to ensure social distancing. Special arrangements apply for parents of children and birthing partners of pregnant women - these are unchanged.
- We have designated wards as Red, Amber or Green depending on the patients confirmed or likely Covid status.
- For patients on a COVID-19 'Red' ward and wards receiving suspected COVID-19 patients, no visiting will be allowed, to minimise any potential spread to visitors.
- Where asymptomatic patient test positive following admission screening or regular inpatient screening, the bay will be closed and treated as a contact bay for 14 days. Visiting to remaining inpatients in the same bay will be suspended during this period, so that we can monitor patients, make sure they have not contracted COVID-19, and minimise any potential spread to visitors. Visiting for patients on the rest of the ward can continue.
- Where wards are closed due to an outbreak there will be no visiting allowed whilst the ward is closed.

It is important to note, however, that the current exceptions for end-of-life patients, those with learning disabilities, paediatrics, and maternity continue to apply. The Keeping In Touch services also will continue to be available for patients who are unable to have in-person visiting.

To further help with infection prevention and control, I am also pleased to report that we have been able to rollout new testing for staff. We have begun the distribution of **rapid COVID-19 self-testing kits** for patient-facing staff. These are kits staff can use at home, twice a week, to help prevent the spread of COVID-19. A nasal swab is used, put in extraction fluid, and then a sample of that fluid placed on a test strip that indicates the result. The process takes about 5 minutes, plus a 30 minute wait for the result.

Any staff testing positive will then take a PCR swab test to confirm the result. We have received a limited number of the kits and these are being distributed across the Trust on a first-come, first-serve basis via managers and are now available, including at community sites. Staff are asked to sign for receipt of the kit, and to acknowledge that they will take twice-weekly tests and report the results to us using an online form. Each kit contains 25 tests, so they should be ready to take the tests twice-weekly for the next three months.

Given all these complex considerations in delivering healthcare at the moment I am truly humbled by the fact that our **stroke team has managed to retain its top ranking** throughout the COVID-19 pandemic, newly published research shows. Researchers at King's College London review data from hospitals across the country as part of the Sentinel Stroke National Audit Programme. The scheme assesses stroke care against 41 key indicators, including how fast patients are seen, scanning, delivery of thrombolysis (treatment to dissolve blood clots), and support to help patients with recovery. In the latest data, covering April to June 2020, West Suffolk again received the top-grade A overall assessment - the ninth time in a row. To maintain an A-level rating for stoke care over such a long period, and particularly alongside COVID-19, is an incredible achievement! It reflects the sustained effort and team work of colleagues right across the hospital to do the best for our patients, whatever the circumstances.

I also want to pay a special tribute to our community teams, who like other staff, have been going the extra mile through the pandemic. This month I went back to the floor and shadowed the Bury Rural District Nursing team. I hope you saw my posts on social media. It was moving to hear some of the highs and lows of the community team. For example, Sian, the team leader, left her young family during the first phase of the pandemic so she could continue to support her patients. I also heard about how a shielding member of staff was both supported and kept involved with the team throughout and helped with triage. And, how they cover each other evenings and weekends when they're really, really busy. None of this must be taken for granted and just underscores to me how committed our staff are to their patients.

I also had the privilege to go out with registered district nurse Michelle and meet some wonderful patients who really appreciated what our district nurses and community teams do for them. I saw the challenges of donning and doffing personal protective equipment going into patient's homes and observed the variety that makes a district nurses case load, including wound care, insulin injections, tinzaparin injections and syringe driver care. It's easy to forget that our community teams' offices are their cars and this is one of the reasons we need to improve their IT which is so crucial for them. Indeed, the Bury Rural team are being migrated back to West Suffolk over the next couple of weeks (hurray) and there are more sites to follow soon! Watch this space - one of our community team leads will be talking at the Board meeting about their experience!

Speaking of technology, bringing together 85 people is a challenge at any time, but technology has allowed the **integrated community paediatric speech and language therapy team** to meet for a day conference, at least on screen. The group is part of the Integrated Community Paediatric Service, and delivers speech and language therapy (SLT) to children and young people countywide. The conference began with smaller pathway meetings in the morning, and the SLT staff were able to welcome a number of non-executive directors who also joined. Topics under discussion included therapy outcome measures; key performance indicators; teletherapy; resources; caseload management; training updates; service delivery; staffing; audit and governance; education and health care plans; COVID-19 projects; and staff wellbeing. The afternoon session included an update from Tracey Thynne and Katie Goble, our AHP clinical practice facilitators talking about managing students. Well done to the team for showing what amazing work can be done despite the social distancing challenges we face – thank you.

I am sure you will also have read in the news that the NHS will receive an extra £3 billion in the Spending Review which will help tackle backlogs in the health service. This is welcome news. Around £1 billion of this funding will go towards ensuring around 1 million additional tests, scans and operations are carried out to tackle the increased waiting times that you see in our board papers. This is welcome, but it will not be easy to address the backlogs caused by the pandemic. Around £1.5 billion will also be used to support existing pressures in the NHS caused by the pandemic.

The Spending Review also targets mental health which we know has suffered during the pandemic. About £500 million is allocated to tackle mental health waiting times. It will also help provide extra support for people with severe mental illness and faster access to psychological support for conditions such as depression and anxiety.

The government also made two major multi-year capital funding commitments which includes £3.7bn until 2024/25, to make progress on building 40 new hospitals by 2030 and £1.7bn until 2024/25, for over 70 hospital upgrades to improve health infrastructure across the country over the long-term. I have described in previous reports that we have been confirmed as one of 40 trusts across the country to **receive funding for new build** projects from the Government's Health Infrastructure Programme.

As noted above our hospital building is no longer fit for purpose and the ongoing challenges of managing the issues around the structure – the reinforced autoclaved aerated concrete (RAAC) plank issue which have talked about in previous board meetings – means that we do need a new hospital and health and care facility as quickly as possible. My paper to the board last month set out the future system team that is working flat out on preparing a strategic outline case (SOC) for the new hospital and health and care facility which is needed as part of the approvals process.

As a Trust, we are committed to involving as many of our current patients, future patients, carers and the public in the design of a new West Suffolk hospital, healthcare service, and the wider health and care system that it sits within. The approach we are using is co-production, where patients, the public, staff and the community work together as equal partners. Co-production has the principle that those who use a service are best placed to help design it. As part of the co-production process we are capturing the views of our patients too. A fuller report on this work is included on the Board agenda for today's meeting.

Last month, I confirmed that the Trust had completed the purchase of Hardwick Manor and stressed that it was one of four potential sites that was being considered as potential future locations for a new hospital and health and care campus. An extensive and detailed site appraisal has now been conducted and there have been a number of workshops to engage the board, the governors and the Trust Executive Group, which have been feeding into the project team's recommendations. Unfortunately, due to concerns about communicating first with staff and local residents as well as commercial considerations, discussions around the site options decision will take place at the closed board meeting. However, we will seek to let Governors and staff and then our public know about the **decision on the preferred site**, which will be subject to planning and public consultation, as soon as possible over the next week.

I would also like to **thank all of our Governors** for their commitment and hard work, the role they have is challenging but much of what they usual do has been doubly difficult this year as a result of COVID restrictions. At the time of writing this report, we are waiting for the results of the elections which take place every three years for our public and staff governors. We look forward to working with our new governing-body, but I would like pass our thanks to those for who this is their last term. Your contribution and challenge in shaping the Trust's strategy and approach has been greatly appreciated.

We also continue to **focus on improving our culture**. Over the last month, I and nine others have been attending the Northumbria University and Mersey Care NHS Foundation Trust programme, "Transforming Organisational Culture - Principles and Practise of Restorative Just Culture". On the programme was myself, Jeremy as Director of Workforce and Communications, his Deputy Claire, as well as a senior HR manager and one of the new HR business managers, the Deputy Director of Nursing and the Head of Patient Safety, the Associate Director of Operations for Medicine, along with the Chair of the Medical Staff Committee and the West Suffolk Trust Convenor and Branch Secretary for Unison.

From the course it was clear that Mersey Care have been on a five-year journey. Initially, there was a difficult and tense partnership relationship between staff side and Mersey Care NHS FT pre the implementation of a restorative just culture. Prior to the development of a restorative just culture cases were dealt with in a very strict and rigid disciplinary process which became difficult and very long. According to staff who we heard from, the procedures that were in place were very black and white, very yes or no, with no consideration of human factors and little empathy.

The big insight that the course conveyed was a recognition that the impact of these processes, even if a case was won, on people's lives and families in terms of the harm that was being created as a result of treating employees in this way. At Mersey Care they sought to learn from the past and embrace civility, dignity and respect as part of the underlying principles of the restorative just culture approach that they sought to develop. There was lots of scepticism amongst staff and

colleagues initially, but the establishment of common ground between trust management and staff side helped establish the shared belief of a commitment to the implementation of a restorative just culture which has been extended beyond HR to encompass quality and safety and organisational learning.

We will be saying lots, I am sure, about the Mersey Care approach over the coming months and years, but one of the campaigns that they talked about was that driven by their civility and respect group. And at the last 5 O'clock Club meeting, the brilliant Dr Chris Turner talked to us about his campaign and campaign group, **Civility Saves Lives**. If you haven't heard of Civility Saves Lives before, they are a group of healthcare professionals in the UK aiming to raise awareness of the power of being civil in healthcare settings. Chris and his colleagues speak to people across the country about how something that seems very simple and normal, like being civil to one and other, and how being civil is not only kind but that it can also make us safer and potentially save lives in healthcare.

One study that Chris spoke about looked at the impact that rudeness and incivility in the workplace has on the quality of an individuals' work. It looked at things we know make a significant difference to being at our best at work – like great teamwork, feeling safe to raise a concern, or not feeling stressed. In the study, when individuals were working with a polite and supportive colleague, 91% performed at the expected level, but this figure went down drastically to 64% when they were faced with rudeness and lack of support. We do not always realise the impact on our own behaviour and we should always be thinking about this. Kindness impacts on us all, and our teams. It was clear from Chris's work that we don't always appreciate just how harmful it can be – either as someone exhibiting rudeness, being on the receiving end of it, or witnessing it around us. It really can affect our self-confidence and the quality of our work. We don't think it impacts upon us, but it does. We are human. And human factors matter. And, they matter especially in healthcare. If we are not at our best then our patients do not get best care and the best outcomes.

I hear in many of the conversations I have around our Trust how incredibly appreciative staff are of their colleagues, and how so many staff work in supportive teams where trust, respect and civility are the norm. However, we all work in stressful and uncertain times and this is especially the case in 2020. It goes without saying that we are all guilty of having a 'bad day' and our stressful reactions may not be the same to how we normally are. From the work done by Chris and his team, he has shown that the way we treat people can really affect their day. So, it's more important than ever to look after each other and demonstrate respect and civility to those we work with. When the going gets tough and we're extremely busy, we need to try our best and be kind. We should and could all work on this, me included! Let's try to be even more compassionate and respectful. You can watch the event via the link below.
https://www.youtube.com/playlist?list=PLpot-guns31ruTbfs4rr6rSnT-vPWC3uu

In terms of kindness one of the many ways NHS staff support their community is to become a **voice for people suffering domestic abuse**, by recognising the signs that someone is being abused and how to raise alerts. The pandemic has seen a dramatic increase in domestic violence and abuse in this country and beyond, with an 80% increase in calls to a national helpline in June alone. Abuse is defined as one individual exerting power, control or coercion over another, includes stalking and harassment and can take the form of one or all of these:

- physical
- psychological
- sexual
- emotional
- economic.

The facts about domestic abuse in this country are stark. Two women a week are killed by their current or former partner, and one in six men will experience abuse in their lifetime. Abuse can start at any stage in a relationship, and is rarely a one-off event, yet many victims will live with it for

years before seeking help. About two-thirds of children living and witnessing abuse are themselves directly harmed by the abuser. It can take a long time for victims to get effective help, even if they are seeking professional support, or in some cases attending hospital with their injuries. The expansion of smart technology is helping abusers, especially stalkers and controlling abusers, who can use methods such as tracking apps against their victims.

As well as injuries such as fractures, the health impacts that a victim can experience range from anxiety, depression and panic attacks to headaches, gynaecological complaints and chronic pain syndrome. Abuse can also lead to overdose or suicide attempts. Supported by specialist staff such as Julia Dunn, our domestic abuse clinical liaison nurse and working as part of a multi-agency approach we work to support our staff be aware of 'the four Rs; to support domestic abuse victims: recognise, respond, refer and record.

In addition to the items already highlighted, key areas of focus of the Trust's senior leadership team are reflected on this month's Board agenda. Key items on the Board agenda include the updated and evolving **integrated quality and performance report (IQPR)** and a report from the most recent improvement programme board, including a copy of the **Trust improvement plan** which highlights lots of progress which staff should be rightly pleased about, given all that is going on at the moment. The board papers also include the important work to support and develop our staff as outlined in our **people plan**, including the BAME network.

Finally, last week NHS England and NHS Improvement set out the **next steps for integrated care systems**. They have published The next steps to building strong and effective integrated care systems across England, which builds on previous publications and the route map set out in the NHS Long Term Plan for health and care joined up locally around people's needs. The document signals a renewed ambition for greater collaboration between partners in health and care systems to help accelerate progress in meeting our most critical health and care challenges. The proposals are designed to serve four fundamental purposes:

- improving population health and healthcare
- tackling unequal outcomes and access
- enhancing productivity and value for money
- helping the NHS to support broader social and economic development.

In practice, this means that from April 2021 all parts of our health and care system will be working together as integrated care systems, involving:

- stronger partnerships in local places between the NHS, local government and others, with a more central role for primary care in providing joined-up care
- provider organisations working more collaboratively at scale
- developing strategic commissioning through systems, with a focus on population health outcomes
- the use of digital and data to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.

In addition to setting out expectations for how integrated care systems will work from April 2021, the document also describes options for giving ICSs a firmer footing in legislation likely to take effect from April 2022 (subject to parliamentary decision). We will need to keep an eye on these developments as they inform our future strategic thinking.

9:40 DELIVER FOR TODAY

9. Operational report

To APPROVE the report

Helen will be joined by Jenny McCrory (Sudbury Team Lead)

For Report

Presented by Helen Beck

Trust Board – 4th December 2020

Agenda item:	9			
Presented by:	Helen Beck, Executive Chief Operating Officer			
Prepared by:	Helen Beck, Executive Chief Operating Officer Alex Baldwin, Deputy Chief Operating Officer Lesley Standring, Head of Operational Improvement Sarah Judge, CCIO community			
Date prepared:	29 November 2020			
Subject:	Operational Update Including: Phase 3 Recovery, Winter and Covid Planning, EU Exit and Community Services Updates			
Purpose:	x	For information		For approval

Executive summary:

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

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

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

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

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

Phase 3 Recovery

There remains significant focus on delivery of the phase 3 recovery plan from both clinical and operational teams.

Pleasingly the elective surgical ward returned to operational use in November and this is supporting increased theatre throughput. There has, however, been an overall reduction in electives through November. This is a result of a combination of issues; theatre staff sickness, reduced elective bed capacity early in the month and patient cancellations at <72 hours. The Trust has delivered 87% of last year's elective plan in the week ending 22 November and 77% overall for the month to date.

Work continues in Endoscopy where we have only achieved 76% recovery month to date, despite insourcing activity. However, we are starting to see improvement in day cases where we are averaging approximately 75% recovery month to date.

Outpatient (first and follow ups) and diagnostics (CT and MRI) are also performing well against the targets. The relocatable CT scanner is up and running and a mobile MRI scanner is expected to be located at Sudbury and be operational from the beginning of January, to enable us to deliver activity to clear diagnostic backlogs and recover the 6 week diagnostic standard.

There are detailed plans in place for all specialties supported by weekly confirm and challenge sessions with divisional leads. There is ongoing focus on endoscopy and day case surgery and whilst we are starting to see greater throughput in day surgery similar levels of improvement are expected in endoscopy.

52 week waits are now 1937. The rate of increase has slowed but there continue to be extended pathways, particularly in the surgical specialties.

Progress

In conjunction with the information team we have developed a weekly Power BI report to track performance against the trajectories. All data as at 30/11/20.

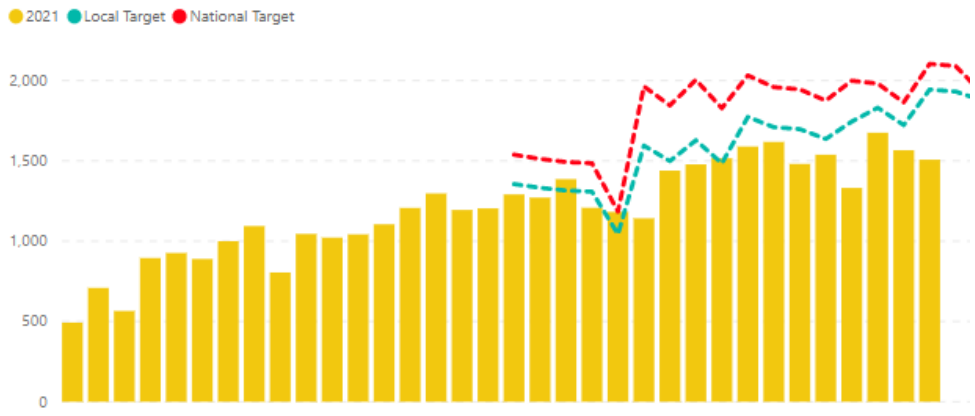


Chart 1: OP First- activity reflects an ongoing reduction in referral numbers

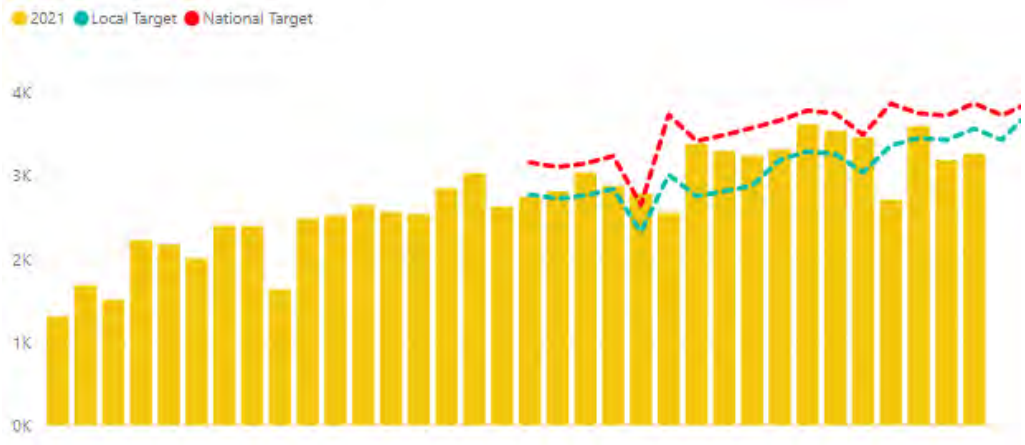


Chart 2: OP follow-up

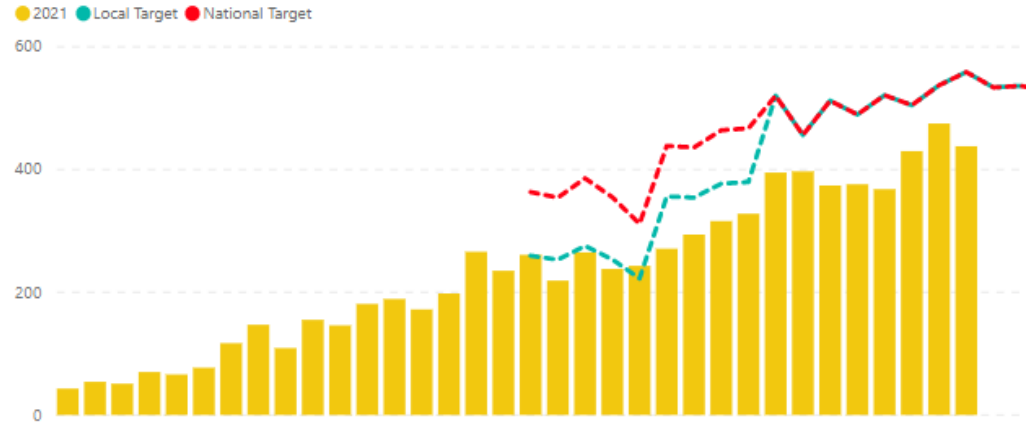


Chart 3: Daycase

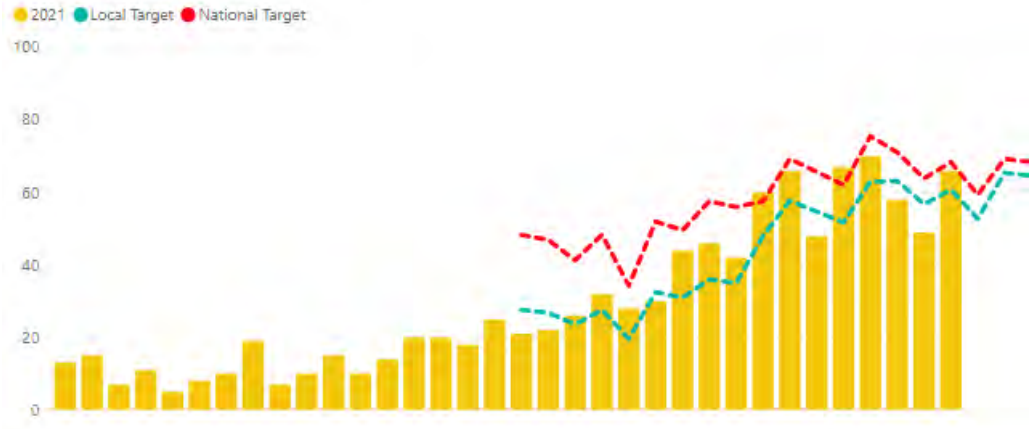


Chart 4: Elective

Chart 5: Endoscopy (note a coding lag means full week performance is reported a week in arrears).

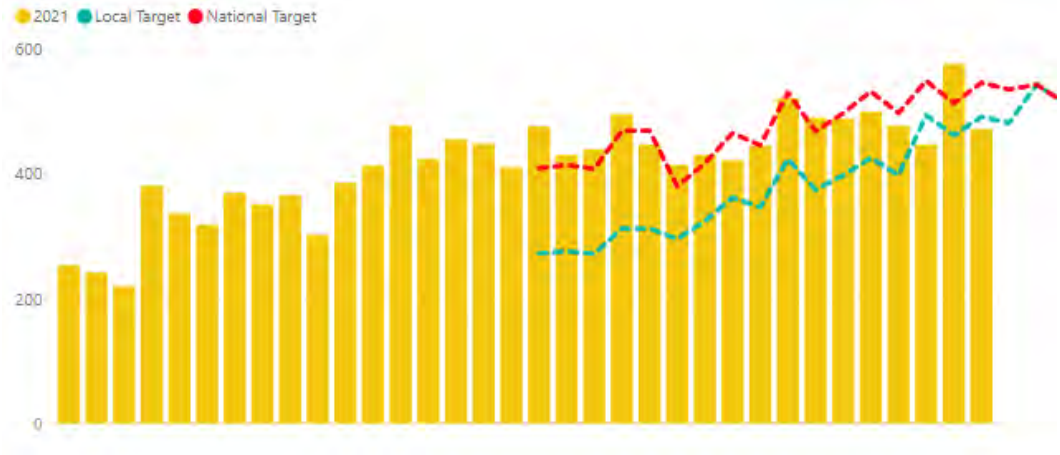


Chart 6: CT

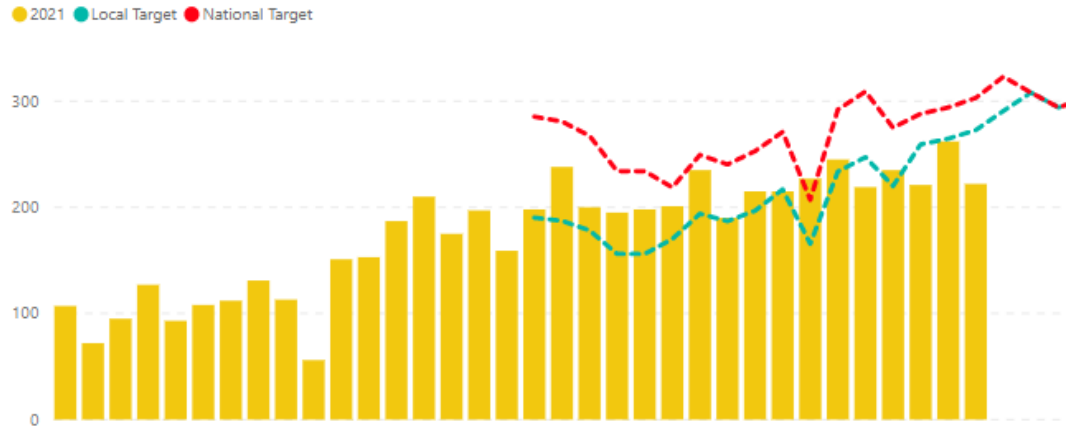


Chart 7: MRI

Winter planning including Covid activity

Given the rapidly changing situation, a verbal update will be given at the board meeting to outline current levels of Covid activity within the Trust. At the time of writing Covid activity is being managed through wards F7, F10 and F12. Plans are in place to convert G4 should it be required. It is also worth noting that there are contact bays on seven wards.

The high-level winter plan was presented to TEG on 2nd November and Board last month. The planning assumptions remain unchanged despite further requests to model 20% and 35% Covid contingency.

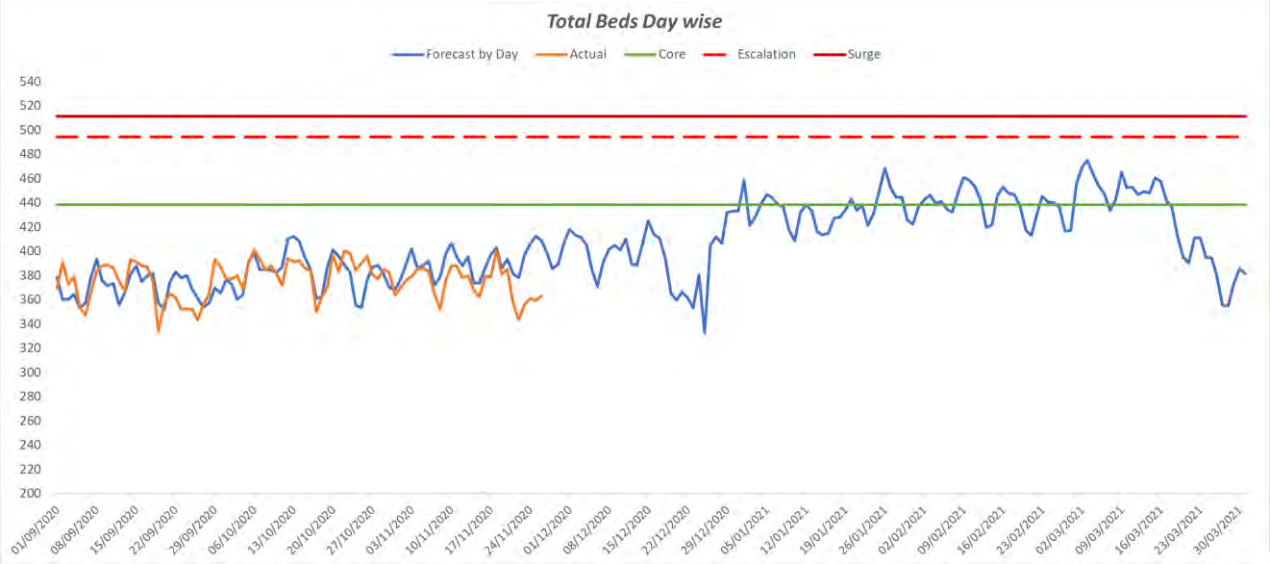
The operational winter adaptations are underway. G9 was handed to the operational team last week and the respiratory team are making final plans for their move to G9 which will take place on 3rd December. Subsequently G5 will relocate to F8. The winter escalation ward on G5 will open on 8TH December and accommodate short stay and the frailty service.

It is also worth noting that the critical care team have developed robust escalation plans which includes the use of F2. The service has escalated to F2 over the past 10 days but at the time of writing has repatriated to the main department.

Currently overall demand is in line with projections. This is, however, an imprecise science and fluctuating Covid demand has made modelling particularly difficult this year.

Average bed occupancy in November is 4.7% lower than for the same period last year. Whilst we have 72 beds designated for the Covid pathway, we have not, yet, seen demand at this level. This also accounts for the operational pressures felt across the organisation, despite the lower bed occupancy.

We will continue to monitor occupancy via the modelling, the current daily occupancy rates are provided below.



It is worth nothing that core beds include beds designated for the Covid pathway and therefore is not a measure of operational pressure and that the usual post-Christmas increase in demand is largely maintained through January and February with a further peak expected in early March.

Operational plans are focused on implementing and embedding the updated discharge planning guidance across the organisation, rather than a single event such as Perfect Week or multi agency discharge event (MADE). Enhanced role specific action cards and detailed guidance relating to criteria to reside provide a framework for improving flow via discharge and transfers of care.

We plan to audit implementation through December with additional focused work, similar to the current stranded patient reviews, to be led by the deputy chief operating officer in early January and through February and March as required.

Think NHS 111 First

The term **NHS 111 First** refers to the development of the current NHS 111 service to offer patients a new approach to the way they access and receive urgent healthcare. This national drive is to capitalise on the reduction in ED attendances, as seen during the first peak of the Covid pandemic where patients were encouraged to access health care pathways differently.

The main principle of this initiative is to provide a system of direct booking into the emergency department following a triage process undertaken by 111, which will enable a controlled flow into the department thereby reducing crowded waiting rooms and minimising the risk of nosocomial spread of infection.

This service commenced in West Suffolk on Monday 30th November, with booking slots via NHS 111 First from 10:00 until 16:00, with a view to extend these operating hours as the service develops. The emergency department has worked closely with IT to install additional IT systems to allow 111 to access these booked slots.

A national communication campaign will support patients to access the right services prior to attendance within the emergency department.

EU Exit Planning

The trust has participated in a number of national workshops in preparation for the end of the EU Exit transition period which concludes on 31 December.

National preparation activity has focused on six key elements; continuity of supply, improved trader readiness, winter pressures, increased complexity for reciprocal and cost recovery, staffing resilience and data.

The preparatory plans assume the absence of a trade agreement.

Trust preparatory activity has mirrored the national effort and we believe the organisation is resilient and primed to respond to any ‘unknown unknowns’ via our business as usual and escalation structures, as recent events have shown.

Continuity of supply

DHSC has pursued a multi-layered approach to minimise potential disruption to supply of all medicines and we are advised to expect minimal disruption. Mitigation includes alternative freight routes, trader readiness (via centralised support), buffer stock, regulatory flexibility and enhanced shortage management and utilisation of push stock replenishment (as used for PPE).

We have been advised that prescribing activity should continue as normal and that stockpiling is not necessary. This reflects practice adopted prior to the initial EU Exit.

Improved trader readiness

National support has been provided to major suppliers and minimal disruption is expected. The trust has also undertaken to write to all suppliers to review individual exit plans. The vast majority have responded with appropriate plans which includes additional stock holding as a primary action. There are a small number of suppliers who provide maintenance services to the trust who have identified supply chain concerns (mostly supply of spares from the continent) but this is under continual review.

Winter pressures

At this time, we do not expect winter pressures to impact or be impacted by the end of the EU Exit transition period. This may change depending on the full impact of the pandemic, potential seasonal flu impact or compound workforce issues, but at present we believe our plans are robust and proportionate.

Reciprocal and cost recovery

There is significant change to eligibility of EU citizens to receive healthcare post 31st December. After this data any individuals whose country do not have a reciprocal healthcare agreement in place will be charged for NHS healthcare. At the time of writing the Government has not confirmed whether reciprocal arrangements with EU member states have been agreed.

In the meantime, our overseas visitors' team are prepared to respond once guidance is issued.

Staffing resilience

The trust has seen no negative impact of EU Exit on recruitment and doesn't expect to have any in the next 30 days. Mutual recognition of professional qualifications will apply for at least two years post the end of the transition period and whilst the new UK skills-based immigration system will be introduced in 2021 the majority of healthcare roles will be exempt.

In preparation for the end of the transition period we will be communicating with EU staff directly to advise and reassure.

Data

The trust is fully compliant with the General Data Protection Regulations (GDPR) which cover data transfers, data storage, data audit and data protection. GDPR will still apply after the UK leave the EU and Sara Taylor, head of information governance and legal services has ensured we have robust plans in place to ensure a smooth transition.

Community Services Updates

Community Engagement Work

In October, following the feedback received in the What Matters To You survey, WSFT commissioned ReTHINK to undertake a deeper listening and engagement exercise with community health staff to:

- Fully understand any issues affecting morale and the concerns that staff may have – now and for the future
- Work with staff to identify how these issues might be addressed
- Engage staff in starting to identify what good would look like to them longer term
- Lay foundations for re-engaging with staff in looking ahead and shaping / delivering a fully integrated health and care delivery model.

Given the focus on health and social care integration ReTHINK spoke to Suffolk County Council Adult Social Care teams as well as NHS staff working in, or connecting with, community health services.

The initial feedback indicates significant opportunity for Alliance Partners to progress their initial strategy but a refocus on strengthening collaboration across partners strategically and operationally. The final report will be available mid December.

A summary of some of the initial feedback is included below:

- West Suffolk Community Health services are a key service in the local health and care economy. Staff working in the community are generally committed, purposeful clinicians and professionals who have a strong sense of local identity, vested in their integrated neighbourhood team. **People love their jobs – what they do, where they do it.**
- Thriving integrated community health and care services are vital to the medium-term plans of the local system led by the Alliance, and to the redevelopment and sustainability of West Suffolk Hospital. In order to really support these services to thrive, WSFT may need to change the lens through which community services are viewed and work to develop a specific identity for community teams.
- The lack of data means that the impact of community work is not visible to the organisation and wider system. There is a concern amongst staff that what is unique and precious about community services risks being lost - *"community is a specialism within itself.*
- COVID-19 has impacted the balance of their work between routine and responsive care. Acuity, complexity and demand are increasing. Staff are playing a significant role in supporting the delivery of other services, and the pandemic has slowed down previously good progress on integration; staff are keen to see all of this restored and rebalanced.
- With integration intended to progress rapidly, there is now an opportunity to create a strong sense of what the community is – its identity, purpose and mission - what it contributes and what it needs around it to support it – as an integral and high priority element of plans for the local system, with the resources, leadership and accountability arrangements needed to ensure success.

Next steps planned for this work include:

- ASC and WSFT Executive briefing sessions
- Alliance briefing session
- Communicate with staff
- Implementation planning

Auto Scheduling

One of the areas of feedback is the lack of community data to support the teams, which is something we have already been working to address. Utilising auto scheduling functionality has been on the community services transformation agenda for a number of years and it is supported within the 2020/21 business plan. The implementation of an automatic scheduling platform meets the Alliance key objective of building community resilience and mitigating system risk. The future system strategy would include an integrated scheduling platform inclusive of all members within an Alliance workforce.

The key objectives of implementing an auto scheduling platform in community nursing services are:

- Increase % of rostered clinician hours spent patient facing (reduce admin burden)
- Enable clear and objective real-time and predictive capacity and demand metrics
- Reduce missed patient visits (automated process vs manual inputting) and improve patient safety
- Deliver enhanced community reporting opportunities – operational and governance
- Deliver enhanced lone worker safeguard tools
- Optimise clinician travel
- Reduce bank/agency spend

An option appraisal of available solutions was presented to executives and has been agreed in principle subject to further work to ensure there is full engagement in the selected solution from the front-line staff. The team are also liaising with ESNEFT around the options for a join procurement and implementation solution.

Benson – demand modelling tool for nursing

Work on the capacity and demand modelling for community nursing teams is well underway. The phase 1 Initial data validation exercise is complete and the outputs from this will drive the phase 2 work.

The final outputs of this model will provide and evidence based indication of the staffing and skill mix required to meet current service demand and indicates areas of development to meet future changes in demand.

We are working with the company to support them to develop a modelling tool for community therapy teams.

The combination of the capacity and demand work and the auto scheduling solution will provide the much-needed data to increase visibility of activity and risks within community services and start to bring them in line with acute services.

Community Digital Progress

The community digital programme, also known as Pillar 3, is also summarised in the Digital Board update to this board.

The programme has been designed to be a three-year programme of investment in digital in community services, both from a financial and support point of view, and is broadly focussed on migration, consolidation and transformation. The first year of the programme is almost complete with the migration of community staff from IT support with NEL CSU to WSFT IT.

The migration project is moving over 650 staff from NEL infrastructure to WSFT, replacing all the computers, screens and other hardware as well as moving their data and emails. The community staff are the first division to have their data (files and folders) moved into the cloud storage platform, Microsoft SharePoint. This will allow staff to access files and folders from whichever location they are working from, and allow real-time collaboration on documents and files across the county. Some teams have moved onto the WSFT file servers due to a shared department with a team already on the WSFT systems (e.g. adult SALT).

In addition to this work, a number of community sites now have the WSFT networks and Wi-Fi on site. Alongside the physical hardware, the migration onto the WSFT email exchange enables much closer working through shared calendars, and access to the WSFT networks gives easier access to essential information such as the intranet.

As of the end of November, the following teams have been migrated:

- Adult speech and language therapy
- Early intervention team
- Wheelchair Services
- Specialist neurology nurses
- Pulmonary rehabilitation
- Haverhill community health team
- Newmarket community health team
- Sudbury community health team
- Community cardiac rehabilitation and heart failure nurses

The feedback from the community staff is positive about their IT move with Jane Sharland, team lead for the Sudbury community health team, commenting "*I have to say that the IT people have been amazing, they are so helpful and so patient. They are also very efficient and getting through it all with ease. No question is too small or too silly for them to spend the time answering so everyone is feeling very happy with all the new kit and new look applications. All that hard work planning for this has really paid off*".

The rest of the adult community health teams (Bury rural, Bury town and COPD team, Mildenhall & Brandon) will be migrated before Christmas. The integrated paediatric community service will follow in January 2020, with the community informatics team migrating in February.

The community digital team has expanded which allows us to work with our clinical systems team more closely to develop the electronic patient record (SystmOne) and to support the implementation of an auto-scheduling solution to assist with scheduling of community visits based on geography, patient needs and staff skills.

We are working towards a period of consolidation with all the digital upgrades that have occurred in 2020. A programme of IT training and support is available to community staff as well as upskilling of the IT engineers to support the variety of locations that are served by the Trust.

Recommendation

The board is asked to note the content of this report.

10. Integrated quality and performance report

To APPROVE a report

For Approval

Presented by Helen Beck and Susan Wilkinson

Trust Board Report - 4 December 2020

Agenda Item:	10			
Presented By:	Helen Beck & Sue Wilkinson			
Prepared By:	Information Team			
Date Prepared:	Nov-20			
Subject:	Performance Report			
Purpose:	**X**	**For Information**		**For Approval**

Executive Summary:

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

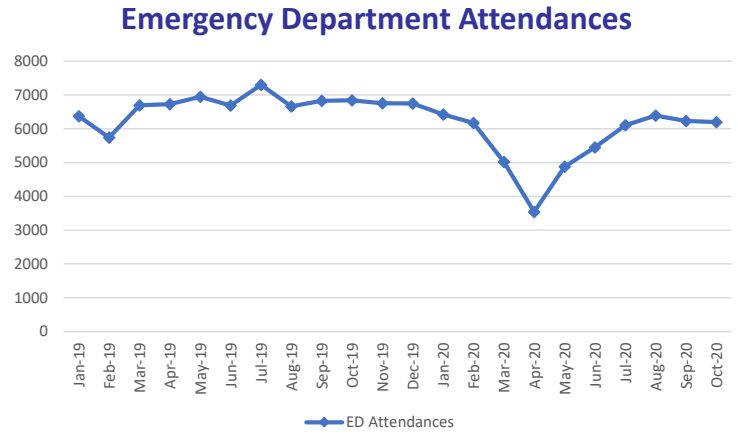
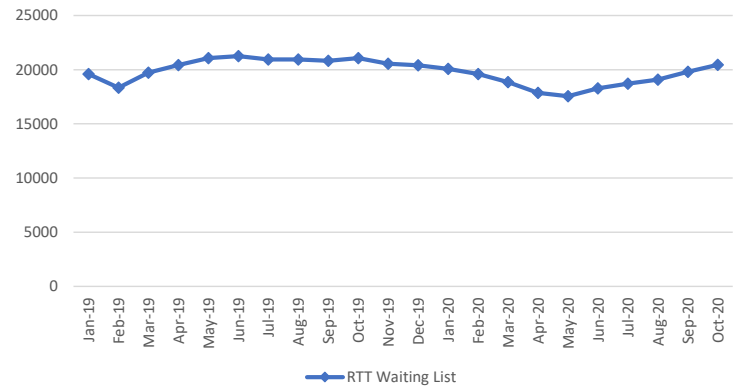
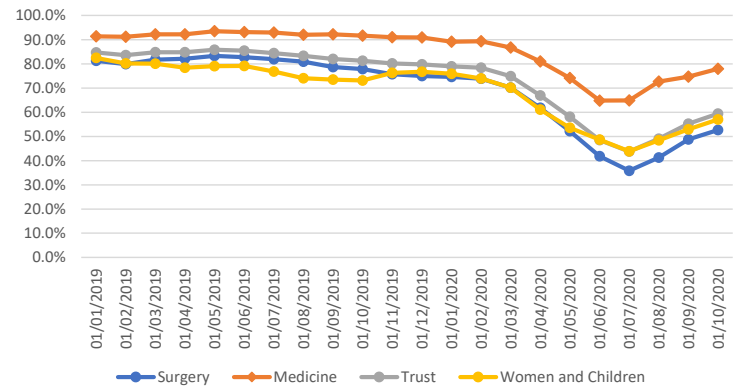
Trust Priorities [Please indicate Trust priorities relevant to the subject of the report]	**Delivery for Today**	**Invest in Quality, Staff and Clinical Leadership**	**Build a Joined-up Future**
	X		

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

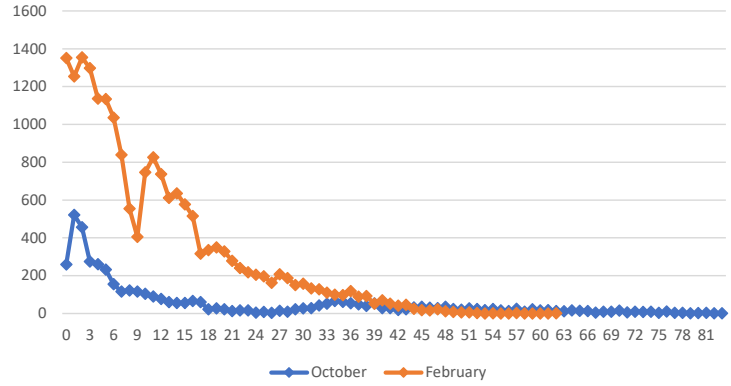
Previously Considered by:	
Risk and Assurance:	
Legislation, Regulatory, Equality, Diversity and Dignity Implications	

Recommendation:

That Board note the report.

Board Report KPIs	Narratives
	There were 6198 attendances in Emergency Department in October compared to 6233 in September. This number remains lower than our pre-Covid attendances and similar to that of September figures. Of these attendances 1709 patients were admitted into the Trust.
A count of the arrivals at the Emergency Department. This metric has no national target but is key to understanding demand for non elective services.	
	Waiting list numbers continue to increase as expected inline with increased referrals. The waiting list size is now larger than it was in February, but the level of patients over 18 weeks is slowly decreasing.
A count of the patients on the waiting list for treatment.	
	This is a new chart this month as we start to monitor improvements in compliance with the RTT standards as a result of the elective recovery programme. Overall Trust level performance for October is 59.41% . The recovery challenge is significantly greater for surgical specialties with the lowest performance being ophthalmology at 41.5% and the highest general surgery at 61.3%.Within medicine perfromance ranges from gastro at 66.81% due to the impact of endoscopy delays and general medicine and geriatric medicine who are both achieveing 93.1% and 100% respectively. gynaecology performance is 56.97%
% of patients on incomplete RTT pathways who have been treated within 18 weeks	

RTT Waiting List Precovid Comparison



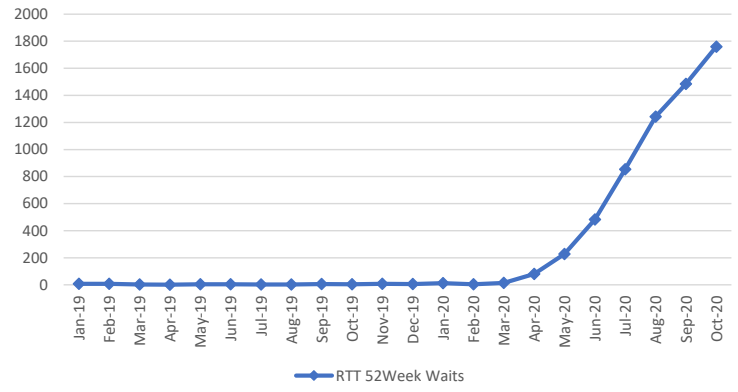
A year on year comparison of the number of patients waiting for treatment.

The overall waiting list shape has changed with a small bulk of patients at the front end of the pathway but the tail is significantly longer than it was pre-Covid due to the wait times for surgery and diagnostics.

Board Report KPIs

Narratives

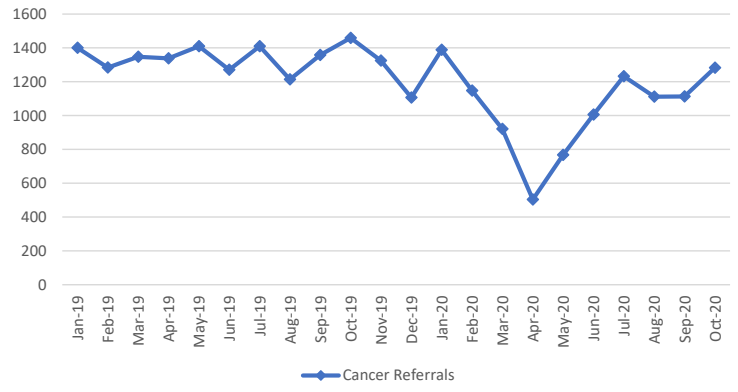
RTT 52Week Waits



A count of the number of patients who are waiting for treatment and have been waiting longer than 1 year for treatment. This is a national key performance indicator with a national expectation of 0.

The wait time for patients shows an increasing trend, with patients waiting longer that 52 weeks continuing to rise. Whilst patients are being given dates for treatment, the number of patients reaching 52 weeks is greater than those that are treated resulting in a growing number of long waiting patients. This is partly due to the need to treat patients in clinical priority as well as waiting time order.

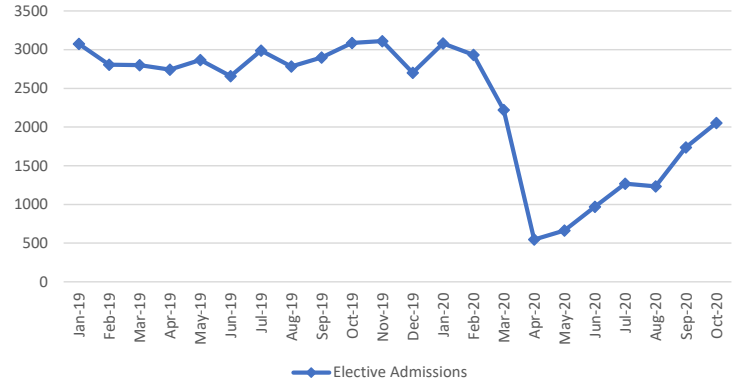
Cancer Referrals



A count of the number of patients referred to the hospital with suspected cancer, requiring investigation. This metric shows the activity by month for cancer services, which informs the national metric which measures the number of these patients that were seen within 2 weeks (further in the performance pack).

Cancer referrals have risen again in October, particularly in Breast Symptomatic, Skin and Lower GI. Lung referrals have not yet returned to pre-Covid levels and this is seen nationally.

Elective Admissions

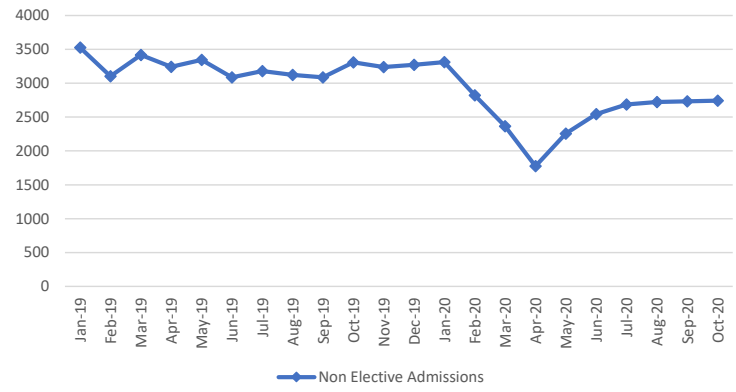


Continued increasing trend of patients attending for an elective procedure. This is anticipated to continue to rise with action plans in place to get back to 90% of pre-Covid activity.

A count of the number of patients that were admitted for an elective/planned procedure. This is a local metric used to monitor changes in activity.

Board Report KPIs	Narratives

Non Elective Admissions



Non elective admissions were 2743 in October which is a slight increase from 2734 in September, but remains significantly lower than pre Covid levels. In comparison to October 2019, this is a decrease year on year in admissions of 17.1%

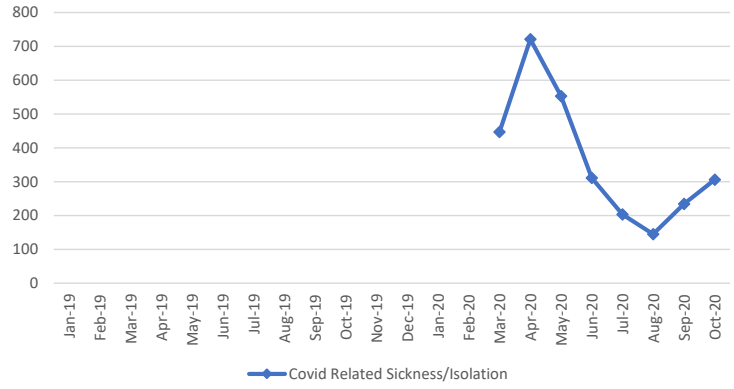
A count of the number of patients who were admitted following an unplanned or emergency episode. This is a local metric used to monitor demand.

Staff Sickness

The Trust's 12 month cumulative absence as at the end of October 2020 remains static at 3.8%, as it was in August and September 2020. This is a reduction from the reported position from April through to July 2020 which was 3.9%.

A measure of staff sickness across the Trust. This includes community staff. This is a local metric to monitor the capacity of our workforce.

Covid Related Sickness/Isolation

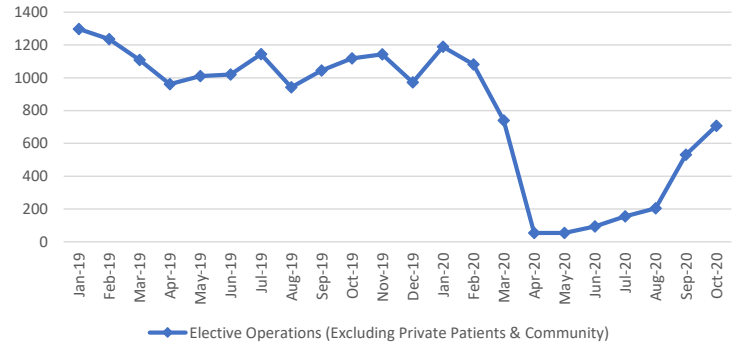


This chart illustrates the number of sickness episodes related to COVID-19. In October 2020 there were 306 episodes recorded which is an increase from September 2020 of 234 episodes. Whilst sickness related to covid showed an improvement from April 2020, this is increasing again during the second wave.

A count of our staff who have been off sick with a Covid related symptoms or to isolate. This is a local metric to monitor the impact of Covid on our workforce.

Board Report KPIs	Narratives

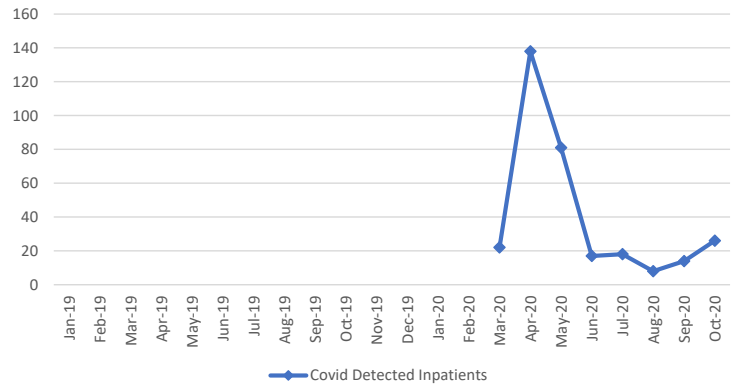
Elective Operations (Excluding Private Patients & Community)



Elective operations continue to increase and this is anticipated to continue throughout November with action plans in place to recover back to 90% and a particular emphasis on day case activity.

This is a count of the number of operations that were carried out. This is a local measure to monitor our productivity and recovery from Covid.

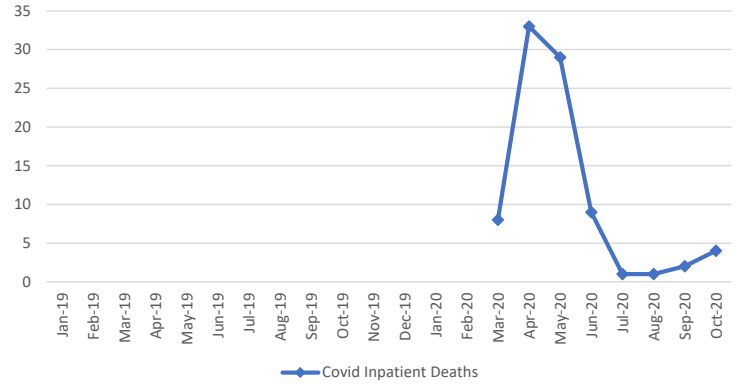
Covid Detected Inpatients



This reflects the national picture of Covid prevalence and increased Covid in our community

This is a count of the number of patients admitted to the hospital who tested positive for Covid. This is a local measure to understand the local impact of Covid. This number is reported daily as part of national daily reporting requirements.

Covid Inpatient Deaths

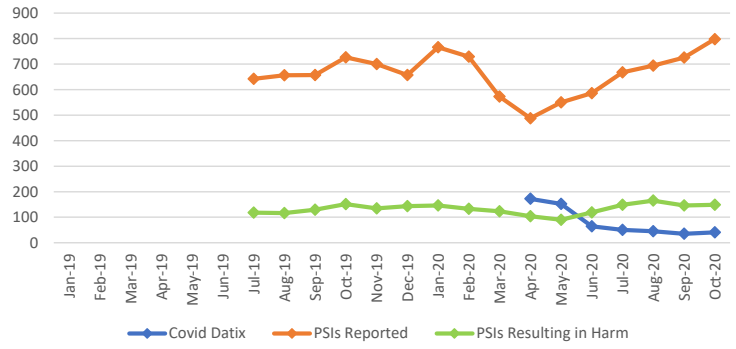


This reflects the national picture of Covid prevalence and increased Covid in our community

A count of the number of patients who have died following a positive Covid result. This is a local metric to understand the local impact of Covid. This number is reported daily as part of national daily reporting requirements.

Board Report KPIs	Narratives

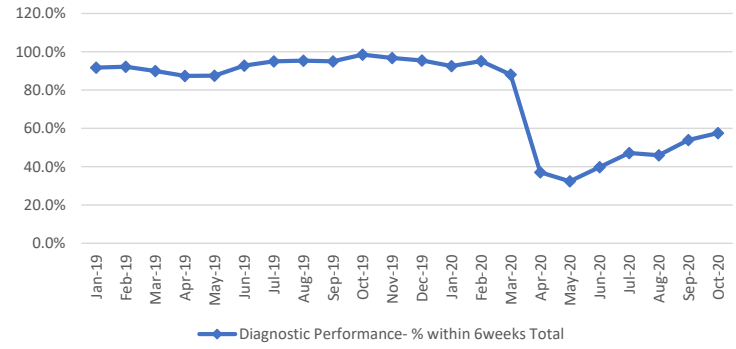
Patient Safety Incidents Reported (Total, Resulting in Harm and 'Related to COVID')



The number of patient safety incidents reported in October rose however the number of those resulting in harm remained consistent with the previous month. The number of incidents reported categorised as relating to a COVID patient rose slightly as might be expected with increased numbers of these patients in the hospital. This indicator is not representative of incidents relating to the management of COVID and will be phased out with the introduction of the COVID ICT dashboard (which will include more focussed measures). The incidents reported per 1,000 bed days has risen slightly over the last two months but remains comparable to the average.

A count of the number of patient safety incidents reported in total, related to harm and those relating to management of Covid patients

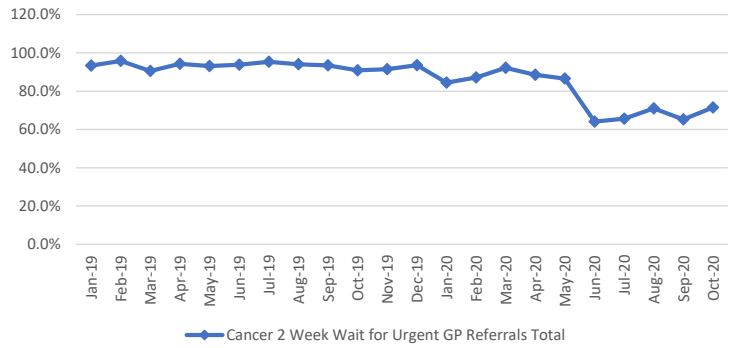
Diagnostic Performance- % within 6weeks Total



The percentage of patients within 6 weeks is improving, despite the addition of a high number of patients being added to the front end of each of the diagnostic waiting lists which are preventing progress with the long waiting patients. The average is now sitting at 46% for Endoscopy, 84% for MRI and 66% for CT.

To measure compliance with the national standards for access to diagnostic treatment. This metric measures the percentage of patients who receive diagnostic treatment within 6 weeks of referral. The national standard is 99% to receive a diagnostic within 6 weeks.

Cancer 2 Week Wait for Urgent GP Referrals Total

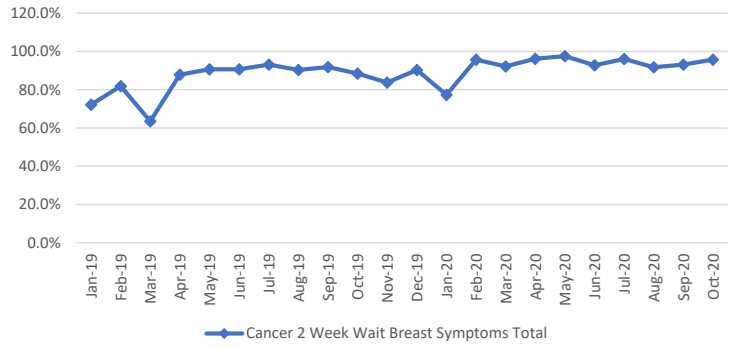


Two week wait performance had a small improvement from September to October, the majority of the tumour sites met the 93% target, but Upper and Lower GI which are reliant on straight to test endoscopic procedures are still at an exceptionally low % compliance within 2 weeks. Additional endoscopy capacity is in development as well as a recovery trajectory.

To measure compliance with the national standards for access to cancer diagnosis. This metric measures the percentage of patients who are seen within 2 weeks from referral from their GP for suspected cancer. The national standard is 93% to been seen within 2 weeks.

Board Report KPIs	Narratives

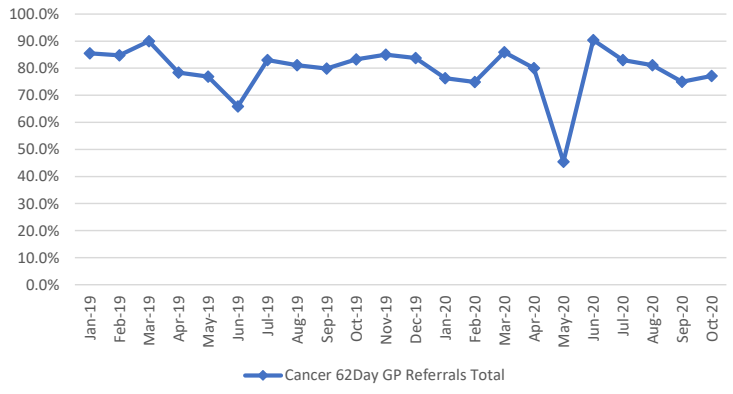
Cancer 2 Week Wait Breast Symptoms Total



Standard achieved.

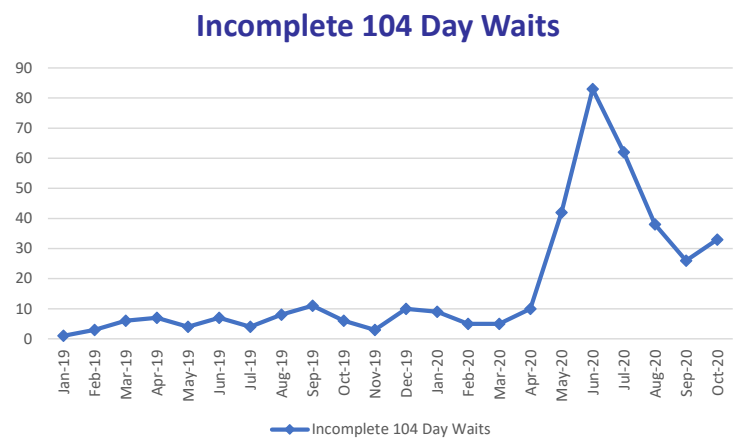
This metric is a sub set of the national 2 week wait metric and measures those GP referrals specifically with breast symptoms. The target is the same as the overall 2 week wait of 93% of patients to be seen within 2 weeks.

Cancer 62Day GP Referrals Total



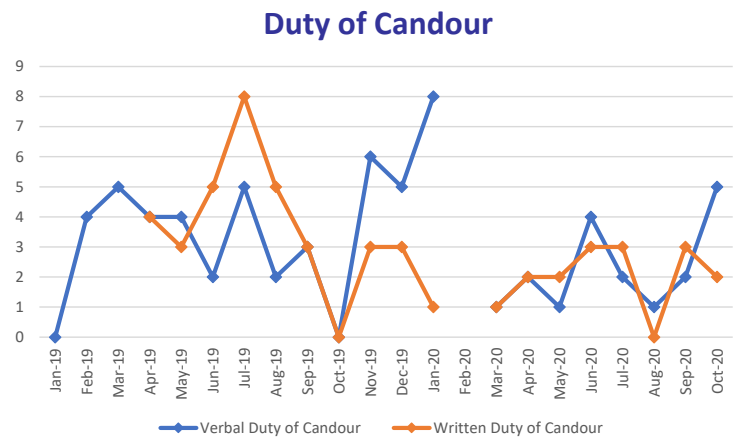
Slight improvement from September to October, however performance is still a way off the 85% standard. The majority of patients being treated over 62 days are those with extended diagnostic delays due to Covid-19 as well as some patient choice elements. This performance is likely to remain at this level for at least the next 3 months.

To measure compliance with the national standards for access to cancer treatment. This metric measures the percentage of patients receive cancer treatment within 62 days of referral by their GP. The national standard is 85% to have received treatment within 62 days.

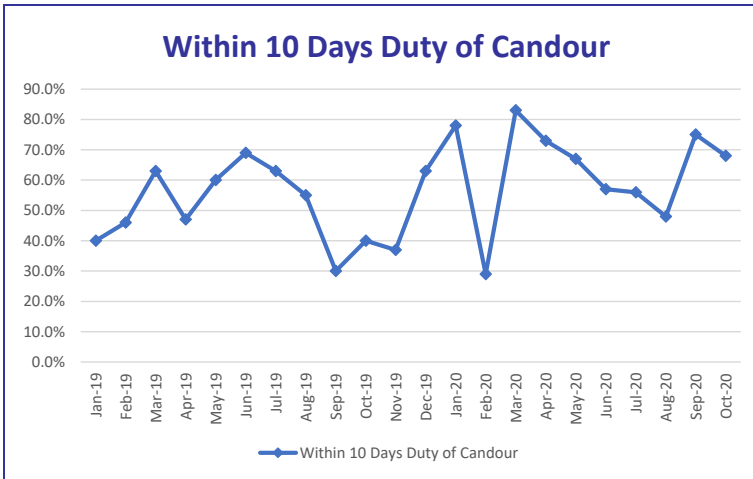


A count of the number of patients who have waited longer that 104 days for treatment for cancer from GP referral. This is a national standard and is expected to be 0.

The number of patients on a 62 day cancer pathway waiting over 104 days remains much higher than pre Covid levels . This is primarily due to significant delays in endoscopy on the colorectal pathway with a number of patient choice delays also impacting on performance.
A detailed action plan to improve endoscopy capacity and efficiency is in place with improvements expected over the next month. Specific clinics have been set up with reluctant attenders to discuss risks and if necessary alternative pathways.
Once diagnosed there are no delays to treatment for patients on these pathways.

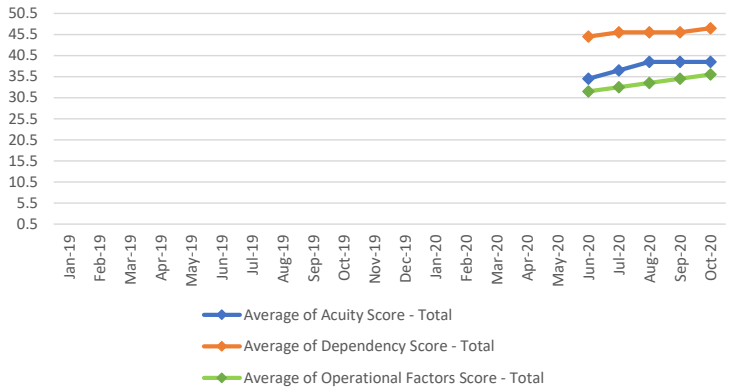


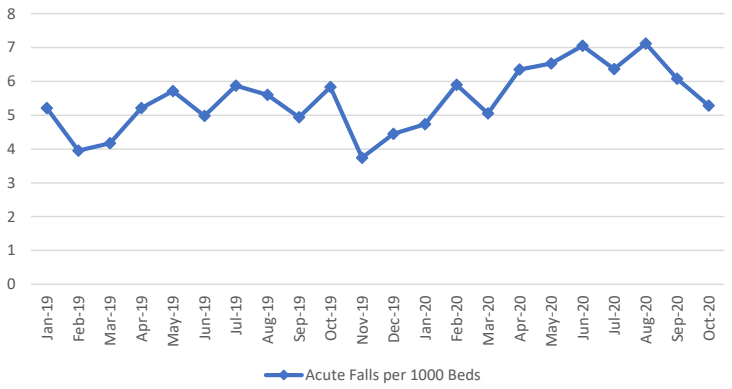
This is a count of the number of verbal and written duty of candour overdue for the reporting month (and earlier) as at the date of report issue

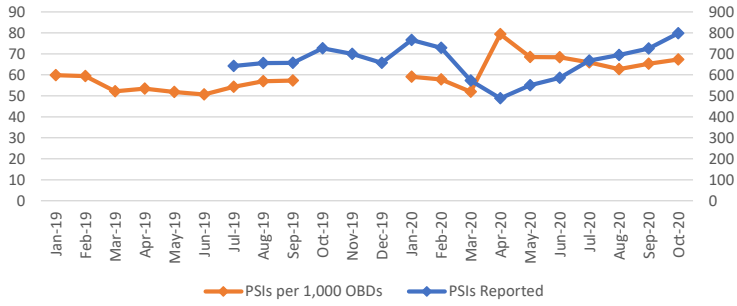


The percentage of cases reported in that month where verbal duty of candour was completed within the nationally required 10 working day timeframe.

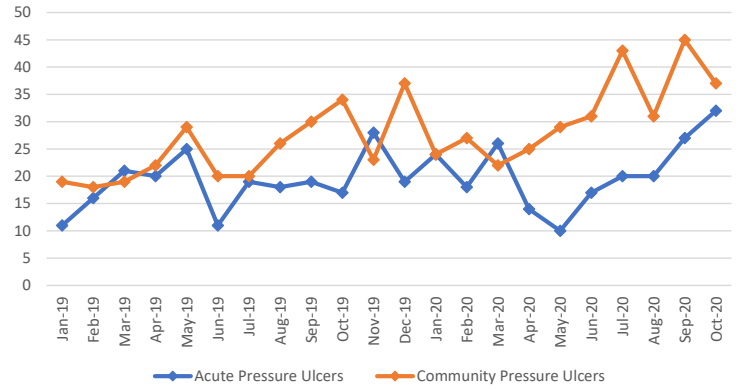
The timeliness indicator fell slightly compared to September and the number of overdue verbal Duty of Candour conversations is currently higher. This does include several incidents relating to infection prevention diagnoses such as MSSA for which a PIR review is undertaken prior to any assessment of harm (and therefore Duty of Candour) requirements.

Board Report KPIs	Narratives
Acuity Measures 	In October there has been a further increase in both dependency and operational measures and there is a clear upward trend. The majority of inpatient wards remain consistent in their acuity scores, but there has been a marked rise on wards F6 and F7, though this has not increased the overall score. The dependency scores have increased in October, with ward's G4 and Rosemary seeing a significant increase in the dependency indicators. Although not recorded on the chart, the overall scores continue to increase each month, which is indicative of the increasing pressures the organisation continues to face, and is likely to increase further as there are increasing numbers of beds made available to the organisation.
A range of measures have been identified which are analysed to provide an overall acuity score, as displayed in this chart. This provides an overview of the acuity of admitted patients.	

Board Report KPIs	Narratives
Acute Falls per 1000 Beds 	October has seen a further decrease in falls from 61 in August to 56. Falls per 1000 bed days decreased from 6.0 to 5.28. Within October 42 falls resulted in no harm, 2 minimal, 10 minor, 1 moderate and 1 major harm. The major harm occurred on F7 where a patient had an unwitnessed fall resulting in #NOF. On 11th November the falls champion day was held, the falls champions will be sharing the information and education with their areas. The falls lead is commencing employment November end. Where patients are at high risk of falls, care plans are being initiated, specials requested and staff deployed to the areas to assist.
A measure of the number of falls in the acute hospital measured per 1000 bed days. Community falls are excluded from this metric.	

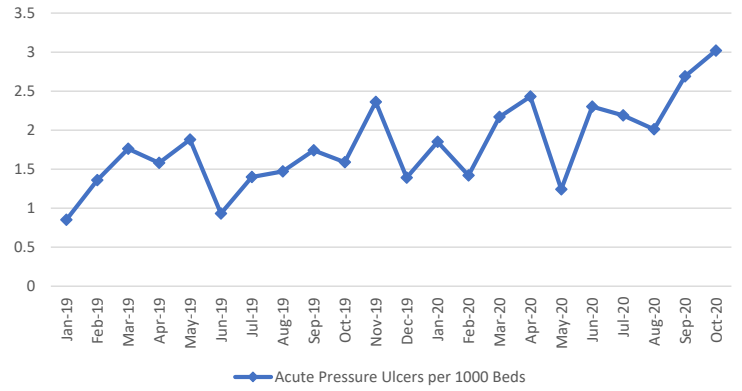
Patient Safety Incidents (PSIs) Reported Total and per 1,000 occupied bed-days (OBDs) 	The number of patient safety incidents reported in October rose however the number of those resulting in harm remained consistent with the previous month. The number of incidents reported categorised as relating to a COVID patient rose slightly as might be expected with increased numbers of these patients in the hospital. This indicator is not representative of incidents relating to the management of COVID and will be phased out with the introduction of the COVID ICT dashboard (which will include more focussed measures). The incidents reported per 1,000 bed days has risen slightly over the last two months but remains comparable to the average.
A count of the number of patient safety incidents reported in total and as a percentage of occupied beddays to measure reporting rates	

Pressure Ulcers



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

Acute Pressure Ulcers per 1000 Beds



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

A very small reduction in overall reported pressure ulcers incidences has been noted during October. An increase in unstageable pressure ulcers has been noted, the majority of which were community (11 Community, 6 Acute). During October increased incidence is also noted across inpatient areas and this is corroborated with incidences per occupied beds days. An increase in incidence has been observed in Critical Care and G8. The Bury Town CHT also reported a high number of Cat 2 pressure ulcers.

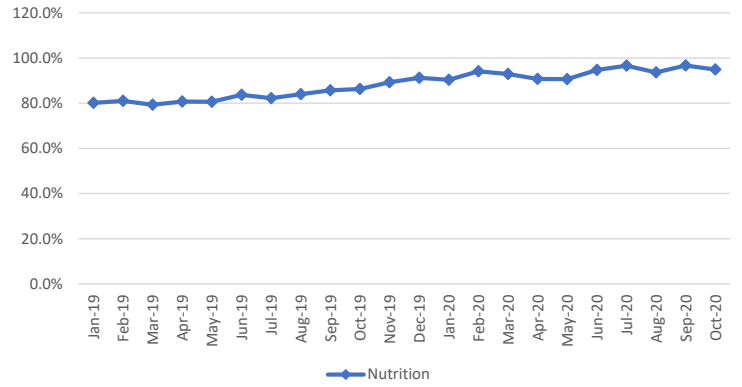
Senior Matrons (Community) are working with the Tissue Viability Team to ensure closer oversight of unstageable pressure ulcers as soon as reported, this will support correct categorisation and a prompt treatment plan to support the CHT's. The development of a 'harm free care collaborative' is also being established to implement QI methodology and interventions, utilising networks across the system to learn and share best practice

Plans to develop a new Patient Information Leaflet to try to address patient concordance were paused due to the unease of the inclusion of pictures of pressure damage, which was felt unsuitable for patients; revised plans are being developed with the use of NHSE/I resources.
Annual 'Stop the Pressure' Day is taking place at the time of writing, where interactive educational stands, and a program of ward visits, promoting the importance of preventing skin damage was delivered. The tissue viability team have developed imaginative aids to demonstrate the levels of damage incurred by poor pressure relief has received positive feedback.

Board Report KPIs

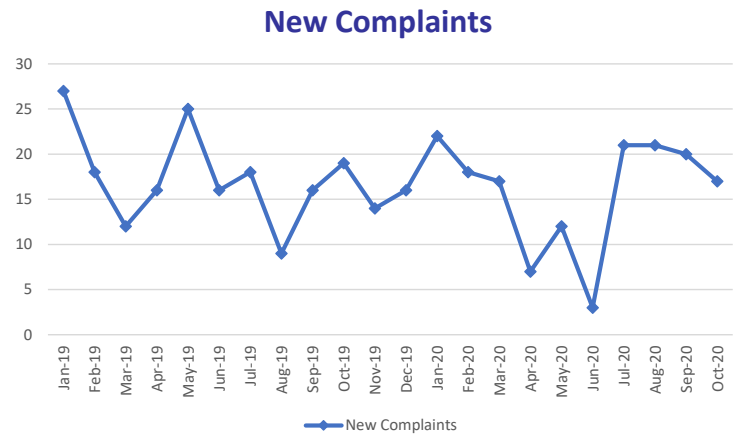
Narratives

Nutrition



% of patients with a Malnutrition Universal Screening Tool (Adults)/Paediatric Yorkhill Malnutrition Score (Children) assessment completed within 24 hours of admission

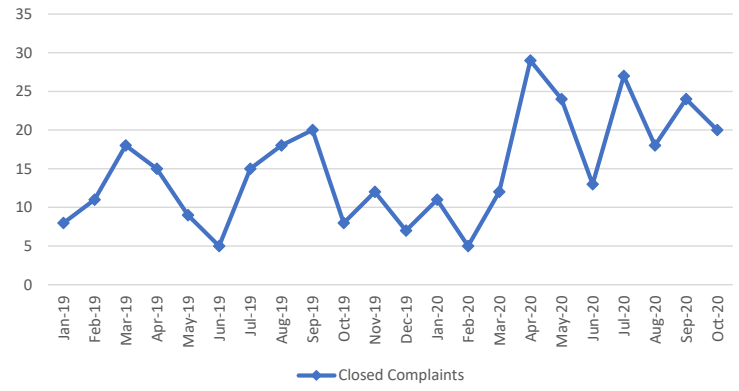
In October, 95% of patients had a nutrition risk assessment completed within 24 hours of admission, a slight decrease from September, but overall, the compliance has been above 90% through the past 3 quarters, a consistent and embedded improvement. There is continued focus on the quality of these assessments, promoting patient weights being recorded and actioning and implementing nutrition care plans. A protected mealtime audit is planned for November following the change of meal delivery times. This audit will be repeated quarterly to gain assurance that the principles of protected mealtimes are being upheld



A trend we continuing to see are complaints within the emergency department. 5 ED complaints received for October. 4 out of 5 complaints related to delay or failure in treatment. The other complaint related to staff attitude and behaviour. Actions and learning to be reviewed with matron, manager and lead consultant, especially upheld complaints. A reduction in complaints received for ward F3 for October compared to 4 in September, however analysing previous volumes, September seemed to be an abnormal month for F3.

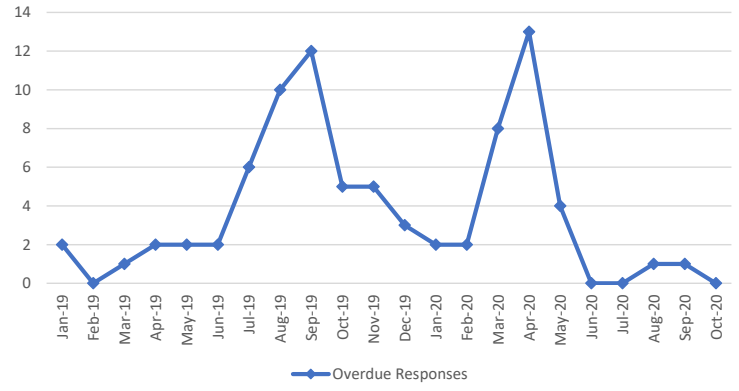
New formal complaints received and accepted, this counts both West Suffolk Hospital and Community

Board Report KPIs	Narratives



More complaints resolved than received in October and we have reduced our overall outstanding volume to a manageable level within the team.

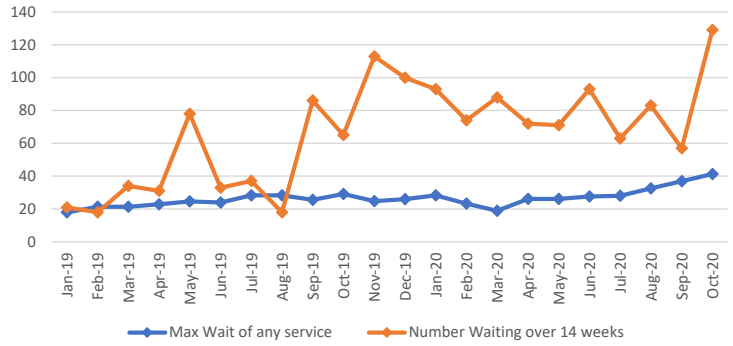
Formal complaints signed off by the CEO, this counts both West Suffolk Hospital and Community



All complaints were resolved within agreed timescale. We have also resolved all outstanding backlog complaints that were overdue and have ensured complainants have been kept up to date with any delays.

Any complaints which were sent outside of the given timeframe and no extension was agreed, this counts both West Suffolk Hospital and Community

Community Non Consultant Led 18week Max Wait



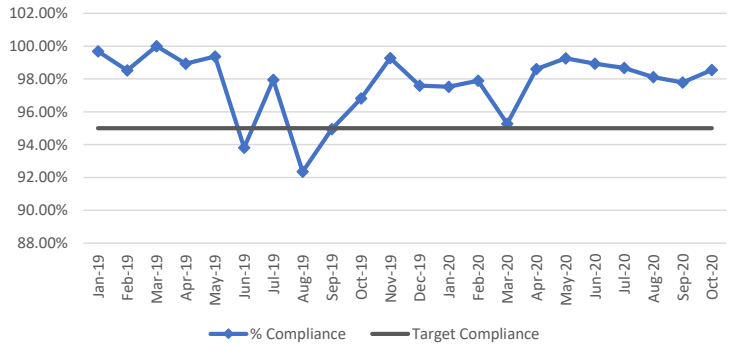
In October 2 services have patients waiting over 18 weeks at the end of October: Paediatric Speech and Language Therapy and Wheelchairs. The maximum wait for each of these services are 41 weeks (increased from 37) and 31 weeks (increased from 23) respectively. Paediatric Speech and Language Therapy and 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

Services covered: Adult SLT, Heart Failure, Neurology Service, Parkinson's Nursing, Wheelchairs, Paediatric Ocupational Therapy, Paediatric Physio and Paediatric Speech and Language Therapy, There are no patients waiting over 52weeks for treatment from referral, so community look at number of patients waiting over 14 weeks. Historically, 14 weeks was agreed on as an internal measure because it gives an approx. number of patients who would breach the 18 week target at the end of the next month.

Board Report KPIs

Narratives

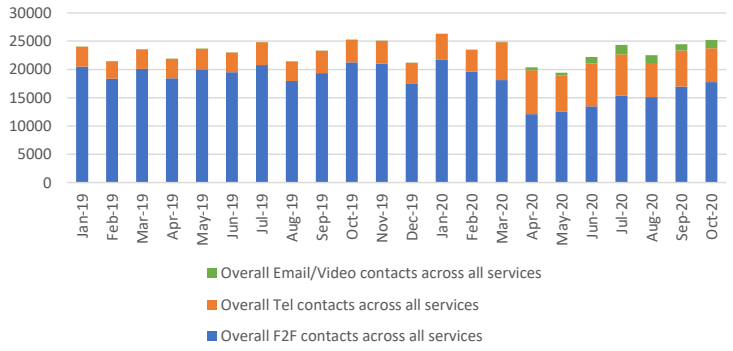
Community Non Consultant Led 18week Compliance



The aggregated % of patients treated within 18 weeks for all community services in October was 98.55%

Services covered: Adult SLT, Heart Failure, Neurology Service, Parkinson's Nursing, Wheelchairs, Pead OT, Pead Physio and Pead SLT. RTT nationally is for consultant led services but the community services are required to report on compliance to 18 week Referral to Treatment locally to our CCG. Target is 95% of referrals are given a first definitive treatment within 18weeks

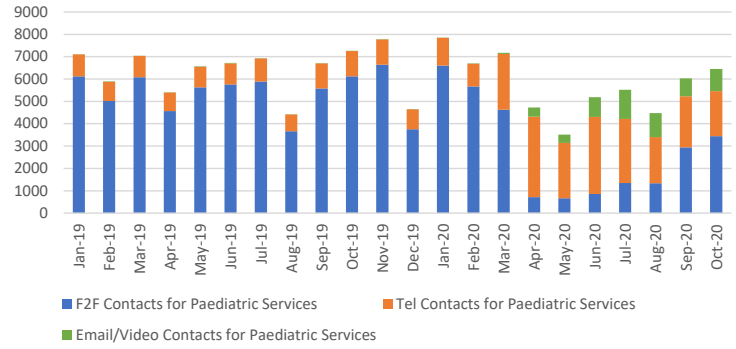
Contacts for ALL Community Services (Adults and Paediatrics)



The total activity for community services has returned to pre-COVID levels although the ratio of face to face and other means of contact (telephone, video and email) has altered. The Integrated Neighbourhood Teams activity is still based in face to face but some other services have moved to telephone contacts successfully.

Activity is counted as a face to face/telephone/email/video contact with a patient/carer/parent which is clinically relevant. This means activity that a clinician carries out which is writing reports, liaising with other healthcare professionals is NOT counted as activity. This is in line with acute systems where there is an assumption that clinicians will carry out related activities that result from contact with a patient.

Contacts for Community Paediatric Services

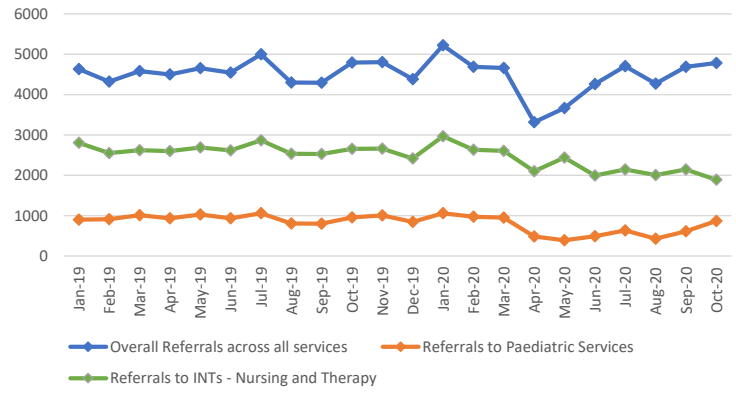


The Paediatric services have moved a high proportion of their activity to telephone and email/video contacts but they are still unable to carry out any group work due to social distancing requirements. There are also shortages in clinic availability in certain locations. The wearing of masks and social distancing means Speech and Language therapy is particularly hard to do. The services are reviewing all possible options.

Activity is counted as a face to face/telephone/email/video contact with a patient/carer/parent which is clinically relevant. This means activity that a clinician carries out which is writing reports, liaising with other healthcare professionals is NOT counted as activity. This is in line with acute systems where there is an assumption that clinicians will carry out related activities that result from contact with a patient.

Board Report KPIs	Narratives

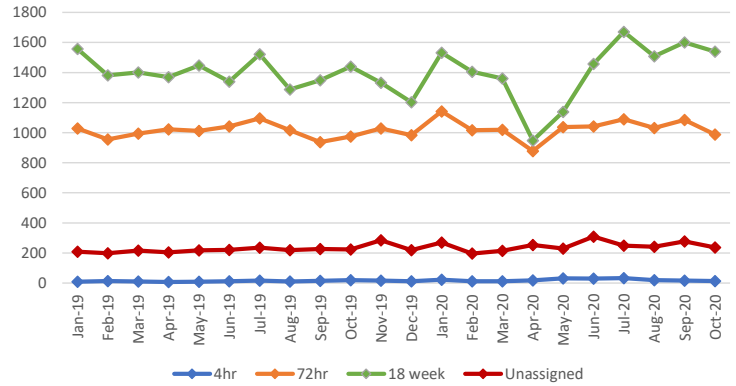
Community Referrals



Referrals to the majority of the community services have returned to pre-COVID numbers.

There should be one reason per referral, i.e. if a patient is referred in to the INTs for 2 requirements either simultaneously or over time, eg leg ulcer dressing and phlebotomy, then there are 2 referrals.

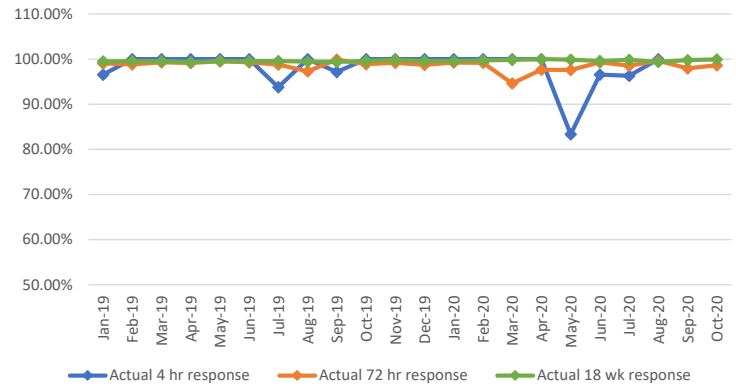
Community INT Referrals by Urgency



Referrals to the Integrated Neighbourhood Team services have returned to pre-COVID numbers, in particular the Green referrals have just moved above pre-Covid numbers though whether this will be long term is still to be seen

Referrals into the Integrated Neighbourhood Teams have urgencies of Red (within 4 hours), Amber within 72hrs) and Green (within 18 weeks). These contractual urgencies are locally agreed pan Suffolk with the CCG and there is a 98% response target for Red, Amber and Green response times have a 95% threshold (These are local contractual targets)

Community INT Compliance by Urgency



All response thresholds were met in October

Referrals into the Integrated Neighbourhood Teams have urgencies of Red (within 4 hours), Amber within 72hrs) and Green (within 18 weeks). These contractual urgencies are locally agreed pan Suffolk with the CCG and there is a 98% response target for Red, Amber and Green response times have a 95% threshold (These are local contractual targets)

Board Report KPIs

Perfect Ward

	Category	Score this month	Score last 12
1	COVID-19 Pathways	97% (36)	97% (36)
2	Hand Hygiene	100% (58)	98% (297)
3	PPE	100% (75)	99% (404)
4	Signage	100% (18)	97% (66)
5	Staff Awareness	99% (63)	99% (395)

Perfect Ward Assessment Audits

Narratives

• Observation and Documentation Audit is officially weekly and information team is kindly average a monthly data for this each month – available in the Quality Report used by Nursing Directorate

• Maternity & Gynae, Theatres, Community, Adult wards have all reviewed and changed their questions. Children & NNU to occur

• IPC audits still done by matrons quarterly basis

• Medicine Management questions have been agreed and Pharmacy trailing further into November

11. Finance and workforce report

To ACCEPT the report

For Report

Presented by Craig Black

Board of Directors –4 December 2020

Agenda item:	11			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	30th November 2020			
Subject:	Finance and Workforce Board Report – October 2020			
Purpose:		For information	x	For approval

Executive summary:
The reported I&E for October is an adverse variance of £262k. However, we expect funding to match any COVID related pressures and therefore forecast that we will break even at the year end. This will include receiving all FRF and MRET funding associated with meeting the Financial Improvement Trajectory (FIT).

Discussions over COVID related funding are ongoing and whilst there is uncertainty over COVID related expenditure and associated income our income and expenditure plan remains unchanged.

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

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

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

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

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

Recommendation:
The Board is asked to review this report.

FINANCE AND WORKFORCE REPORT
October 2020 (Month 7)

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

Financial Summary

I&E Position YTD	£0.3m	deficit
Variance against Plan YTD	£0.3m	adverse
Movement in month against plan	£0.3m	adverse
EBITDA position YTD	£27.6m	adverse
EBITDA margin YTD	19%	adverse
Total PSF Received	£27.4m	accrued
Cash at bank	£24.6m	

Executive Summary

- The forecast position for the year is to break even.
- We anticipate receiving funding associated with any further COVID related costs.
- This position will include receiving all FRF and MRET funding associated with meeting the Financial Improvement Trajectory (FIT)
- Our focus is on our underlying income and expenditure position in readiness for 2021-22

Key Risks in 2020-21

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

SUMMARY INCOME AND EXPENDITURE ACCOUNT - October 2020	October 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	17.9	17.9	0.0	130.9	125.9	(5.0)	218.5	216.0	(2.5)
Other Income	3.2	3.3	0.0	21.1	19.5	(1.5)	36.3	35.7	(0.6)
Total Income	**21.1**	**21.1**	**0.0**	**152.0**	**145.4**	**(6.5)**	**254.8**	**251.7**	**(3.1)**
Pay Costs	15.7	16.3	(0.6)	111.5	115.8	(4.3)	191.2	195.4	(4.2)
Non-pay Costs	8.0	8.2	(0.2)	57.9	50.1	7.7	94.3	90.7	3.6
Operating Expenditure	**23.7**	**24.5**	**(0.7)**	**169.3**	**165.9**	**3.4**	**285.5**	**286.1**	**(0.6)**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA excl STF	**(2.7)**	**(3.4)**	**(0.7)**	**(17.4)**	**(20.5)**	**(3.1)**	**(30.7)**	**(34.4)**	**(3.7)**
Depreciation	0.7	0.4	0.2	4.7	4.1	0.6	8.1	8.1	0.0
Finance costs	0.3	1.2	(0.9)	2.3	3.1	(0.8)	3.9	5.3	(1.4)
SURPLUS/(DEFICIT)	**(3.7)**	**(5.0)**	**(1.4)**	**(24.4)**	**(27.6)**	**(3.3)**	**(42.7)**	**(47.7)**	**(5.1)**
Provider Sustainability Funding (PSF)									
PSF / FRF/ MRET/ Top Up	3.7	4.8	1.1	24.4	27.4	3.0	42.7	47.8	5.1
SURPLUS/(DEFICIT) incl PSF	**0.0**	**(0.3)**	**(0.3)**	**0.0**	**(0.3)**	**(0.3)**	**(0.0)**	**0.0**	**(0.0)**

FINANCE AND WORKFORCE REPORT – October 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 – October 2020

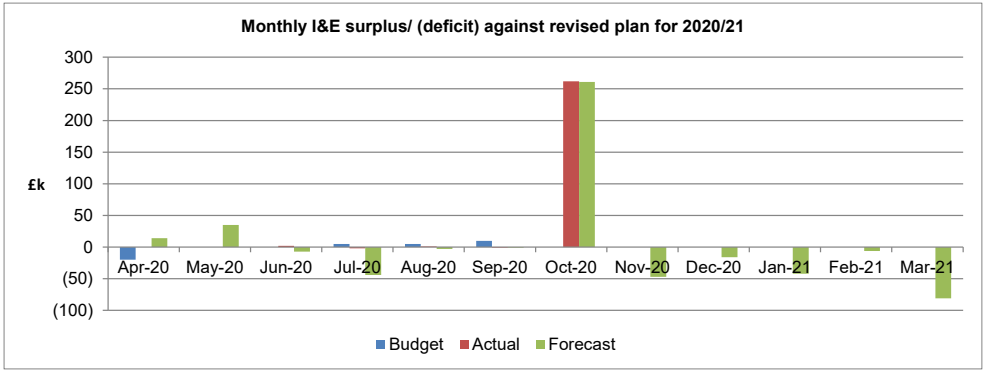
Income and Expenditure Summary as at October 2020

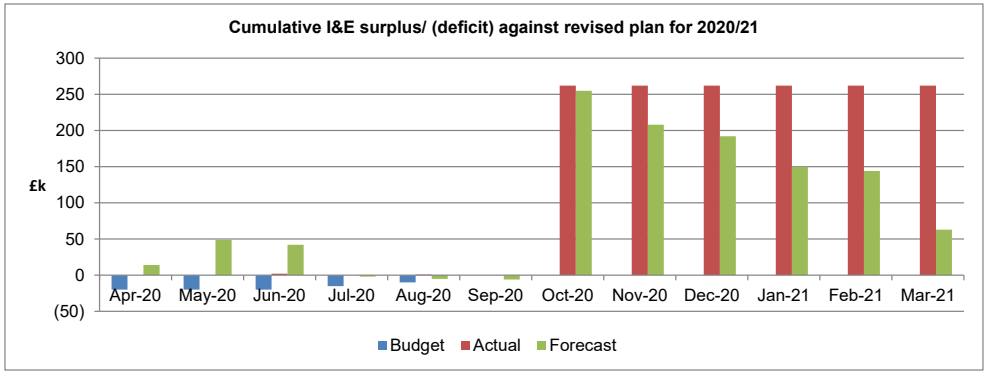
The reported I&E for October is an adverse variance of £262k. Due to COVID-19 we are receiving top up payments that includes MRET and FRF. This ensures we break even YTD. The 'top up' element is £22.6m YTD.

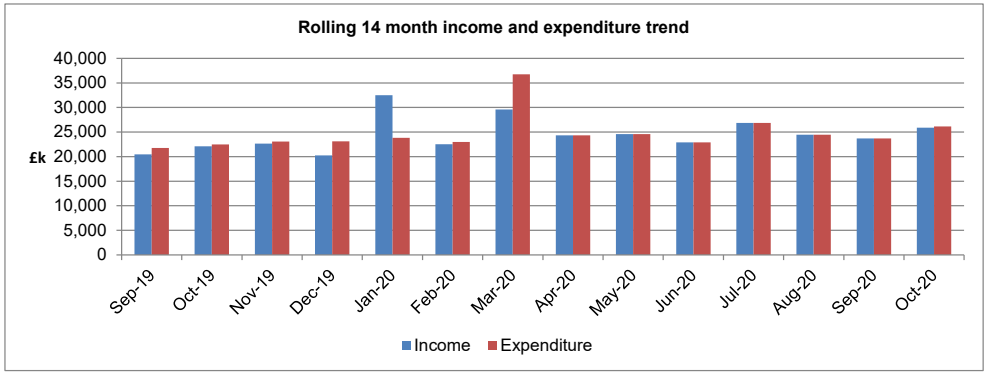
During September we submitted a revised activity plan. However, discussions over COVID related funding are ongoing and whilst there is uncertainty over COVID related expenditure and associated income our income and expenditure plan remains unchanged. We therefore forecast to break even at year end.

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	(262)	(262)	⇔	Green
YTD surplus/ (deficit)	0	(262)	(262)	⇔	Green
Forecast surplus/ (deficit)	(0)	0	0	⇔	Green
EBITDA (excl top-up) YTD	(3,655)	(5,017)	(1,362)	↑	Red
EBITDA %	(17.3%)	(23.8%)	(6.4%)	↑	Red
Clinical Income YTD	(137,847)	(132,280)	(5,568)	↑	Green
Non-Clinical Income YTD	(38,477)	(40,526)	2,049	↑	Green
Pay YTD	111,471	115,789	(4,318)	↑	Red
Non-Pay YTD	64,851	57,278	7,573	↓	Green
CIP Target YTD	5,115	2,637	(2,478)	↑	Red





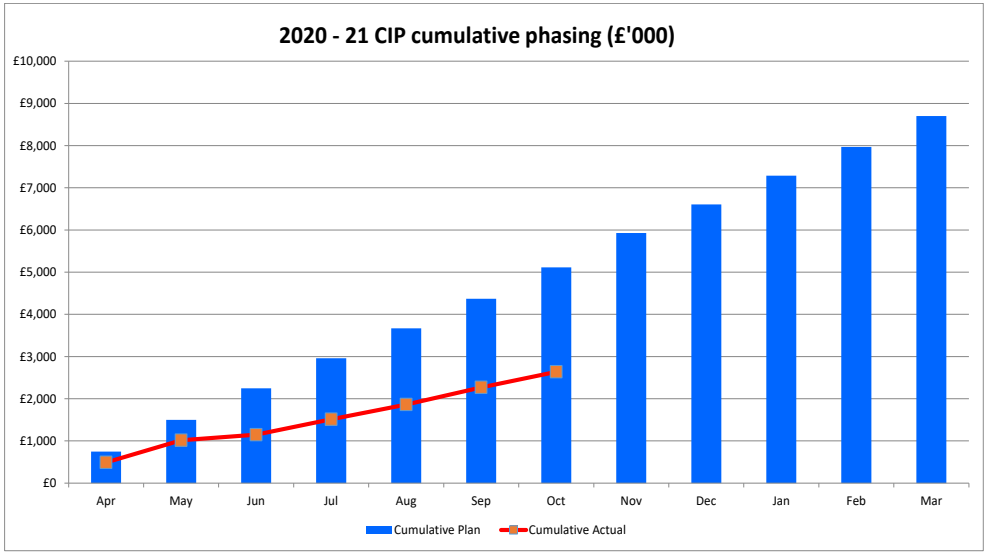


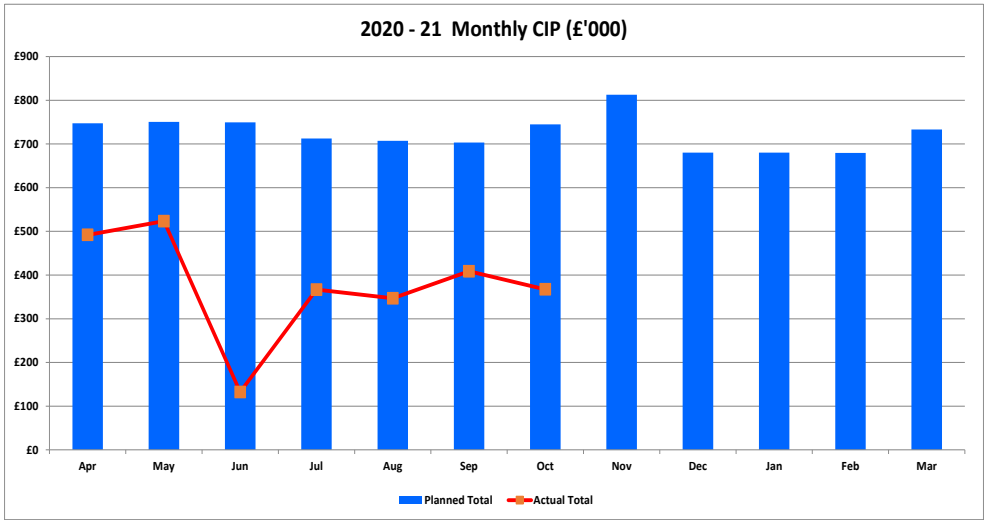
Cost Improvement Programme (CIP) 2020-21

In order to deliver the Trust's control target in 2020-21 we need to deliver a CIP of £8.7m (3.4%). The plan for the year to October is £5.1m (58.8% of the annual plan) and we achieved £2.6m (30.3%). This represents a shortfall of £2,478k.

Recurring/Non Recurring	2020-21 Annual Plan	Plan YTD	Actual YTD
	£'000	£'000	£'000
Recurring			
Outpatients	254	111	32
Procurement	492	287	296
Activity growth	200	117	117
Additional sessions	363	212	-
Community Equipment Service	510	298	218
Drugs	367	214	208
Estates and Facilities	172	117	65
Other	1,069	619	588
Other Income	493	287	42
Pay controls	327	168	114
Service Review	16	16	16
Staffing Review	819	469	412
Theatre Efficiency	302	176	-
Contract Review	50	29	-
Workforce	-	-	-
Consultant staffing	-	-	-
Agency	-	-	-
Unidentified CIP	991	563	-
Recurring Total	**6,424**	**3,682**	**2,108**
Non-Recurring			
Pay controls	580	392	436
Other	1,690	1,035	88
Estates and Facilities	6	6	6
Non-Recurring Total	**2,276**	**1,432**	**529**
Total CIP	**8,700**	**5,115**	**2,637**

Division	Divisional Target £'000	YTD Var £'000	Unidentified plan £ YTD	Unidentified plan £ year
Medicine	2,555	(1,353)	149	255
Surgery	2,029	(444)	118	203
W&C/CSS	1,847	(95)	0	0
Community	1,422	(235)	73	125
E&F	516	(226)	112	218
Corporates	331	(125)	111	191
Stretch	0	0	0	0
Total	**8,700**	**(2,478)**	**563**	**991**

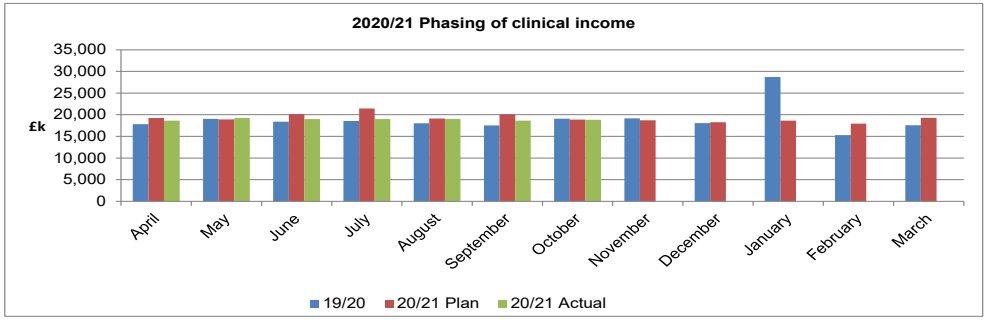




FINANCE AND WORKFORCE REPORT – October 2020

Income Analysis

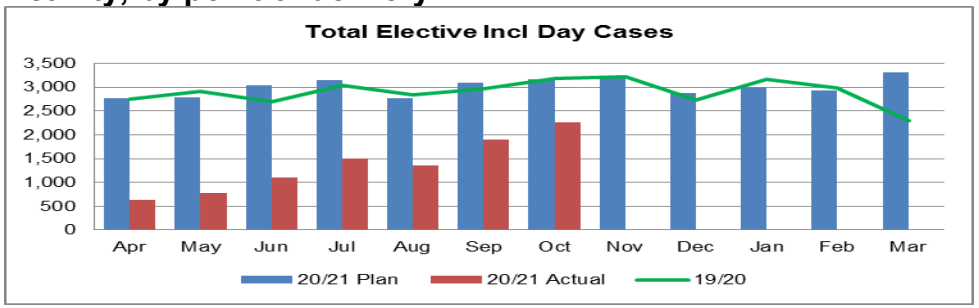
The chart below demonstrates the phasing of all clinical income plan for 2020-21, including Community Services. This phasing is in line with phasing of activity.

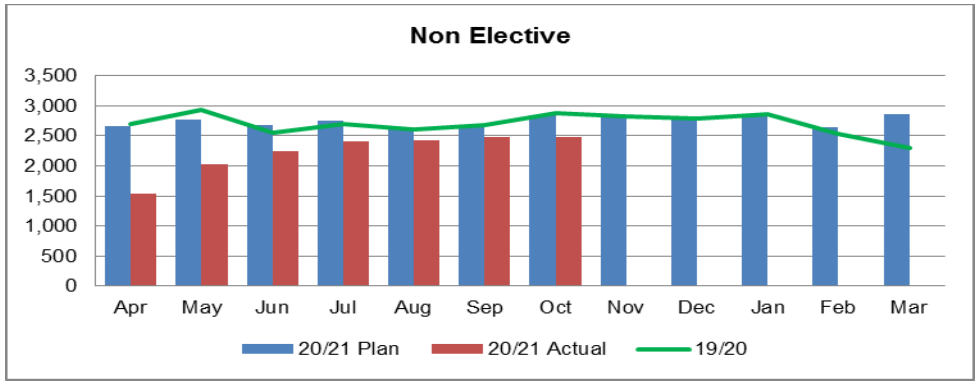


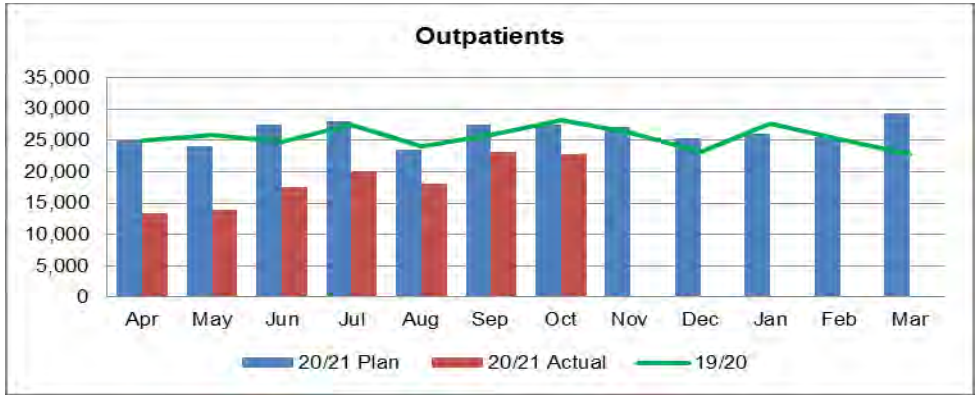
The income position was as per plan for October. The income was based on the national agreed block payments as set out by NHS England, these were put in place to give Providers assured income during the coronavirus period.

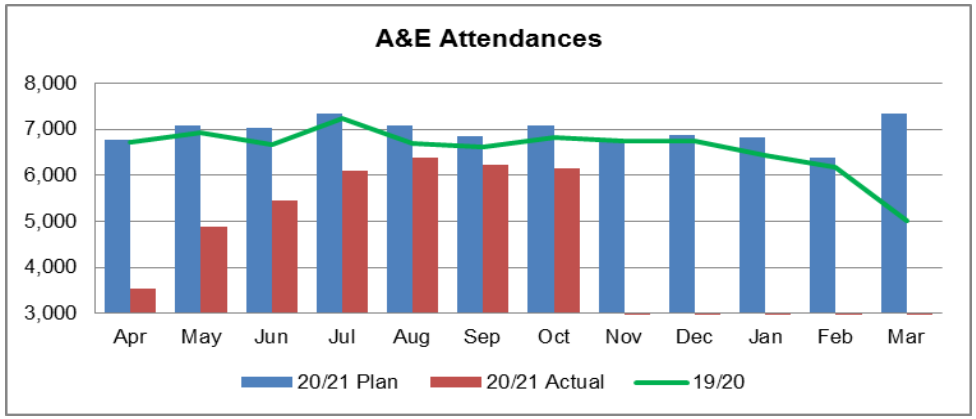
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	1,037	941	(96)	7,211	5,969	(1,242)
Other Services	1,727	2,867	1,140	21,512	39,148	17,636
CQUIN	187	171	(16)	1,260	974	(286)
Elective	3,036	2,555	(480)	20,056	8,350	(11,706)
Non Elective	6,649	6,862	212	45,325	44,921	(404)
Emergency Threshold Adjustment	(346)	(346)	0	(2,379)	(2,379)	0
Outpatients	3,342	2,582	(759)	22,244	13,258	(8,986)
Community	2,988	2,988	0	20,916	20,916	0
Total	**18,620**	**18,620**	**0**	**136,143**	**131,156**	**(4,987)**

Activity, by point of delivery



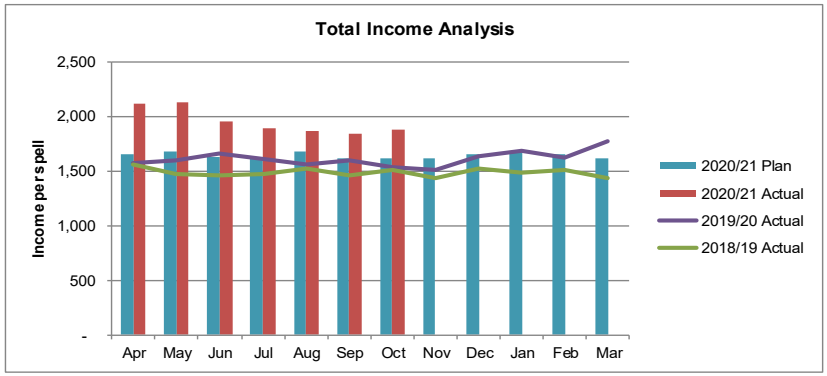


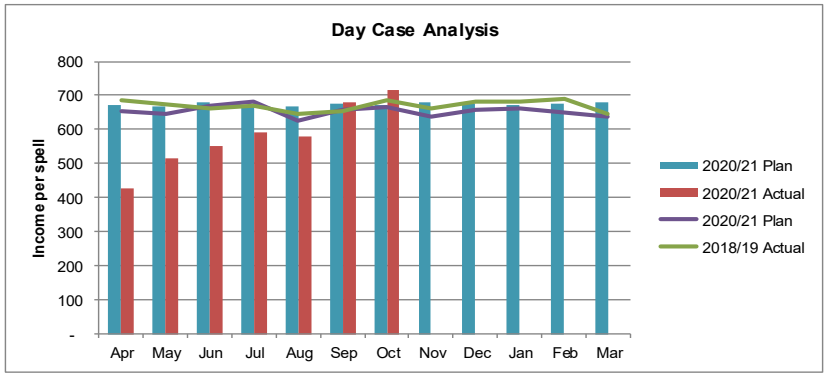


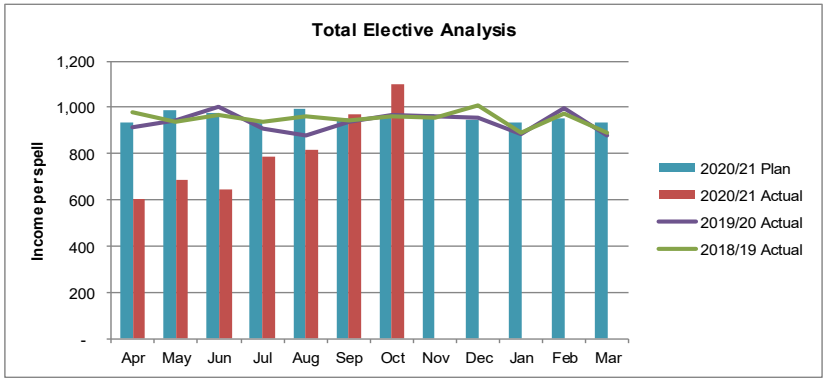


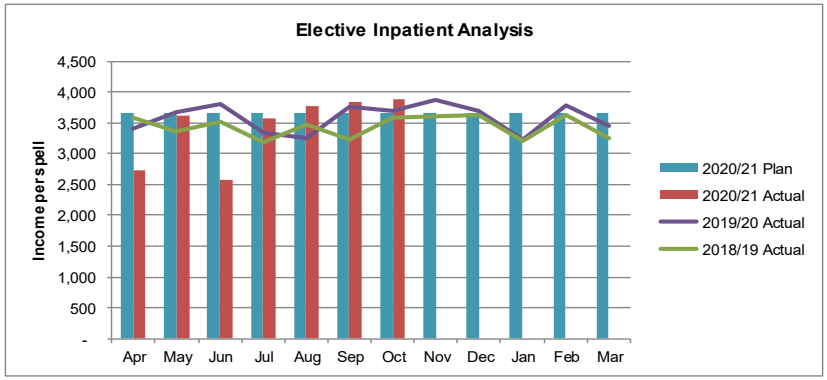
FINANCE AND WORKFORCE REPORT – October 2020

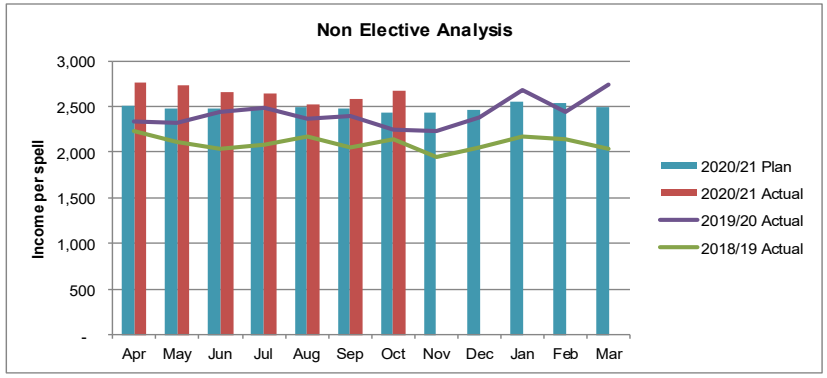
Trends and Analysis

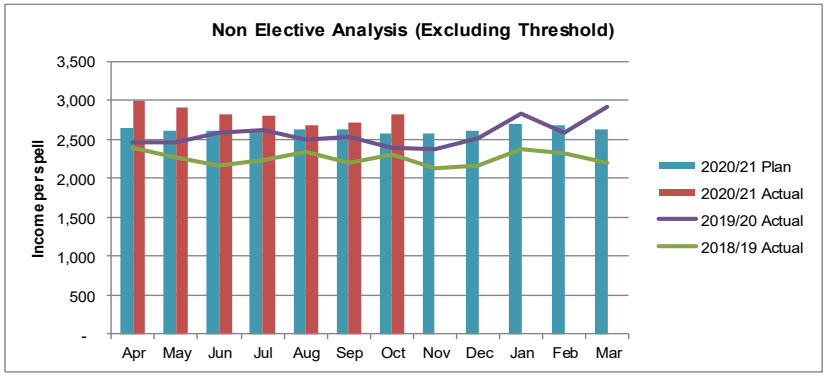










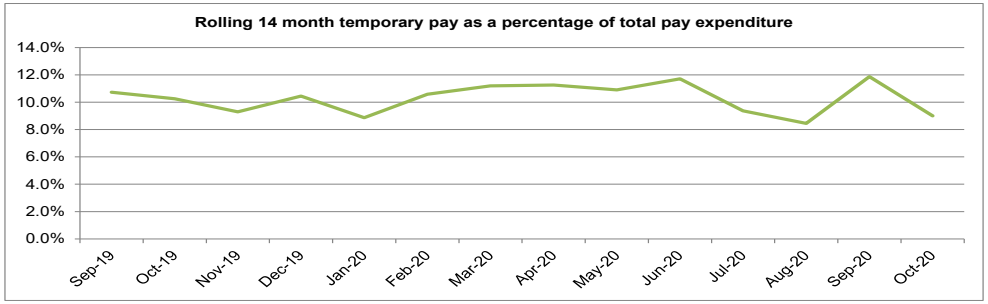


FINANCE AND WORKFORCE REPORT – October 2020

Workforce

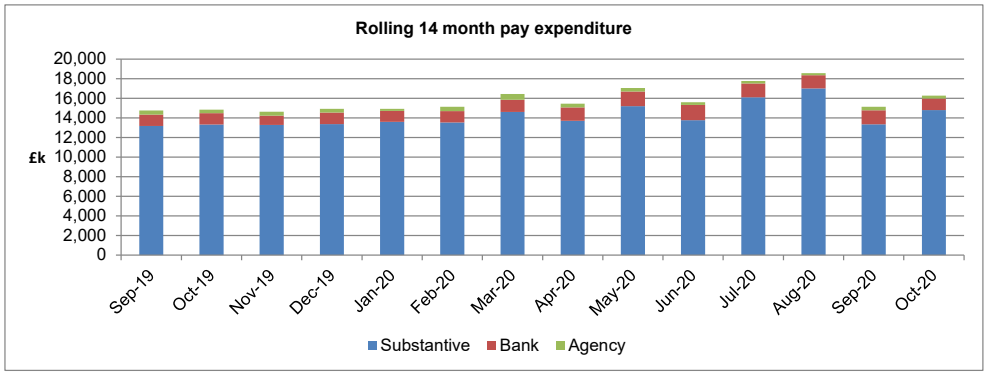
Monthly Expenditure (£)				
As at October 2020	Oct-20	Sep-20	Oct-19	YTD
	£000's	£000's	£000's	£000's
Budgeted Costs in-month	15,705	15,657	14,204	111,471
Substantive Staff	14,795	13,333	13,310	103,877
Medical Agency Staff	149	200	173	1,255
Medical Locum Staff	213	369	295	2,142
Additional Medical Sessions	201	236	279	1,973
Nursing Agency Staff	41	69	129	477
Nursing Bank Staff	407	418	331	2,911
Other Agency Staff	90	81	60	358
Other Bank Staff	195	237	135	1,443
Overtime	84	82	66	782
On Call	83	102	53	571
Total Temporary Expenditure	1,463	1,794	1,521	11,912
Total Expenditure on Pay	16,258	15,128	14,830	115,789
Variance (F/(A))	(553)	530	(626)	(4,318)
Temp. Staff Costs as % of Total Pay	9.0%	11.9%	10.3%	10.3%
memo: Total Agency Spend in-month	280	350	362	2,089

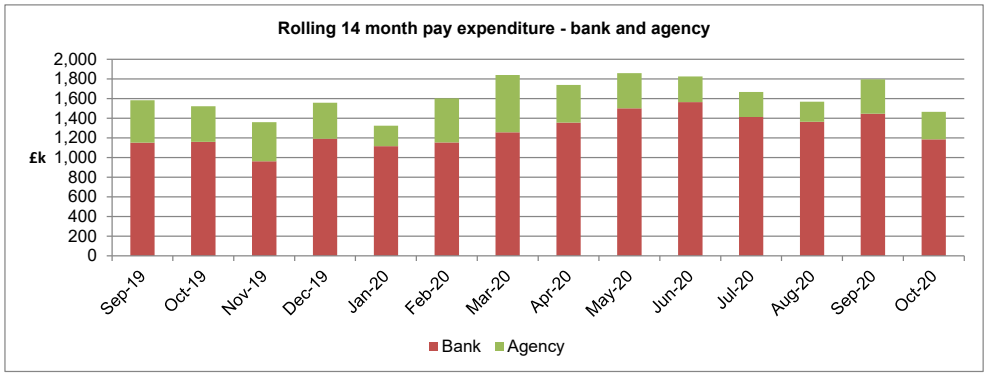
Monthly WTE				
As at October 2020	Oct-20	Sep-20	Oct-19	YTD
	£000's	£000's	£000's	£000's
Budgeted WTE in-month	4,072.0	4,071.2	3,887.8	29,609.3
Substantive Staff	3,760.3	3,745.4	3,583.5	26,354.3
Medical Agency Staff	11.6	13.3	10.6	115.3
Medical Locum Staff	22.4	28.0	24.8	189.8
Additional Medical Sessions	3.6	6.3	12.0	35.1
Nursing Agency Staff	6.4	16.8	21.7	97.7
Nursing Bank Staff	121.5	123.5	99.5	875.7
Other Agency Staff	11.5	10.1	11.7	67.8
Other Bank Staff	81.4	98.1	56.9	576.1
Overtime	20.4	23.1	7.3	211.0
On Call	4.9	6.8	6.4	45.8
Total Temporary WTE	283.7	326.0	250.8	2,214.3
Total WTE	4,044.1	4,071.4	3,834.3	28,568.6
Variance (F/(A))	28.0	(0.1)	53.6	1,040.7
Temp. Staff WTE as % of Total WTE	7.0%	8.0%	6.5%	7.8%
memo: Total Agency WTE in-month	29.6	40.2	44.0	280.8

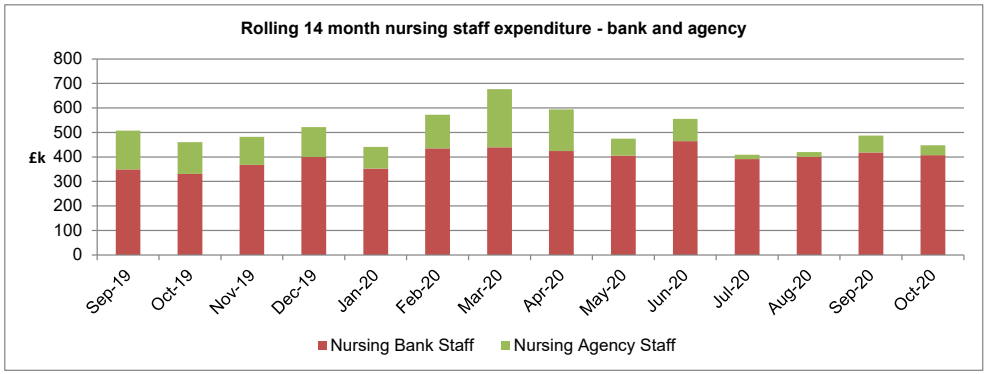


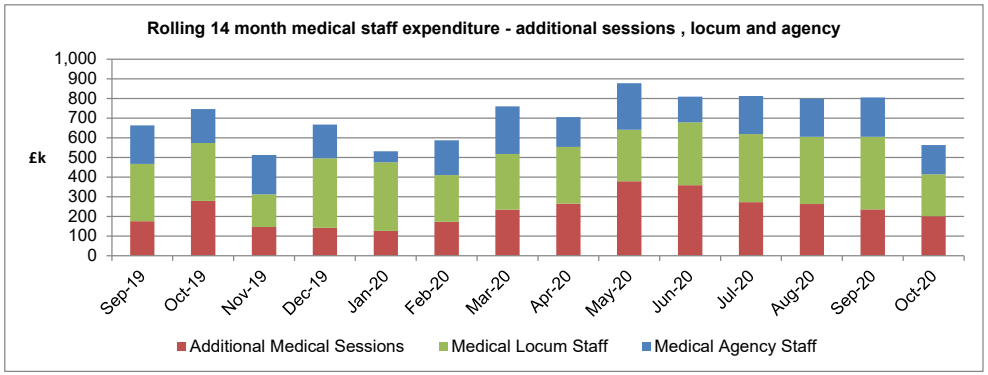
Pay Trends and Analysis

During October the Trust overspent by £553k on pay (£4.3m overspent YTD). This includes all COVID related pay costs.

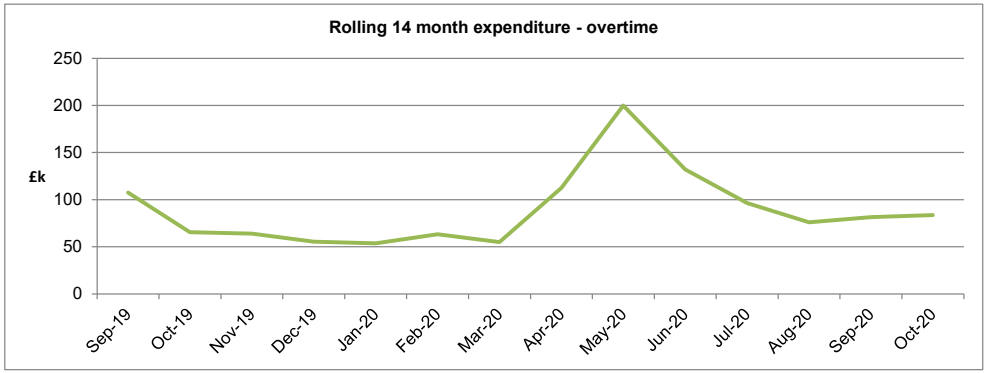








Expenditure on Additional Sessions was £201k in October (£236k in September)



FINANCE AND WORKFORCE REPORT – October 2020

Income and Expenditure Summary by Division

	Current Month			Year to date		
	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)
MEDICINE	£k	£k	£k	£k	£k	£k
Total Income	(7,846)	(7,502)	(344)	(52,094)	(42,548)	(9,547)
Pay Costs	4,262	4,705	(443)	29,696	33,686	(3,990)
Non-pay Costs	1,632	1,542	89	10,845	11,039	(194)
Operating Expenditure	**5,894**	**6,247**	**(353)**	**40,541**	**44,725**	**(4,184)**
SURPLUS / (DEFICIT)	**1,952**	**1,255**	**(697)**	**11,553**	**(2,177)**	**(13,731)**
SURGERY						
Total Income	(5,644)	(5,334)	(311)	(38,003)	(22,812)	(15,191)
Pay Costs	3,391	3,501	(110)	23,716	25,620	(1,904)
Non-pay Costs	1,188	1,128	60	7,885	6,029	1,856
Operating Expenditure	**4,579**	**4,629**	**(50)**	**31,602**	**31,649**	**(48)**
SURPLUS / (DEFICIT)	**1,065**	**704**	**(361)**	**6,401**	**(8,837)**	**(15,238)**
WOMENS AND CHILDRENS						
Total Income	(2,036)	(2,264)	228	(13,755)	(11,632)	(2,123)
Pay Costs	1,419	1,413	6	9,961	10,066	(104)
Non-pay Costs	168	205	(37)	1,196	1,242	(46)
Operating Expenditure	**1,586**	**1,618**	**(31)**	**11,157**	**11,308**	**(151)**
SURPLUS / (DEFICIT)	**450**	**646**	**197**	**2,598**	**324**	**(2,273)**
CLINICAL SUPPORT						
Total Income	(871)	(710)	(161)	(5,938)	(4,394)	(1,545)
Pay Costs	1,680	1,609	72	11,491	11,139	352
Non-pay Costs	1,092	1,598	(506)	7,711	8,238	(527)
Operating Expenditure	**2,772**	**3,207**	**(435)**	**19,202**	**19,377**	**(176)**
SURPLUS / (DEFICIT)	**(1,901)**	**(2,497)**	**(596)**	**(13,263)**	**(14,984)**	**(1,720)**
COMMUNITY SERVICES						
Total Income	(3,513)	(3,587)	74	(24,590)	(24,640)	50
Pay Costs	2,546	2,613	(67)	17,734	18,156	(423)
Non-pay Costs	1,033	1,336	(303)	6,814	8,798	(1,984)
Operating Expenditure	**3,579**	**3,949**	**(370)**	**24,548**	**26,954**	**(2,406)**
SURPLUS / (DEFICIT)	**(66)**	**(363)**	**(296)**	**43**	**(2,314)**	**(2,357)**
ESTATES AND FACILITIES						
Total Income	(463)	(221)	(242)	(3,037)	(1,359)	(1,679)
Pay Costs	902	913	(11)	6,308	6,587	(279)
Non-pay Costs	655	650	5	4,381	4,524	(143)
Operating Expenditure	**1,557**	**1,563**	**(6)**	**10,689**	**11,110**	**(422)**
SURPLUS / (DEFICIT)	**(1,094)**	**(1,342)**	**(248)**	**(7,652)**	**(9,752)**	**(2,100)**
CORPORATE						
Total Income	(4,350)	(6,253)	1,903	(38,843)	(65,322)	26,479
Pay Costs	1,505	1,504	1	12,566	10,535	2,031
Non-pay Costs	2,258	1,760	499	19,009	10,245	8,764
Capital Charges and Financing Costs	993	1,655	(663)	6,949	7,063	(114)
Operating Expenditure	**4,756**	**3,264**	**1,492**	**38,523**	**20,780**	**17,743**
SURPLUS / (DEFICIT)	**(406)**	**2,990**	**3,395**	**320**	**44,542**	**44,222**
TOTAL						
Total Income	(24,724)	(25,871)	1,147	(176,261)	(172,706)	(3,555)
Pay Costs	15,705	16,258	(553)	111,471	115,789	(4,318)
Non-pay Costs	8,026	8,219	(193)	57,841	50,115	7,726
Capital Charges and Financing Costs	993	1,655	(663)	6,949	7,063	(114)
Operating Expenditure	**24,724**	**26,132**	**(1,409)**	**176,261**	**172,967**	**3,294**
SURPLUS / (DEFICIT)	**0**	**(262)**	**(262)**	**0**	**(261)**	**(261)**

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Medicine (Sarah Watson)

The division is behind plan in month by £697k and £13.7m YTD.

Clinical income is behind plan in month by £329k and £9.4m YTD. This continues to be driven by the reduced activity (against plan) across the Trust as a result of COVID 19 and is witnessed in medicine across all types of activity (elective, non-elective & outpatient).

We had previously seen the gap between anticipated and actual activity decreasing steadily since April as more services return to normal operating levels. Indeed, this continues in Elective activity which is now only 29% behind plan (September 34%). However, in October, we saw non-elective activity drop, and the gap increase to 8% behind plan (September 3%). It is anticipated that this gap will remain in November due to the impact of the 2nd national lockdown. Outpatient activity has remained 10% behind plan throughout the last two months. It is noted that this loss of divisional income is offset within the Corporate division due to the guarantees over the block contract.

With the effect of Clinical Income removed, Medicine division is recording a negative variance against budget of £368k in month and £4.4m YTD. This variance continues to be driven by the additional costs of COVID (£250k) and unmet CIP schemes (£187k).

To date, the division has recorded £7.6m of expenditure towards COVID YTD, £3.1m is a result of additional costs being incurred due to COVID, £3.2m is using existing resources (e.g. medical wards) solely towards COVID. The remaining £1.3m is recognising the CIP schemes that are unable to be met due to COVID.

Surgery (Simon Taylor)

The division is behind plan in month by £361k in month and £15.2m year to date.

COVID has had a major effect on Surgery's activity due to having to stop a significant proportion of elective work which is still causing issues for the division. Surgery is working hard to maximise patient numbers within social distancing requirements and increased complexity of patients. This has been further complicated through some patient's unwillingness to attend appointments in the hospital or to isolate for surgery. However, in month there has been a significant improvement in elective inpatients with both Orthopaedics and General Surgery over achieving against in month plan and most other specialities seeing an improvement.

Surgery is £311k underachieved against plan for income in month (£15.2m YTD).

Pay was overspent by £110k in month and (£1,904k YTD) due to COVID related pay costs.

Non-pay has underspent by £60k in month (£1,856k YTD) due to less activity.

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

Women and Children's (Michelle O'Donnell)
In October, the Division reported a favourable variance of £197k and an adverse variance of £2,273k YTD.

COVID continues to depress activity with low levels of elective activity in Gynaecology and low levels of non-elective activity in Paediatrics. Also, in-month neonatal and maternity activity was lower. Consequently, income is ahead of plan by £228k in-month and behind plan by £2,123k YTD.

Pay reported a £6k underspend in-month and an overspend of £104k YTD. In-month, the maternity service continued to have vacancies which created an underspend. Year to date, the overspend has been caused by additional COVID nursing support in F1 and the COVID related double running of antenatal clinics. The Division has a favourable underlying pay spend without the COVID costs.

Non-pay reported a £37k overspend in-month (£46k YTD). Non-pay costs increased on a one off basis as the service purchased new equipment.

Clinical Support (Michelle O'Donnell)
In October, the Division reported an adverse variance of £596k (£1,720k YTD).

Income for Clinical Support reported £161k behind plan in-month (£1,545k YTD). In-month, activity from outpatient, direct access and breast screening dipped as the second wave of COVID took effect. Overall activity has increased from the start of the year as the department has overcome many of the COVID related capacity constraints.

Pay reported a £72k underspend in-month (£352k YTD). It has been difficult to fill vacancies in Radiology, Outpatients and Pharmacy, resulting in a consistent underspend.

Non-pay reported a £506k overspend in-month (£527k YTD).

Community Services (Michelle Glass)
The division reports an adverse variance of £296k in month (£2,357k YTD).

Income reported a £70k over recovery in month (£50k YTD). The division currently expect to achieve income in line with budget in 20-21. Where income is linked to a cost and volume contract, the division will continue to track and forecast the impact of COVID on the activity levels.

There was an in-month over spend on pay of £67k (£423k YTD). £463k YTD has been incurred to support the division's response to COVID and the division has a favourable underlying pay spend without COVID costs. The division is utilising agency staff to cover some vacant roles in Integrated Therapy services and to provide a peripatetic team of nurses operating across the Community Health Teams. This will continue to be required through winter to ensure service resilience and increased capacity to meet increasing demand for services.

Non-pay reported an adverse variance of £303k in October (£1,984k YTD). £989k YTD has been incurred to support the division's response to COVID. The in-month and year to date position primarily reflects delays in the delivery of some CIP schemes due to the impact of COVID and an overspend on Community Equipment. Additional community equipment costs were incurred to provide the equipment needed to enable timely hospital discharges, including an increase in same day and out of hours and to support a doubling of discharges through Pathway 1 this year. Additional community equipment costs were also incurred to support end of life patients to remain at home in line with the revised end of life patient strategy and to provide community equipment for additional external bed capacity procured. One-off costs were incurred to further support home and mobile working across our teams and community property costs.

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

FINANCE AND WORKFORCE REPORT – October 2020

Statement of Financial Position at 31 October 2020

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2020	Plan 31 March 2021	Plan YTD 31 October 2020	Actual at 31 October 2020	Variance YTD 31 October 2020
	£000	£000	£000	£000	£000
Intangible assets	40,972	48,986	43,581	42,951	(630)
Property, plant and equipment	110,593	142,614	121,519	121,176	(343)
Trade and other receivables	5,707	6,366	6,366	5,707	(659)
Total non-current assets	**157,272**	**197,966**	**171,466**	**169,834**	**(1,632)**
Inventories	2,872	3,000	3,000	3,086	86
Trade and other receivables	32,342	18,000	16,000	19,743	3,743
Cash and cash equivalents	2,441	2,005	20,005	24,625	4,620
Total current assets	**37,655**	**23,005**	**39,005**	**47,454**	**8,449**
Trade and other payables	(33,692)	(30,838)	(30,054)	(34,747)	(4,693)
Borrowing repayable within 1 year	(58,529)	(3,200)	(3,200)	(3,064)	136
Current Provisions	(67)	(70)	(70)	(57)	13
Other liabilities	(1,933)	(2,000)	(22,000)	(23,352)	(1,352)
Total current liabilities	**(94,221)**	**(36,108)**	**(55,324)**	**(61,220)**	**(5,896)**
Total assets less current liabilities	**100,706**	**184,863**	**155,147**	**156,068**	**921**
Borrowings	(52,538)	(51,358)	(52,772)	(53,146)	(374)
Provisions	(744)	(750)	(750)	(744)	6
Total non-current liabilities	**(53,282)**	**(52,108)**	**(53,522)**	**(53,890)**	**(368)**
Total assets employed	**47,424**	**132,755**	**101,625**	**102,178**	**553**
Financed by					
Public dividend capital	74,065	164,063	129,053	129,053	0
Revaluation reserve	6,942	6,900	6,900	6,942	42
Income and expenditure reserve	(33,583)	(38,208)	(34,328)	(33,817)	511
Total taxpayers' and others' equity	**47,424**	**132,755**	**101,625**	**102,178**	**553**

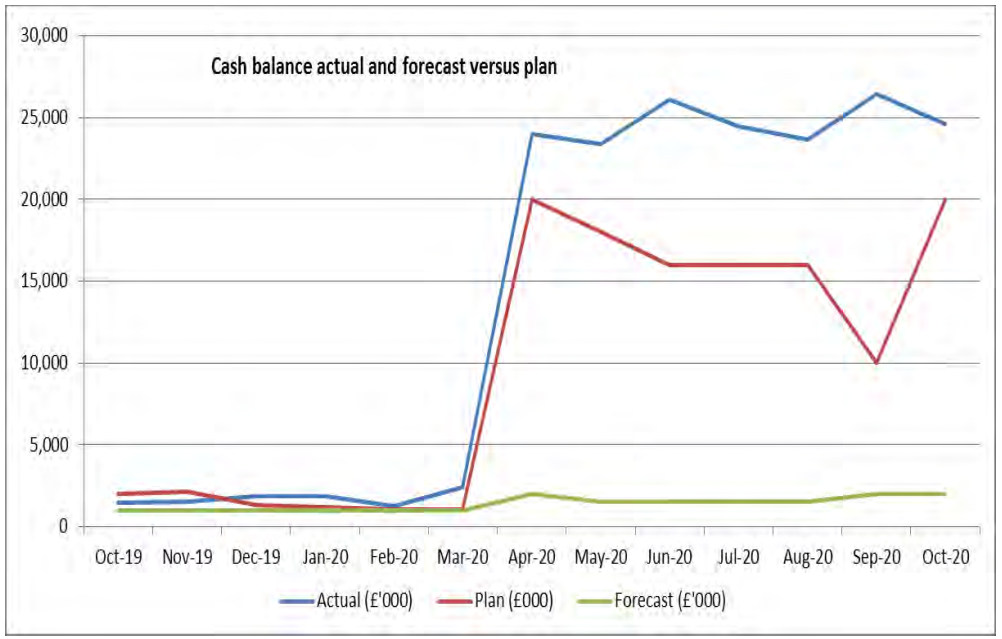
The Trust re-submitted its forecast plan for 2020/21 during month 7. As a result there has been a slight change in the plan for the Balance Sheet, although not significant. The cash plan for each month up to the year-end has been revised.

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

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

Cash Balance Forecast for the year

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



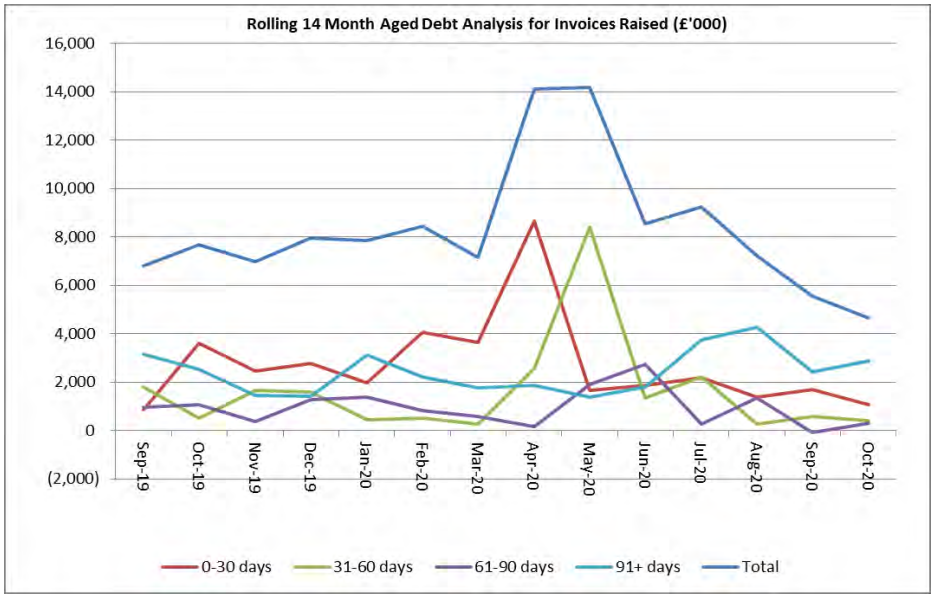
The cash balance has increased significantly and this is due to the current cash regime within the NHS. Contract payments have been paid in advance to ensure that there are adequate cash balances across the NHS and to ensure that payments to suppliers can be made quickly to keep the supply chain in full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

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

FINANCE AND WORKFORCE REPORT – October 2020

Debt Management

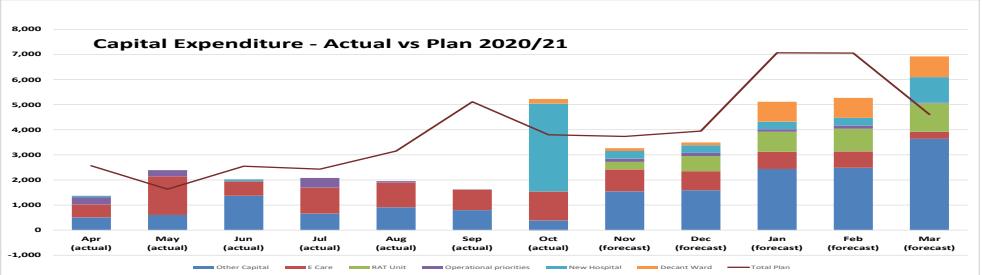
The graph below shows the level of invoiced debt based on age of debt.



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

The overall level of sales invoices raised but not paid is slowly decreasing each month. This is mainly due to the majority of NHS income being paid through block payments without the need for an invoice to be raised. The majority of the debts outstanding are historic debts. Over 72% of these outstanding debts relate to NHS Organisations, with 67% of these NHS debts being greater than 90 days old. We are actively trying to agree a position with the remaining corresponding NHS Organisations for these historic debtor balances.

Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Actual £'000	Aug Actual £'000	Sep Actual £'000	Oct Actual £'000	Nov Forecast £'000	Dec Forecast £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	Total 2020-21 £'000
E Care	520	1,541	568	1,037	988	813	1,156	876	759	681	653	284	9,876
RAT Unit	0	0	0	0	0	4	1	300	600	800	900	1,133	3,738
Operational priorities	289	243	24	382	52	11	-12	130	130	100	135	21	1,505
Decant ward	0	0	0	0	0	0	181	112	112	794	794	825	2,818
New Hospital	51	2	62	3	0	0	3,501	302	302	302	302	1,022	5,849
Other Schemes	507	605	1,369	658	911	797	385	1,545	1,590	2,438	2,485	3,636	16,926
Total / Forecast	1,367	2,391	2,023	2,080	1,951	1,625	5,212	3,265	3,493	5,115	5,269	6,921	40,712
Total Plan	2,562	1,632	2,546	2,430	3,151	5,113	3,799	3,734	3,945	7,063	7,053	4,608	47,636

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

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

The Forecast also reflects the recent Trust Board and Scrutiny Committee discussions and show increased expenditure on bringing Theatre 1 back into use and the Rapid Assessment Treatment Area (RAT). The funding for the RAT is primarily from PDC agreed under the Urgent and Emergency Care funding scheme (£2.7m) and the balance of £1.637m is to be funded from slippage within the Capital Programme.

10:20 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

12. People and organisational development (OD) highlight report

To APPROVE a report

For Approval

Presented by Jeremy Over

Board of Directors – Friday 4 December 2020

Agenda item:	12			
Presented by:	Jeremy Over, Executive Director of Workforce and Communications			
Prepared by:	Jeremy Over, Executive Director of Workforce and Communications			
Date prepared:	26 November 2020			
Subject:	People & OD Highlight Report			
Purpose:	✓	For information		For approval

Further to the positive feedback at the recent two Board meetings, we have now established a monthly report to strengthen the Board's focus on how we support our people, grow our culture and develop leadership at all levels. This format will continue to be developed to incorporate Board colleagues' feedback and to reflect more of the work that is ongoing, bringing together various reports that the Board has routinely received into one place.

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

This month the report provides updates on the following areas of work:

- The Restorative Just and Learning Culture priority in our WSFT People Plan
- Putting You First Awards
- International Nurse Recruitment
- Supporting our EU colleagues
- Staff health and wellbeing – including COVID risk assessment and flu vaccination
- Consultant appointments

Furthermore, during the course of the morning's Board meeting, Dr Ayush Sinha has agreed to join the Board at an appropriate break in his clinical work to introduce himself to the Board and talk about his priorities as Chair of the WSFT BAME Staff Network.

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

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
		✓					✓
Previously considered by:	N/A						
Risk and assurance:	Research demonstrates that staff that feel more supported will provide better, higher quality and safer care for our patients.						
Legislation, regulatory, equality, diversity and dignity implications	Certain themes within the scope of this report relate to legislation such as the Equality Act, and regulations such as freedom to speak up / protected disclosures.						
Recommendation:	For information and discussion. Feedback is sought from the Board as to the future content and frequency of this report.						

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

Last month the Board received and endorsed our West Suffolk People Plan, drawn directly from the 'bottom-up' feedback from staff through our 'What Matters to You' (WMTY) programme, the learning from supporting staff through our enhanced staff psychological wellbeing service, the national People Plan, and learning from Mersey Care's cultural transformation through adopting a 'just and learning culture'.

The plan identifies a set of priorities for the next six months, aligned with the five themes of feedback from the WMTY work. A detailed action plan to underpin the People Plan is in development, (which will be presented to the Board next month), and additional resource has been identified to help us drive forward several of the priorities. The plan has been shared with staff through Core Brief and other communication channels, and this work will continue during December to further promote the plan and its aims.

A particular focus since the previous Board meeting has been on the second of the five WMTY themes, which related to culture:

WMTY2: Create an empowered culture

- **Develop a just and learning culture** – during November a group of ten West Suffolk staff benefitted from the training package provided by Mersey Care and Northumbria University. The group included executive team members, representatives from HR and from patient safety, and staff representatives
- The training provided significant opportunity for the West Suffolk group to reflect on our current organisational practice – the positive elements and where we can make improvements
- It was recognised that cultural change can take a significant period of time, however there are positive foundations we are building on – including good levels of staff engagement and strong partnership working with staff representatives
- Fundamentally this work is focused on the response of an organisation when something goes wrong – for example, behaviour between colleagues, or where a mistake or incident happens. A restorative just and learning culture seeks to ensure that, every time, there is a compassionate and supportive approach, that focuses on identifying the learning from whatever it is that has happened
- Where this is not the case in organisations, perhaps where the focus in on apportioning blame, individuals can feel bruised as a result of being on the receiving end of organisational processes, and this is what we want to avoid
- The next steps involve the group of ten forming an action learning set to develop the plan around the work that is needed to take this forward, and further updates will be provided to the Board in due course
- In anticipation of the progression of this work at WSFT at the time of writing we have paused all active formal HR investigations (disciplinary, grievance and bullying & harassment) to check that all restorative options have been explored prior to proceeding further. This review has now been completed and the Board will be provided with an update on this at the next meeting.
- This priority was further supported by the learning from the *Civility Saves Lives* movement, which provided the focus of our 5 o'clock Club meeting in November. This helped us develop our appreciation of the impact on individuals when behaviour in the workplace is not respectful and civil. This includes the impact that

organisational processes have on individual members of staff and teams. It impacts on the quality and productivity of an individual's work, and compromises their ability to feel safe to speak up about concerns. That is why we are taking forward this work, to ensure every staff and team feel supported to be at their best.

Putting You First – November Awards

Sarah Ryan

Palliative care specialist nurse

Nominated by Sam Hobson, Macmillan Practice Development Nurse in Palliative Care

Recently, Sarah had a call from the emergency department just before she was due to go home at 5pm, asking for advice for a patient who was dying.

Sarah could have quite easily given advice to the ED staff over the phone about symptom control and medications but instead she went to the department to assist, despite knowing that this would mean leaving work late. She assisted and supported the staff and stayed with the patient and the patient's family, at the family's request, until the patient died.

As a palliative care nurse, it is not uncommon to be called to advise and support staff, patients and families in these situations and many staff members would probably have done the same – however, this is not always recognised. Sarah was due to leave on time that day as she had made specific plans. However, she put her plans on hold to sit with a dying patient and give support to their family, truly putting them first.

Victoria Farrant

Ward F14 nurse

Nominated by a patient, via Julie Ingham, F14 ward manager

A patient was compelled to write to us following a recent visit to F14. She came to us feeling scared and lonely, and needing to terminate a pregnancy. She said:

"Vicki instantly put me at ease. She was able to read my emotional cues, knowing exactly when I needed friendly humour or a distraction and when I needed comfort and reassurance.

"Vicki talked me through what to expect and reassured me that she would be on the end of the phone if I had any questions or worries – or just a friendly voice if needed. I left my appointment feeling much calmer, braver and more content."

Unfortunately things didn't go to plan and the worried patient called Vicki who advised her to come back to the ward:

"Vicki knew who I was immediately," she explained. *"She calmed me and promised that she would be at the hospital waiting for me and would take care of me."*

"She reassured me during every moment, answering so many questions without sounding tired and was sensitive and tactful, comforting me whilst I cried.

"Vicki's gentle humour and friendship was the main thing that stopped me from crumbling. I will carry this termination with me for the rest of my life, but I will also remember Vicki. She has given me faith in people, compassion and kindness."

International Nurse Recruitment – an update

We are delighted to report that during November we welcomed the arrival of five nurses recruited from Nigeria. International recruitment has played a role in our workforce plans for a number of years here at WSFT, although this work has been impacted by the pandemic. The recruitment and education teams have restarted this work together and are undertaking it without having to rely on an external agency.

Since developing this new route we have been inundated with applications, and interviews are being held weekly by the Nursing Education team; the advert remains live so this will continue should new applicants meet our requirements. We have nine nurses from Nigeria who are currently in this process.

We have also successfully recruited six nurses from India through our partnership work with Health Education England; conditional offers have been made and we look forward to welcoming these nurses to West Suffolk in February/March 2021. Additionally, five nurses are due to arrive in January 2021 from the Philippines, with a further three in the process.

Discussions between HR and Nursing are exploring the ongoing numbers of nurses required from outside of the UK as part of our wider recruitment plans. We also continue to assess the option of managing the recruitment process ourselves, avoiding agency costs, resulting in a much more personal and supportive experience for our international nurse recruits.

EU Exit – end of transition period and the Settlement Scheme

In preparation for the EU Exit and end of the transition period on 31 December 2020 we have reached out to our c.400 WSFT colleagues from other EU nations, by way of a letter from our CEO in September 2020. This provided continued reassurance to our valued EU colleagues that they remain very much part of the WSFT family and thanking them for the contribution they make to health and social care services in Suffolk. This warmly encouraged colleagues to apply for the EU Settlement Scheme which they have access to until June 2021. We will continue to promote the Settlement Scheme and encourage staff to progress their application for 'settled' or 'pre-settled status'.

Supporting our staff's health during the pandemic - risk assessment

A version 6 of the individual staff risk assessment tool for COVID 19 was published in October. This latest version of the tool provides advice for staff in the red risk group (including those who were shielding). All previously shielding staff completed a return to work risk assessment tool and the occupational health team provided individual advice where this was needed to support staff. Version 6 of the risk assessment will now be

completed by all new staff joining the trust and any existing staff who become pregnant or whose health changes.

Flu vaccination campaign 2020

The 2020 flu vaccination campaign has provided staff with more opportunities than ever before to have easy access to a flu vaccination. Clinics were set up in the community in addition to our community peer vaccinators. At West Suffolk Hospital flu 'vaccination stations' were established at two entrances and staffed from 7am to 6pm Monday to Friday to enable staff to get their vaccinations as they arrived or left the hospital. The communications team ran a high profile campaign starting in September with a message from the Executive Chief Nurse and senior leaders were given lists of departmental uptake to enable them to target areas with lower vaccination rates.

We were less successful with our community pharmacy voucher scheme this year as our pharmacy partner did not have an adequate supply of vaccine and staff were unable to access vaccinations. Our mutual exchange arrangement with ESNEFT for staff working in the east of the county also suffered from the trust running out of vaccine during the campaign. The 2020 flu campaign may need to be suspended from early December to accommodate the requirements of a COVID vaccination programme.

We saw an extremely strong start to the campaign with record uptake from staff, but this tailed off after the first month and at 24.11.2020 we have delivered over 3,300 vaccines. This represents 10% fewer front line staff who have had the vaccine at this stage in 2020 compared with 2019 (60.1% in 2020 versus 70% in 2019). The latest figures for the East of England show a range of organisational uptake from 47 to 83% as at 19 November. Whilst it is possible to speculate on the reasons we do not yet have evidence to explain this disappointing situation. We will be seeking feedback from staff as to better understand why some chose not to take-up the vaccine offer.

As a Board we should extend our thanks and appreciation to the team who have worked tirelessly on this programme of work over recent months, and continue to promote the importance of taking up the flu vaccine.

Recent Consultant Appointments

Post: Consultant in Cardiology
Interview: 26 November 2020
Appointee: [redacted]
Start date: To be confirmed

Current post: [redacted]

Previous Positions:
[redacted]

[redacted]

Post: Consultant in Radiology
Interview: 10 November 2020
Appointee: [redacted]
Start date: 11 November 2020

Current post: [redacted]

Previous Position: [redacted]

Jeremy Over
Executive Director of Workforce & Communications
November 2020

13. Quality, safety and improvement reports

To APPROVE the reports

Presented by Susan Wilkinson and Nick Jenkins

13.1. Maternity services quality & performance report

For Approval

Trust Open Board – 4 December 2020

Agenda item:	13.1			
Presented by:	Sue Wilkinson, Executive Chief Nurse/ Karen Newbury, Head of Midwifery			
Prepared by:	Karen Newbury – Head of Midwifery/Rebecca Gibson Compliance Manager			
Date prepared:	13th November 2020			
Subject:	Maternity quality & safety performance report			
Purpose:	X	For information		For approval

Executive summary:

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

This report contains:

- Maternity Clinical and Quality dashboard **(Annex A)**
- Maternity Safety Highlight Report incorporating CNST Maternity incentive scheme **(Annex B)**
- Other Maternity indicators including those incorporated elsewhere in board reporting schedule
- Strategy update
- Response to national HSIB report
- Learning form incidents/ learning from deaths
- Continuity of Carer update
- Saving Babies Lives Care Bundle version 2 Board Report **Minute the receipt (Annex C)**
- Monthly Obstetric and Gynaecology Governance Report **(Annex D)**

Strategy update

The first draft of the Maternity Quality and Safety Framework has been drafted which will replace the Maternity Risk Management Strategy. It includes all aspects of Clinical Governance and it reflects the Trust's overarching policies and processes.
The draft is currently being circulated to key Maternity staff for comment before being shared more widely with the wider Trust Safety and Quality teams. It is expected that the framework will be in place by 31st December 2020.
In addition, all groups and forums involved in Quality and Safety are reviewing their Terms of Reference to ensure that these are clear on the purpose, level of decision making, core membership and escalation of concerns.

Response to national HSIB report

HSIB have published (on 12th November) a new national report '*Investigation into delays to intrapartum intervention once fetal compromise is suspected*'. This collates the learning from multiple investigations and presents key themes on loss of situation and the importance of team-working and multidisciplinary training. The report outlines 12 findings and HSIB asks all maternity units to consider a series of questions against those findings. It also makes one safety recommendation R/2020/103*: It is recommended that the Care Quality Commission, in collaboration with relevant stakeholders, includes assessment of relational aspects such as multidisciplinary teamwork and psychological safety in its regulation of maternity units.*

A local reflective self-assessment is planned involving the trust's Human factors team. More details will be provided in a future iteration of this report.

Learning from incidents / learning from deaths (LfD)

The August meeting of the LfD group received a presentation from the Obstetric lead Miss Kate Croissant providing an outline of the three maternal deaths reported in the last decade. In November the group received an update report detailing assurances relating to the action plans from the two earlier deaths (the most recent 2018 death was reported via HSIB and has an associated improvement plan reported elsewhere). These two cases related to a lady with a congenital disease advised to avoid to pregnancy (in 2017) and a lady who contracted community acquired Swine flu (in 2011).

The group was reassured to receive evidence of action completion at the time and (given the passage of time, especially for the first case) that these actions were still current and/or further improvements had been made through clinical advancements.

The Maternity strategy refresh is including a review and update of the local perinatal mortality framework which will form part of the trust's PSIRF development.

MBRRACE-UK provides a national reporting framework for the surveillance and investigating the causes of maternal deaths, stillbirths and infant deaths. The most recent national report (a COVID-19 specific edition) was issued in August 2020 and is still under local review.

The most recent annual reports of Maternal deaths/morbidity and Perinatal mortality surveillance were published in December and October 2019 respectively and with a full local baseline assessment and improvement plan developed at the time.

https://www.hqip.org.uk/resource/maternal-newborn-and-infant-programme-saving-lives-improving-mothers-care-2019/

https://www.hqip.org.uk/resource/perinatal-mortality-surveillance-report-2019/#.X7JG4p77TX4

Maternity dashboard (see Annex A)

Indicators of maternity safety & quality are regularly reported and reviewed at monthly Maternity Governance meetings. A sub-set are provided for board level performance (the Performance & Governance dashboard). In October there were four indicators categorised as Red and four as Amber on our clinical dashboard (NB: RAG rating currently still based on National Maternity Perinatal Audit 2016/2017 data. There is an ambition to update all indicators to reflect more recent standards such as 'Saving Babies lives' care bundle v2 and that of the other units within our LMNS and this will be reflected in next month's clinical dashboard).

New this month the **Quality Dashboard** has been included. This is to give assurance that the maternity service has a robust monitoring and auditing programme relating to quality and safety. The indicators include, appraisal completion, mandatory training overview, equipment safety checks, and audit results. The RAG rating has been determined by the department and purposely to reflect a small window of non-compliance. This will be reviewed once compliance is improved and embedding of changes is reflected.

Indicators	Narrative
Total Women Delivered Total Number of Babies born at WSH Midwifery Led Birthing Unit (MLBU) Births	Variable month by month. With increased number of induction of labours this is affecting the number of women eligible to birth in the birthing unit
Total number of Instrumental Deliveries	This is an isolated variance from previous months.
Inductions of Labour (ex pre-labour & twins)	With the full implementation of SBLCBv2 and an increase of gestational diabetes this is to be expected. This is comparable to the other 2 units in our LMNS
Postpartum Haemorrhage >=1500mls	QI project has taken place since July. To monitor closely.
Midwife to birth ratio	High staff absence due to COVID
Supernumerary Labour Suite Co-ordinator	NHSI – Improvement Officer supporting workforce plans to resolve this issue.
Appraisal completion	Part of wider Trustwide improvement plans
Mandatory training	
Emergency equipment checks	Identified non-compliance is discussed at an individual level with clinicians including escalation to line manager any continued non-compliance. In addition an 'all Consultants' feedback session was provided in November
Smoking cessation / CO checks	
Domestic violence checks	

Indicators	Narrative
Swab count	Although still 'red' these have started to show an improved trajectory following highlight in Take 5
Drug chart completion	
MLBU 'fresh ears' (documentation)	Quality assurance midwife lead working with the Birthing unit lead midwife on strategies to improve performance

Local audit / monitoring

Currently a report is submitted monthly to the CQC for the indicators highlighted within the Section 29A letter. Compliance has been high and any areas of non-compliance have been addressed and documented within the report. Results from October 2020 report are represented in our quality dashboard (see Annex A)

CNST Maternity incentive scheme

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

This month there are improvement in MSDS (maternity services data set) as Euroking have confirmed software update timeframes will be achieved and in workforce: Medical through provision of anaesthetic and neonatal rotas and Midwifery through last month's staffing paper and the ongoing progress to achieve supernumerary status for labour suite coordinators.

Other Maternity indicators including those incorporated elsewhere in board reporting schedule

- Maternity serious incidents in October - 0

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

- Saving Babies Lives Care Bundle version 2 (SBLCBv2) Report see Annex C

  The Trust has committed to the implementation of SBLCBv2 which brings together five element of care that is widely recognised as evidence-based and/or best practice to achieve a 50% reduction in the rate of pre-term and stillbirths by 2025. The report highlights the areas of non-compliance and the action plan in place to address this. The Board will receive a quarterly update.

- Obstetric & Gynaecology Monthly Governance Report see Annex D

  This has been added this month to give the Board oversight of the report that is presented monthly at Women's Health Governance. Contents include; incident reporting, incident investigations, GREATIX, Compliments and Complaints, Duty of Candour, National Best Practice/Clinical Effectiveness and Learning to be shared.

- CCG/NHSE/I Assurance Visit

Assurance visit 25/09/2020 had a very positive outcome with a number of elements able to be evidenced as moving into business as usual. Report of recommendations and subsequent improvement plan to be added to the SRO Cluster pack next month.

- NHSI – Improvement Officer Mai Buckley appointed to the WSFT for Maternity. Mai has started within her role and is supporting the team in meeting all of the concerns/actions raised by the CQC.

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

Trust ambitions	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
		X	X	X			
Previously considered by:			Women's Health Governance				
Risk and assurance:							
Legislation, regulatory, equality, diversity and dignity implications							
Recommendation: The Board to discuss content							

Annex A – Maternity Clinical and Quality Dashboard

	Green	Amber	Red	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Total Women Delivered	>208 or <216	>216 or <208	> 224 or <200	178	180	187	174	183	202	203
Total Number of Babies born at WSH	>208 or <216	>216 or <208	> 224 or <200	179	182	190	175	187	204	206
Twins		No target		1	2	3	1	4	2	3
Homebirths	2.5%	2% or less	Less than 1%	5 2.8%	7 3.9%	5 2.7%	3 1.7%	2 1.1%	6 3%	7 3.4%
Midwifery Led Birthing Unit (MLBU) Births	≥20%	19- 15%	14% or less	3 1.7%	12 6.7%	26 13.9%	22 12.6%	20 10.9%	27 13.4%	26 12.8%
Labour Suite Births	77.5%	69% - 74%	68% or less	170 95.5%	161 89.5%	154 82.4%	149 85.6%	161 88%	169 83.7%	170 83.8%
Total Caesarean Sections	<26.%		> 22.6%	34 19.1%	36 20%	56 29.9%	46 26.4%	43 23.5%	48 23.8%	47 23.2%
Total Elective Caesarean Sections	11%	>11% -13%	13% or more	14 7.9%	14 7.8%	23 12.3%	14 8%	20 10.9%	20 9.9%	18 8.9%
Total Emergency Caesarean Sections	14.3%	14.4%-14.9%	15% or more	20 11.2%	22 12.2%	33 17.6%	32 18.4%	23 12.6%	28 13.9%	29 14.3%
Total Instrumental deliveries	12% - 14%	>14% - 15%	> 15%	9.6%	10.6%	7.0%	8.6%	11.5%	14.9%	14.3%
Inductions of Labour (ex pre labour & twins)	<31%	>31% -32.9%	>33%	39.9%	35%	32.6%	36.2%	39.3%	38.1%	38.9%
Grade 1 Caesarean Section (Decision to Delivery Time met)	100%	96 - 99%	95% or less	100%	100%	100%	100%	100%	91%	100%
Grade 2 Caesarean Section (Decision to delivery time met)	80%	76 - 79%	75% or less	57%	81%	67%	95.4%	78%	83%	82.3%
Postpartum Haemorrhage 1500 mls or more	<3.5%	3.5% - 3.8%	> 3.8%	1.7%	1.1%	8%	4.0%	2.7%	2.5%	3.9%
Shoulder Dystocia	2	3-4	5 or more	3	7	4	4	5	2	2
Total women delivered who breastfed babies with first 48 hours	>80%	75-80%	<75%	76.7%	72.8%	78.4%	71.4%	79.2%	82.2%	81.8%
1 to 1 Care in labour	100%	96-99%	95% or less	97.4%	100%	100%	100%	100%	99.5%	100%
Supernumerary Labour suite co-ordinator	100%			100%	100%	No data	84%	74%	Insuff data	83%
Midwife to birth ratio	1:30		1:32 or more	1:26	1:26	1:27	1:30	1:27	1.31	1:31
Completion of WHO checklists	>95%	80-94%	<80%	No data	No data	93%	96%	96%	90%	96%
Unit Closures	0		1	0	0	0	0	0	1	0

West Suffolk NHSFT		MIDWIFERY SERVICE: QUALITY DASHBOARD											
QUALITY TOPIC		Denominators											
		RAG	GREEN	= Standard or above		AMBER	≥5% below standard		RED	> 5% below standard			
STAFF SUPPORT & DEVELOPMENT													
Appraisal completion	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Midwives Hospital % in date	90%				94.0%	97%	97%	97%					
Midwives Community & ANC % in date	90%				83.0%	90%	80%	100%					
Support Staff Hospital % in date	90%				90.0%	90%	88%	84%					
Support Staff Community & ANC % in date	90%				100.0%	100%	No data	93%					
Medical Staff % in date	90%	Medical Staff appraisal suspended during Covid pandemic											
Mandatory Training Overview	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Midwives: % compliance for all training	90%		70.3%	74.8%	77.6%	78.3%	79.9%	80.1%					
Midwives: % compliance with PROMPT training	90%		52.7%	75.0%	75.9%	77.2%	81.4%	85.5%					
Midwives: % compliance with GAP training	90%			79.0%	91.0%	92.0%	98.0%	96.0%					
Midwives: % compliance with Safeguarding Children training	90%					99.3%	No data	99.0%					
MCA: % compliance for all training	90%		81.5%	83.2%	84.9%	85.6%	81.2%	85.7%					
MCA: % compliance with PROMPT training	90%		58.8%	72.2%	72.2%	72.2%	57.1%	65.0%					
MCA: % compliance with Safeguarding Children training	90%					99.4%	No data	100.0%					
Obstetric Medical Staff: compliance with PROMPT training	90%			70.0%	70.0%	73.3%	57.1%	69.6%					
Obstetric medical staff: % compliance with GAP training	90%			88.0%	83.0%	58.0%	92.0%	87.0%					
Obstetric Medical Staff: compliance with Safeguarding Children training	90%						No data	84.0%					
Anaesthetic compliance with PROMPT training	90%						No data	50.0%					
Theatre staff compliance with PROMPT training	90%						No data	34.3%					
Sonographer: % compliance with GAP training	90%			93.0%	93.0%	79.0%	86.0%	79.0%					
EQUIPMENT SAFETY													
Checking of Emergency Equipment	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Labour Suite: Adult Trolley	100%			86%	100%	100%	100%	100%					
Labour Suite: Resuscitaires				73%	86%	76%	88%	96%					
Ward F11: Adult Trolley					97%	100%	97%	100%					
Ward F11: Resuscitaire					77%	84%	93%	97%					
MLBU: Resuscitaires	100%				95%	100%	93%	94%					
Community: Emergency Bags					89%	98%	95%	84%					
Checking of Fridge Temperatures	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Labour Suite	100%				97%	100%	100%	100%					
Ward F11					100%	100%	93%	100%					
MLBU					97%	100%	100%	100%					
ANC					100%	100%	100%	100%					
Ambient Room Temperature (where medication is stored)	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Labour Suite	100%				97.0%	100.0%	100%	100%					
Ward F11					100.0%	100.0%	97%	100%					
MLBU					97.0%	100.0%	100%	100%					
ANC					100.0%	100.0%	100%	100%					
Checking of CD's	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Labour Suite	100%				100.0%	98.0%	100%	100%					
Ward F11					100.0%	100.0%	97%	100%					
MLBU					97.0%	100.0%	100%	100%					

MONTHLY QUALITY & SAFETY AUDITS:

	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Supernumerary Status of LS Coordinator	100%				84%	74%	No data	83%					
		8%											
1-1 Care in Labour	100%	97.4%	100.0%	100.0%	100.0%	100.0%	99.5%	100.00%					
MW: Birth Ratio	1:28	1:26	1:26	1:27	1:30	1:27	1:31	1:31					
No. Red Flags reported				3	4	2	1	14					
DOCUMENTATION & CARE AUDITS	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Compliance with MEOWS completion	100%			98.0%	99.5%	99.0%	99. 8%	99%					
Compliance with NEWTT completion	100%	97.0%	97.0%	96.0%	95.0%	99.0%	100%	100%					
Carbon Monoxide Monitoring													
Smoking at booking recorded	95%	Audit suspended due to Covid-19				100.0%	100%	100%					
Smoking at 36 weeks recorded	95%					45.0%	78%	74%					
Compliance with DV questions													
Antenatal period	100%					95.0%	100%	98%					
Postnatal period	100%					97.5%	95%	90%					
Swab Count Compliance													
Birth	100%				56.0%	85.0%	87%	93%					
Suturing	100%				54.0%	90.0%	87%	96%					
Compliance with completing WHO checklist @ CS	95%	No audit		93.0%	96.0%	96.0%	90%	96%					
Recording of Pain Score													
Labour Suite	100%					99.0%	100%	100%					
Triage						100.0%	100%	100%					
MLBU						100.0%	100%	100%					
Ward F11						97.0%	100%	100%					
MDAU						100.0%	100%	100%					
Completed Drug chart information: weight and allergies	100%						7.00%	73%					
Fresh Eyes													
Labour Suite	100%						20%	100%					
Fresh Ears													
MLBU	100%					80.0%	50%	80%					
Epidural response <30 min	90%					92%							
Breast Feeding													
Total women delivered who breastfed their babies within the first 48 hrs	80%	76.7%	72.8%	80.7%	71.4%	79.2%	82.2%	81.8%					

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

Maternity Safety Highlight Report

Trust: West Suffolk NHS Foundation Trust	October data	Date:13/11/2020

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

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

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

Number of	
Serious Incidents this month	On-going SI's
0	2
DATIX	Outstanding DATIX
23	4
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

Annex C Saving Babies Lives Care Bundle version 2 Quarterly Board Report

Annex D Monthly Obstetrics and Gynaecology report

Trust Board Meeting November 2020

Agenda item:	Demonstration of the progress of all five elements of the Saving Babies 'Lives Care Bundle			
Prepared by:	Jane Lovedale Clinical Risk Manager Women and Children's Services			
Date prepared:	November 2020			
Subject:	Quarterly Survey			
Purpose:	√	For information		For evidence of completion

Executive summary:

- Evidence of the completed quarterly SBL care bundle surveys for 20/21 has been completed.
- The quarterly care bundle survey should be completed until the provider trust has fully implemented the SBLCBv2 including data submission requirements.

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:	No
Risk and assurance:	
Legislation, regulatory, equality, diversity and dignity implications	There are no issues with the data presented in this report as it is anonymised information.

Saving babies Lives care bundle version 2 (SBLv2)

<u>The Trust has commited to the implementation of Saving babies Lives Care Bundle v2</u>
The second version of the care bundle brings together five elements of care that are widely recognised as evidence-based and/or best practice:

1. Reducing smoking in pregnancy
This element provides a practical approach to reducing smoking in pregnancy by following NICE guidance. Reducing smoking in pregnancy will be achieved by offering carbon monoxide (CO)

testing for all women at the antenatal booking appointment, and as appropriate throughout pregnancy, to identify smokers (or those exposed to tobacco smoke) and offer them a referral for support from a trained stop smoking advisor.

2. Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)

The previous version of this element has made a measurable difference to antenatal detection of small for gestational age (SGA) babies across England2. It is however possible that by seeking to capture all babies at risk, interventions may have increased in women who are only marginally at increased risk of FGR related stillbirth. This updated element seeks to address this possible increase by focussing more attention on pregnancies at highest risk of FGR, including assessing women at booking to determine if a prescription of aspirin is appropriate. The importance of proper training of staff who carry out symphysis fundal height (SFH) measurements, publication of detection rates and review of missed cases remain significant features of this element.

3. Raising awareness of reduced fetal movement (RFM)

This updated element encourages awareness amongst pregnant women of the importance of detecting and reporting RFM, and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM. Induction of labour prior to 39 weeks gestation is only recommended where there is evidence of fetal compromise or other concerns in addition to the history of RFM.

4. Effective fetal monitoring during labour

Trusts must be able to demonstrate that all qualified staff who care for women in labour are competent to interpret cardiotocographs (CTGs), always use the buddy system and escalate accordingly when concerns arise or risks develop. This element now includes use of a standardised risk assessment tool at the onset of labour and the appointment of a Fetal Monitoring Lead with the responsibility of improving the standard of fetal monitoring.

5. Reducing preterm birth

Version 2 has an additional element to the care bundle developed in response to The Department of Health's 'Safer Maternity Care' report.

Safety Ambition' to include reducing preterm births from 8% to 6%. This new element focuses on three intervention areas to improve outcomes which are prediction and prevention of preterm birth and better preparation when preterm birth is unavoidable.

Required standard C
The SBLv2 survey is sent to the Trust by the Clinical network and should be completed and returned to the Clinical network.

Minimal evidential requirement for the Trust board
Evidence of the completed quarterly care bundle surveys for 2020/21 should be submitted to the Trust board .

Element	Non compliance
Reducing smoking in pregnancy : non compliant with 1 standard .	The maternity service is unable to record outcomes of CO testing in pregnancy relating to element 1 activities on the Maternity information system (MIS)enabling submission to MSDS v2.0 monthly submission.
Action	**See Action plan**
Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)	The WSH does not currently undertake uterine artery dopplers (UAD)required for women with high risk factors for fetal growth restriction. *Currently women have increased scans to mitigate this risk this an acceptable pathway to the Local maternal system and in cases of very high risk referral for Cambridge Fetal medicine unit is made.*
Action	**See Action plan**
3. Raising awareness of reduced fetal movement (RFM)	The maternity service is unable to record the findings of reduced fetal movements on MIS enabling their submission as coded clinical entry in MSDS v2.0 monthly submissions.
4. Effective fetal monitoring during labour	Compliant with all elements, June 2020 midwives 97% medical staff 86.7% ongoing monitoring.
Action	**See Action plan**
5. Reducing preterm birth	Compliant with all elements

Action Plan

Element	Issue	Responsibility	Progress
Element 1Reducing smoking	E3 v2 not available	IT department	Email received from the current MIS system (Euroking), confirming that a document has been received to review and sign off then agree an implementation date. *Local audit April 2020 suggests CO monitoring at booking recorded 87.5% of the time, At 36 weeks 85%,*

			SBL threshold of compliance is for successful implementation 80%. Action plan in place to achieve >95%
Element	**Issue**	**Responsibility**	**Progress**
Element 2 Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)	Not all sonographers have the required training to undertake UAD.	Lead Ultrasonographer	Plan for the one already WSH sonographer to cascade this training to the reminaing sonographers this has been supported by their clinical proffessional body and the obstetric clinical team. **Other parts of implementation are compliant to :** *Risk status for growth restriction identified and recorded at booking =97.3%.* *Women with BMI >35 kg are offered seriel growth scans from 32 weeks onwards =100%* *Quarterly audit of the % of babies born <3rd centile > 37+6 weeks.*
Element	**Issue**	**Responsible**	**Progress**
4. Effective fetal monitoring during labour Staff training.	Maintain to this compliance	Practice development Midwife	Ongoing monitoring of training Compliance 90% each staff group, Actions in place to increase medical staff compliance.

OBSTETRIC AND GYNAECOLOGY

MONTHLY GOVERNANCE REPORT

MONTHLY Governance Report for Obstetrics and Gynaecology

October 2020

Contents

MATERNITY SAFETY AND QUALITY TEAM

Data from Datix for: October 2020

1. Incident Reporting

a: Number of Obstetrics and Gynaecology COVID-19 linked incidents reported in the last month
(incidents reported ticked as Covid -19 patients or with Covid in the narrative)

Covid -19 Related Reporting by severity						
Department	**Catastrophic**	**Moderate**	**Minor**	**Negligible**	**None**	**Grand Total**
Obstetric	0	0	0	0	5	5
Gynaecology	0	0	0	0	1	1
Grand Total	**0**	**0**	**0**	**0**	**6**	**6**

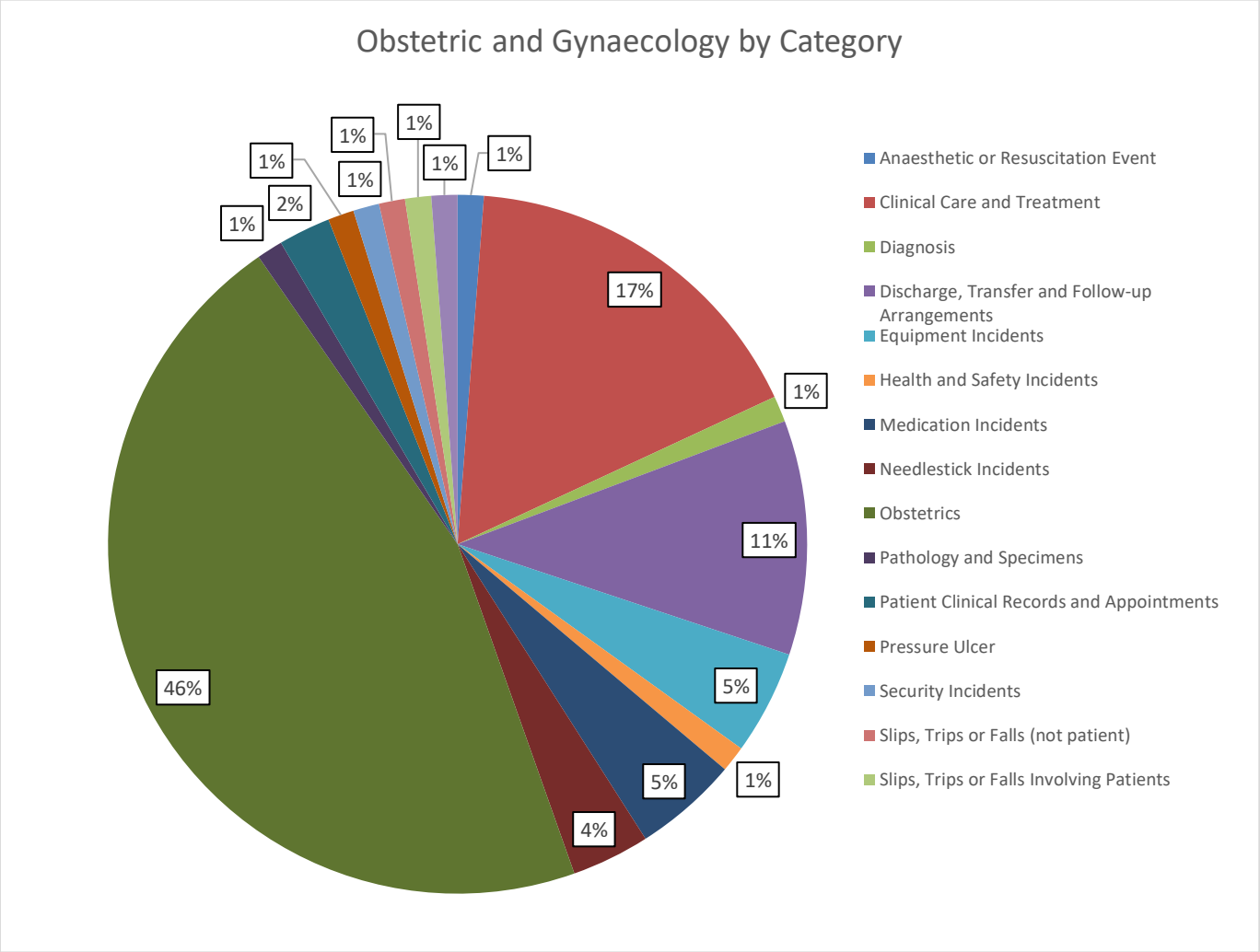
b: Number of incidents reported in the last month

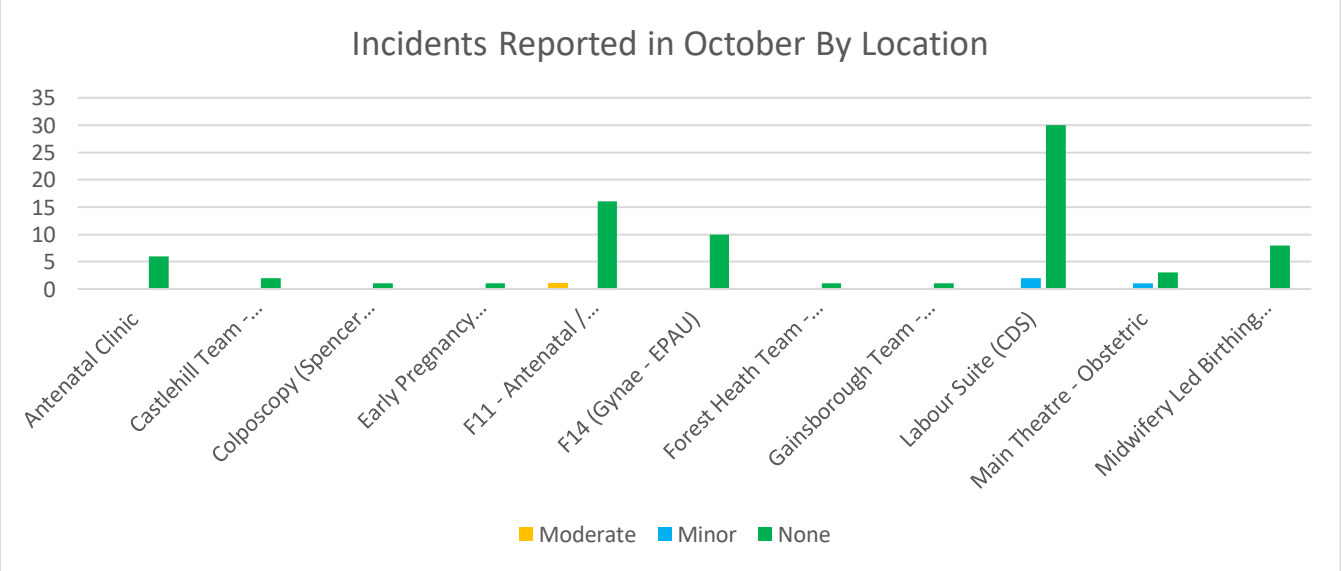
Trust Wide Incident Reporting by severity						
Department	**Catastrophic**	**Moderate**	**Minor**	**Negligible**	**None**	**Grand Total**
Obstetrics	0	1	3	0	67	71
Gynaecology	0	0	0	0	12	12

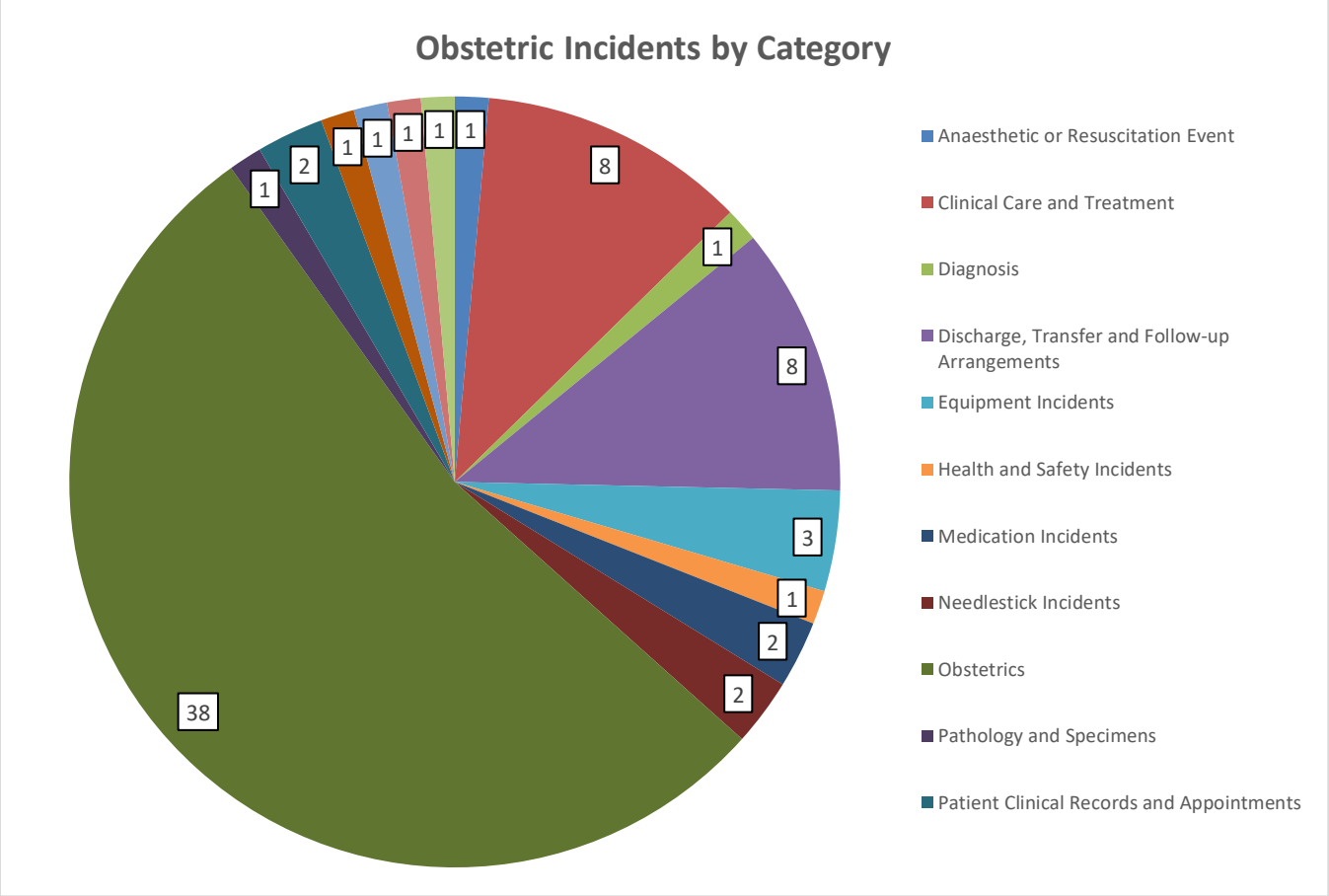
c: NEW Red and Amber Incidents reported in the last month by SEVERITY

Actual Severity	Ref	Description	Action taken	Location
	WSH-IR-63447	Patient discharged home with weakness in leg following a labour epidural and forceps delivery under anaesthesia in theatre. this was discovered when patient returned to hospital for her baby`s phototherapy treatment.	MDT meeting. No CDP identified,however some learning around checking motor power following delivery. Care of anaesthetic team.	F11 - Antenatal / Postnatal Ward

d: Incidents reported by CATEGORY


Obstetric and Gynaecology by Category
17%
1%
11%
5%
1%
5%
4%
46%
1%
2%
1%
1%
1%
1%
1%
1%
Anaesthetic or Resuscitation Event
Clinical Care and Treatment
Diagnosis
Discharge, Transfer and Follow-up Arrangements
Equipment Incidents
Health and Safety Incidents
Medication Incidents
Needlestick Incidents
Obstetrics
Pathology and Specimens
Patient Clinical Records and Appointments
Pressure Ulcer
Security Incidents
Slips, Trips or Falls (not patient)
Slips, Trips or Falls Involving Patients


Incidents Reported in October By Location
35
30
25
20
15
10
5
0
Antenatal Clinic
Castlehill Team -...
Colposcopy (Spencer...
Early Pregnancy...
F11 - Antenatal /...
F14 (Gynae - EPAU)
Forest Heath Team -...
Gainsborough Team -...
Labour Suite (CDS)
Main Theatre - Obstetric
Midwifery Led Birthing...
Moderate
Minor
None


Obstetric Incidents by Category
1
8
1
8
3
1
2
2
38
1
2
1
1
1
1
1
Anaesthetic or Resuscitation Event
Clinical Care and Treatment
Diagnosis
Discharge, Transfer and Follow-up Arrangements
Equipment Incidents
Health and Safety Incidents
Medication Incidents
Needlestick Incidents
Obstetrics
Pathology and Specimens
Patient Clinical Records and Appointments

Maternity Red Flags events	**Midwifery Staffing**		
October 2020			
Area		**Date**	**Reason**
Labour Suite	8		• **Labour Suite co-oredinator not supernumery during a period of the shift. 4** • **Redeployment of staff due to increased acuity 3** • **Care compromised due to high activity (not in labour) 1.**
		06/10/2020	RED FLAG: labour suite band 7 not supernumary for 2 hours.
		07/10/2020	Maternity Red Flag. Relocation of staff from the community to the hospital.
		15/10/2020	labour suite coordinator not supernumary over night on the 14.10.2020
		16/10/2020	Relocation of staff. The midwife was moved from MLBU to Labour Suite. Following the review of another incident it became apparent that two Maternity Red Flag Incidents were not reported during the night of the 17/10/2020.
		17/10/2020	Maternity Red Flag for Labour Suite Coordinator not being supernumery. Discovered during the investigation of another incident.
		17/10/2020	A woman booked for MLC, triaged on labour suite for labour assessment due to high activity on labour suite. FH on auscultation 175 bpm over three minutes, EFM commenced. Maternal pyrexia noted of 37.5. IV fluids and bloods taken. Maternal pyrexia still 37.5 sepsis pathway commenced. CTG normalised after IV fluids, paracetamol and antibiotics. Due to another labourer being transferred from the ward and no other staff member available to see her, this woman was left at 06:00 on the CTG. I asked if a member of staff on LS could check in on her, but the labour ward activity was too high to facilitate this. The woman next received midwifery and obstetric input at

			handover at 08:00. The CTG had been normal, but no obervations had been carried out, or the CTG visualised by a member of staff.
		22/10/2020	Midwifery Red Flag due to redeployment of staff due to staff absence for isolation following family member with Covid 19.
		29/10/2020	Maternity Red Flag due to staffing issues. Labour Suite coordinator not supernumary on night shift. Escalation to community midwife who took an hour to arrive requiring co-ordinator to provide labour care to a preterm lady with a pathological trace with code RED doctor delivery. Both on call midwives called in for escalation.
F11	5		• **Relocation of staff due to activity levels** • **Tinzaparin missed x 3** • **Reduced Staffing overnight for significant periods due to LS activity. 1**
		13/10/2020	Maternity Red Flag for relocation of staff.
		14/10/2020	Tinzaparin was due at 1800, but was missed.
		14/10/2020	Regular dose of Tinzaparin missed at 1800 on 13.10.2020.
		14/10/2020	Dose of prescribed Tinzaparin missed at 1800 on 13.10.2020. This omission was discovered on the drug round at 0000 on 14.10.2020. Tinzaparin prescription then altered to ensure appropriate coverag
		29/10/2020	On nightshift of 28/10/ into 29/10/2020 ward F11 was staffed by one midwife from 00:30 and one MCA, with 4 antenatals (3 ongoing IOLs, one PET lady) and 10 postnatal women/babies, one of whom required IV abx and two babies on red care pathways, one woman day 0 post lscs. Also had a ward attender during this time. The other midwife was taken to labour suite at 00:30 with one of the inductions who was labouring. Two community midwives were called in, one of whom was sent to help at 2am with obs, then was taken back to MLBU and then back to F11 for an hour. Concerns over safety with only one midwife to care for 14 women plus their babies. Delays occurred with care such as analgesia and bladder scanning, difficulties in providing basic care such as feeding support due to lack of staff/time.

MLBU			0
MDAU			0
ANC			0
Community			0

Top incident catagories reported during October 2020

1. **Newborn Screening-7**

- Avoidable NST Repeat-2
- NST rejected due to contamination-1
- NST taken later then Day 5-2 - due to miscommunication.
- NST taken on day 5, but forgotten and not mailed until day 12.
- Baby went home without the NIPE-1 - NIPE was actually done prior to discharge within the recommended timeframe, but not recorded on electronic system.

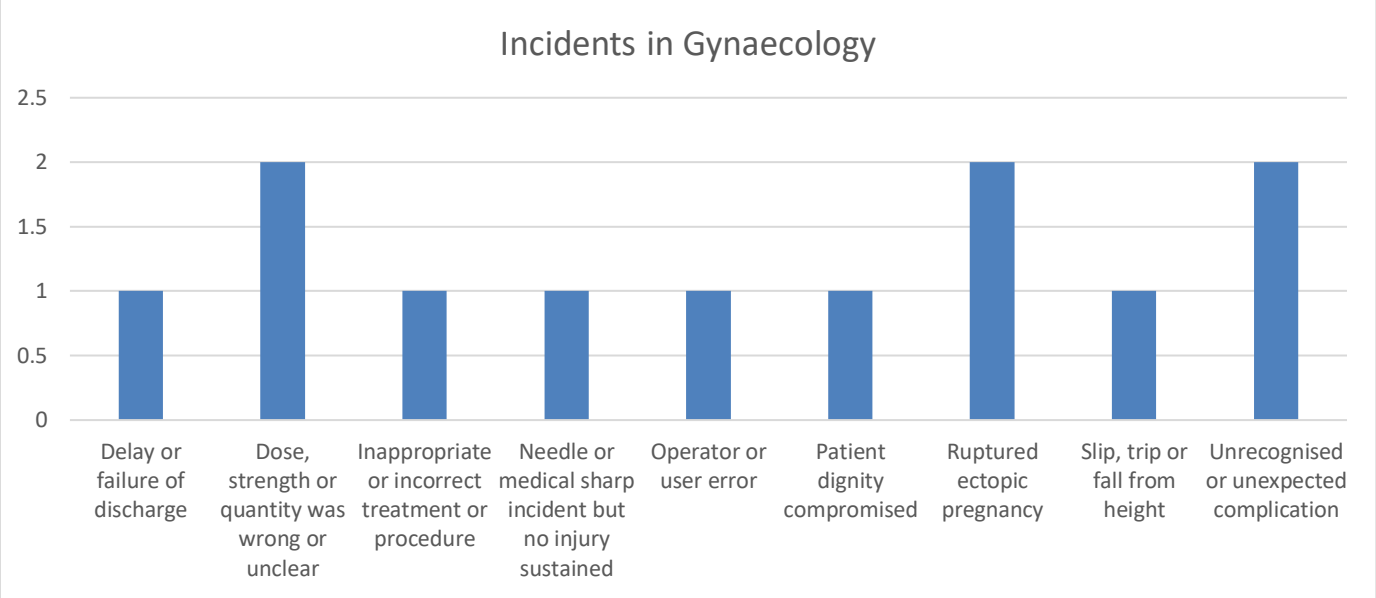
2. **Failure to monitor adequately-5**

- Cylinder with Air and Oxygen empty on the portable resuscitaire on Labour Suite-1. Likely not turned off following the check on the previous day.
- Low temperature on admission to NNU-2- borderline, 36.4 and 36.3. Theme of the Month- Hypothermia, as few more incidents in September.
- Two sets of observations missed as centile unknown at the time-1- normal observations following this, no adverse outcome.
- Missed SGA-1- A midwife consistently measured at around 75th centile during the pregnancy. When seen in the clinic and measured by the Doctor, SFH well below the 10th centile. IOL, baby born on the 2.3 centile. Midwife is GAP compliant, experienced and demonstrated a correct measuring technique.

3. **Unanticipated transfer from MLBU to LS-5.** All appropriate, timely, and for reasons that were unavoidable.

4. **PPH-5.** All well managed.

   In one case the amount of the APH prior to transfer to Theatre was not communicated well with Anaesthetist and the woman's weight was approximately 50 kg. The management could have been more pro- active.



Gynaecology: F14 and GOPD:

12 incidents ; No common themes.

2. Incident Investigations

a. Ongoing Serious Incidents (SI) or Red Clinical Incident Investigations-

Ref	Incident date (oldest first)	Case	Reported to	Progess
WSH-IR-58103	20/04/2020	Therapeutic cooling	HSIB	Final report received **Safety recommendations** • Medical & nursing staff supported in the use of the ventilator equipment. • Blood gas measurements are completed in a timely manner • Multidisciplinary communication is clear. MDT meeting action plan agreed
WSH-IR-58400	30/04/2020	Neonatal death	HSIB	Final report received **Safety recommendations** • Sharing of patient information • Holistic approach to care in labour including alalysis of fetal monitoring and incorporate risk assessment of risk factors. • Ensure a member of the intrapartum team maintains a helicopter view to maintain situational awareness . MDT meeting action plan agreed

b. Ongoing Moderate / Amber Clinical Incident Investigations-

Ref	Incident date	Description	Sub category	Location (type)
WSH-IR-61729	.28/08/2020	Patient attended on the afternoon of 28th August with absent fetal movements since the previous evening. Intrauterine death confirmed	Obstetrics	MDT No CDP that contributed to the outcome. Learning identified Amend guideline for SFGA in relation to management of EFW on 3rd centile. Highlight to Obstetric team.

3. Duty of Candour (DOC)

a. Duty of Candour (DOC)
Non outstanding

New **risk assessment(s)** which are out of date for its next review

ID	Issue	Title	Risk level (current)	Opened	Risk Approver	Approval status
4652	Unable to purchase xray detectable gauze woven balls. Current xray detectable gauze swabs are too large for this procedure and uncomfortable for the patient.	Colposcopy Use of non xray detectable gauze balls	Green	28/10/2020		
4654	Suspension of Co monitoring for pregnant women during covid	CO monitoring during Covid	Amber	30/10/2020		

Risks needing review **risk assessment(s)** which are out of date for its next review

ID	Issue	Title	Risk level (current)	Opened	Risk Approver	Approval status
3720	Achieving all 5 elements of SBLv2	Complince with elements of SBLv2	RED	28/06/2019	N Jenkins	

4. GREATIXs, Compliments and Complaints

GREATIX-1

Reference	Who has achieved excellence?	What did they do that was excellent?
WSH-IR-63032	gp trainee Sneha Padmanathan	Sneha acted as a translator for a woman on f11 who is a non English speaker and was undergoing induction of labour with a complicated medical history. She was patient, understanding and compassionate throughout, offering her services when she was already busy.
WSH-IR-63256	Vicki Dekker	She assisited a midwife on labour suite who had not worked on there for a period of time. She offered her support without being asked.
WSH-IR-63342	Mandy Welch	Mandy was called in to labour suite for unit escalation due to high acuity. When she arrived at 01:30am, she provided excellent clinical care. Despite the challenges that the patient presented, she demonstrated caring, kindness and patience and was a true advocate for the woman's wishes. It was lovely to witness Mandy the standard of care Mandy provided and she was a true asset to our hospital.
WSH-IR-63432	Jac Reeve	Due to Dr's shortage within the maternity department Jac Reeve has gone over and above to support F11 and MDAU. Jac would always attend when asked and nothing was too much trouble even when she was inundated with work.

WSH-IR-63658	Gynae out-patients Dr B Sinha Andrea Hayes	I brought my mum for a check up post surgery for ca. I wanted to share our experience yesterday 26/10/20 @10am. My mum was treated with such care, compassion and loveliness by both staff members. You made us feel at ease and were reassuring to my mum. You both were so lovely and I want to thank you both for being just amazing. Thank you so so much again.
WSH-IR-63771	Heather Sowman, Senior Midwife, Labour suite	On 20/10/2020, Heather was rostered for a management day, however she showed great flexibility and team work in stopping her management work in order to help with high acuity on the unit. Heather took over the care of a high risk patient, providing labour care for a lady undertaking an induction of labour with a twin pregnancy. Over the course of 12 hours, I witnessed Heather provide outstanding care to this patient. She provided woman-centred care, acted as an advocate to ensure the patients wishes were met. She was compassionate, patient and kind. Heather delivered both twins herself prior to the end of her shift and although the obstetric medical staff were present, Heather managed the delivery herself. This showed great skill and knowledge of the physiology of twin birth. Heather used all of her skills as a midwife to ensure this family had a positive experience of birth and it was a joy to watch her provide care.
WSH-IR-63778	On Tuesday 27th October the maternity unit had high activity of women, most of which had complications and needed Obstetric review. All teams were very busy and stretched and there was only 1 consultant and registrar on call. The doctors did not stop all day. Not once did they snap at the midwives or make us feel a nuisance for calling them. They were really supportive	Both Dr Reeve (con) and Dr Shreeve (reg) were amazing. they were asked to review obstetric women on labour suite, F11 and day assessment unit. This was the case all day. The obstetric team made themselves available, they were easy to contact throughout the day and did not make the midwives feel guilty about each bleep we sent. It was felt that as a whole maternity team all levels of staff pulled together

	throughout a difficult shift.	

Compliments- 0

Complaints- 2

Date Recieved	ID Reference	Description
08/10/2020	WSH-COM-1829	Patient complains about her post-natal care and treatment. She raises concerns about poor catheter care, a lack of assistance with carrying our personal hygiene tasks and no support with breastfeeding. Patient also feels that she was given conflicting information about her discharge and that staff did not communicate effectively which she states resulted in her not receiving information about her baby.
15/10/2020	WSH-COM-1835	Patient complains about the service she received when attending to which she believed was a hysteroscopy procedure only to be seen by a doctor who dismissed the patients problems.

6. learning to be shared

a: Patient Safety Bulletins

b: New recommendations from national and local clinical audits that apply to division

Disclaimer: All information taken directly from Datix.

Any inaccuracies require updating locally or by emailing Datix@wsh.nhs.uk

13.2. Quality and learning report, including learning from deaths

For Approval

Trust Open Board – 4th December 2020

Agenda item:	13.2			
Presented by:	Sue Wilkinson – Executive Chief Nurse			
Prepared by:	Governance Department			
Date prepared:	November 2020			
Subject:	Quality and Learning report			
Purpose:	X	For information		For approval

Executive summary:

This report provides a summary of key learning points, trend analysis and opportunities for improvement that have arisen from in the quarter ending 30/09/20.

Information has been obtained from the following data sources:

- Investigation of serious incidents and resultant action plans
- Thematic analysis of incidents at all grades for the quarter
- 'Learning from deaths'
- Review of complaints received and responded to and themes arising from the PALS service within the quarter
- Raising concerns: pathways for staff and learning examples
- HSIB reports (Maternity)
- Risk assessments created or updated within the quarter
- Other soft intelligence gathered within the quarter

Key highlights in this report are as follows:

- PSIRF update (including requirement for **Board minute** delegating authority to Scrutiny committee to approve 2021 plan)
- eCare alerts

Please note:

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

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

Trust ambitions	 *Deliver personal care*	 *Deliver safe care*	 *Deliver joined-up care*	 *Support a healthy start*	 *Support a healthy life*	 *Support ageing well*	 *Support all our staff*
	X	X	X	X	X	X	X
Previously considered by:							
Risk and assurance:							
Legislation, regulatory, equality, diversity and dignity implications							
Recommendation: 1. The board to **formally delegate authority** to the Scrutiny committee to approve the trust's 2021 patient safety incident response plan in January							

Activity within the quarter

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

1. Learning themes from investigations in the quarter

SI RCA reports submitted in Q2

There were eight SI reports submitted in Q2. All cases which included a patient's death in WSFT care have the final report reviewed by the 'learning from death' group to determine preventability (there was one relevant case in Q2).

This is the first quarter to report incidents related to COVID-19.

Incident details	Learning
WSH-IR-47782 COVID-19 outbreak leading to G9 ward closure (note ward F8 on G9 at the time as a consequence of RAAC plank management)	<u>Multiple care and service delivery problems identified including</u>**:** • Sub optimal PPE use • Staff undertaking aerosol generating procedures (AGP), predominantly suction, in open bays with multiple staff participating in the care of patients undergoing AGP rather than following advice which is to limit exposure. • Insufficient single room isolation, open plan environment and hand hygiene facilities • Availability of patient level data • No onsite testing capability at time meaning COVID-19 swabs were sent to an offsite laboratory with concurrent delay in receiving a result Key actions from this and subsequent COIVD-19 outbreaks / nosocomial infections are contained in detail within the separate IPC BAF board report and are therefore not reproduced here.

Incident details	Learning
WSH-IR-59709 Patient required readmission due to DKA as a consequence of failures in discharge planning related to Insulin management	Root Cause: Nursing staff did not clarify with carer who was going to administer the patient's insulin at home following discharge Lessons Learned: • Communication failure between the clinical helpline and the ward team to the carer on the day of discharge as well as between members of the multi-disciplinary team (MDT) • Need to think how to manage complex discharges (in the middle of COVID pandemic) when no visitors were allowed, video calls between patients and relatives in place but use is dependent on personal preference or relative's technology Recommendations/actions: • Diabetes care plan to be made part of the daily clinical summary, which forms part of the ward round note, to be more visible and improve communication between teams. • Clinical helpline will contact wards directly if notes are unclear or if they have any specific queries. • Implement discharge prompt signage for ward staff, including: o Who is going to administer the insulin? o Has person administering the insulin been spoken to and confirmed arrangement? o Does a single point of access referral need to be made for same day or following day • Discharge Project Group formed with input from community nursing, patient safety, diabetes specialist nursing, discharge planning, therapies and care co-coordinators to review and improve discharge safety. Shared Learning: Communication to therapies staff to advise escalating concerns about discharge to ward clinical staff Ward manager and Matron communicate to the whole team about thoroughly checking the whole discharge checklist prior to any patients leaving the ward.
WSH-IR-56797 Failure of referral pathway from WSFT to Papworth for CABG* Patient since deceased. **Coronary artery bypass graft (CABG)*	NB: feedback from Papworth noted "*surgery would likely not have been 'prognostic' ...by which we mean that given his comorbidities and (in particular) age we cannot say that an operation would have prolonged life. It may well have offered improved symptomatic wellbeing*." **Root cause** Omission of referral letter submission by electronic or conventional means. **Lessons learnt** ED unable to find previous ECGs to compare with presenting ECGs. No audit trail in place to ensure letter or email delivery to external healthcare providers Clerical bank staff unware of referral process. **Actions** • Safety netting, 'read receipt' for electronic referral letters to be implemented • Implement database to record referrals sent and outcome for monitoring • Monitor referral database to ensure outcome is reported for all referrals **Shared learning** • Training and/or bulletins to educate staff in retrieval of archive information. • e-Care training package to ensure staff (including bank) aware of letter templates to be used and to adhere to local processes.

Incident details	Learning
WSH-IR-59112 Not all patients notified of outcomes of COVID testing if the results came in after discharged between late April and May	**Root cause** Lack of a clearly documented pathway which engaged multiple teams and did not have a safety net procedure for follow up. **Lessons learnt** Guidance continually changed; however, the public were aware of the need to self-isolate through national press release. **Actions** The ED team led an 'all patient' contact exercise beginning with the COVID +ve patients. 21 patients were identified as tested positive with no evidence this result had been communicated to them. A chronology was prepared for each of these patients to ascertain level of harm; no harm was identified. Patients were self-isolating as expected and there were no implications for family members. All patients identified as negative received written notification regarding their results. The potential for harm in this latter group was principally the extended timeframe of unnecessary self-isolation.
WSH-IR-60907 Small section of corridor ceiling fell onto floor during routine surveying of roof. Material fell near to passing staff member	No harm to staff member (a 'near miss') **Lessons learnt** Risk of invasive survey to roof finishes on the RAAC planks ahead of new works may cause small section of RAAC planks to come loose and fall to the interior causing a further risk of impact of debris to users of the interior. **Actions** Further surveys planned for quiet time. Operative with radios communications under the areas is survey to ensure no plank breakage is in progress during the survey. Survey tools changed from light hammers and chisel.
WSH-IR-58337 Patient fall in Marham House (residential home - patient receiving care from WSFT therapists).	A full RCA was undertaken by Marham House for local learning and action This was received by WSFT **Root cause / Lessons learnt** No access for strong analgesia/ medical care for the patient as not registered with a local GP surgery. Difficulties securing a temporary GP Datix completed retrospectively as incident unwitnessed by WSFT staff. **Actions** Quality assurance visit to Marham House by Head of nursing Expectation of temporary GP registration to be completed within 24 hours of admission to Marham House. **Shared learning** Regular meetings set up between WSFT and Marham House to discuss all issues arising and maintain an action log.
WSH-IR-56961 Patient developed Category 4 Pressure ulcer to buttock	**Root cause** Occurrence and deterioration of pressure wound due to complex clinical comorbidities. **Lessons learnt** Patient had been an inpatient during the deterioration (attending hospital for blood transfusion) and unclear documentation regarding moving and handling methods has questioned whether there was a shearing injury which impacted on the wound **Shared learning** Reflection of the incident to be shared with all Community Teams via CREWS newsletter and in the Medicine Division Governance meeting

Incident details	Learning
WSH-IR-57216 Patient seen in Emergency Department and discharged with diagnosis of influenza. Patient died at home following day	**Root cause** Overall presentation (temperature of 40+ and new confusion) would indicate potential sepsis however these did not trigger the sepsis alert on e-Care due to the elements of the tool currently in use and therefore staff did not follow the sepsis bundle and administer antibiotics. **Lesson learnt**: • Need to follow guidance and professional judgement and not rely on electronic system to for the delivery of immediate care requirements. • Antibiotics were prescribed using the regular medication portal as opposed to the 'stat' (one off) method. • Limited documentation at the time of clerking, including actual outcome of investigations taken (i.e. blood tests, X-ray) until the following day when this was entered onto the discharge summary (CRP rise and sepsis markers). • Wi-Fi signal in the emergency department triage rooms is poor necessitating manual input of observations as opposed to vital link machines connection to eCare resulting in a potential for omission (note: WIFI access point has subsequently been relocated away from a steel doorframe to address this issue) **Actions** • Review current sepsis tool: • Review current sepsis education and delivery methods, ensuring that this is consistent amongst disciplines and includes ED • Review sepsis protocol/ guidance in ED • Review sepsis related prescribing options **Shared learning**: • Results and subsequent (potential) changes to the sepsis pathway to be shared trust wide • Specific feedback to medical and nursing staff involved with this incident and ED senior staff

2. Other learning themes – Exploring new ways of working through eCare SmartZone

In May 20 this report included a (VTE specific) update on '*Improving patient safety through reduction in alert overrides and introduction of reassessment'*. This edition provides an update.

A trustwide doctors survey overseen by the Better working lives group highlighted excessive disruption due to pop-up alerts as the primary complaint about the electronic health record and a major perceived contributor to IT-related burnout.

In addition to the ever increasing number of alerts there was the additional problem whereby all alerts popped up unrelated to the user in the record and some alerts were aimed at the wrong staff group (e.g. an AHP getting alerts only able to be actioned by Medical staff).

Alert fatigue	**Why**
When clinicians inadvertently ignore clinically useful alerts or stop responding to them increasing the chance that patient safety alerts may be over-ridden. (Embi & Leonard, 2010; Kesselheim et al, 2011; Coleman et al, 2013)	*Alert overload and inability to cognitively process them.* *Reduced responsiveness due to repeated exposure, becoming desensitized.* (Embi & Leonard, 2010; Phansalkar et al, 2012)

eCare has a 'behind the scenes' web-based analytics platform known as the Lights On Network. This allows a review of data rather than relying on anecdotal evidence of alert overriding and it identified high override rates.

The data showed an average of 500,000 pop up alerts firing at clinicians each month.

One alert in particular was overridden on 93% of the occasions it fired, which questions its purpose.

Two major improvements have been put into place to address these issues:

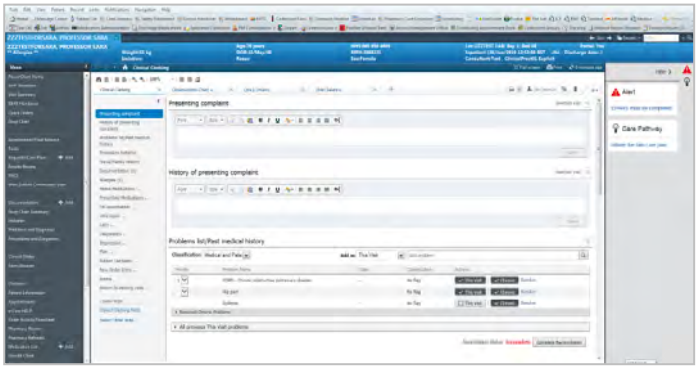
1. Alerts linked to user group (i.e. only doctors get 'medical' alerts such as EPARS) a review was undertaken to tailor the alerts to the recipient user groups even more than the original settings.

A future development ambition is the linking of alerts to the individual for whom they apply rather than just their staff group (e.g. Dr Smith needs to complete EPARS for his patient Mr Jones)

2. Introduction of SmartZone

Smartzone moves from pop-up alerting to display elsewhere in the EPR, thus alerts can be actioned by the right clinician at the appropriate time, and remove the disruption to clinical workflows within the EPR.

In addition Smartzone has the facility to click on the alert and be taken directly to the relevant page within the eCare record to speed up the process although there are some limitations (the link does not work for EVOLVE specific sections for example).



3. Patient safety incident response framework (PSIRF)

December's Scrutiny committee will receive a detailed outline of the proposed content of our PSIRF plan (referred to as the PSIRP). This will act as the formal engagement for the Executive and non-Executive Board members as part of the wider stakeholder engagement strategy.

It is proposed to present the final PSIRP to January's Scrutiny committee for formal sign-off and the trust board is asked to **formally delegate the authority to provide this approval** to the Scrutiny Committee.

Key recent and future milestones:

24 Nov 20 – VOICE group stakeholder engagement	01 Feb 21 – PSIRP go live
09 Dec 20 – Scrutiny committee stakeholder engagement	August 21 - Self-assessment of roll out
15 Dec – CCG / NHSI review of final draft PSIRP	December 21 – 2022/23 PSIRP board approval
13 Jan 21 - Scrutiny committee approval of draft plan	

4. HSIB reports

4.1 Issued in Q2 20/21 which relate to the care of a WSFT patient

This provides details of HSIB Maternity reports which relate to the care of a WSFT patient that have been issued. The report contains a high level summary of the learning, local review of content and any actions arising from these reports. A full action plan from each HSIB report received is submitted to the CCG.

Local ref.	Case (date)	Final report receipt	Key learning points	Safety actions identified following review of HSIB report and recommendations	Stage of WSFT pathway*
38400	30/04/2020 Neonatal death Sepsis very difficult caesarean section (CS).	Nov/20	1.Holistic approach to care in labour which includes analysis of fetal heart rate monitoring and consistently applied and incorporate an ongoing assessment of risk factors for mothers and babies.	Service has appointed a fetal monitoring midwife lead to facilitate multi-disciplinary, twice weekly fetal monitoring training sessions for midwifery and medical staff. Proposal for expected standard for MDT(multidisciplinary team) ward rounds on the Labour Suite: • 08.00 and 20.00 hrs MDT board based round led by coordinator • 08.30 & 20.30 hr MDT labour suite round led by Obstetrician • 1700 board based round led by day obstetrician to night obstetrician.	3
			2.Ensure that a member of the intrapartum team maintains a helicopter view to maintain situational awareness to ensure the safe management of complex clinical situations	Supernumerary co-ordinator of the labour Suite who does not take a case load.	
			3. Ensure that staff are supported to follow local guidance to administer antibiotics to women undergoing VBAC (vaginal birth after caesarean section) when labour has not completed 24 hours after ARM (artificial rupture of membranes).	Audit of women undergoing VBAC. Note: audit demonstrated 100% compliance over previous 6 months. Guideline reviewed with minor amendment made for clarity. Reminders on Take 5 communication.	
*Stage	*1. Report received, 2. Baseline assessment of recommendations in progress, 3.action plan agreed and being implemented*				

4.2 National HSIB reports issued in Q2 20/21

Whilst HSIB documents are available for specialty level review and learning, there is not currently a formal structured process for receipt and responding to publications that are not specifically related to the care of a WSFT patient (i.e. national thematic reports) although it is anticipated that these may be reviewed locally.

It is intended that this process will form part of the role of the clinical audit and effectiveness post currently being appointed to. In the meantime the list below provides an example of the type of reports being published.

Issued	Title
Jul 20	Life threatening risk posed by delay in group B strep treatment
Aug 20	Importance of clinical vigilance in immediate postnatal period for safe care of babies
Aug 20	PPE guidance safety risk when delivering care in people's homes
Sept 20	Importance of the 'family voice' in healthcare investigations
Sept 20	High-risk medication errors

5. Learning from Deaths (LfD)

5.1 LfD team activity

The second edition of the LfD bulletin was published in October (see hyperlink) with a theme of 'What is a good death' as well as the MEs 'first 60 days'.

http://staff.wsha.local/Intranet/Documents/E-M/LeadershipandQualityImprovementFaculty/docs/Sharedlearningbulletins/Learning-from-deaths-bulletin-edition-2.pdf

The next edition planned for December/January. This will contain articles on the theme of 'The complex patient'.

Progress since the last report to achieve 'business as usual' for the CQC Improvement plan MUST requirement is as follows:

Ref 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.

- Appointment of LfD caseload manager to oversee the 'Learning into action' strategy
- Collation of all specialties M&M (morbidity & mortality) reporting and recording pathways
- Presentation to Clinical senior leaders meeting to agree Trustwide standardisation of M&M

5.2 LfD data

Table 1: LfD data Q4 (19/20) – Q2 (20/21)

	Deaths	Deaths with an SJR* completed	SJRs classified as Poor / Very poor care	Poor care reported as an SI
Jan-Mar	302	72 (134 for SJR)	13	1 (Fall with #)
Apr-Jun	254	99 (161 for SJR)	12	0
Jul-Sep	188	40 (102 for SJR)	7	1 (Deteriorating patient)

** SJR - Structured Judgement Review*

6. Quality assurance

During COVID the formal Tuesday morning walkabouts ceased to continue due to the pandemic requirement to reduce visitation to ward areas. Due to the unplanned break there was an opportunity to review the process to ensure the scope and outcome of the walkabouts are as efficient as possible providing assurance of safety and quality in the organisation.

Quality walkabouts are being redesigned to be aligned with the multi professional QA visits agreed through the Improvement Board, the first of which took place in Maternity in September followed by a visit to Main Theatres, Day Surgery and ED in October to review medication security.

The Maternity visit enabled the Improvement Board to classify a number of actions within the wider plan as 'business as usual' (further details provided in last month's Improvement Board report) and following the positive feedback from the Medication security visit it is envisaged that further actions can be likewise turned 'blue'.

A further quality assurance 'round table event' (in place of a visit) is planned in December to review the safe, effective and high quality care for patients with a learning disability.

7. Raising concerns

WSFT has in place a number of options for staff to raise their concerns internally including opportunities to do this anonymously. Formal pathways include talking to: line managers, member of the human resources department, trade union representative and the 'Freedom to Speak Up' Guardians and for staff who want to raise a concern anonymously there are two available pathways: intranet reporting form or answerphone message on anonymous reporting phone-line.

Concerns raised through all the above methods are captured on a trust database held on a secure drive active since January 2020. Some concerns were raised through the email web-form but none through the anonymous reporting telephone line. Some staff chose to give their details and did not require anonymity.

6/21 concerns raised in the period Sept-Oct included an element of patient safety/quality and 2/21 included an element of bullying and/or harassment. There was no report of staff experiencing detriment as a result of raising their concern.

Route for raising concern	
Freedom to Speak Up Guardian	5
Senior Independent Director (SID)	0
Chief Executive	12
Anonymous phone line	0
Web form	4
Other e.g. NED other than SID	0

Division / Directorate of staff member raising concern			
Medical	3	Clinical support	1
Surgical	2	Women & children	1
Corporate	0	Community & Integrated services	0
Not disclosed	6	Estates & facilities	8

Staff group raising concerns			
Not disclosed	5	Maintenance and ancillary	5
AHP	0	Manager	0
Medical	2	Senior leader	0
Registered nursing and midwifery	5	Professional and technical	0
HCA	0	Other	0
Administrative and clerical	4		

Two concerns raised in the two month period related to sustainability and the Trust's approach to recycling and another three concerns related to the safety of equipment. Two of these are under investigation and the third is being addressed by providing staff with easy to access information about maintenance arrangements and where to report equipment that may require attention.

8. Mitigated red risks

During Q2 there was one red risk downgraded or closed:

The pharmacy production unit is running close to or over capacity (Datix id 4067)
The risk assessment has been downgraded to Amber (Annually x Major)
The current mitigation includes:

- The Trust approved a business case for 7wte additional staff for the production unit
- to date 5.8wte have been appointed and are coming into post
- The remaining post is on a rolling advert on NHS jobs, as are the remining pharmacy technician posts within the pharmacy department.
- The Pharmacy department has a further 17wte posts that have been appointed to and are awaiting staff to take up these posts.
- The pharmacy production unit was re-inspected on the 2nd March 2020, at which point the units risk rating was reduced to low, on the basis of active staff recruitment

9. Learning from RIDDOR incidents

There were 5 incidents in Q2 reported to the HSE under RIDDOR:

- Three incidents were due to moving and handling
- One incident was due to a needle stick injury
- One incident was due to a trip

Learning and mitigation included:

- Moving and handling training

10. Learning from patient and public feedback:

Nine complaints received in Q2 were deemed to be upheld at the time of producing this report. Actions from these are set out in the table below. The complaints team are reviewing ways of ensuring that actions are implemented and effective including monthly spot checks, more details will be provided in the next report

Ref.	Issues identified	Actions and learning
WSH-COM-1781	Medication was not given in a timely manner and lack of updates provided to family	A communication book has been put in place for information to be handed over to the nurse in charge. Furthermore, AAU Manager has reiterated with the nursing team that when they receive information regarding prescriptions that they inform a doctor in person and document the name of the Doctor they have informed.
WSH-COM-1759	CT scan should have been performed during patient's second attendance which would have led to an earlier diagnosis.	Emergency department doctors have been reminded of the importance of ensuring that scans are undertaken when appropriate.
WSH-COM-1798	Patient was not referred and escalated to the paediatrician	A reminder has been sent to medical staff in ED of the importance of ensuring that staff review previous medical documentation and ensure that children who represent to the ED within twenty four hours are appropriately escalated to the paediatric team.
WSH-COM-1753	Alcohol wipes should not have been used which the patient was allergic to	Staff have reflected on this case and have been reminded to check for any allergies before applying medication/equipment. The patient's story will be shared with ward managers and senior matrons to ensure lessons are learnt.
WSH-COM-1787	Delay in MRI	A meeting was offered to the family to discuss the events which took place. Limited amount of staff that can perform this specific procedure who was off sick. Aim to increase the expertise in this area.
WSH-COM-1796	Patient's pregnancy could have been managed conservatively to confirm an ectopic pregnancy before the use of methotrexate	A presentation of early pregnancy cases, including the patients will be shown at gynaecology clinical governance meeting to highlight uncertainty in early pregnancy scanning and emphasise methotrexate should only be used when there is no chance of an intrauterine pregnancy or patient does not wish to continue with the pregnancy. A checklist for the use of methotrexate will be considered to ensure documentation of discussion of potential intrauterine pregnancy
WSH-COM-1762	No documentation to prove that medication was provided therefore assume it wasn't. no clear recording of medication	Staff have been reminded of the importance of ensuring accurate documentation regarding patient medications. Midwife involved with patients care has been spoken to by ward manager and maternity services manager.
WSH-COM-1779	Delay in fitting a catheter	Reminders have been sent to ensure clear documentation of urine output and the importance of this.
WSH-COM-1803	Safeguarding referral incorrectly made against husband. Referral was supposed to be raised against a different patient.	All safeguarding referrals have been removed from medical records. Complainant has direct phone number for senior matron for any further issues.

13.3. Infection prevention and control assurance framework

For Approval

Board of Directors – 4th December 2020

Item	13.3			
Presented by:	Sue Wilkinson Exec Chief nurse			
Prepared by:	Rebecca Gibson – Compliance Manager			
Date prepared:	November 2020			
Subject:	NHSE ICT assurance framework			
Purpose:	x	For information		For approval

Executive summary:

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

- Development of a dashboard to gather robust assurance
- Learning from outbreaks

In addition NHSE have issued (on 17th November) the document *Key actions: infection prevention and control and testing.* This sets out a 10-point summary of actions at organisation (8) and local system (2) level (listed in Annex A) to minimise nosocomial infection. The requirements are being incorporated into the trust ICT BAF and a self-assessment is in progress with an update to be provided next month.

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/11/key-actions-infection-prevention-and-control-and-testing-171120.pdf

Please note: This report does not provide details of the ongoing COVID-19 management plan.

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

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

Previously considered by:	
Risk and assurance:	As per attached assurance framework
Legislation, regulatory, equality, diversity and dignity implications	NHSE
Recommendation: Receive this report for information	

Development of a dashboard to gather robust assurance

Following the provision of admission swab data in last month's report, this is being extended to develop a dashboard of indicators linked to the individual elements of the BAF. It is recognised that not all indicators will be available and some which are may already be reported elsewhere. Future iterations of this report will aim to provide more data and so this should be considered a first draft.

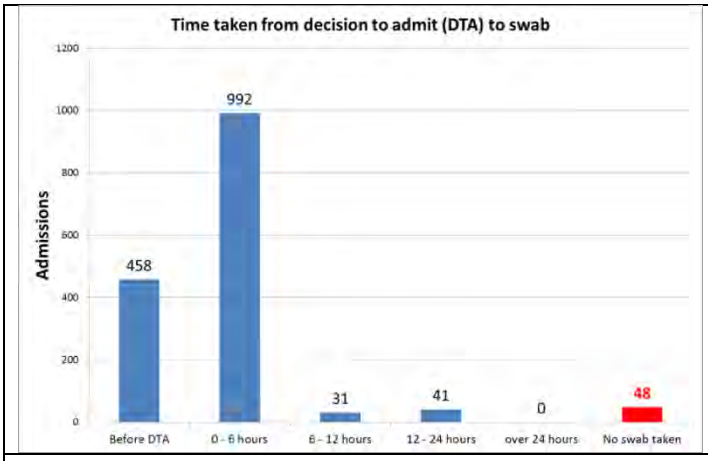
Key indicators should enable the organisation to measure compliance against the newly issued NHSE guidance (Annex A).

Dashboard indicator	Measure (or narrative where measure not yet identified)
Admissions swabs	Time between decision to admit (DTA) and swab (Standard = 100% within 24 hours)
Admission day swabs	Swab undertaken on day of admission (all patients who are not already confirmed +ve)
Nosocomial (hospital onset) transmission	Defined by the days from admission to first positive specimen sample date
Incidents relating to C19 management	Number of incidents where C-19 is mentioned in incident description.
C19 Outbreaks	Reported in the month.
Antimicrobial audit compliance	Data reported from Q2 onwards. Reports are sent to IPCC, AMG and are shared with the Lead Pharmacists so any actions are discussed and actioned accordingly
Staff work-related C19 cases reported to RIDDOR	The reporting requirements changed in May 2020 to be more specific thus March/April data is not comparable and is not reported https://www.hse.gov.uk/coronavirus/riddor/index.htm
Data information team is exploring options / developing reports for	
Day 3 swabs	Day 7 swabs
Discharge to care home swabs	Pre-admission elective testing
Possible additional indicators for future reporting months	
Equipment training	IPC audits
Donning & doffing training	Contact tracing
Cleaning audits compliance	Staff risk assessments % completion
Indicators where a quantitative measure is not currently available	
Patient moves	eCare now captures and records the number of patient moves (see screenshots below) on the safety dashboard and the whiteboard. This does include in ward moves (i.e. between bays). The system is not currently able to report totals (e.g. patients in October who have had >5 moves during an inpatient stay). It does however provide a source of information for staff to prevent excessive individual patient moves when looking to manage timely bed-flow. A planned table-top exercise by eCare and the Patient safety team is scheduled for December 15th 2020
Staff moves between clinical areas	Our current assurance notes that *Matron of the day records and monitors staff movement between areas across the organisation*. However the ability to evidence this needs strengthening. The Heads of Nursing have taken an action to ensure this happens consistently via a manual recording system whilst we explore and implement an electronic system.In the Community assessment beds the ward managers maintain paper records although there are not currently many moves in these environments.
Contacts with wellbeing services	Options to measure this have been proposed including number of people who have been supported whilst off sick and the number of people we have supported in their return to work. Data on this doesn't get formally reported at the moment apart from an overview in the People plan & OD report to the board.

Dashboard (version 1)

Measure	Time period reported	Data
Compliance to Antimicrobial stewardship (AMS) standards	Q2	91.7%
AMS ProTectis compliance	Q2	85.8%
Nosocomial C19 (probable + definite)	Oct 20	2
Staff work-related C19 cases reported to RIDDOR	Jun-Oct	0
Incidents relating to C19 management	Oct 20	33
Admissions swabs within 24 hours of DTA	Oct 20	97%
C19 outbreaks	Oct 20	1

Associated charts / tables / narrative



97% of patients had a swab taken within 24 hours of the DTA in October.

Last month non-compliance was reported for 174 patients however review of the data highlighted that the denominator included patients attending Ambulatory Emergency Care (AEC) or Children's assessment unit (CAU).

Removal of this cohort meant that 96% of September swabs were taken within 24 hours of the DTA in October.

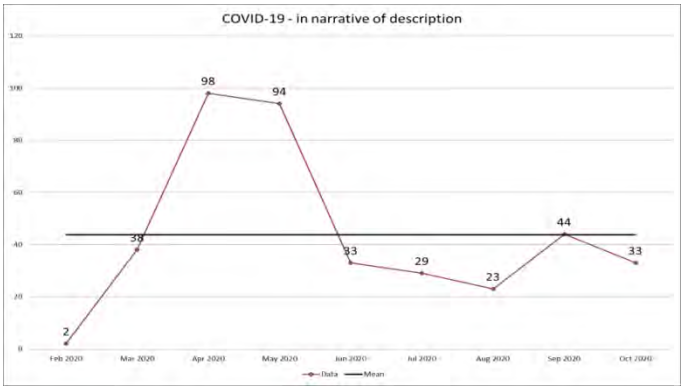
NB: Next month's report will also include data for Day 3 and Day 7 swabs

Nosocomial (Hospital-Onset) C19 definition based on first positive specimen date X days after admission:

Probable (8-14 days)	Definite (15 + days)

There were two identified probably/definite cases in October including one on F12 (reported as an outbreak).

Month	Probable	Definite
Mar-20	3	4
Apr-20	12	10
May-20	16	11
Jun-20	2	1
Jul-20	6	0
Aug-20	5	0
Sep-20	2	0
Oct-20	1	1



The number of incidents recorded relating to C-19 remains considerably lower than in the period Apr-May. This earlier spike was mainly composed of:

- health & safety incidents reporting members of staff with confirmed C-19 (76 in two months) prior to RIDDOR reporting clarifications and

- cross infection / isolation breaches (45 in that time).

Despite C-19 admissions beginning to rise the number of incidents currently remains much lower than in the spring.

Learning from outbreaks - To date the organisation has reported five outbreaks. In line with national reporting requirements each event was reported as a serious incident (SI) on STEIS and to Public Health England. A 'learning from COVID' plan is being collated to pull together evidence from SIs as well other reviews such as the observation study on staff adherence to distancing requirements reported to a previous meeting.

G9	May 20
F3	Jul 20
F12	Oct 20
G5	Nov 20
Rosemary	Nov 20

Annex A: Key actions: infection prevention and control and testing (NHSE)

Organisations: It is the board's responsibility to ensure that:

1. Staff consistently practice good hand hygiene[1] and all high touch surfaces and items are decontaminated[2] multiple times every day – once or twice a day is insufficient.
2. Staff maintain social distancing in the workplace, when travelling to work (including avoiding car sharing) and to remind staff to follow public health guidance outside of the workplace.
3. Staff wear the right level of PPE when in clinical settings, including use of face masks in non-clinical settings.
4. Patients are not moved until at least two negative test results are obtained, unless clinically justified.
5. Daily data submissions have been signed off by the Chief Executive, the Medical Director or the Chief Nurse, and the Board Assurance Framework[3] is reviewed and evidence of reviews is available.
6. Where bays with high numbers of beds are in use, these must be risk assessed, and where 2m can't be achieved, physical segregation of patients is considered, and wards are effectively ventilated.
7. **Staff testing:**
    a) Twice weekly lateral flow antigen testing for NHS patient facing staff is implemented. Whilst lateral flow technology is the main mechanism for staff testing, this can continue to be used alongside PCR and LAMP testing.
    b) b. If your trust has a high nosocomial rate you should undertake additional targeted testing of all NHS staff, as recommended by your local and regional infection prevention and control team. Such cases must be appropriately recorded, managed and reported back.
8. **Patient testing:**
    a) All patients must be tested at emergency admission, whether or not they have symptoms.
    b) Those with symptoms of COVID-19 must be retested at the point symptoms arise after admission.
    c) Those who test negative upon admission must have a second test 3 days after admission, and a third test 5-7 days post admission.
    d) All patients must be tested 48 hours prior to discharge directly to a care home and must only be discharged when their test result is available. Care home patients testing positive can only be discharged to CQC-designated facilities. Care homes must not accept discharged patients unless they have that person's test result and can safely care for them.
    e) Elective patient testing must happen within 3 days before admission and patients must be asked to self-isolate from the day of the test until the day of admission.

Systems: Local systems must:

9. Assure themselves, with commissioners, that a trust's infection prevention and control interventions (IPC)[4] are optimal, the Board Assurance Framework is complete, and agreed action plans are being delivered.

10. Review system performance and data; offer peer support and take steps to intervene as required.

[1] https://improvement.nhs.uk/documents/4957/National_policy_on_hand_hygiene_and_PPE_2.pdf
[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/910885/COVID-19_Infection_prevention_and_control_guidance_FINAL_PDF_20082020.pdf
[3] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/IPC_Board_Assurance_Framework_V1.4_15_October_2020.pdf
[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/910885/COVID-19_Infection_prevention_and_control_guidance_FINAL_PDF_20082020.pdf

13.4. Quality improvement programme board report

For Approval

Trust Open Board – 4 December 2020

Agenda item:	13.4			
Presented by:	Sue Wilkinson, Executive Chief Nurse			
Prepared by:	John Connelly, Head of PMO			
Date prepared:	27 November 2020			
Subject:	Improvement programme board report			
Purpose:		For information	X	For approval

The Improvement programme board meeting, held on 9th **November 2020**, considered the following:

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

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

Eighteen change requests submitted for approval at November IPB were approved including:

1. Six plans moving from Complete (Black) to BAU (Blue)
- Plan No 4.4: Patient Experience
- Plan No 21: Maternity – Monitoring women's records
- Plan No 23: Maternity – Women asked questions about domestic violence
- Plan No 25: Maternity – Vital signs observations for new borns
- Plan No 26: Maternity – Daily checks of resuscitation equipment
- Plan No 29: Timely diagnostic test results

2. Two plans move from Green to Black (Complete):
- Plan No 19: Medicines Management in main Theatres & DSU
- Plan No 27: Maternity – Up to date clinical guidelines

3. One plan moves from Amber to Black (Complete):
- Plan No 66: Compliance with best practice and national guidance

4. Three plans move from Amber to Green
- Plan No 3 / 4.3: Incident reporting
- Plan No 65: Clinical Audit - Community
- Plan No 67: Maintaining cleaning records

5. One plan moves from Red to Amber
- Plan No 6: Follow up and Surveillance patients

6. The completion dates for five plans are extended:

- Plan No 3 / 4.3: Incident Reporting extended to 31.01.21
- Plan No 4.1: Clinical audit extended to 31.03.21
- Plan No 15: ED Equipment and Medication checks extended to 30.11.20
- Plan No 42: Team meetings undertaken to share information extended to 30.11.20
- Plan No 65: Clinical Audit – Community extended to 31.03.21

One change request to move Plan No 55/64/71 from Red to Amber submitted for approval at November IPB was not approved as further progress regarding compliance is required.

- The interim internal audit programme reported that the Trust Improvement Programme was providing 'Substantial Board Assurance' which is the highest rating standard

- Divisional Triumvirate Leads were identified completing IPB Membership (Appendix 4).

- Proposed BAU assurance process was approved. (Appendix 2: Schedule of Embeddedness)

- A favourable Medicines Management report was received based on the 20th October visit by the CCG Clinical Quality Team. The report findings will inform change requests for relevant improvement plans at the next IPB

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

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

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

Recommendation:

1. Note the report and contents
2. Approve the updated Trust improvement plan (Annex A)

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Curre overall
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**	**IPB Update 09.11.20: Plan remains on track to complete Nov '20. Key actions presented below (1 - 9) in response to stat** 1. 'What Matters to You' captured feedback from over 2,000 staff with 5 key themes arising. Shared Trust-wide through Gre 2. Draft People Plan for WSFT incorporating WMTY, Just Culture and national People Plan developed and shared at TEG on 5 3. Board Development programme in place; proposal for next steps with Chair. Revised Executive Director objectives for 20 4. Plan for M.E.S in place. Intention to do this in partnership with BWLG who have raised queries that ideally need to be res 5. Staff Psychological Support service established and operational. Recruitment to expand the team in progress. Feedback system-wide bid for resources. 6. BAME and Disabled staff networks set-up. Comms support to improve profile in place. Annual E&D report to TEG and Bo 7. 4xHRBPs recruited and commencing during period Sept-Nov 2020, aligned to clinical divisions. 8. Workforce director report submitted to Board with positive feedback on 2.10.2020 with further feedback sought for deve 9. Plan submitted to H.E.E. detailing actions to respond to the concerns raised by the review. Other Updates via SRO Cluster and Planning Reviews: - Merseycare NHS Trust presented their 'Just and Learning Organsation' findings at the 5 o'clock club. We have reserved ter - HR Business Partners recruited to support cultural improvemt with review and implementation of HR policies that is consis - The detail of the improvement actions has been enhanced following feedback from CQC. - 2020 national NHS staff survey launched this month. Concern re. survey 'fatigue' coming quickly on the heels of WMTY. - Weekly COVID workforce and staff support engagement meeting continues to meet - Medical Director leading on clinical director role development
2	The trust must ensure the culture supports the delivery of high quality sustainable care, where staff are actively encouraged to speak up raise concerns and clinicians are engaged and encouraged to collaborate in improving the quality of care.	1. Recruitment a new Lead Freedom to Speak Up Guardian, who in turn will develop a network of Speak Up ambassadors. 2. Implement lessons learned from external review of whistle blowing matters	Stephen Dunn	Jeremy Over	Green	30.11.20	**Update 09.11.20: Both new FTSU Guardians in place and planning underway. This includes communications – meeting sc OD)** Update 12.10.20: - 100 staff TUPE back from ESNEFT & PHE. Expression is favourable amongst staff to rejoin Trust from 01.11.20 which is cos - Anaesthetics: AXA accreditation actions in focus. Update: 07.10.2020: 1. Interviews for FTSU Guardian completed 11.08.2020. Amanda Bennett & James Barrett appointed. Publicised in Green Sh 2. Further Speak Up plans and improvements detailed in separate project plan within IPB pack. 3. External review in progress. Information gathering phase still ongoing. 4. Proposal for the future oversight and governance arrangements for workforce and culture to be developed, to include op 5. Staff consultation programme undertaken to support Pathology transfer. Dedicated HR support in place. 6. Anaesthetics team have fed back to execs following consideration of report's recommendations. Execs to discuss this and 7. Task and Finish Group to enhance support for staff in stressful times established. Plans to elicit feedback from staff to inf Other Updates via SRO Cluster and Planning Reviews:- The detail of the improvement actions has been enhanced this month
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	Green	**31.01.21**	**Update 09.11.20: Request to IPB is to move the plan RAG from Amber to Green and to extend the end date to 31.01.21.** **-PSIRP pilot site work is due to start and complete by end October** **-Project leads and HoNs are conferring to develop a new way to ensure learning is shared at ward level** **-Number of actions in plan has been revised accordingly.** Update 18.10.20: Plan updates made to accommodate issue of wider shared incidents learning which can be accommodate Update 12.10.20: Request to IPB is to approve the move the overall Plan RAG to Amber as work is progressing within constraints of: - National PSIRF programme - WSFT review of Patient Safety and Quality Expectation PSIRF document accounting for organisational changes complete 31.12.20 1. Trusts Patient Safety and Learning Strategy document is on intranet - will be informed/updated with outputs from interna - WSFT PSIRF Project group formed first meeting first week August 20. - Co-production with PSIRF being developed at ICS meeting in partnership with Trust. - Regional and National meetings have recommenced following Covid-19. - Heads of PS, Clin Gov, Human Factors, LfD and QI have established an internal informal forum and will continue to work cl - Review of (non SI) incident pathways / addressing untimeliness of investigations is dependent on PSIRF work 2. A PSIRP stakeholder consultation will be undertaken when draft is complete. There have been two PSRIP Project Group m - JD for divisional Governance Manager under review taking in to account divisional / service level requirement to support c - PS, Human Factors, QI, LfD working together to establish framework for regular shared learning bulletins and events on tra - PSIRF education, training to be rolled out
4.1	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - clinical audit is monitored and reviewed to drive service improvement.	1. Review and define opportunities to improve the current organisational pathways for recording and reporting on local and national audit participation including consideration of a new bespoke audit information system. 2. Working with divisions, develop a structure to enable the inclusion of audit actions within wider divisional improvement plans 3. Widen the scope of clinical effectiveness to address all elements of national best practice including but not limited to NICE guidance, Royal college publications, HSIB and other national best practice publications	Nick Jenkins	Rebecca Gibson	Red	**31.03.21**	**Update 09.11.20:** **- Request to IPB is to approve plan completion date extension to 31.03.20** **- Recruitment to new Clinical Audit Support role is underway but is unlikely to be in post before Christmas. Interim solut** Update 12.10.20: - Audit actions guide being trialled in maternity and will be rolled out to other divisions if successful. Completion of key corporate and divisional clinical audit programme actions subject to appointment of clinical effectiveness the current timeframe. - Clinical effectiveness / audit facilitator recruitment process ongoing. Update: 07.09.20:Approval required from IPB to extend project completion date by three months as certain Clinical Audit ac expected. - A co-production approach will be adopted going forward to deliver an agreed Patient Safety and Quality Governance struc

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Curre overall
4.2	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - mortality reviews are monitored and reviewed to drive service improvement.	1. Set up the National Medical Examiners service which will review all deaths and agree a reporting pathway into the trust for any cases requiring further review. 2. Supported by the appointment of a Learning from deaths (LfD) caseload manager; 3. Implement the LfD strategy including the specific action to streamline and centrally capture learning from local M&M reviews	Nick Jenkins	Jane Sturgess	Green	31.3.21	**Update 13.10.20:** **- LfD team recruitment is underway with the doctor role now being VAF-assessed. HR has been unable to process the job des** **- LfD Caseload Manager has now been appointed and a start date has been agreed for 01.02.21** **- A pathway for case transfer from ME to LfD is being written and a consideration log approach is being discussed to cross-ref** Update 12.10.20: 1. Medical Examiners service set up with agreed case transfer pathways in to Trust where cases require further review 2. Medical Examiner's now in post. One MEO to be appointed to complete recruitment. LfD Caseload Manager interviews w/c 0 3. Embedded strategy will be evidenced by 3 - 6 month service evaluation given potential impact of Trust PS&Q review to furth given interdependency with QI team. However, processes in place and actions complete to ensure that mortality reviews are be Request to IPB is to agree to an extension date to 31.03.21 as whilst there is a structured QI improvement plan progressing at p recruitment for senior staff departing the central team. - ME to LfD case transfer pathway complete and under review re embeddedness - Preparing to go to advert for the LfD Team (Clinical reviewers) and Caseload Manager is advertised on NHS Jobs this week - Service evaluation embedding evidence being collected re implementation of LfD plan - Divisional leads discussing divisional governance for the M&M to LfD case transfer pathway / agree standard process. Pathwa rather than 3. Pathway updates to go in to LfD policy by Dec 20. - PALS to LfD case transfer pathway progressing in September with meeting taking place this week between clinical lead and pa - Last appointed Medical Examiner starting 14.09.20. Recruitment is in progress for the final ME officer
4.3	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - incidents are monitored and reviewed to drive service improvement.	1. Through participation in the national pilot for the implementation of the Patient safety & improvement framework (PSIRF) design pathway for monitoring, investigation and review of outcomes from incident reporting 2. Implement the trust patient safety & learning strategy developed in 2019	Susan Wilkinson	Lucy Winstanley	Green	31.12.20	**Sc**
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	Blue	31.10.20	**Update 09.11.20: Request to IPB is to move Plan 4.4 to Blue (BAU) as 3 board papers have been collected demonstrating presented reporting on experience metrics such as PALS enquiries, compliments, formal complaints and Friends & Family meeting to allow for discussion around themes and trends, allowing learning and service improvement across the divisio** Update 20.10.20: Plan is reported as on track to move to BAU on schedule. Update 12.10.20: The overall RAG is expected to move to BAU (Blue) in November based on 3 months compliance data being collected in ter demonstrate BAU. - The plan is to return to IPB in November with an ongoing BAU assurance plan e.g. review sample of learning and testing th Update 14.09.20: - All actions complete - Team attending divisional board meetings to evidence BAU - Quaterly 'You Said/We Did' ward posters prepared to demonstrate engagement with patient feedback. There will be a ru feedback.
5	The trust must ensure that effective process for the management of human resources (HR) processes, including staff grievances and complaints, are maintained in line with trust policy. To include responding to concerns raised in an appropriate and timely manner and ensuring support mechanisms in place for those involved.	The management of HR processes, including investigations, will be strengthened by embedding the following in practice: 1. Monitoring time lines for each case 2. Reviewing cases that are not progressing in a timely fashion, taking action where possible. 3. Actions to be recorded on the database and effectiveness reviewed at subsequent fortnightly Case Review meetings. 4. Escalate cases where there is a significant delay to the Executive Director of Workforce for review in regular meeting with Deputy Director of Workforce 5. Consider use of external investigators where there is a lack of internal investigatory resources 6. HR Policies will be reviewed to ensure a more kind and compassionate approach that is aligned to a 'just' culture.	Jeremy Over	Claire Sorenson	Green	**31.03.21**	**IPB Update 09.11.20:** **- Recruited 4 HRBP all in place by 2.11.20. Supports cultural movement.** Update 12.10.20: - HR Business Partners are currently being appointed to lead on adopting and embedding kind, compassionate and inclusive - HR Business Partners will be aligned and support all divisions and corporate services across the Trust. - HR Business Partners will also support a planned review and development of HR policies to ensure they are written and ad [Policies for Review by January 2021: Disciplinary, Capability, Improving Health, Wellbeing and Attendance, Grievance, Bully February and March 2021. - Merseycare HR policies received and will be reviewed as a benchmark for our own HR policies - Formulataion of an Investigation Toolkit is progressing and due to complete in November '20, utilising a working group. - The wider HR Team will support our managers to ensure delivery of compassionate and timely HR Investigations, effective - A training programme provided by Merseycare and Northumbria will take place in November - A pre investigation assessment process is currently being introduced to ascertain whether informal interventions and mea

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Curre overall
6	The trust must ensure that robust processes are embedded for patient follow up appointments and those on surveillance pathways. To include systems and process for regular oversight and assurance that patients are not being lost to follow up across all specialties within the organisation.	1. Design process for follow up booking 2. Recruit two new members of staff in TAC for all ward booking follow ups. Write SOP for Endoscopy. 2. Update all relevant Standard Operating Practices for Follow Ups and Surveillance. Write SOP for Endoscopy. 3. Identify and deliver any training needs within each specialty and Endoscopy 4. Design process for virtual surveillance booking of patients 5. Clinic Patients Missing Follow Ups - e-Care work 6. Prepare Communications piece for Green Sheet/Staff Briefing 7. Agree Go-Live date and communicate to all relevant parties	Helen Beck	Hannah Knights	Amber	31.03.21	**Update 03.11.20: Request to IPB is to approve plan to move from Red to Amber. All processes are in place to progress ke** **Update 22.10.20:The SRO Cluster approve the plans to move to Amber on the basis that there are still some risks around that the plan is progressing.** Update 21.10.20: Follow-Ups: additional SOPs have been added to the workplan, extending completion of this action to 31.10.20. Training pr develop new reporting dashboard. Outpatients: Message Centre process has been agreed and templates for appointment requests are bring set up. Clinic Follow-Ups: deficiencies in current eCare worklists have been identified and a conversation with Cerner is due to start to weekly recovery action plans. An SOP for the current follow-up management practice has been written which will develo Surveillance: All SOPs for 'as is' process have been written and sent to departments for feedback. Training issues have been service leads. A possible new audit framework is due to be discussed with the Patient Safety Team. Outlining of the change and expected to continue for a few more weeks. U
7	The trust must take definitive steps to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant.	The main themes from the actions plans are: 1. RTT Reporting – update to the reporting solutions to remove as many as possible of the manual workarounds within RTT reporting. Requires support from Cerner on technical fixes and testing by the WSFT Information Team. 2. RTT Training – working with users of the system and patient pathway trackers to ensure accurate information recorded relating to RTT pathways. 3. Data Quality – work to ensure there is a programme in the organisation to focus specifically on DQ. 4. Theatres Information – development of the initial theatres dashboard after end user pilot to version 2.	Craig Black	Nickie Yates	Green	31.12.20	**IPB Update 09.11.20: SRO to provide verbal update.** IPB Update 12.10.20: SRO to provide verbal update **Update 07.09.20: Request IPB approval based on+S16 progress regarding collation of RTT training data and data quality - Next steps rationalise plan before next SRO Cluster'** Update 03.08.20: 1. RTT Reporting: workarounds with significant risk addressed - modifications built in to system hence relevant actions BAU **Workaround issues identified by CQC addressed so this element is BAU given that the actions have defined outcomes. [B** 2. RTT Training: Remains amber. List of trained / not trained will be reviewed at next cluster and agree training compliance **compliance target at next cluster. Update 07.09.20: Accurate percentage of those trained from which BAU can be deterr company to monitor compliance with training. Cut-down e-learning training versions produced for clinicians. Support fe** 3. Data Quality: Data Quality strategy going to IG Steering Group 05.08.20 and agreement is crucial to completing the action required. **Update 10.08.20: Draft DQ strategy went to IGST which is the forum this work will progress. Update 07.09.20: project is Green.** 4. Theatre Dashboard live and approved via Trust Board. Use of dasboard embedded so can move to **Blue**
8	The trust must continue to develop information technology systems and integration across the community services	1. Submit Business case for approval at Trust Board 2. Appoint Project Manager 3. Establish programme reporting governance to Digital Board 4. Undertake technical reviews at Community Sites 5. Undertake infrastructure upgrades including service migration, provision of laptops and remote access solution 6. Monitor programme delivery	Craig Black	Mike Bone	Blue	31.12.20	Update 31.07.20: Change Control: End date moved to 31.03.21 with additional item No 5 in MB Plan version 31.07.20 for IPI Update 03.08.20: 1. Business Case approved at Trust Board in March 20 2. Project manager appointed 3. Programme Reporting to the Digital Board is now an embedded process 4. Reviews of technical requirements in Community completed 16.07.20 which can be evidenced. 5. Infrastructure upgrades have been signed off and are being implemented. 6. Programme delivery being monitored via Digital Board and key risks and mitigations identified including partner (NEL CSU Move Plan 8 to Black. IPB approval required. Update 10/08/20: IPB approved move to Black as all CQC requirements have been met although it is acknowledged improve **Update 10.08.20: The plan contains actions with defined outcomes in line with the agreed actions and these are already Community IT will be permanantly ongoing.**
9	The trust must continue to take action to improve performance against national standards such as the 18 week referral to treatment (RTT) standard, six week diagnostic standard ad access standards related to suspected and confirmed cancer management	1. Develop business cases for Orthopaedics, Ophthalmology, General Surgery and Gynaecology 2. Business Cases to include up to date demand and capacity models, outline plans and costings to reduce current backlog, whilst balancing demand to enable the services to meet the national standard. 3. Continue to update Action Plans for all other specialities on a monthly basis 4. Review and monitor plans at new RTT steering group meeting with the ADO's, Weekly Access Meeting and Cancer PTL Meeting 5. Develop comprehensive action plan for Endoscopy now demand and capacity exercise complete for review at new bi-weekly Endoscopy oversight meeting	Helen Beck	Hannah Knights	Red	31.3.21	**Update 22.10.20: Holding statement has been written to reflect the fact that this plan is no longer monitored at IPB but** Update 02.09.20: Request to IPB is that Plan 9 is removed from list of plans reviewed in detail at IPB as the actions are no lo activity monitoring, new action plans and remove the development of business cases (2). Updates discussed in 02.09.20 SRO cluster meeting: <u>Cancer</u> - System demonstration planned w/c 07.09.20 to develop cancer training strategy <u>Diagnostics</u> - Work continuing to assess the impact of new guidance on post polypectomy and post cancer resection surveillance guidan <u>RTT:</u> -RTT Business Cases awaiting approval for CT, MRI, Endoscopy re Covide Recovery -RTT Action Plans will be revirewed in detail at the weekly access meetings from 09.09. Plan information including revised v - Further amendments will be made to the RTT National Validation Programme participation information. First upload was additional validation.

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10	The trust must ensure that the duty of candour is carried out as soon as reasonably practicable, in line with national guidance	1. Continue to highlight key areas of non (or late) compliance via the IQPR and divisional performance reporting pathways. 2. Seek staff feedback on reasons for non (or late) compliance with DoC to identify opportunities for improvement using QI methods 3. Enable staff to fully achieve the remit of the Being Open framework through provision of training and support recognising that the patient / family conversations can be emotive and distressing both for the families but also the clinicians providing that message on behalf of the organisation	Susan Wilkinson	Lucy Winstanley	Red	31.12.20	**Update 20.10.20:** **Development of webinars and other training forums are being considered as a short-term solution for DoC training until** IPB Update 12.10.20: Co-production approach with support from Suffolk Healthwatch agreed to oversee assurance process. Update 12.10:20 Plan subject to same constraints as Plan 3 with development of the Trust's Patient Safety and Quality Agenda. -- DoC Mandatory training and education will be provided for consultants, senior nursing staff, senior managers and executi serious incident as part of Trust wide safety education syllabus - Review of PS&L strategy now reflects data sources, training requirements and consideration of document through PSIRF - Registration of DoC Improvement Plan, Datix review and introduction of data in PRM all complete, - IQPR/compliance monitoring on track but not embedded - Matrons and CD meetings will be part of escalation mechanism - Daily briefings have been key in improving timeliness of completion / also reporting in PRM - DoC work is continuing. The actions are designed to improve what currently doing. Challenge is to understand how better in the new strategy. Request to move to Amber will be subject to achieving agreed compliance levels.
11	The trust must ensure effective processes are in place to meet all the requirements of the fit and proper persons regulation	1. Put in place clear procedures that ensure full compliance with all FPP requirements and record keeping, including recruitment, ongoing declarations and appraisal. 2. Implement structured reporting and audit of compliance through the audit committee.	Jeremy Over	Angie Manning	Green	30.11.20	**IPB Update 12.10.20:** **- Awaiting final audit report. Met with auditors historical data issue to be resolved.** Update 12.10.20: Internal audit complete. Currently awaiting auditor report. The completion timeframe is 30.11.20 at which time any action Update 09.09.20: The request to the IPB is to agree to move the project end date to 30.11.20 from 31.08.20 at which point have been put in place. Time will be required for auditor feedback and to make any suggested changes to processes. At tha to BAU. Update 13.07.20: The small number of identified gaps within personal files have been of senior appointments have been re appointments Update 21.07: 1. Remaining action in plan to fully document recruitment process for NED's and Executives to be completed Update 10.08.20: extension approved at IPB; on track as above
12	The trust must ensure that mandatory training attendance, including training on safeguarding of vulnerable children and adults, improves to ensure that all staff are aware of current practices and are trained to the appropriate level	1. Build, review and implement the mandatory training recovery plan with tracking to ensure 90% compliance	Jeremy Over	Denise Pora	Amber	31.05.21	**Update: Overall MT compliance risen by 1% based on 08.10.20 data** **Update 12.10.20: Multiple additional activities are in place to improve Mandatory Training compliance including Moving been capitalised but there are still risks regarding room capacity and a greater staffing capacity risk with winter approac required time off to complete their mandatory training.** Update 09.09.20: Compliance slightly down on last month. Mandatory training requirements have increased due to additio and accommodation). Exploring options for new ways of delivery including OOH and external providers. Issues of staff not
13	The trust must ensure staff complete patient risk assessment to identify patients at risk of deterioration and risk assessments for day to day care activities.	Put eCare change requests in place to amend: 1) Changes to triage form, mandate safeguarding concerns yes/no box 2) Changes to triage form, mandate falls history/risk of yes/no box, to then generate ED falls assessment if yes ticked 3) Changes to ED safety checklist, to mandate all fields, to add n/a column, to move pressure area assessment from 2nd hr to 1st hr, to add drop down box on pressure area assessment to choose from skin intact, DTI, category 1-4 (to be able to choose more than one) 4) To mandate observation, pain score fields on triage form for both adult & paediatrics 5) To communicate changes to staff 6) To complete weekly audits to monitor compliance 7) To request compliance data from the information team 8) To have 1-1 with staff to identify areas of concern and address if required 9) Add to perfect ward 10) Monitor through weekly compliance audits and regular communications with ED staff re changes and be proactive with feedback re further changes	Susan Wilkinson	Ian Pridding	Blue	31.8.20	**Update 12.10.20:** **SW to provide 3 months data for LN. LN to provide external assurance re ED data. Assurance visit will be planned report - Plan 13 will move to appendix 6 for BAU Plans from November as holding place for Blue (BAU) Plans within the pack. - Appendix 6 will inform Appendix 2 Schedule of Embeddeness to include BAU quarterly reviews** Update 14.09.20: Request to IPB to move Plan 13 to Blue (embedded) as 3 months compliance data is in place and process to address compli - All actions complete and 3 months compliance data now received from information team. - A 4% - 7% dip was identified overnight between+S26 9pm - 4am with the lowest compliance at 93% on Fridays. - This is being addressed by the co-ordinators - Weekly compliance audits are in progress - Safety checklist also added to the Perfect Ward App

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14	The trust must ensure staff record medication temperatures and escalate any concerns in line with its medications policy.	1) Pharmacy to audit all fridge temperatures in Emergency Department. Actions to address issues resulting from temperature audit: - Introduction of trays into the fridge to keep stock together to minimise time looking for drugs - Pharmacy Assistant responsible for stock replenishment to return all excess fridge stock to pharmacy to improve airflow within the unit - Assess requirement of rigid cold blocks in fridge and remove if unnecessary - Installation of more accurate external fridge thermometers on advice of pharmacy - Request monthly audits from pharmacy to ensure continued compliance 2) Ambient temperature monitoring Ensure appropriate systems and processes are in place to monitor ambient room temperatures in areas where drugs are stored and appropriate escalation processes where required. Actions to address issue: - Installation of thermometers in all rooms used for storage of drugs. - Introduction of ambient room temperature checking on to existing fridge temperature checks - Compliance to be audited within monthly perfect ward assessments 3) Escalation of increased temperatures Ensure appropriate escalation of increased temperatures to Unit Manager to ensure appropriate action taken Actions to address issues - Email communication to all staff to remind to escalate high temperatures to Unit Manager (regular escalations since communication.) - Issue included in weekly hot topics discussed at all handovers. - Unit manager informs pharmacy of any escalations to ensure appropriate actions if required. 4) Long term strategy: Trust wide consideration of centralised temperature monitoring	Susan Wilkinson	Dona Bowd	Black	31.08.20	**IPB Update 09.11.20:** **Expectation is that this plan will move to BAU at December IPB subject to assurance visit 20.10.20 report and IPB approv** Update 12.10.20: Evidence gathering process underway. Expectation is that plan moves to BAU November 2020. Update 14.09.20: All actions complete. Data gathering in progress including daily manual checks and monthly Perfect Ward audits.
15	The trust must ensure that staff records in relation to equipment and medication checks are completed.	1) Review of documentation for equipment and medication checks Departmental review of existing documentation with a view to simplifying checklists and improve compliance. 2) Review of online checking duplication of paper and online checking was causing confusion and impact on compliance. 3) Long term strategy to replicate improved paper checklist on to the online system. 4) All changes communicated to staff via email and hot topic	Susan Wilkinson	Dona Bowd	Green	**31.11.20**	**Update 09.11.20:** **Request to IPB is to extend the completion date by one month to 30.11.20. Revised plan is to go live 09.11.20 with final 20.10.20** Update 20.10.20: The project is delayed due to technical problems. Online checks cannot continue until November and so t Update 12.10.20: Request to IPB is to extend project completion timeframe by one month to 31st October. Changes in IT st 2020. Update 14.09.20: - Final action on plan now green. No further delays are expected and so IT will finalise and upload online customised chackin August IPB.
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	Black	31.10.20	**IPB Update 09.11.20:** **The expectation is that the plan will move to Blue (BAU) at the December IPB subject to external assurance site visit and** Update 12.10.20: Request to IPB is to move plan to Black (complete). All actions complete preparing to move to BAU assurance process in No - Plan to run 3-month BAU audit from Nov '20 with Perfect Ward App calibrated is on track with the pharmacy team piloting Update 14.09.20 Final incomplete action in plan changed to include inspections using Perfect Ward App rather than mock inspections and wi - Audits now happening on wards / appropriate monitoring arrangements in place for the plan to move to Blue (BAU) from - Actions are happening to clarify the messaging across to relevant ward staff, including managers and matrons, to ensure th Update 21.07.20: - Inspection regime has been developed incorporating Covid-19 measures - ready to enact by 31.10. Final amber action 4 co - Challenge to find messaging strategy ref medications management better than already in place but will review further till
17	Obsolete		Obsolete	Obsolete		**Obsolete**	
18	The trust must ensure that all bank and agency staff have documented local inductions.	West Suffolk Professionals 1. A generic trust induction checklist is to be enhanced and re-implemented for all new agency and bank workers. This will be followed up with a local area induction to be completed during first worked shift. 2. Agency and Bank workers will complete local area induction on the commencement of their first shift. 3. If additional shifts are undertaken in different areas, it is the expectation of the trust that a local induction will be conducted for each new area worked. 4. All bank staff training is to be reviewed and recorded on OLM. Medical Staffing 1. All Agency staff are given induction booklets before their first day, which they are required to sign and return a statement confirming they have read and understood this on their first day. 2. Bank medical staff are formed by current training and trust doctors, therefore are covered by local induction process. Ad hoc audits will be undertaken by WSG and MS with findings reported to HRD on a quarterly basis	Jeremy Over	Chris Nevill / Helen Kroon	Green	**31.12.20**	**IPB Update 09.11.20: Relevant induction forms are now in place as part of the initial engagement with all new starters o** Update 12.10.20: The end date for the plan will revert to 31.12.20 as there are no training interdependencies with the Mandatory Training Pla The Medical Staffing plan has been reviewed. These actions are also complete. Three months compliance is data required and that a return is signed on the first day of work confirming that the induction booklet has been read. The Trust will also Update 08.09.20: - A detailed review of Plan No 18 has been undertaken since the last IPB with the new WSP management team. The outcon no red actions. - However, the request to IPB is that the project end date is extended to 31.05.21 as the review of training action will comp - The plan will now be reviewed with the Medical Staffing lead regarding the three relevant improvement actions. The WSP delivery plan to review and record training.
19	The trust must ensure that medicines are stored securely within the main and day surgery theatre department.	1. Identify storage requirement and purchase cupboards 2. Local audits planned whilst areas accessible re Covid-19 3. Identify cupboard locations and estates to hang cupboards 4. Risk assessments can then take place 5. Perfect Ward App to be introduced to ensure compliance	Helen Beck	Irene Fretwell	Black	**31.3.21**	**IPB Update 09.11.20: Request to IPB is to approve plan move from Green to Black. Project lead has confirmed that the ou register.** **Update 22.10.20: CQC auditors have carried out an assurance visit on theatres, surgery and wards and gave very positive remaining actions closed so that the plan can progress to BAU.**

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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	Black	28.2.20	**Update 20.10.20:** **The expectation is that the plan will move to Blue (BAU) at the December IPB subject to the findings of the external assurance visi** Update 12.10.20: Co-production / joint working assurance visit agreed for 20.10.20 as agreed at Sept IPB. - The Maternity deep dive recommendation is to move the maternity element in plan to BAU monitoring based on evidence seen. - The current expectation is that the plan will move to Black in October with BAU assurance process agreed as part of joint working as Update 06.10.20: In line with Plan No 16, the plan to run 3-month BAU audit from Nov '20 with Perfect Ward App calibrated is on track with the pharma range temperatures are logged on Datix. - The piece of work to develop a business case re centralised electronic temperature monitoring system is ongoing. The solution will in Update 14.09.20 Final incomplete action in plan changed to include inspections using Perfect Ward App rather than mock inspections and will complete - Audits now happening on wards / appropriate monitoring arrangements in place for the plan to move to Blue (BAU) from 31.08.20 a - Actions are happening to clarify the messaging across to relevant ward staff, including managers and matrons, to ensure the actions Update 21.07.20: - Inspection regime has been developed incorporating Covid-19 measures - ready to enact by 31.10. Final amber action 4 could theref - Challenge to find messaging strategy ref medications management better than already in place but will review further till end August
21	The trust must improve monitoring of women's records and ensure that a greater number of records are audited monthly.	Audit programme to be put into place including sampling methods and timescales	Susan Wilkinson	Karen Newbury	Blue	28.2.20	**Update 09.11.20: The request to IPB is to move the Plan to Blue (BAU) based on the external assurance report presented** IPB Update 12.10.20: Move 21, 23, 25 and 26 to BAU (Blue). Plan No's 22 and 24 are not ready to move to BAU. Update 12.10.20: Maternity Deep Dive completed 25.09.20. Report will be presented at October IPB as part of BAU assurar Update 10.08.20: Deep dive approach agreed at IPB as part of assurance to move plans to Blue (BAU).
22	The trust must ensure that carbon monoxide monitoring assessments and records are in line with trust policy..	Monitor compliance through audit and (when required) action to address non-compliance	Susan Wilkinson	Karen Newbury	Complete	28.2.20	**Update 20.10.20:** **RAG status remains Black (complete) as monthly check must continue until carbon monoxide monitoring recommences** Update 12.10.20: Actual test for Co monitoring levels is still on hold nationally due to Covid as this is an aerosol generated procedure. Mitigat answer documented. Action implemented, assurance testing ongoing. Recognised that pandemic has impacted on our ability to deliver this moni **Update 08.07.20: The RAG for Plan 22 cannot move from Black to Blue (BAU) given national stop on carbon monoxide m**
23	The trust must ensure that women are asked about domestic violence in line with trust policy.	Monitor compliance through audit and (when required) action to address non-compliance	Susan Wilkinson	Karen Newbury	Blue	28.2.20	**Update 09.11.20: The request is to move the Plan to Blue (BAU) based on the external assurance report presented at the** Update 12.10.20: Maternity Deep Dive completed 25.09.20. Report will be presented at October IPB as part of BAU assurar
24	The trust must ensure that they implement a nationally recognised monitoring vital observations tool for women attending triage on labour suite and the maternity day assessment.	1. Project plan for the implementation of MEOWS first in the maternity areas (complete) and then in the wider hospital for peripartum ladies (including the wider group of miscarriage, termination and ectopic pregnancies) 2. Continue to monitor compliance through audit and (when required) action to address non-compliance	Susan Wilkinson	Karen Newbury	Complete	28.2.20	**Update 20.10.20: Currently continuing monthly auditing.** **Update 12.10.20: Maternity Deep Dive completed 25.09.20. Report will be presented at October IPB as part of BAU assu**
25	The trust must ensure they implement a national recognised monitoring vital observations tool for new born babies on the labour suite and F11 ward.	1. Project plan for the implementation of NEWTTS (complete) 2. Continue to monitor compliance through audit and (when required) action to address non-compliance	Susan Wilkinson	Karen Newbury	Blue	28.2.20	**Update 09.11.20: The request is to move the Plan to Blue (BAU) based on the external assurance report presented at the** Update 12.10.20: Maternity Deep Dive completed 25.09.20. Report will be presented at October IPB as part of BAU assurar
26	The trust must ensure they carry out daily checks of resuscitation equipment.	1. Key actions are to remove paper checking of resuscitation equipment and replace with electronic checking	Susan Wilkinson	Karen Newbury	Blue	31.1.20	**IPB Update 09.11.20: The request IPB is to approve the Plan move to Blue (BAU) based on the external assurance report** **IPB Update 12.10.20: Aproved to move to BAU.** **Update 12.10.20: Plan is to move overall RAG to Blue (BAU) at end of October when 3 months data will have been collec** Action implemented, assurance testing ongoing
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	Black	31.10.20	**IPB Update 09.11.20:** **The request to IPB is to approve the plan move from Green to Black as all the guidelines have now been updated.** Update 20.10.20: Plan remains Green and on track to meet completion date. Update 12.10: Request to IPB is to move Plan RAG from Amber to Green. Only three guidelines remain to be completed an Update 23.06.20: 29/36 guidelines updated in maternity. Project plan being prepared to roll-out new technology to support Update 23.06.20: Clarity needed re divisional engagment via Tri Update 21.07.20: - Maternity guidelines nearing completion Update 18.08.20: - Tri-divisional representatives will feed in on this as the matter is organisation-wide - Discussed at the Quality Group 18.08.20

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Curre overall
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	Se
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	Blue	31.12.20	**IPB Update 09.11.20 Request to IPB is to move this plan to BAU as final action to provide clarification regarding the SOP process.** Update 12.10.20: Update 12.10.20: Radiology performance report received for Sept 20 for presentation at Oct IPB as part o - Plan is to share Diagnostics waiting times with patients. Update 14.09.20: IPB approve move to Black Update 03.09.20: - Request to IPB is to move the Plan to Black (Complete) as all actions are complete and can now be audited. - SOP regarding timely results for clinics has been reviewed and performance reporting has also been resolved.
30	The trust must ensure there is an effective process in place for monitoring patients requiring a follow up appointment and for those on surveillance pathways.	See No 6	Helen Beck	Hannah Knights	Amber	31.03.21	**See**
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	**IPB Update 09.11.20: The action points continue to be progressed. Please see next slides for details regarding Plan no. 31** Update 12.10.20: Request to IPB is to move plan to Green as the Task and Finish Group has met as planned and agreed whe available. The agreements have also been included in a communications document as a user guide. Update 01.10.20: The plan to achieve compliance is to engage and listen to a group of clinicians regarding what and how often a pain assessm clinicians through engagement commencing 02.10.20. Agreed compliance rates will then be monitored including the use o Update 23.09: Plan updated following meeting with Sandra Webb. Actions can be delivered within timeframe 31.12.20 Update 14.09.20: Plan moves to Amber following IPB. Plan to be updated with additional actions to achieve and measure compliance with ag Update 03.09.20 Request to IPB is to move Plan No 31 from Green to Black as the plan has been completed but has not delivered the require division to address this issue via a rapid Task & Finish Group.
32	The trust must ensure all staff complete mandatory training including safeguarding training.	See No 12	Jeremy Over	Denise Pora	Amber	31.5.21	

13.5. Nursing staffing report

For Approval

Trust Board – 4 December 2020

Agenda item:	13.5			
Presented by:	Susan Wilkinson, Executive Chief Nurse			
Prepared by:	Susan Wilkinson, Executive Chief Nurse, and Daniel Spooner Deputy Chief Nurse			
Date prepared:	November 2020			
Subject:	Quality and Workforce Report & Dashboard – Nursing October			
Purpose:	X	For information		For approval

Executive summary:

This paper reports on safe staffing fill rates and mitigations for inpatient areas. It complies with national quality board recommendations to demonstrate effective deployment and utilisation of nursing staff. The paper identifies how well planned staffing was achieved and the resulting impact of these staffing levels. It will go onto review vacancy rates, nurse sensitive outcomes, and recruitment initiatives.

Highlights

- Nurse staff fill rates were favourable this month across most areas.
- Vacancy rates have reduced from previous month
- Sickness rates have decreased across all nursing levels

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

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

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

Recommendation:

This paper is to provide overview of Octobers position about nursing staff and actions taken to mitigate, future plans and update on national requirements.

The dashboard provides summary of nursing staffing levels and effect on nurse sensitive indicators

Provides an update on implementation of NHSI Document 'Developing workforce safeguards – October 2018'

1. Introduction

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

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

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

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

2. Nursing Fill Rate

The Trust's safer staffing submission has been submitted to NHS Digital for October within the data submission deadline. Table 1 below shows the summary of overall fill rate percentage for this month and for comparison the previous two months. Fill rates for the overall trust remain favourable with no significant underfill. The overfill seen at night for care staff is consistent with the use of additional staff to provide 1:1 care for patients that may be at risk of harm to themselves. or others. Individual ward/department fill rates can be found in appendix 1.

	Day		Night	
	Registered	Care Staff	Registered	Care staff
Average fill rate for August 2020	103%	95%	98%	109%
Average fill rate for September 2020	99%	89%	96%	107%
Average fill rate for October 2020	100%	93%	97%	109%

Table 1: Fill rates are RAG rated to identify areas of concern (Purple >100%, Green: 90-100%, Amber 80-90%, Red <80.

This month, the first in a series of 'check and challenge' meetings commenced and fill rate data for this month's unify submission was reviewed. Areas where RN 100% fill was over 100% were reviewed to ensure wards have sufficient control on staff utilisation and areas under 90% were explored to understand why and what mitigations were put into place to support staff and patient safety. Only one area fell into a red risk rating which was the day fill rate of nursing assistants (NAs) within the Acute Assessment Unit (AAU). Daily mitigations were enacted by the Matron of the day (MOD) to address any concerns regarding safety providing additional support as required.

3. Care Hours per Patient Day (CHPPD)

CHPPD is a measure of workforce deployment and is reportable to NHS Digital as part of the monthly returns for safe staffing (Appendix 1)

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

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

4. Sickness

Sickness levels for Nursing/Midwifery and support staff were impacted in the initial months of Covid 19, both April and May saw an increase in absences in both nursing and support staff, these are demonstrated in chart 2. Sickness levels have improved in both RNs and NAs in October, with the lowest percentage in both groups within the last 6 months. (Chart 2 and Table 2b).

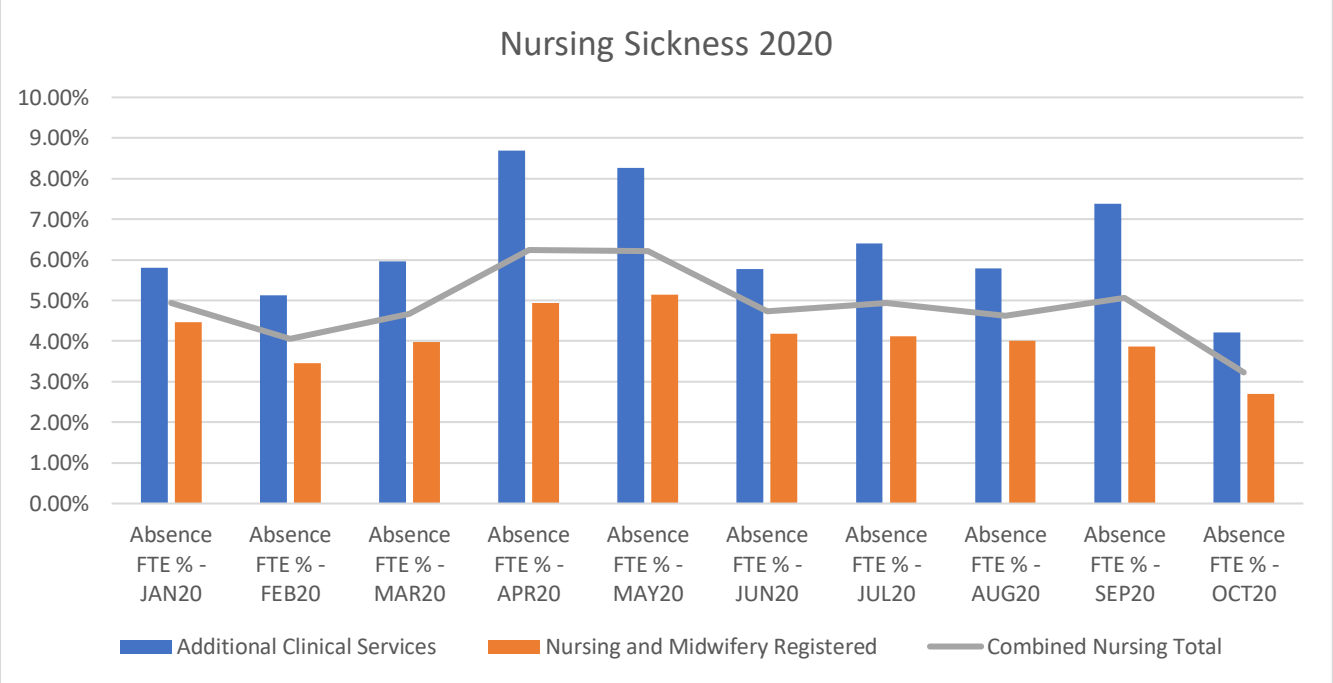


Chart 2.

	April	May	Jun	July	August	Sept	October
Unregistered staff (support workers)	8.81%	8.34%	5.69%	6.41%	5.82%	7.48%	4.22%
Registered Nurse/Midwives	5.14%	5.61%	4.78%	4.37%	4.31%	4.02%	2.71%
Combined Registered/Unregistered	6.42%	6.55%	5.10%	5.90%	4.84%	5.20%	3.23%

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 staff requiring to isolate has reduced to the lowest number in both RNs and NAs since this data has been collected.

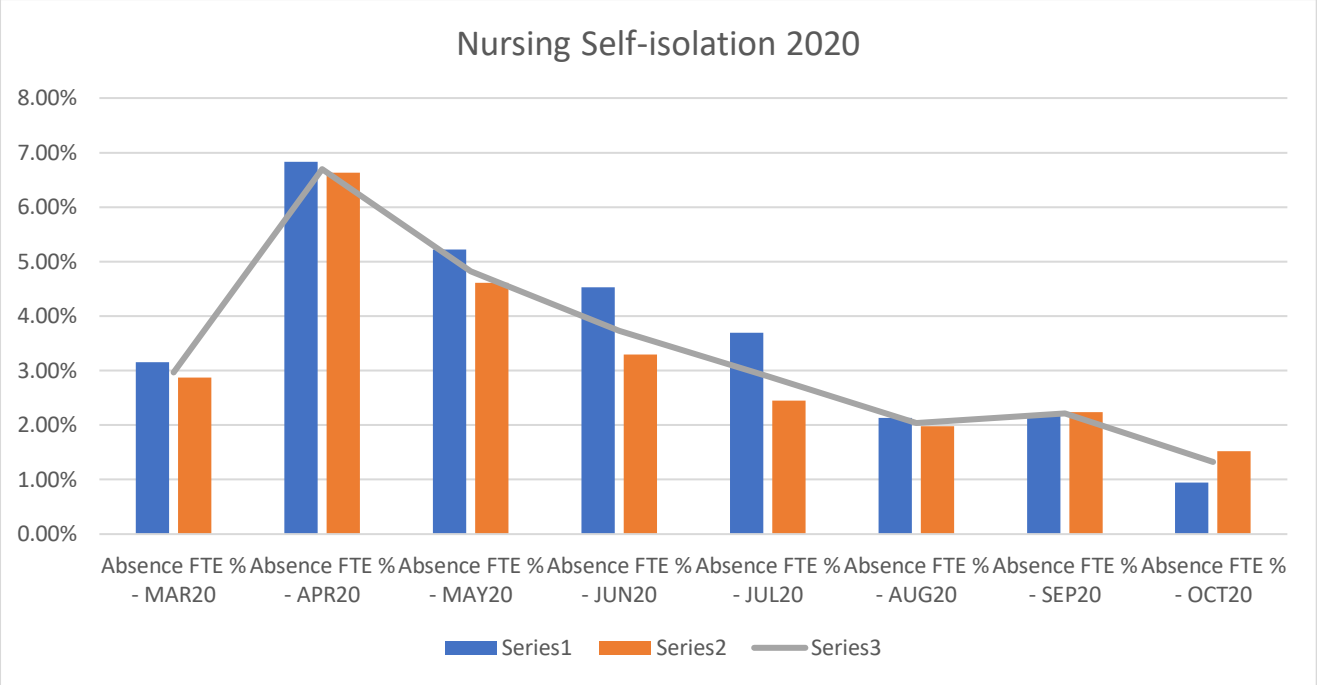


Chart 3

5. Patient Flow and Escalation

Good patient flow is central to patient experience, clinical safety and reducing the pressure on staff. It is also essential to the delivery of national emergency care access standards. (NHSI 2017). Ward closures and moves can add additional staffing challenges and opportunities and are documented below

Ward Closures in October: F4 elective surgical ward remained closed and was based on F2 to provide elective orthopaedic surgery – the capacity on F2 is reduced to 7 beds. Where required staff were redeployed to assist shortfalls within the division.

Ward Moves in October: F3 moved to F4 on 12/10/2020 to facilitate structural survey and essential estate repairs on F3. Works finished and completed 30/10/2020, F3 (on F4) moved back to original footprint on 2/11/2020

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

6. Recruitment and retention

Vacancies: Registered nursing (RN):
Using budgeted versus contracted staff there is a shortfall of 67.6 RNs, a decrease from 82.5 last month. However, this is further improved by substantive staff that have been reflected in the coronavirus support costs. The net vacancy rate is 29.4 WTE, a decrease from 40.1 WTE the previous month (Table 4). It should be noted that the cross charging and representation of substantive staff against covid19 cost makes identifying an overall trust vacancy rate challenging. This has resulted in an overall vacancy rate of inpatient areas including ED and AAU of 5% (6.4% last month). This positive position is likely to be driven by the September cohort of newly qualified nurses joining the NMC register this month.

	Ward Nursing		Sum of Actuals Period 3 (June)	Sum of Actuals Period 4 (July)	Sum of Actual Period 5 (Aug)	Sum of Actual Period 6 (Sept)	Sum of Actual Period 7 (Oct)	Sum of CURRENT MONTH VARIANCE
RN Substantive	Ward		510.9	518.6	537.0	542.8	555.2	67.6
	CV19 Costs		97.1	68.0	50.2	42.4	38.2	(38.2)
Total: RN Substantive			**608.0**	**586.6**	**587.2**	**585.2**	**593.4**	**29.4**

Table 4

Vacancy rates are reviewed in the monthly 'check and challenge' meetings that commenced this month. Areas with significant shortfall (>15%) are supported in giving authorisation to seek temporary staffing solutions earlier than the standards 72-hour window. A breakdown of ward by ward vacancies can be found in Appendix 2.

Vacancies: Unregistered Nursing assistants (NAs): The vacancy rate of unregistered support staff is also demonstrating an under establishment of 20 WTE, this is an increase from 7.6 WTE last month.

	Ward Nursing	Sum of Actuals Period 2 (May)	Sum of Actuals Period 3 (June)	Sum of Actuals Period 4 (July)	Sum of Budget Period 5 (Aug)	Sum of Budget Period 6 (Sept)	Sum of Budget Period 7 (Oct)	Sum of CURRENT MONTH VARIANCE
Nursing Unregistered Substantive	Ward	275.8	288.0	307.5	320.2	330.7	330.7	53.3
	CV19 Costs	102.6	109.0	102.5	80.1	42.4	33.3	(33.3)
Total: NA Substantive		**378.4**	**396.9**	**409.9**	**400.3**	**373.2**	**364.0**	**20.0**

Table 5

Overseas Nurse recruitment:

No overseas nurses have landed within the organisation in October, however five nurses are scheduled to arrive mid November where they will begin their two-week isolation to join an induction program in early December.

New starters

	August 2020	September	October
Registered Nurses	6	10	14
Non-Registered	6	14	12

Table 6: Data from HR and attendance to WSH induction program

Fourteen RNs commenced in the trust in October, nine for the acute, two for bank, and three for community services. Recruitment continues with rolling adverts for medical and surgical areas. Harder to recruit areas are working with HR and communications team to design bespoke adverts.

7. Quality Indicators

Falls

Falls per 1000 bed days have reduced again in October which is positive although too early to be considered a trend. The newly appointed falls practitioner is due to commence in post in November

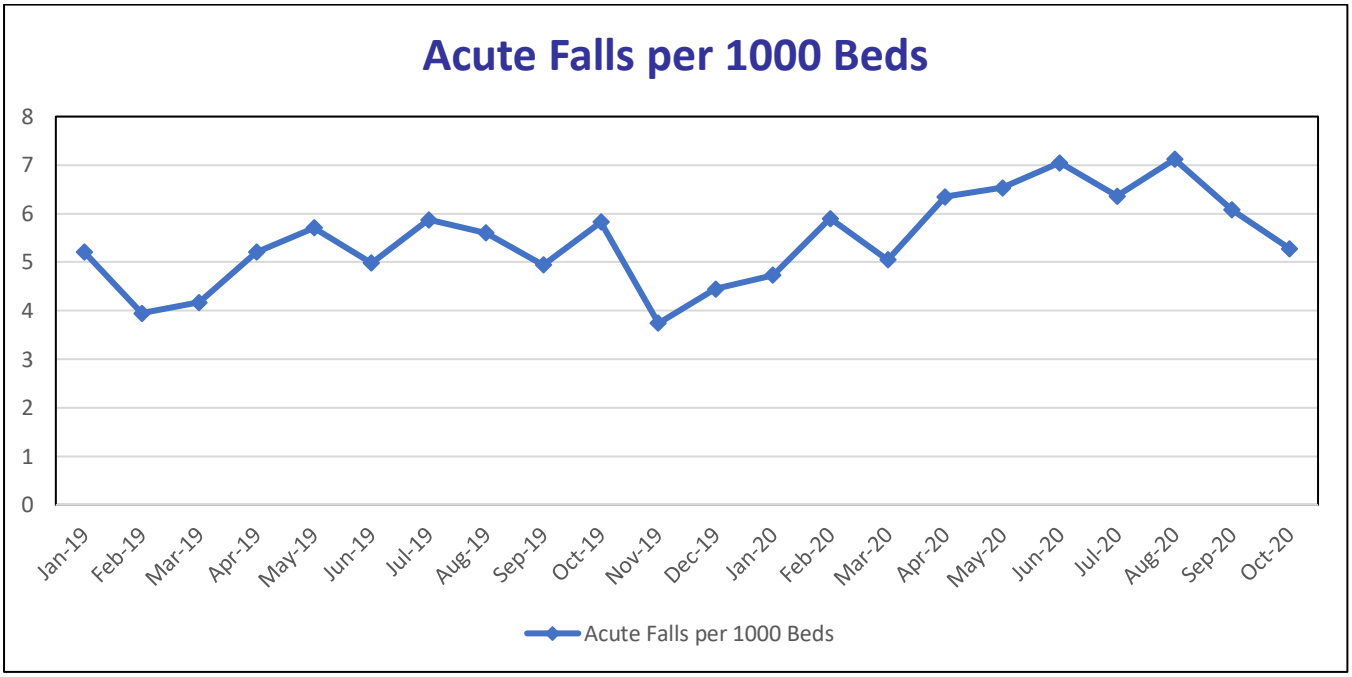


Chart 6

Pressure Ulcers

October saw a rise in the total number of Hospital Acquired Pressure ulcers (HAPU) since May 2020 (Chart 7a). The highest incidence this month is on G8 and Critical Care unit. Staffing has improved in both these areas this month but this is yet to be reflected in quality outcomes. This increase is also observed in occupied bed days (Chart 7b) The Trust is currently collaborating with the senior nursing teams and specialist teams to create a harm free care collaborative that will focus on using QI methodology to focus on ward-based improvements. A full ward breakdown of incidences and locations can be found in Appendix 3.

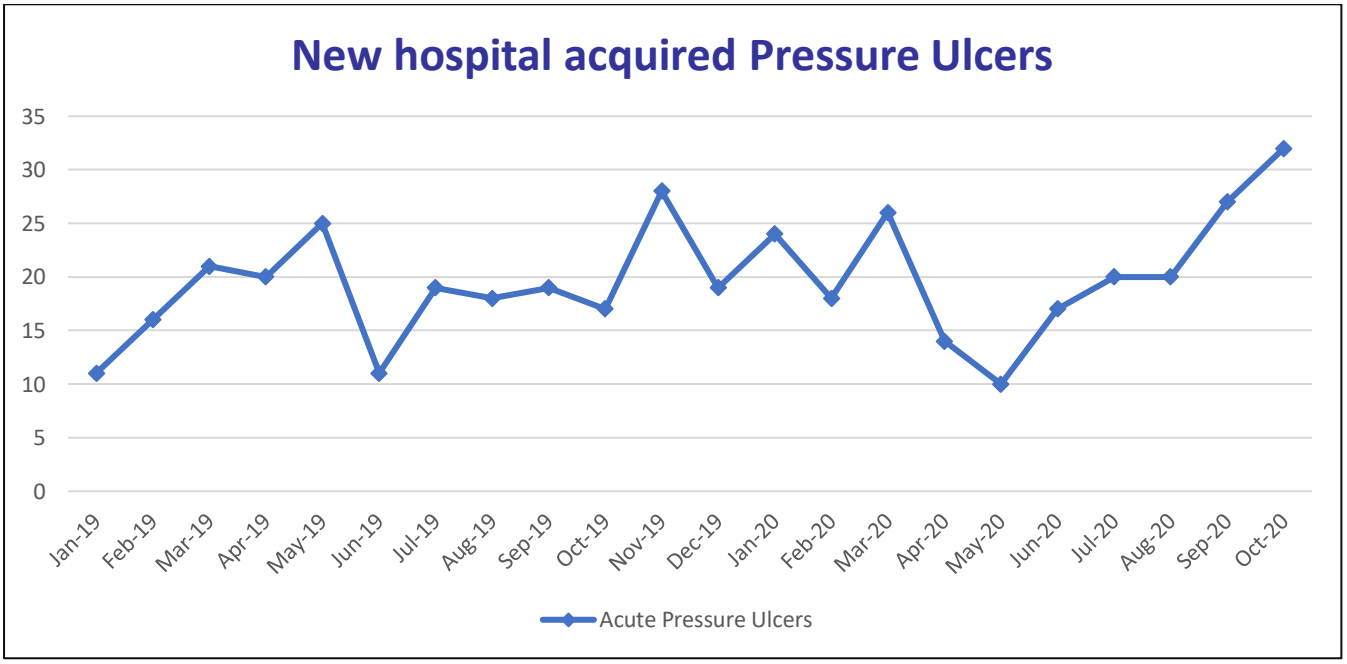


Chart 7a

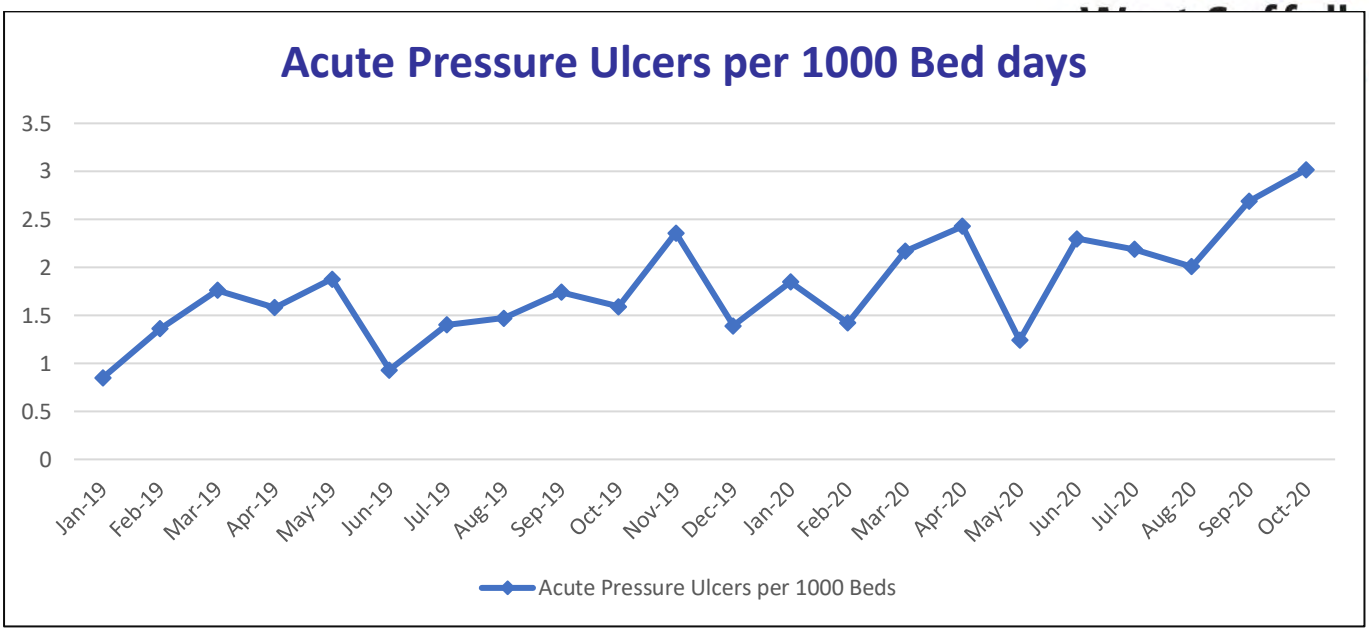


Chart 7b

8. Compliments and Complaints

Table 8 demonstrates the incidence of complaints and compliments for this period. There is a small reduction in complaints from the previous month. High incidences have been observed in the ED. Four out of five complaints related to delay or failure in treatment. The other complaint related to staff attitude and behaviour. Actions and leaning will be reviewed with matron, manager and lead consultant. A reduction in complaints was observed from ward F3 this month compared to four in September, however analysing previous volumes, September seemed to be an abnormal month for F3.

It is positive to see that 100% of complaints resolved were responded to within timescale and 100% were acknowledged within our agreed internal standard of 3 working days.

	Compliments	Complaints
April 2020	14	8
May 2020	14	9
June 2020	8	3
July 2020	7	21
August 2020	18	21
September	20	20
October	11	17

Table 8

9. Maternity Services

A full maternity staffing report will be attached to the maternity monthly paper.

Red Flag events

Safe midwifery staffing for maternity settings (NICE, 2015) defines red flag events as negative events that are immediate signs that something is wrong and action is needed to resolve or mitigate the situation. Actions include escalation to the senior midwife in charge of the service who can respond by 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 thirteen red flag incidents reported in October– which indicates that not only reporting midwifery staffing red flags is becoming more imbedded but it is also reflected in the midwife to birth ratio for this month below.

Midwife to Birth ratio

In October 2020 the midwife to birth ratio was 1:31 this is the upper limit of a safe ratio, Birthrate+ recommend a midwife to Birth ratio of 1:27.7. Staff isolating due to COVID or awaiting swab results was a contributing factor to not be able to achieve more favourable ratios.

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 October 2020 we achieved 83% compliance. There were some shortages in shifts, which is reflected in the midwife to birth ratio, and many were last minute which resulted in the shifts not being filled. The escalation policy was activated, however, there is a short time delay from on-call staff being called to them being onsite and present on the unit. To note all women received one to one care in labour.

10. Establishment Review using the Safer Nursing Care Tool (SNCT)

As per NQB (2016) recommendations and strengthened by the developing workforce safeguards document (NHSE, 2018), acute providers are expected to formally review nursing establishments biannually. The biannual acuity and dependency audit commenced in September and concluded in October. During this month, review meetings were arranged with the nursing leaders of the areas to triangulate the outcomes of the audit with professional judgement and nurse sensitive indicators such as falls and pressure ulcers incidences. The recommendations of this review will be presented to the board in January 2021.

11. Resource Management

Following Lord Carters review in 2016 operational productivity is improved when eRostering is used to its fullest potential (NHSE, 2020). WSH has had eRostering in use for many nursing teams for a while, however, formal oversight has been light due to covid 19 restriction. In order to better identifying improvements and best practice, virtual monthly meetings between the Deputy Director of Nursing, eRostering team and nursing leaders have been re-established and commenced in October as planned. These 'check and challenge' meetings will identify areas of good practice in roster management and areas of improvement and will track concordance. The meetings have driven an improvement plan that will be updated monthly (appendix 5). All actions are on track or completed other than the rapid response pool of staff. This is delayed following a payment solution to be realised by Serco partners.

12. Recommendations and Further Actions:

- Note the information on the nurse and midwifery staffing and the impact on quality and patient safety
- Note the content of the report and that mitigation is put in place where staffing levels are below planned.
- Note that the content of the report is undertaken following national guidelines using research and evidence-based tools and professional judgement to ensure staffing is linked to patient safety and quality outcomes.
- Note the work commenced with the clinical teams to ensure accuracy of eRoster to illustrate accurate fill rates and robust management of nursing resource

Appendix 1. Fill rates and CHPPD. October 2020 (adapted from unify submission)

NHS West Suffolk

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each day	RNS/RMs	Non registered (care staff)	Overall
Name	Day Reg Planned Hrs	Day Reg Actual Hrs	Day Unreg Planned Hrs	Day Unreg Actual Hrs	Night Reg Planned Hrs	Night Reg Actual Hrs	Night Unreg Planned Hrs	Night Unreg Actual Hrs	Day Reg Fill Rate	Day Unreg Fill Rate	Night Reg Fill Rate	Night Unreg Fill Rate				
Rosemary Ward	706.50	1,041.25	1,046.50	1,262.50	667.00	781.50	483.5	920.25	147%	121%	117%	190%	643	2.8	3.4	6.2
Glastonbury Court	706.00	752.00	1,042.00	1,019.00	713.00	703.00	542.50	554.25	107%	98%	99%	102%	601	2.4	2.6	5.0
AAU	2115	2016.417	2493	1782.25	1782.5	1792.5	1419.5	1373	95%	71%	101%	97%	604	6.3	5.2	11.5
Cardiac Centre	2,795.00	2,750.50	1,368.50	1,210.50	1,778.00	1,720.50	706.50	604.00	98%	88%	97%	85%	648	6.9	2.8	9.7
F10	1,421.00	1,424.00	1,424.75	1293.25	1069.5	994.5	1068.5	1287.5	100%	91%	93%	120%	670	3.6	3.9	7.5
F8	1,426.00	1,420.50	1,426.00	1,273.67	1414.5	1,334.00	1,069.50	1,110.50	100%	89%	94%	104%	810	3.4	2.9	6.3
F12	563.50	671.50	356.25	327.75	712.50	607	356.50	368.00	119%	92%	85%	103%	199	6.4	3.5	9.9
F7	1,426.00	1,539.67	1,842.50	1,543.25	1,391.50	1329.5	1,745.50	1,507.00	108%	84%	96%	86%	548	5.2	5.6	10.8
F9	1,421.50	1,420.50	2,129.00	1,773.92	1,069.50	1,063.50	1,426.00	1,587.00	100%	83%	99%	111%	1006	2.5	3.3	5.8
G1	2,595.80	2,428.78	992.00	846.50	712.00	706.50	356.50	313.17	94%	85%	99%	88%	339	9.2	3.4	12.7
G3	1,421.00	1,521.25	2,132.50	2,195.75	1,058.00	1,045.50	1,069.50	1,823.00	107%	103%	99%	170%	1009	2.5	4.0	6.5
G4	1426	1,344.25	2,100.50	2,092.25	1070	1041	1414	1544	94%	100%	97%	109%	956	2.5	3.8	6.3
G5	1527.1	1543.183	1,932.00	2,156.00	1069.5	1071.25	1403	1616.75	101%	112%	100%	115%	984	2.7	3.8	6.5
G8	2122.5	2063.6	1756.75	1758.167	1426	1439.417	1069.5	1184	97%	100%	101%	111%	867	4.0	3.4	7.4
Critical Care	2,947.50	2,844.00	275	281	2,844.50	2,779.00	44.00	45	96%	102%	98%	102%	214	26.3	1.5	27.8
F3	1,426.00	1,446.00	2,118.00	1,962.00	1,069.50	1,025.00	1419.5	1453.5	101%	93%	96%	102%	554	4.5	6.2	10.6
F4	759.00	766.5	494.50	483	713	679.5	391	380.25	101%	98%	95%	97%	588	2.5	1.5	3.9
F5	1,401.00	1,367.25	1,398.50	1,240.25	1,067.50	1022.5	713	656	98%	89%	96%	92%	748	3.2	2.5	5.7
F6	1,759.50	1,746.00	1579	1267.667	1,069.50	1,062.98	713	713	99%	80%	99%	100%	965	2.9	2.1	5.0
F11	4185.75	3944.667	1371	1251.5	2974	2609.75	1102.5	985.5	94%	91%	88%	89%		-	-	-
Neonatal Unit	1,047.50	1,054.00	132	108	1,008.00	978.50	240	228	101%	82%	97%	95%	82	24.8	4.1	28.9
F1	1,081.00	1,290.50	609.5	773.75	1,069.50	1,143.50	0	271.25	119%	127%	107%	100%	130	18.7	8.0	26.8
F14	726.5	765.7833	144	145	720	732.2833	0	8.5	105%	101%	102%	100%	137	10.9	1.1	12.1
Total	37,006.65	37,162.10	30,163.75	28,046.92	28,469.00	27,662.68	18,753.50	20,533.42	100%	93%	97%	109%	13302	4.9	3.7	8.5

Appendix 2. Ward by ward vacancies (September 2020)

RAG: Red >15%, Amber 10%-15%, Green <10%

NHS West Suffolk NHS Foundation Trust

Ward/Department	Registered Nursing				Ward/Department	Non Registered Nursing (HCSW)			
	Budgeted Establishment	Actual Establishment	Vacancy rate	Percentage Vacancy rate		Budgeted Establishment	Actual Establishment	Vacancy rate	Percentage Vacancy rate
AAU	30.1	29.8	0.3	1%	AAU	28.3	21.1	7.3	26%
Accident & Emergency	64.0	61.1	3.0	5%	Accident & Emergency	26.5	21.2	5.3	20%
Cardiac Centre	40.7	37.3	3.3	8%	Cardiac Centre	15.7	13.7	2.0	13%
Community - Glastonbu	11.7	11.4	0.3	3%	Community - Glastonbu	12.6	12.2	0.5	4%
Critical Care Services	45.4	39.0	6.4	14%	Critical Care Services	1.9	2.8	(0.9)	-49%
Day Surgery Wards	11.0	9.8	1.2	11%	Day Surgery Wards	3.9	0.9	3.0	78%
Ward F14	12.8	10.5	2.3	18%	Ward F14	1.0	1.0	0.0	0%
Hospital Midwifery	59.2	49.8	9.4	16%	Hospital Midwifery	15.6	14.9	0.7	5%
Neonatal Unit	21.4	19.3	2.1	10%	Neonatal Unit	3.6	4.5	(0.8)	-23%
Newmarket -Rosemary	12.4	13.0	(0.6)	-5%	Newmarket Hosp-Rose	13.5	16.6	(3.1)	-23%
Recovery Unit	21.9	18.5	3.4	15%	Recovery Unit	0.9	0.9	0.0	1%
Ward F8	23.7	22.0	1.7	7%	Ward F8	18.0	17.8	0.2	1%
Ward F1 Paediatrics	20.4	20.9	(0.5)	-3%	Ward F1 Paediatrics	7.2	6.7	0.5	6%
Ward F3	22.2	17.6	4.6	21%	Ward F3	25.8	24.7	1.2	5%
Ward F4	14.2	13.1	1.1	7%	Ward F4	13.9	7.1	6.9	49%
Ward F5	22.2	19.6	2.6	12%	Ward F5	12.9	11.9	1.0	8%
Ward F6	24.0	18.8	5.2	22%	Ward F6	14.8	12.0	2.8	19%
Ward F9	19.3	17.4	1.9	10%	Ward F9	25.8	20.5	5.3	20%
Ward G1	27.7	22.3	5.4	20%	Ward G1	10.5	9.8	0.8	7%
Ward G3	19.5	18.7	0.8	4%	Ward G3	25.6	22.3	3.2	13%
Ward G4	19.5	18.2	1.3	7%	Ward G4	25.4	21.7	3.6	14%
Ward G5	19.4	19.6	(0.2)	-1%	Ward G5	25.8	22.8	3.0	11%
Ward G8	27.5	28.3	(0.8)	-3%	Ward G8	20.6	18.4	2.2	11%

HAPU

	Cat 2	Cat 3	Unstageable	Total
Total	**28**	**1**	**3**	**32**
Critical Care Unit	5	0	1	6
F3 - ward	4	0	1	5
G8 - ward	3	0	1	4
F10 Winter Escalation	3	0	0	3
F5 - ward	2	1	0	3
G5 - Ward	3	0	0	3
Cardiac Centre - Ward	2	0	0	2
G3 - Endocrine and General Medicine	2	0	0	2
F7	2	0	0	2
G4 - ward	1	0	0	1
Rosemary Ward	1	0	0	1

Falls

	None	Negligible	Minor	Moderate	Major	Total
Total	**64**	**2**	**13**	**1**	**1**	**81**
Rosemary Ward	12	0	3	1	0	16
G8 - ward	8	0	2	0	0	10
Respiratory Ward	6	1	2	0	0	9
G3 -	3	1	1	0	0	5
G4 - ward	5	0	0	0	0	5
F7	4	0	0	0	1	5
G5 - Ward	3	0	1	0	0	4
Acute Assessment unit (AAU)	3	0	1	0	0	4
F10 Winter Escalation	3	0	0	0	0	3
F3 - ward	3	0	0	0	0	3
Cardiac Centre - Ward	1	0	1	0	0	2
Emergency Department	1	0	1	0	0	2
Eye Treatment Centre - First Floor	2	0	0	0	0	2
F6 - ward	2	0	0	0	0	2
Glastonbury Court	2	0	0	0	0	2
Eye Treatment Centre - Ward	1	0	0	0	0	1
F11 - Antenatal / Postnatal Ward	1	0	0	0	0	1
G1 - ward	1	0	0	0	0	1
Macmillan Unit	0	0	1	0	0	1
Radiology Department	1	0	0	0	0	1
Wheelchair Services	1	0	0	0	0	1
Early Intervention Team	1	0	0	0	0	1

Appendix 4: Maternity Red Flag Events

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

Appendix 5: Nursing resource management improvement plan

NHS West Suffolk

Utilising Nursing Resource Improvement Plan					Version date: 15.10.2020 V1.1		
Find no.	Improvement required	Improvement action	Action Owner	Overall status / RAG	Completion date	Actual completion date	Current status / overall RAG rationale
1.1	Improved confidence and knowledge in using eRostering and expectations of robust roster management	Review rostering training program. Scope adequacy of eRostering training with senior nursing team (survey monkey)	DS/LR		1.2.21		update required
1.2		Implement roster check and challenge meetings with ward teams. Including KPIs, with clear TOR and deliverables	DS		12.10.20	9.10.20	TOR completed and circulated to Matrons. First check and challenge meetings scheduled for 9.10.2020
2.1	eRosters to be update live	Review and update rostering policy with clear accountability and responsibilities	DS/LR		1.12.20		Policy to be updated
2.2		Review and scope roster access to ensure all that are responsible for staff management/moves are able to	LR		1.11.20		update required
2.3		Include unify fill rate discussion in check and challenge to explore inconsistencies of roster management	DS		12.10.20	9.10.20	Check and Challenge meetings commenced in October. Unify review and narrative included to inform board paper.
2.4		Review redeployment function as feedback from staff is that 'Blue boxing' is onerous and not ser friendly therefore not used	LR		1.12.20		roster team to scope alternate simpler way to redeploy staff
3.1	Shifts to be filled by temporary staffing are clearly escalated and filled efficiently by WSP	Define and agree staffing shortfall escalation process for forward planning	DS		1.12.20		Policy to be updated to capture changes and
3.2		implement 8 week roster lead time (current 6 weeks)	LR		1.1.21	11.11.20	Complete: 8 week roster lead time implemented commenced on roster starting 17th January. Communication to nursing staff completed. Reiterated at Check and challenge meeting 11.11.20
4.1	Ensure WSP working practices are maximised to provide more capacity to source temporary staff	Implement electronic time sheet management for bank shifts	CN/LR		1.12.20		On track to commence on 1.12.2020. Rationale and benefits discussed in Check and Challenge meeting. Comms and 'how to guide' to be sent week commencing 16.11.20
4.2		Clarify time owing or adjust shift times in rostering policy	DS/CS		1.12.20		DS to review with CS to establish working practices and clarity to inform rostering policy
5.1	Clarity on nurse vacancies	Ward to board reporting to use single point of information. Data cleanse to be complete from finance	NM/DS		1.11.20	24.10.20	Data cleanse complete by finance team. Removing anomalies for cross charging non nursing covid costs. September staffing paper displaying accurate figures
5.2		Finance training to be delivered to all ward managers	NM		1.12.20	3.11.20	Complete: 4x sessions scheduled in November 2020. delivered by Deputy Director of Finance to Ward Managers and Matrons. First session delivered 3.11.2020
5.3		Programme of Biannual establishment reviews to be rolled out	DS		1.12.20		1st interaction of audit completed in October 2020. Output meetings completed with the nursing team to add professional judgement. Establishment recommendations to go to board, via execs
6.1	Improved daily oversight and management of staffing risks	SafeCare to be reintroduced to be tool for oversight/risk management	LR/DS		1.2.21		Areas for inclusion have been scoped
6.2		Increased reporting of red flag events on Datix	DS		1.11.20	22.9.20	Datix template updated with mandatory field to demonstrate staffing shortfalls and NQB red flag events. Discussed and informed at NMCC in September
6.3		Implement and deliver rapid response pool for addressing late notice short falls	DS/CN		1.11.20		Partial: proposal approved by exec team. Waiting for serco to comfirm payment method for shifts

11:00 BUILD A JOINED-UP FUTURE

14. Future system board report

To APPROVE the report

For Approval

Presented by Craig Black

Open Board Meeting – 4th December 2020

Agenda item:	14			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Gary Norgate, Programme Director Future System, Jo Rayner, Head of Performance and Efficiency			
Date prepared:	23/11/2020			
Subject:	Update on the Future System Programme			
Purpose:	X	For information		For approval

1.0 Executive summary

The following paper provides an update on progress being made towards realising the construction of a new West Suffolk Health and Care facility.

The status of the overall Future System Programme remains 'Green' with significant strides having been made in several key areas:

Estates – Having completed the formal objective appraisal of 4 site options, The Board are, in closed session, being asked to approve a recommendation for a preferred site. The decision has to be taken in closed session as the report contains commercially sensitive information and the decision will require careful and considerate communication.

Clinical Design – The co-production workshops that underpin the creation of the outline clinical design have progressed at pace and said outline is expected to be completed, on time, by early December.

System-wide Support – Programme Board met in November and allowed a wide set of stakeholders to consider the different site options whilst receiving and discussing updates on co-production, digital roadmap and our financial business case. Presentations were also given to The Integrated Care System (ICS) Chairs Group and ICS Board.

Structure – The safety of our patients and staff is paramount at West Suffolk NHS Foundation Trust (WSFT). The estate problems that the hospital has, including the concerns around the use of reinforced aerated autoclaved concrete (RAAC) planks in the walls and roofs, has been widely reported. The estates team is doing remedial work in order to maintain the current premises however further, more extensive work is required urgently. In order to carry out this work, services currently situated within the hospital need to be temporarily re-located. External consultants, Attain, have been commissioned to understand which services need to be re-located together and the possible temporary locations that could be used whilst the repair work takes place.

2.0 Programme Dashboard

	Milestone	Status	Comments
	Clinical - co-production workshops completion - 7.12.20		The clinical co-production workshops on target for completion 4.12.20.

Timelines	Estates – site acquisition Strategic site appraisal report		Hardwick Manor acquired on 20.10.20 Decision from Board on site 4.12.20
	Submission of SOC by 31.12.20		Clinical and financial models on track
	Measurement	Status	Comments
Cost	Budget Status		Underspent
	Capital Forecast		Current estimate of cost suggests a challenge to affordability
	Measurement	Status	Comment
Quality	Engagement strategy	Green	Dedicated communications and engagement lead appointed. Co Production of clinical design is underway. Communication of acquisition of Hardwick Manor completed.

3.0 Estates

The WSFT Estates team, supported by professional partners representing; planning, highways and the construction industry have conducted highly detailed surveys and appraisals of several potential sites.

The scoring for these sites has been discussed in detailed sessions with Programme Board, Council Executives, Governors and The Trust Board.
In addition to the technical assessment, a series of five non-financial / non-technical parameters have discussed the extent to which each site:

1. Provides flexibility for the future and changing or developing services
2. Aligns with the health system strategies
3. Enhances the environmental quality and sustainability of services
4. Makes more effective use of resources
5. Offers ease of access to the facilities

The non-financial assessment was shared amongst members of the Trust Executive, Governors, Staff-side Union and members of the Programme Team.

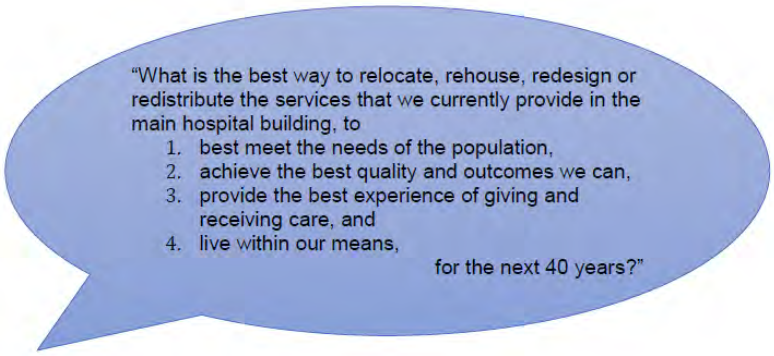
The resultant scores and associated comments have been considered and combined to rate each site and to arrive at a recommendation for a preferred site.

If this recommendation is accepted, a detailed communications plan will be executed, stressing that the named site is simply the Trust's preference and that there is no guarantee that the site will ultimately prove suitable and acceptable. The Trust will continue to seek input from its community, staff and partners whilst working to understand and mitigate the challenges associated with this choice.

4.0 Clinical Design

Progress so far – work towards the strategic outline case

The first phase of design work is to answer the following question at a high enough level to inform the strategic outline case.



A series of 4 workshops to achieve this for each workstream have been devised with support from health care planners and Healthwatch Suffolk, and refined following testing with the endoscopy services. A toolkit to support participation in each workshop has been created by Healthwatch. The co-production leads have all been appointed and the planning groups recruited. The workshops are underway and by the time of the Trust board we expect to have largely completed them all. Attendance from staff stakeholders has been good and the quality of the discussions is high.

Alongside staff stakeholders, our plan was to have people and partners present in each of the workshops too. Taking each of these in turn:

1. People and their families • Our goal is to achieve really meaningful patient, family, carer and public involvement in the programme, using a combination of our existing engagement channels, partners' engagement channels, and new methods, to reach the most diverse and representative audience possible
    - Healthwatch Suffolk, the council of governors and the trust's VOICE group are all supporting the programme team to design and execute an effective engagement plan
    - This will include a wide range of opportunities to participate both online and in person, and to help us get the approach right, three new lay roles will be created with VOICE to work specifically on the Future System programme
    - Initial progress has been slower than was hoped, though, because some of the infrastructure to support the commencement of public engagement needed to be put in place first
    - A small number of groups will be well-involved during the first phase of work, but we expect to begin public involvement in earnest in January 2021
    - To mitigate the immediate risk that low patient involvement poses to the quality of the clinical workstream content for the strategic outline case, a plan B has been devised
    - This comprises attendance at the workshops by VOICE members and the patient experience team to represent the views and interests of patients and families, supplemented by views gathered from recent patients for all service areas and the existing bank of feedback and intelligence that the patient experience team holds
    - Healthwatch's coproduction ambassador has adapted the co-production toolkit for the public audience. This will form the basis of all conversations with members of the public.

2. Partners • As a minimum, each workstream needs to benefit from having professionals involved from primary care, mental health and social care, to ensure that the clinical model that is devised is the right fit for the way the rest of the health and care system in west Suffolk works
    - Other partners, relevant to each workstream individually, should also be able to participate as fully as they wish to
    - To support this, 3 GP leads and key points of contact for Norfolk and Suffolk NHS Foundation Trust and Suffolk County Council adult and children's services are being sought
    - One GP lead has been recruited so far. A second round of recruitment has opened and the eligibility criteria have been widened so that the roles are now available to all clinical and

managerial staff who work in general practice, as well as practices which are beyond the West Suffolk CCG boundary, as long as they are within the West Suffolk NHS Foundation Trust catchment area.

- A plan B to achieve primary care attendance at the SOC workshops is underway.
- Social care and mental health attendance at some of the SOC workshops has been achieved, but not many. This was no doubt hampered by invitations for the first round of workshops being issued at very short notice. More notice has been given for subsequent workshops and we will put more effort into making sure partners have a good understanding of what their participation will consist of and how it will help us.

Other relevant partners are being identified in the early workshops and invitations to participate are being issued accordingly, for example to Care UK for the emergency and paediatric workstreams.

As mentioned, a small number of specific stakeholder groups have been engaged in this first phase of work. They comprise:

- Children and young people o A virtual assembly will run in local schools for us by Will Wright, children and young people's officer at West Suffolk Council
- The students attending the WSFT Health and Care Academy – 16-18 year olds who are interested in health and care careers
- Suffolk Coalition of Disabled People
- WSFT Council of governors' engagement committee
- Suffolk County councillors – a subgroup of the Health Scrutiny Committee will be formed to specifically focus on the Future System programme

Next steps - The workshops will conclude by Friday 27th November. A debrief and team building day for the co-production leads will be held on Wednesday 16th December, when we will plan the approach to co-production for the outline business case.

5.0 System-wide Support

In the past month significant work to engage our partners from within the Suffolk and North East Essex Integrated Care System (ICS) have continued. Highlights include; a meeting of the Programme Board that was attended by over 30 of our system partners and stakeholders; presentation to the Chair of the LMC (who has agreed to join the Programme Board), presentation to the ICS Chairs Board and presentation to the ICS Board and CCG Governing body. Discussions with Suffolk HOSC resulted in the construction of a task and finish Group who will aid the co-production of the clinical design.

6.0 Structure

The safety of our patients and staff is paramount at West Suffolk NHS Foundation Trust. The estate problems that the hospital has, including the concerns around the use of reinforced aerated autoclaved concrete (RAAC) planks in the walls and roofs, has been widely reported. The estates team is doing remedial work in order to maintain the current premises however further, more extensive work is required urgently. In order to carry out this work, services currently situated within the hospital need to be temporarily re-located. External consultants, Attain, have been commissioned to understand which services need to be re-located together and the possible temporary locations that could be used whilst the repair work takes place.

The final report will be presented and discussed at the Oversight Committee on 30th November. A full sign off process beyond delivery of the final report has been developed which will see a round of engagement to introduce the report and seek feedback on the options. This feedback will be used to shape the final recommendations which will then be brought back to all stakeholders for approval, with the final sign off at Board on 29th January 2021.

7.0 Next Steps

In the coming months the Programme will:

- communicate the decision on its preferred site
- complete the outline clinical design
- complete the economic and financial cases
- submit its strategic outline case (sign off will be sought from WSFT Board and CCG / ICS at the end of December.

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:	Part of Scrutiny Committee work program.						
Risk and assurance:							
Legislation, regulatory, equality, diversity and dignity implications	None						

Recommendation:

To note progress and next steps with the future systems programme

15. Digital board report

To APPROVE report

For Approval

Presented by Craig Black

Trust Board – 4 December 2020

Agenda item:	15			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Sarah Judge, Digital Operational Lead			
Date prepared:	24 November 2020			
Subject:	To receive update from Digital Board			
Purpose:	x	For information		For approval

Executive summary:
This paper provides a summary of key points of interest raised at the last Digital Board meeting on 19 October 2020.

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

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

Previously considered by:	**Separate Pillar group meetings and Digital Board meeting**
Risk and assurance:	*All risks and issues are fully reviewed at each Pillar meeting and escalated to the Board if required. High level risks are reported through to board assurance framework as appropriate.*
Legislation, regulatory, equality, diversity and dignity implications	*Relevant legislation is applied to all projects.*

Recommendation:
The board is asked to note the update.

Our Global Digital Exemplar programme

1. Background

1.1 In May 2016, the trust embarked on a major change programme to introduce a new electronic patient record (EPR) using Cerner's Millennium EPR. The programme was branded e-Care. Since our initial go-live, a rolling programme of additional functionality has continued.

1.2 The West Suffolk Hospital NHS Foundation Trust (WSFT) was one of 16 hospitals chosen to become a flagship Global Digital Exemplar (GDE). Our GDE programme is coming to an end with some programmes of work continuing – in particular the achievement of HIMSS level 6 and 7 accreditations.

1.3 Our digital programme comprises of four 'pillars' of work, underpinned by a foundation of optimisation and transformation.

Pillar 1	Digital acute trust	Completing the internal journey of digitisation
Pillar 2	Supporting the integrated care organisation	Creating the digital platform to support the regional ambitions of integrated care and population health.
Pillar 3	Community digital programme	Migration, consolidation and transformation of digital and IT capabilities in our community division.
Pillar 4	Hardware and infrastructure	Ensuring that we have a robust and compliant infrastructure at the foundation of the programme
Foundation	Optimisation and transformation	Supporting trust-wide initiatives and transformation programmes, optimising digital platforms and training

1.4 We continue to share our learning from digital implementations with a series of blueprints which are submitted to NHS Digital for sharing across the NHS, several of which have been first of type in the UK.

2. HIMSS accreditation

2.1 Application for HIMSS 6 and 7 accreditation is a requirement of the GDE programme. Several of the ongoing projects will help us achieve HIMSS 6 accreditation and work continues to deliver on HIMSS 7 standards whilst these projects are ongoing. A focus for HIMSS 7 is the embedding and pervasive use of digital systems across the hospital and this is underway.

2.1 A review of progress towards achieving the HIMSS requirements has been undertaken. Whilst we remain off target due to some outstanding projects, these are due to be completed in 2021. Of note, the scanning of patients (positive patient identification) at medication administration has improved with the work of the digital clinical team and provision of integrated 'drug trolley WOWs'.

Update on our digital programmes

3. Pillar one

3.1 Whilst many of the existing projects were temporarily put on hold to facilitate the Trust's

response to the COVID-19 pandemic in the first half of 2020, the projects have now planned for new go-live dates in 2020/21. These include digital capabilities for infection control, management and administration of medication, management and administration of blood products, maternity and neonatal services, ophthalmology systems and upgrades to existing systems.

3.2 The medication management project continues closely with NHS Digital and other trusts across the UK to determine the best approach to manage the medication catalogue and integration with pharmacy systems.

3.3 The DrDoctor project to enable outpatient appointment correspondence is being rolled out beyond the specialities trialling digital letters.

3.4 A Cerner Millennium 'code upgrade' (update to the underlying version of e-Care) was successfully completed in October 2020.

3.5 All of these projects are now running alongside the ongoing need to support the COVID-19 pandemic response, such as the vaccination programme, COVID testing integration with clinical systems and more.

4. Pillar two

4.1 The health information exchange (HIE) links health and social care records across providers and gives access to key clinical information in the user's native clinical system. It continues to make excellent progress, with HIE now showing discharge summaries from ESNEFT as well as linking all GP practices in Suffolk and north-east Essex. The wider Eastern Region HIE is making progress with work on connecting hospices in Colchester and Ipswich, as well as community units with ESNEFT.

Use of HIE from within the acute record continues to rise with both GP and west Suffolk community unit data visible by all partners.

4.2 The patient portal has continued with advertising locally to encourage patients to register for access to their clinical records

4.3 Our population health projects have been delayed due to the resource demands on the information team during the COVID pandemic.

4.4 Pillar two has successfully appointed a clinical information fellow to lead on the clinical engagement in this pillar, particularly in regards to the patient portal and HIE.

5. Pillar three

5.1 Historically, the IT support for community staff has been provided by NEL CSU. The focus of the community digital programme is the exit from this IT support contract and bring it back in-house. This requires migration of over 650 community staff from NEL to WSFT IT provision.

Following three months of delay due to COVID, we have migrated over half of the adult community staff, with the remainder due to be completed by Christmas, with the integrated paediatric community services and informatics following in January.

The community staff are having their data moved into Microsoft SharePoint, a cloud-based storage solution, to allow for greater flexibility in accessing their files and folders which befits a more mobile staff group as well as providing the option for greater remote collaboration.

5.2 The NEL migration is being supported by a wide-ranging offer of training and support, being delivered in a variety of ways. This includes regular virtual sessions as well as a dedicated online training library. Alongside this there has been a increase in communication and engagement sessions in order to keep all staff informed of progress and developments.

5.3 Additional projects continue alongside the NEL exit, including upgrading of the networks at a number of community sites to provide access to the WSFT networks and Wi-Fi, and the provision of new printers across the community estate.

5.4 Whilst the community digital programme is planned as three-year piece of work (migration, consolidation and transformation) we are running some transformation projects alongside the infrastructure upgrades, including procurement of an auto-scheduling solution which allows automatic scheduling of community visits, based on patient needs, staff skills and geography. This will allow us to provide a real time picture of capacity and demand across the adult community services.

5.5 Video consultations with patients continue, both as 1:1s and groups. We have a number of virtual classes running, some of which are recognised as leaders in their field such as cardiac rehabilitation and pulmonary rehabilitation. Further educational and/or exercise classes are in the planning stages.

6. Pillar four

6.1 The primary focus of infrastructure is currently the provision of devices to support the pandemic, the upgrade to Windows10 across the estate and the NEL exit.

6.2 The Windows 10 migration is now over 60% complete which includes requests for an additional 500 devices.

6.3 The service desk continues to be faced with unprecedented demand; monthly call numbers have risen from c.800 per month to c.1500 per month, the majority of which are service requests rather than incidents. The technical teams have built over 400 additional computers and devices above our expected replacement (400) and planned new devices (1180) numbers in order to facilitate remote working through the pandemic.

6.4 During COVID, the opportunity was taken to tag the medical devices and beds in the hospital with RFID (radio frequency identification) tags, providing instant digital tracking of the beds and devices; this innovation has been welcomed by the estates and EBME teams.

6.5 The access to the WinPath pathology system is due to be updated; this is behind schedule currently and remains the responsibility of Capita rather than WSFT.

7. Recommendation

7.1 The board is asked to note the report.

11:20 GOVERNANCE

16. Governance report

To APPROVE the report, including subcommittee activities

For Approval

Presented by Richard Jones

Board of Directors – 4 December 2020

Agenda item:	16			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	27 November 2020			
Subject:	Governance report			
Purpose:	X	For information		For approval

This report pulls together a number of governance items for consideration and approval:

1. **Agenda items for next meeting** (for information)
   Annex A provides a summary of scheduled items for the next meeting and is drawn from the Board reporting matrix, forward plan and action points. The final agenda will be drawn-up and approved by the Chair.

2. **Use of Trust seal** (for information)
   To note that there has been no use of the trust seal to report.

3. **Audit committee report** (for information)
   The Audit Committee meeting was held on 6 November 2020. The key issues and actions discussed were:

   - **BAF Deep Dive** – 'Data Quality and Business Intelligence' - This session was led by Nickie Yates and Ian Coe. An update was provided on the work undertaken to improve the accessibility, availability and accuracy of clinical data. The work was undertaken as a result of the issues raised by the CQC and Internal Audit. The presentation included an overview of what data can be viewed using the key BI (Business Information) tools and how these can be accessed. The Committee praised Nickie and Ian for the huge efforts that had been undertaken in this area and how this is a huge step forward in terms of the information available to Operational Teams.
   - **Internal Audit** - The Internal Audit Progress Report confirmed that six final reports have been issued to date, with four included on the agenda for November. Internal Audit commended the Trust for the hard work undertaken in implementing robust processes in terms of the CQC action improvement plan. Discussions were also held around the ten overdue recommendations raised by Internal Audit and how the process needs to be improved to ensure that all outstanding recommendations are implemented within the timeframes set. An action was raised to take this forward.
   - **Counter Fraud** – The Counter Fraud Progress Report was presented, which confirmed that the 2020/21 Plan is continuing to progress and that fraud training has been provided to Finance and Estates as part of the Plan. It was confirmed that the proactive exercise on agency had been completed and the final report would be issued imminently.
   - **External Audit** – The External Audit Progress Report was presented, which included a follow up of the recommendations raised during the 2019/20 audit, all of which are on track to be implemented by the due date set.
     External Audit also informed the Committee that the audit of the **Charitable Funds** had been rescheduled, meaning that the results of the audit would not be presented to the Committee until 29 January 2021, with the accounts submission deadline being 31 January 2021. Discussions were also held around the audit fee, which will increase for 2020/21 due to additional work required for the NAO as well as additional requirements in relation to audit quality.

- **Debt Write Offs** – The Committee approved the write off of debts amounting to £39,886. This predominately related to Overseas Visitor Patients where the Trust has been unable to recover the debt.
- **Annual Assessment** of Internal Audit and Local Counter Fraud Service – the Committee received a report on the assessment of the work completed by RSM.

4. **Council of Governors report** (for information)
This report provides a summary of the business considered at the Council of Governors meeting held on 11 November 2020 via Microsoft Teams. The report is presented to the board of directors for information to provide insight into these activities. Key points from the meeting were:

- Due to COVID social distancing requirements the public were excluded from to attending this meeting.
- The Chair welcomed and introduced Rosemary Mason, Associate Non-Executive Director and Sue Wilkinson, Interim Chief Nurse. This was the last meeting of the current governing body she and thanked governors for their commitment and the contribution they had made during their term of office.
- A written report was received from the Chair which provided a summary of the focus of the meetings and activities that she had been involved in over the last three months.
- The Chief Executive's report provided an update on the ongoing challenges facing the Trust. A discussion took place around governor engagement in the future system work which had also been the focus of the recent engagement committee meeting.
- Responses to governors' issues raised were received and clarification provided on a number of the issues.
- The finance and quality and performance reports were reviewed and questions asked on areas of challenge.
- Rosemary Mason gave a short resume of her career and how her experience could contribute in her role as an associate NED.
- A report was received on the Trust's people plan which had been developed using a bottom up approach, taking into account feedback from What Matters to You.
- A report was received from the engagement committee, including proposals for governor engagement in the future system work and how they would be updated on progress. Different ways of engaging with the public were also considered taking into account social distancing requirements.
- Reports were received from the lead governor and staff governors.

5. **Trust Executive Group report** (for information)
TEG continued with a different structure and approach to its meetings, focusing the agenda on key strategic issues. The meeting on 2 November considered:

- Operational challenges, including Winter planning, COVID, structural risk, recovery and EU exit
- WSFT people plan, focusing on supporting our staff through winter
- Quality and safety committee structure – discussion took place in the context of divisional performance review meetings and the future role of TEG

The meeting on the 19 October delivered the second stage (2/3) of the training programme for senior leaders on human factors. The programme is complementary to the specialist training being delivered to members of the Trust's human factors leads. The session also reviewed the future system work on site evaluation and the engagement process for TEG members.

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

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X	X	X	X	X	X	X
Previously considered by:	The Board receive a monthly report of planned agenda items.						
Risk and assurance:	Failure effectively manage the Board agenda or consider matters pertinent to the Board.						
Legislation, regulatory, equality, diversity and dignity implications	Consideration of the planned agenda for the next meeting on a monthly basis. Annual review of the Board's reporting schedule.						
Recommendation: To noted the report							

Annex A: Scheduled draft agenda items for next meeting – 29 January 2021

Description	Open	Closed	Type	Source	Director
Declaration of interests	✓	✓	Verbal	Matrix	All
Deliver for today					
Patient story	✓	✓	Verbal	Matrix	Exec.
Chief Executive's report	✓		Written	Matrix	SD
Operational report, including 7-day services update	✓		Written	Action	HB
Integrated quality & performance report	✓		Written	Matrix	HB/SW
Finance & workforce performance report, including CIP programme for 2021/22	✓		Written	Matrix	CB
Risk and governance report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
Invest in quality, staff and clinical leadership					
People plan, including: - People plan - Staff recommender scores (if published) - Mandatory training - Appraisal performance, including consultants - Consultant appointment report - Car parking tariff reviews - "Putting you first award"	✓		Written	Matrix	JO
Quality, safety and improvement report - Maternity services quality and performance report - Quality improvement programme board report - Safe staffing guardian report - Nursing establishment review - Nurse staffing report - National patient survey report – improvement plan	✓		Written	Matrix	SW / NJ
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	SW
Build a joined-up future					
Integration report	✓		Written	Matrix	HB
Future system board report	✓	✓	Written	Matrix	CB
Strategic update, including Alliance, System Executive Group and Integrated Care System (ICS). Including timetable for strategy review.	✓	✓	Written	Matrix	SD
Governance					
Governance report, including - TEG report - Charitable funds annual report	✓		Written	Matrix	SD

- Planning for annual governance review - Use of Trust's seal - Agenda items for next meeting - Risk appetite statement - Review of COVID governance arrangements - Review of register of interests - Review of NED responsibilities					
Scrutiny Committee report		✓	Written	Matrix	LP
Board assurance framework		✓	Written	Matrix	GN
Confidential staffing matters		✓	Written	Matrix – by exception	JO
Reflections on the meetings (open and closed meetings)		✓	Verbal	Matrix	SC

11:25 ITEMS FOR INFORMATION

17. Any other business

To consider any matters which, in the opinion of the Chair, should be considered as a matter of urgency

For Reference

Presented by Sheila Childerhouse

18. Date of next meeting

To NOTE that the next meeting will be held on Friday, 29 January 2021 at 9:15am in West Suffolk Hospital

For Reference

Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

19. The Trust Board is invited to adopt the following resolution:

“That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest” Section 1 (2), Public Bodies (Admission to Meetings) Act 1960

For Reference

Presented by Sheila Childerhouse