Board of Directors (In Public)

Schedule	Friday 25 June 2021, 9:30 AM — 11:45 AM BST
Venue	Via video conferencing
Description	A meeting of the Board of Directors will take place on Friday, 25 June 2021 at 9:30am. The meeting will be held virtually via video conferencing
Organiser	Karen McHugh

Agenda

AGENDA
Presented by Sheila Childerhouse

Agenda Open Board 2021 06 25 June.docx

9:30 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

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

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6. Minutes of the previous meeting
   To APPROVE the minutes of the meeting held on 28 May 2021
   For Approval - Presented by Sheila Childerhouse

   Item 6 - Open Board Minutes 2021 05 28 May Draft.docx

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

   Item 7 - Matters arising action sheet - open board.doc

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8. Patient or staff story (verbal)
   To reflect on the experience shared with the Trust
   For Report - Presented by Susan Wilkinson

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

   Item 9 - CEO Board report June 2021.docx

10:15 DELIVER FOR TODAY

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10. Operational report
    To APPROVE a report
    For Approval - Presented by Helen Beck

    Item 10 - Operational Board update June 2021.doc

    Item 10 Appendix A - IQPR May 21.pdf

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11. Report from 3i Committees: Improvement & Involvement
    To APPROVE the report
    For Approval - Presented by Susan Wilkinson and Alan Rose

    Item 11 - 3i committee reports.docx

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

    Item 12 - Finance and workforce Board report Cover sheet - M02.docx

    Item 12 - Finance and workforce Report- May 2021.docx

Comfort Break - 10 minutes

11:00 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

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

    Item 13 - People OD highlight report June 2021.doc

    Item 13 Appendix A - New Disciplinary policy FINAL.docx.doc

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14. Medical Revalidation Annual Report
    To RECEIVE the report
    For Approval - Presented by Paul Molyneux and Katherine Rowe

    Item 14 - Medical revalidation annual report - Trust Board June 2021.doc

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15. Quality and safety reports
    To APPROVE the reports
    Presented by Susan Wilkinson and Paul Molyneux

15.1. Maternity services quality & performance report
For Approval

- Item 15.1 - Maternity Quality and performance report June 2021.docx
- Item 15.1 Annex A - Audit of consultant led ward rounds April 2021 for Trust Board.docx
- Item 15.1 Annex B - Audit of involvement in decision making 2021.docx
- Item 15.1 Annex C - Audit of RFM and DR CTG June 2021 board report.docx
- Item 15.1 Annex D - Audit of risk assessment PCPs etc 2021 board report.docx
- Item 15.1 Annex E - Audit of SBLV2 BMI and serial USS May 2021.docx
- Item 15.1 Annex F - Audit of complex women 2021.docx
- Item 15.1 Annex G - Safety Action 5 Midwifery Staffing Report April FINAL.docx

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15.2. Infection prevention and control assurance framework
For Approval

- Item 15.2 - 21-06-25 COVID IPC assurance framework.docx

15.3. Nursing staffing report
For Approval

- Item 15.3 - May 2021 nurse staffing report.docx

11:25 BUILD A JOINED-UP FUTURE

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16. Digital Board Report
To receive report
For Report - Presented by Craig Black

- Item 16 - Digital Board - June 2021.doc

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

- Item 17 - Future system public Board overview June 2021.doc

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11:35 GOVERNANCE

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18. Governance report
To APPROVE the report, including subcommittee activities
For Approval - Presented by Ann Alderton

Item 18 - Governance report.doc

18.1. Council of Governors report with Foundation Trust Membership Strategy
For Approval - Presented by Sheila Childerhouse

Item 18.1 - CoG Report to Board June 2021.doc

18.2. Certificate for NHS Improvement licencing
For Approval - Presented by Ann Alderton

Item 18.2 - NHSI Certification June 21.doc

11:45 ITEMS FOR INFORMATION

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

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20. Date of next meeting
To NOTE that the next meeting will be held on 30 July in West Suffolk Hospital
For Reference - Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

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21. 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, 25 June 2021 at 9:30**. The meeting will be held virtually via video conferencing.

Sheila Childerhouse
Chair

Agenda (in Public)

9:30 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 28 May 2021	Sheila Childerhouse
7.	**Matters arising action sheet (attached)** To accept updates on actions not covered elsewhere on the agenda	Sheila Childerhouse
8.	**Patient or staff story (verbal)** To reflect on the experience shared with the Trust	Sue Wilkinson
9.	**CEO report (attached)** To receive an introduction on current issues	Steve Dunn
10:15 DELIVER FOR TODAY		
10.	**Operational report (attached)** To approve the report	Helen Beck
11.	**Report from 3i Committees: Improvement & Involvement (attached)** To approve the report	Sue Wilkinson / Alan Rose
12.	**Finance and workforce report (attached)** To approve report	Craig Black
	Comfort break – 10 minutes	

11:00 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP		
13.	**People and OD Highlight Report:** To approve the report	Jeremy Over
14.	**Medical Revalidation Annual Report** To receive the report	Paul Molyneux
15.	**Quality and safety reports** To approve reports: 15.1 Maternity services quality and performance report (attached) 15.2 Infection prevention and control assurance framework (attached) 15.3 Nurse staffing report (attached)	Sue Wilkinson / Paul Molyneux
11:25 BUILD A JOINED-UP FUTURE		
16.	**Digital Board Report** To receive report	Craig Black
17.	**Future system board report (attached)** To approve report	Craig Black
11:35 GOVERNANCE		
18.	**Governance report (attached)** To approve report, including subcommittee activities 18.1 Council of Governors report with Foundation Trust Membership Strategy 18.2 Certificate for NHS Improvement licencing	Ann Alderton Sheila Childerhouse Ann Alderton
11:45 ITEMS FOR INFORMATION		
19.	**Any other business** To consider any matters which, in the opinion of the Chair, should be considered as a matter of urgency	Sheila Childerhouse
20.	**Date of next meeting** To note that the next meeting will be held on 30 July 2021 in West Suffolk Hospital	Sheila Childerhouse
RESOLUTION TO MOVE TO CLOSED SESSION		
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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 28 May 2021

For Approval

Presented by Sheila Childerhouse

DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 28 MAY 2021 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)*		
Christopher Lawrence	Non Executive Director as from 1 June 2021		
Paul Molyneux	Deputy Medical Director		
Daniel Spooner	Deputy Chief Nurse		
Governors in attendance (observation only): Derek Blackman, Allen Drain, Adrian Osborne, Joe Pajak, Jane Skinner, Liz Steele, Clive Wilson, Martin Wood			

Action

GENERAL BUSINESS

21/082 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."

It was noted that this meeting was being streamed live via YouTube to enable the public to observe the meeting.

The Chair welcomed everyone to the meeting and introduced Chris Lawrence who would be joining the board as a Non Executive Director (NED) from 1 June. He had a wealth of experience, having previously been a chair, and an extensive background and would be an asset to the board and as an audit chair.

21/083 APOLOGIES FOR ABSENCE

Apologies for absence were noted above. Richard Jones and Kate Vaughton had also sent their apologies.

21/084 DECLARATION OF INTERESTS FOR ITEMS ON THE AGENDA

No declarations of interest were received.

21/065 QUESTIONS FROM THE PUBLIC RELATING TO MATTERS ON THE AGENDA

Q In the Guardian of Safe Working Report Item 13.1 (Page 87) it states that 'Surgery out of hours' is an issue and 'very little concrete action' is being taken. Is this problem understood and has it been escalated to the appropriate level?

A This question would be addressed under agenda item 13.1.

Q What is an exception report in the Guardian of Safe working Annual report?

A This question would be addressed under agenda item 13.1.

Q In the Future System Report Item 15 reference is made (Page134) to 'extensive public engagement' in June/July and October/November. Is the Board happy with the level of public awareness, interest and support to push the case; King's Lynn have members of the public with placards on major roundabouts demanding a new hospital?

A This question would be addressed under agenda item 15.

Q Thank you for the full report on the 3i s committees with the terms of office. Can we be assured that the new structure and brief of these committees has been or will be communicated to all staff and partners to ensure transparency?

A This question would be addressed under agenda item 11.

21/086 REVIEW OF AGENDA

The agenda was reviewed; item 13.1, Guardian of safe working annual report, would be brought forward to follow item 3 due Francesca Crawley's clinical commitments.

21/087 MINUTES OF MEETING HELD ON 30 APRIL 2021

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

21/088 MATTERS ARISING ACTION SHEET

The ongoing actions were reviewed and the following noted:

Ref 1943; Set timeline for development of SPC charts at Trust, division and specialty level. This had been discussed at the insight committee meeting and a report would be coming back to its next meeting; feedback from this would be taken to the next board meeting. **C Black**

The completed actions were reviewed and the following noted:

Ref 1931: Consider use of SPC charts within maternity (prior to reintroduction within wider IQPR). It was explained that this had been incorporated into action 1943.

21/089 PATIENT OR STAFF STORY

- It was explained that work was being undertaken with the patient experience team to try to bring live patient stores to board meetings but this was quite a challenge.
- A letter was read out from a patient about her experience when undergoing a colonoscopy.

- She came through the rapid access clinic and having previously had a gastroscopy could not understand why her experience this time was so different and the most painful thing she had ever experienced. She had been fully conscious throughout and was very traumatised as the medication/sedation did not work.
- Sue Wilkinson explained what was involved for a patient having a colonoscopy, both prior to and during the procedure, which was not a pleasant experience.
- This was being fully investigated and initial feedback had been received. Work would be undertaken with the endoscopy team to look at how they could improve the patient experience. It was confirmed that during this procedure the size of the scopes had been swapped to the smallest possible and the maximum level of sedation possible was given to the patient.

Q Was it known if there were any trends or increasing trends of this nature in the current situation?

A It was important to try and have a perspective of what had changed as a result of Covid and the effect on endoscopy. This had never affected what happened when a patient had an endoscopy and there had been no reduction in the standard of the procedure given to patients. Staff were kind and caring and explained things well but it was harder for a patient to understand everything they were being told when they were sedated.

It was noted that despite her experience the patient commented that she was grateful to the ward sister and nurse who assisted with the colonoscopy who were very kind and efficient.

- Every patient's experience would be different and the Trust's scopes and equipment were not out of date. The procedure was consistent but dependent on the patient.
- This kind of feedback was very helpful and allowed people to reflect on their practice. This type of complaint was discussed together by all endoscopists.

Q It was important not to scare patients but to educate them as to what they could expect for both the preparation and procedure. What focus did the Trust put on this?

A It was important to give people information before they had the procedure and explain exactly what would happen. The Trust has some very good literature, however, as it moved more towards 'straight to test' face to face communication was less and there was a need to look at whether this was enough or if people would like a telephone conversation with someone.

ACTION: consider whether patients given sufficient opportunity for face to face/verbal communication prior to a procedure. **S Wilkinson**

- From a psychological point of view, the use of the correct language was important when explaining to people about having a procedure, ie discomfort rather than pain.
- A gastroenterologist was going to work with the patient and encourage her to have the ongoing investigations that had been recommended.

21/090 CHIEF EXECUTIVE'S REPORT

- The Trust was increasingly busy, there were currently no Covid inpatients but there was an increase in attendances and the organisation continued to try to recover its elective position.

- The clinical and operational teams were doing an excellent job in working around the ongoing structural work. All staff were being very understanding and flexible in responding to the difficult situation and challenges.
- Matt Hancock and Jo Churchill had recently visited the Trust and had been taken around the building to see the structural issues and the new modular ward which would assist in providing capacity to mitigate this.

  They had also been taken to see the preferred site for the future system and Matt Hancock had confirmed that west Suffolk would be getting a new facility. They both appreciated how the organisation was managing the structural challenges.

  Nursing and medical staff had also shared with them their experiences of managing through the pandemic.
- International nurses' day on 12 May had been celebrated by the Trust and was a reflection on how it came through the last year.
- Next week would be volunteers' week; volunteers were now coming back into the organisation and had been a great help through the vaccination programme.
- The Trust continued to try to improve culture. The freedom to speak up assessment was included in the board papers today together with a report from the 3i improvement committee which had discussed the establishment of freedom to speak up champions.
- The clinical and medical orthopaedic teams were commended for delivering the best hip fracture care in the country throughout the pandemic.

DELIVER FOR TODAY

21/091 OPERATIONAL REPORT

- The one Covid patient in the hospital had been successfully discharged and there had been no transmission in the organisation which was a credit to the medical and nursing teams. Everyone continued to be very vigilant.
- The Trust was now over halfway through the ICU decant and was managing well within the reduced footprint. There had been a couple of occasions when the a nearby Trust had been required to assist with capacity.
- The elective recovery fund (ERF) gateway summary provided information on how to assess whether or not an organisation was eligible for additional funding. The Trust now needed to look at how it measured against these.
- A range of actions were being taken to address the shortfall in theatre capacity which would start to have an impact from next week.
- Information on the accelerator programme was emerging day by day and the scrutiny committee would continue to be updated on this.
- Appendix 1 showed point of time data. However, the four-week average column should be looked at rather than the latest week data, as this was provisional.

Q The report referred to a third surge in Covid cases, how was this being factored into the Trust's planning?

A This involved an element of guesswork; however the Trust benefited from having its own public health clinicians. The current suggestion was that there was likely to be a lesser impact on healthcare but a significant increase in cases in the community. Therefore, a lot of effort was going into increasing the vaccination programme.

Nationally and locally organisations were being asked to send positive Covid samples for specialist analysis to Porton Down so that new variants could be tracked. Currently the thinking was that sometime in August/September there would be up to 20 cases in the hospital which would take up more capacity. By then G10 would be open and could be designated as Covid capacity.

It was also hoped that this would align with completion of the end bearing support work but it was possible that these could overlap.

Q Given the challenges of the structure, could the board be assured that emergency preparedness, resilience and response (EPRR) was being co-ordinated regionally, ie with the Queen Elizabeth, Kings Lynn, closing facilities?

A The regional planning and co-ordination group, as well as the CCG, were focussing on this but this was an ongoing process. The plan was for WSFT to undertake an exercise and the team was working with estates to identify an appropriate day to enact a scenario, alongside the ambulance trust and regional colleagues.

A regional exercise was undertaken 6-8 months ago and learning from this that needed to be embedded, ie evacuation of a hospital. The chairs of the effected hospitals were also meeting on a regular basis to discuss the strategic approach.

The Chief Executive and Craig Black had met with Ann Radmore and the CCG to discuss plans and the need for a co-ordinated regional response but this needed to be progressed and planned for.

Q One of the objectives of the accelerator programme was transformational change of outpatients. Was this already being worked on and was there a timescale? Was there also an action plan to improve performance of first outpatient appointments and follow up outpatient appointments?

A The plan was to reduce the number of people coming into outpatients, however this could cause a dilemma in terms of the requirement to deliver 120% of 19/20 baseline. Plans were in place and WSFT was ahead of national expectations in a lot of ways, including advice and guidance on where GPs could access consultants for advice on managing a patient and patient initiated follow up (PIFU). The idea of PIFU was to reduce follow ups and put safety nets around patients and bring them in on a fast track basis when needed, rather than at a regular period.

Virtual outpatients was another initiative and a there was a further stream of work on high volume, low complexity pathways which looked at elective pathways rather than long term conditions and how to reduce the number of visits.

Consultants were part of the outpatient transformation group as consultants were anxious about the added burden of some of these initiatives, particularly advice and guidance (A&G) as this was like an outpatient clinic without an appointment. There was a need to look at how to allocate people time in their job descriptions to manage A&G referrals who would otherwise previously had an appointment to attend an outpatient clinic.

21/092 REPORT FROM 3i COMMITTEES: INSIGHT, IMPROVEMENT & INVOLVEMENT

<u>Insight Committee</u>

- This was the inaugural meeting therefore discussions for all three committees were around terms of reference and membership.

- In response to the governor question about communication and transparency of these committees; it was recognised that communication was a very important part of this.

  A discussion took place at this meeting about ensuring that it was clear to the organisation and through the board and wider population that the purpose behind these committees was about getting clinical involvement in the governance of the organisation and that there was a process for interrogating data about what was going on in the organisation and triangulating this data with other sources of information, eg patient stories, governor/public feedback.

- When issues were identified the focus would then be on improvement.
- Insight was about scrutinising data; involvement was about triangulating issues highlighted and improvement about continuous improvement of the organisation to increase levels of quality. Therefore, it was important that there was some consistency in membership across the three groups and ensuring that membership of the groups reflected the broad nature of the organisation.
- It was important that staff in the organisation understood how they could feed in issues. The aim was to encourage curiosity and interrogation as to what was going on in the organisation.
- There would be an evaluation of the process as these committees progressed.

<u>Improvement committee</u>

- This committee was about a holistic approach to improvement with oversight, support and development of what have been and would be identified as areas where the organisation needed to demonstrate improvement.
- The aim was to for discussion and review to be real and in depth and allow individuals attending to have time and for the committee to truly understand what was required and how to link with the other committees.
- There would be a high-level overarching improvement plan with details underneath.
- This was slightly different in approach to the improvement programme board and was more about driving improvement internally as well as using new ways of working to empower people in the organisation to drive improvement.
- Communication was key to people understanding how this was going to work. Groups of staff would attend the committee on a rotational basis as part of their training to give them confidence to participate and give them the tools to improve and drive things forward. The aim was to encourage ownership of true quality improvement.

<u>Involvement committee</u>

- The success of the committee would be that the three communities identified, ie staff, patients and stakeholders, felt more involved.
- Feedback from What Matters to You was that prominence and platforms given to subject matter experts could be improved. This would create room for the board to be influenced by subject matter experts.
- The focus of the first meeting was on two major areas of work; proposals from freedom to speak up guardians to create a network of 'speak up champions' and the people plan and workshops held in May. The theme of these had been the role of line managers in supporting staff and developing the culture across the organisation.

- The committee would play an important role in the cultural change programme of the Trust, ie involving, listening, encouraging and supporting people.
- The two topics for the next meeting would be line manager development and competencies and supporting staff in stressful times. This was about enabling and empowering people to implement initiatives.
- A discussion had also taken place about how to measure performance and progress that was being made by the committee.
- It was noted that it was important that committees linked together and did not create new silos.
- One of the ways in which the role of these committees would be communicated to the organisation was to try to use real life examples, eg maternity services where it was evident that there was a difference in perception as to the quality of the service but there were issues that the board did not have sight of. This would be used as an example to ensure that the process was fit for purpose and to identify issues.
- It was important to ensure the continuous review of issues that the board needed assurance on and not to lose sight of these. These would be monitored through the scrutiny committee and board meetings.
- The board should not delegate any of its key responsibilities. Although it was not intended to go through the IQPR report at board meetings, exceptions still needed to be focussed on and the board needed to be aware of areas of concern and any major issues.
- It was proposed that the NED Chairs of committees should present reports to the board if they were present at the meeting.

21/093 FINANCE AND WORKFORCE REPORT

- The position reported for month one was breakeven.
- The board had previously agreed a financial plan for the first six months of the year in accordance with the national process. The first six months of the year were being dealt with separately as it was not yet known what the assumptions would be for the second six months.
- The board had submitted a plan that had subsequently changed. The plan now was to breakeven for the first six months as income had been set on the basis of expenses that Trusts incurred in the second half of the last financial year and these had been heavily influenced by the response to Covid.
- The main concern this year for WSFT was around capital. The bulk of the capital programme would be consumed by the response to the structural issues that had already been discussed at this meeting. The plan was to spend approximately £30m on remedial structural issues this year and this would be a feature of future years.
- The rest of the capital programme would be severely constrained and some of the problems that this would cause would have to be managed on a daily basis. The Trust was currently in conversations with the regional office and national team about accessing additional capital and had highlighted some of the issues that not having sufficient capital would cause the organisation.

Q The capital improvement programme (CIP) had been set for this year at 1% plus any unrealised targets from last year, ie £4.2m. How would this be focussed on?

A The financial plan for the first half of the year was having to be revised. The CIP programme would feature in the second half of the year but work needed to be done

to properly determine what the plans would be for the second half of the year. Further details would be brought to a future board meeting.

ACTION: provide details of the CIP programme for the second half of the financial year to a future board meeting. **C Black**

Q Did Craig Black or his colleagues have any sense of when organisations would return to a more normal financial situation in the future?

A The uncertainty around a third wave had already been discussed and nationally the number of patients in hospital had increased over the last week. This was also reflected in the financial position nationally as it was not known what the allowance to the department of health from the government would be for this year.

The finance team would try to work out what the underlying position would be and what the CIP requirement would be. This was being done independently to the rest of the NHS and it was expected that there would be more certainty around the second six months of the financial year in the next couple of months.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

21/094

- Emily Fell (Macmillan unit) and Chloe Bonner (physiotherapist, lung function) received Putting You First awards this month. The citations put forward for both had highlighted their personal focus to the particular needs of individuals at the right moment in time.

  The board recorded its thanks to Emily and Chloe for the exemplary care that they provided in the scenarios that were described.

<u>Freedom to speak up (FTSU) board review</u>

- The board last undertook this assessment/review in autumn 2019. Since then a lot had happened in relation to the Trust's approach to supporting staff to report concerns, however further work was still required.
- It was explained that this was very much the board's self-assessment and lines of enquiry for the board as senior leaders to reflect on.
- In preparing this Jeremy Over has consulted with the two FTSU guardians and Richard Davies as the named NED for FTSU, together with members of the HR team who provided support to staff and FTSU.
- This report detailed areas where further work was required and reflected proposals put forward by the FTSU guardians when they presented to the board last month, ie 'even better if'. This would be incorporated as part of the Trust's people plan.

Q 'Fully met' was an area of qualitative judgement; how did the organisation keep testing this and ensuring that this was fully embedded?

A 'Fully met' items had a review date of six months' time, therefore these would not be lost sight of and would be re-visited to ensure that they were fully embedded.

Q Re: expectation around "evidence that you receive assurance to demonstrate that the speaking up culture is healthy and effective". A lot of the actions were more formal in terms of reporting; should some sort of informal mechanisms be considered to understand that these changes were being achieved and that people were happy to speak up? How could this be done?

A Some lines of enquiry were relatively straight forward to test, but there were also lines of enquiry which were deeply cultural and it would be difficult to say were fully met. What was true for one team in the organisation would not be true for another. In getting assurance, the experiences of staff would be different depending on the culture within different teams.

The next step was to focus more on supporting and developing line managers and team leaders to appreciate their role in creating the right culture in their teams. Following this Jeremy Over and his colleagues could then think about how to gain assurance that this was fully embedded. The staff survey results from both the most recent (2020) and the previous year (2019) would help to identify teams where there was a particular issue.

Q Re the appraisal programme; how could appraisals be taken to the next level and would any work be done around succession planning and training and skills development that linked with the FTSU programme?

A The thread that ran through all of this was relationships and trust in colleagues so that people felt able to speak up in their appraisals, so that these were more meaningful. Many line managers already understood this and created a good working environment and working relationships for their staff. This needed to exist in every team.

This also related to the quality of the appraisal and succession planning.

- This review conveyed the journey that the Trust was on, the actions that had been implemented and actions that were still required. It was important that the board did not become complacent about the work that still needed to be done. The National Guardian's office had published a report on the 2021 FTSU index which included three cases studies. WSFT could look at this and engage with Guardian's office about additional actions that could be added to the list to further improve culture within the organisation.
- The board endorsed this self-assessment and approved the proposal that it should be delegated to the involvement committee for oversight of delivery of the ongoing improvement actions.
- It was requested that when this committee reported to the board it commented on the progress of this on a regular basis, rather than wait of the six-month review of this assessment.

ACTION: Improvement committee reports to the board to include update on progress of actions arising from FTSU self-assessment. **J Over / A Rose**

94.1 Guardian of safe working annual report

Francesca Crawley, guardian of safe working, attended the meeting to present this report.

- Francesca thanked the organisation for being so supportive during the challenging period of the pandemic. She explained that the junior doctors had really stepped up to the mark despite the very difficult conditions.
- Helen Kroon, medical staffing manager, had been a great support to the junior doctors and had set-up a WhatsApp group for them which she monitored and responded to any issues or queries, or forwarded to the appropriate person.
- In response to the governor's question about exception reporting; there were three reasons for exception reporting; time worked, safety concerns, missed training opportunities. Junior doctors should only work the hours that they were paid for; if for some reason they worked longer than their shift they could claim for up to two

hours' time in lieu or be paid for that time. They could also submit an exception report for immediate safety concerns; there was a process for formally recording this, including a datix.

- 99% of exception reports were for time and this was acknowledged by offering time off in lieu so that staff were not exhausted.
- Re the surgery out of hours issue, there had been an issue about cover for surgery. At the beginning of the academic year (Autumn 2020) there was a serious incident relating to a junior doctor on the ward who was very new to the Trust. A datix was raised and this was fully investigated. An exception report was then put in about safety in surgery out of hours.

  As a result the meetings with various senior managers and consultants in surgery were reinstated. They had met approximately five times over the last six to eight months and a lot of discussion has taken place about this issue but there was still a concern that this had not yet been resolved. Although this was currently not a problem it could be an issue when new junior doctors came into the Trust.
- It was important that the board were aware of this challenge in surgery; a number of changes had been made but there was still more to do. This had been discussed recently at senior meetings in the organisation, including the learning from deaths group. There was now a 'sick' list in surgery which identified the patients who needed to be specifically monitored over a weekend or bank holiday.

Q This issue had been appropriately escalated to the right level and some actions had been taken. How did the board get assurance that there would be ongoing action to address this?

A This had been addressed over a number of years but it was very difficult to resolve. A number of specific changes had been made since this serious incident.

- Given the concerns relating to the new intake of junior doctors in August it was proposed to ask surgery to forward a paper to the executive team which could then be taken to the board; this would enable the NEDs to ensure that this would fully followed up and addressed.

ACTION: Surgical team to be asked to submit a paper on actions taken and proposals to mitigate the out of hours issue in surgery prior to the intake of junior doctors in August. **P Molyneux**

- In medicine there was a medical registrar available 24/7. This was not possible in surgery as there was not a resident registrar, therefore there would need to be tier of doctors supporting the junior doctors.
- There were actions that could be taken to solve this issue and in her next quarterly report Francesca Crawley could given an opinion as to whether the paper that it was proposed to present to the board in July had been successful.
- The board thanked Francesca for everything she was doing and the support she was giving the junior doctors.

21/095 QUALITY AND SAFETY REPORTS

95.1 Maternity services quality and performance report, including Ockenden report

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

- As previously reported e-Care went live in maternity in March, however there continued to be some issues with the reporting which meant that some data was

missing from this and the previous report. This had been escalated and the e-Care team were working closely with maternity and the information team to resolve this.

- The Ockendon portal was now open for Trusts to input evidence on how they were meeting the requirement of part one of the Ockendon report. A huge amount of data was required and this was being signed off by the executive team and checked by the region before it was submitted. The closing date for the portal had been extended to 30 June.

Q Re the issues with e-Care; having access to good quality data was critical and this report referred to the need for a business case for digital support in maternity. What was this, what stage was it at and what was the timeframe?

A Karen Newbury had met with the executive, e-Care, information and maternity teams to discuss what was required. Data was available but needed to be produced in the right domain so that it could be in the appropriate reports. Currently people were working on this and it was proposed to second someone into this role as soon as possible. The next step was to review the situation in a couple of weeks. Currently resources and support were being provided but long-term someone would be need to be in this position.

- The Ockendon report stated that as part of the requirements of the perinatal surveillance tool some of the standing items in this report, eg safety champion walkabout feedback, feedback from friends and family and service users should be shared with the board.
- The maternity clinical and quality dashboard was received and noted. As previously advised some data was missing due to the issues with e-Care.
- Despite the issues with e-Care it was reported that during a maternity safety champions walkabout the over whelming view of the maternity team and consultants in the department at the time was that this was already improving things and making things easier and would enable them to provide even better care to patients.
- The final report from the recent CQC visit was expected imminently and the Trust would then have ten days to look at this for factual accuracy. Actions highlighted from immediate feedback received were already being implemented and had been fed back to the CQC. It was requested that details of this report were circulated to the board as soon as possible, ie before the next board meeting.

ACTION: circulate final CQC report on maternity visit as soon as it is received. **S Wilkinson**

95.2 Infection prevention and control assurance framework

- A full gap analysis had been undertaken around the findings that were documented from previous Health & Safety Executive (HSE) inspections of other organisations and guidance as a result of this.
- As previously reported there had recently been one Covid positive patient in the organisation. Infection control processes were enacted and all contacts had been discharged or were within the organisation but were outside the 14 day isolation window.
- Interviews had taken place last Friday for an infection control nurse which was a role that was very difficult to recruit to. Amanda Devereux who was currently part of the infection control team had been appointed to this position and would be developed into this role over the next six months.

Q Was there enough capacity in the team to undertake the recommended 'wash-up' review as well as continuing with the day to day business?

A The 'wash-up' review would be undertaken once all of the final RCAs were completed. There would be enough capacity in the team and there would be a report on this review.

Q At a recent governors meeting an issue had been raised about the lack of social distancing and overcrowding in the emergency department reception area. What steps had been taken to address this?

A The infection control team were working with the emergency department to advise on how to manage potential over crowding should this occur. They were working collaboratively with the team to try to ensure that there was social distancing, however there would be occasions when this was a problem if there was a high number of attendances. Actions had already been put in place and implemented and this would continue to be managed and monitored.

95.3 Nurse staffing report

Daniel Spooner, deputy chief nurse, attended the meeting to present this report.

- The figures looked positive for this month; fill rates had remained good at above 90% in all shifts in all areas.
- The safer care module initiative was launched in April; this was a daily risk assessment of nurse staffing against actual need and provided an insight on staffing for each area each day. A meeting took place every morning to look at any risks around staffing and how to mitigate for these. The nursing team had fully endorsed this and 100% of wards were entering data into this system.
- Vacancy rates had increased this month but this was expected and planned for as a result of the establishment review and following the introduction of the uplift. It was also due to the uplift as a result of the increase in the footprint of the emergency department.
- The emergency department (F6) was the main concern due to the increased establishment. All positions had been recruited to and work was being undertaken to support the team whilst it was waiting for the newly recruited staff to join the Trust.
- Turnover had been reviewed and details of this were in the report. Turnover was higher in the nursing assistant group and this was often because new recruits had not worked in healthcare before and it was not what they expected it to be. Two people had been appointed to provide support to nursing assistants and assist them in completing their training. Initial funding for this was through NHSI for six months but if it proved successful this would be considered for the long term.
- NHSI's aim was for Trusts to have 100% fill rates for nursing assistants by the end of March 2021 and WSFT had achieved this. However, due to the increase in establishment this was no longer the case.
- Nursing related indicators had improved again this month which correlated with the increase in staffing numbers.

Q How did Dan Spooner consider the culture in the nursing team was and would be in the future?

A He had only been in the Trust for nearly a year but had been very impressed with the level of engagement of nursing staff and this continued. The nursing team were engaged and wanted to do more to improve the level of care they provided. He was very pleased with how well the team had engaged with the new safer care module initiative that had recently been rolled out.

Quality improvement initiatives were being adopted across all wards and the nursing teams took pride in their work. There was still work to be done around empowering staff to improve things in their own areas, eg ward accreditation programme. Further information would come to be board on this in the future.

ACTION: provide further information to the board on the ward accreditation programme. **S Wilkinson**

Q Considering all the work being done in maternity around the Ockendon report, CQC and e-Care and the appointment of a new deputy head of midwifery, when could the board realistically expect to see the outcome of the neonatal staffing review in the context of wider maternity services (ongoing action 1993)?

A The neonatal area had a similar acuity dependency tool to the safer care tool; therefore, data should be available to do this piece of work and Dan Spooner would be working on this with the deputy head of midwifery when they joined the Trust.

Q Given all the nurses joining the Trust was their sufficient accommodation and training capacity to manage and support these new members of staff?

A There was a very good education team and sufficient people to provide the level of education and training required. However, the challenge over the last few months had been accommodation for training due to social distancing restrictions and the limit on how many people could be in a training room. The introduction of pastoral support for nursing assistants had been well received.

95.4 Quality and learning report – learning from deaths, quality priorities

- The ongoing work around the patient safety framework was highlighted and themes that had been identified for investigation.
- Incident review meetings were being increased to two meetings a week to ensure that each incident was given the required amount of time for discussion and allocation to an agreed pathway. Each incident was reviewed in its entirety. These meetings discussed being open (rather than duty of candour) to ensure verbal and then written documentation to patients or their family/carer.
- There had been a lot of information in the press around managing patients with mental health and that this was an illness in itself. In January last year Natalie Bailey was appointed as head of mental health for the organisation but had been acting as the head of nursing for medicine. She had now returned to her original role and was working across the Trust and alliance to deliver the mental health agenda for the acute hospital and community.
- Learning from deaths continued and members of the team attended meetings to raise the profile of this work and the organisation's learning from this.
- Quality walkabouts had been restricted during Covid. The team was now looking at how this could be reintroduced in some form and these would be more about experiences on the ward rather than a quality improvement visit. NEDs and governors were keen to be involved in these.

ACTION: consider how quality walkabouts could be reintroduced. **S Wilkinson**

Q Given the importance of mental health and wellbeing, particularly following the pandemic, could Natalie Baily attend a board meeting to present the work she is doing on mental health.

A **ACTION: invite Natalie Bailey to present to a future board meeting.** **S Wilkinson**

Q The patient safety incident response framework referred to a patient being readmitted due to medicines management. The CQC report last year had identified issues around medicines management, could assurance be provided that this not a related issue?

A The CQC had identified issues around the way in which medicines were stored and managed. This incident was not related.

BUILD A JOINED-UP FUTURE

21/096 FUTURE SYSTEM BOARD REPORT

- This report provided details of work that had been undertaken over the last month, including an engagement process around the environmental impact assessment including a couple of sessions with members of the public, particularly local residents.
- Digital fortnight finished last month. This was an initiative where people were taken out of their normal role for a fortnight to focus on the footprint for the future system programme. A number of external partners contributed to this, and facilitation was assisted by ATOS (who were working with Department of Health on the new hospitals programme).
- ATOS had fed back that the work being done constituted a national exemplar around planning for new technology within the new hospitals programme. This had been highlighted to the Department of Health as they wanted to develop a blueprint for the use of technology within all of the 40 hospitals in the programme and WSFT should be able to contribute to this nationally.
- A photo of the construction of the new ward (G10) using modern methods of construction was included in this report. 92 modular units that had been constructed off site were transported to WSFT over the early May bank holiday weekend. This had involved a huge amount of work and caused a degree of disruption for local residents. WSFT was very grateful for their forbearance during this process.
- In response to the governor question; 'is the Board happy with the level of public awareness, interest and support to push the case?', WSFT was fully supportive of Kings Lynn, which faced the same structural issues, in their attempt to become one of the hospitals in the new hospitals programme.

  However, WSFT was in a different position to Kings Lynn as it had a comprehensive engagement plan and its approach went much further than the statutory requirements. There was a genuine desire to hear as many voices as possible in the design of pathways to improve the quality care provided to its population. It was recognised that it was important to listen throughout this process and respond accordingly.

Q There is good co-production work on the design of the new hospital/future system; was there a concern that the national new hospital programme might bring a more centralised programme to the build and would this affect WSFT's plans?

A There was some concern around this but it should not be an issue. The plan was to develop a standardised approach to some of the units within the development which should be repeatable eg wards, theatres, outpatient rooms. The way in which these would be put together should be a reflection of the environment in which the facility was being built and the clinical model that was being put together. The Trust should be able to learn from other organisations but implement this so that it reflected the good work that was being done on clinical pathway development.

GOVERNANCE

21/097 GOVERNANCE REPORT

- The board received and noted the content of this report

ITEMS FOR INFORMATION

21/098 ANY OTHER BUSINESS

- The Chair explained that she had asked Nick Jenkins, who was stepping down from his role as medical director at the end of this month, to reflect on the current situation within the clinical teams and some of the challenges ahead.
- He considered that generally things were good and staff took a lot of pride in their work and caring for patients, with good team work,

  Over the last couple of weeks there had been a number of never events in the region which could be a reflection on people getting back to working but in slightly different ways with some level of stress. So far this had not happened at WSFT due to the care and attention of the teams.

  Some of engagement work was not yet complete, ie support in stressful times, which Paul Molyneux was leading on and this would continue

  There was now the best group of clinical directors that the Trust had had during his time as medical director. They were universally of good quality and would be an asset. There was now a real opportunity progress under Paul Molyneux's stewardship.

  It was difficult to balance the demands of recovery and the increase in emergency work and there were tensions that arose as a result of this, with the remedial building work presenting further challenges.

  There had been a number of good appointments to hard to recruit to specialties.

  There are also remained some challenges in some areas, eg urology, histopathology, anaesthetics.

  There was now a widespread willingness to collaborate more, not just with Addenbrooke's but also with ESNEFT.

  The teams were engaging with the future system work, both hospital and primary care.

  All the above meant that things should continue to improve.
- The Chair thanked Nick Jenkins for all his work as medical director and the contribution he had made to the Trust, for staff and patients. He had always shown great professionalism and brought humour at times when it was needed. The vaccination programme was exemplary and was a credit to him, the team and the Trust. She thanked him and wished him well on behalf of the board, governors and all his colleagues.
- The Chair also thanked Angus Eaton for being an excellent NED and audit chair. He had always instilled his colleagues with confidence in the understanding he had of the governance and risk agenda. He also brought human compassion as well a sense of humour. He had provided great support to the executive team, NEDs and governors.
- The Chief Executive echoed the Chair's comments. He was very pleased that Nick was remaining in the organisation with his expertise and thanked him for everything he had done in leading the medical team through the pandemic and vaccination

programme and for bringing pathology back into the Trust. Amongst other things he had also helped modernise job planning and been very supportive of the digital initiatives that had been introduced in the Trust over the last few years. He had always done everything with great humour and professionalism.

Angus Eaton exemplified the best of NEDs and even when he was challenging he continued to be thoughtful and supportive. He had been a great asset to the board and would be missed.

- Angus Eaton thanked the Chair and Chief Executive for their kind words. He would have liked to remained in this role but due to his time commitments he felt it was better for the Trust if he moved on. He said that WSFT should own its own future. The board may hear things that it was not going to like but they must remember everything good that they did for patients, staff and the wider NHS.

  Nick Jenkins said that he had appreciated and really enjoyed being part of the board and wished them the best for the future.

21/099 DATE OF NEXT MEETING

Friday 25 June 2021, 9.15am

RESOLUTION TO MOVE TO CLOSED SESSION

21/100 RESOLUTION

The Trust board agreed 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

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 – 25 June 2021

Agenda item:	7			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Ruth Williamson, Trust Office Manager			
Date prepared:	24 May 2021			
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
1915	Open	29/1/21	Item 12	Community services leaders to recommend appropriate community effectiveness metrics for future reporting	At April meeting it was proposed that this action should remain open as community metrics had not yet been fully resolved. It was noted that this was work in progress and updates would be provided to the board - update scheduled for May (or timing for completion). Working group of community team members established and work is progressing. Work on-going. **A workshop with nurses and therapists to be held on the 13th July. Updates to follow.**	HB	28/5/21 26/3/21	Green
1929	Open	26/2/21	Item 11	When clearer on national reset expectations (standards/targets) develop local metrics for IQPR to support local innovation and drive improvement	IQPR pack being developed but the revision (taking out) and update (adding in) will take more time. This is also impacted changes in roles and options being considered. Unfortunately, we have again needed to second a key member of the team to support CRT for the RAAC works. We are actively looking for external support to backfill this gap. Matter on-going. **Recruitment continues to find suitable support.**	HB	30/04/21	Green

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1933	Open	26/2/21	Item 14.1	Consider how neonatal staffing is reviewed in the context of wider maternity services	This will be reviewed with the commencement of the Deputy Head of Midwifery and will be re-assessed using the latest staffing assessment tool. **On track as part of Trust safer staffing review.**	SW	25/06/21	Green
1943	Open	26/3/21	Item 10	Set timeline for develop SPC charts at Trust, division and specialty level	Reviewed date proposed following review with information team and head of performance. Potential for some earlier iterations as the Insight work progresses as we as some different/additional metrics to be reported to the Board. **Report going to Insight committee on 5 July; outcome of this would be fed-back to board meeting on 30 July.**	CB	30/04/2021 30/07/21	Red
1944	Open	26/3/21	Item 12	Consider how to develop information on the quality of training provided in the 6-monthly education report		JMO	01/10/21	Green
1954	Open	30/4/21	Item 13	Develop report to include an indication of outcome for issues raised to FTSUGs		JO	31/07/21	Green
1955	Open	30/4/21	Item 13	Confirm how “even better if” issues from FTSU report have been reflected in plans		JO	31/07/21	Green
1957	Open	30/4/21	Item 14.3	Staff retention and attrition rates (particularly for new staff) – develop indicators to support visibility of this indicator	**Data for turnover received and is included in this month's board paper. Data for new staff still being scoped.**	JO / SW	28/05/21	Green

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1958	Open	30/4/21	Item 14.3	Provide visibility for future recruitment pipeline within report	**Future pipeline being created by DCN and DHRD with completion anticipated for reporting at July board.**	JO / SW	30/07/21	Green
1959	Open	30/4/21	Item 14.3	Provide visibility of the developing national safety nursing care tool for community	**National Development detail awaited.**	SW	30/07/21	Green
1969	Open	28/5/21	Item 8	Sue Wilkinson agreed to consider whether patients given sufficient opportunity for face to face/verbal communication prior to a procedure.	**Matter on-going. Discussions to be undertaken at senior nursing team meetings.**	SW	25/06/21	Green
1970	Open	28/5/21	Item 12	Provide details of the CIP programme for the second half of the financial year to a future board meeting.	**Clarity on the income position anticipated within the next month. Overall assessment (including CIP) to come to July Board meeting.**	CB	30/07/21	Green
1971	Open	28/5/21	Item 13	Improvement committee reports to the board to include update on progress of actions arising from FTSU self-assessment.		JO/AR	30/09/21	Green
1972	Open	28/5/21	Item 13.1	Surgical team to be asked to submit a paper on actions taken and proposals to mitigate the out of hours issue in surgery prior to the intake of junior doctors in August.	**Paper being submitted for July Board Meeting.**	PM	30/07/21	Green
1973	Open	28/05/21	Item 14.1	Circulate final CQC report on maternity visit as soon as it is received.	**Received and being checked for factual accuracy.**	SW	25/06/21	Green
1974	Open	28/05/21	Item 14.3	Provide further information to the board on the ward accreditation programme	**Paper going to execs and update to Board to follow.**	SW	30/07/21	Green
1975	Open	28/05/21	Item 14.4	Consider how quality walkabouts could be reintroduced.	**Work in progress, first meeting undertaken 17.6.21.**	SW	30/07/21	Green

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1976	Open	28/05/21	Item 14.4	Invite Natalie Bailey to a future board meeting to present on the work she is doing around mental health.	**To be confirmed.**	SW	30/07/21	Green

Closed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery

None to report.

8. Patient or staff story (verbal)

To reflect on the experience shared with the Trust

For Report

Presented by Susan Wilkinson

9. Chief Executive’s report

To RECEIVE an introduction on current issues

For Report

Presented by Stephen Dunn

Board of Directors – 25 June 2021

Agenda item:				
Presented by:	Steve Dunn, Chief Executive Office			
Prepared by:	James Goffin, Communications Manager Helen Davies, Head of Communications			
Date prepared:	17 June 2021			
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

In many ways it feels like an age ago that we were in the depths of winter, dealing with an influx of **Covid-19** patients and wondering when – or if – things would ever return to 'normal'. Today we sit, a little nervously, in a much better place. Infection levels locally are very low and in the last month we have only had the occasional Covid-19 inpatient within the Trust. The vaccination programme has seen large numbers of people, including around 80% of our staff, receive a high level of protection from the virus.

We know, however, that there has been rapid spread of the Delta variant, and the Government has now delayed the final stages of the unlocking of our daily lives until at least 19 July. Much of what we do in the Trust is still substantially affected by Covid-19: we continue to have limited visiting for inpatients, our staff are taking extra precautions in social distancing and wearing higher levels of personal protective equipment, and many non-clinical staff are still working from home. Covid has not gone away, and our clinical, operations, and public health teams remain on high alert and ready to respond to a potential third wave in the coming weeks.

We are also, however, working hard on **restoring services affected by the pandemic**. Our waiting lists have substantially increased over recent months, and we know this is upsetting for patients – as well as our staff who want to do their best for people in their care. The board has previously discussed the Suffolk ICS' successful bid to the national elective accelerator programme, which will see £10m spent locally – largely between us and East Suffolk and North Essex NHS Foundation Trust.

Our staff are working incredibly hard on this, and as of the end of May are seeing increased activity in all areas, at upwards of 81% of the 2019/20 baseline. This is above our target trajectory of 75%. This work is not just about doing more of the same, but also thinking more fundamentally about how we diagnose, treat, and monitor our patients with clinically-led pathways that maximise our efficiency. It is worth noting that as a result of redesigning our processes, although our headline targets are based on 2019/20 baseline activity in some areas we may actually benefit more patients by having less, but better targeted, activity. For example, rather than bringing every patient in for routine review at set periods, we may offer bespoke support plans with a mix of in-person appointments, online consultations, and self-driven recovery techniques and support. This is better for patients, and means our staff can focus time on the patients that need it the most.

To help with this, we are rolling out **increased use of the DrDoctor text messaging system** for appointments. This digital technology allows our clinicians to get updated information from patients and offer treatment at a quicker pace than postal letters allow, as well as significant financial and environmental savings. We are also **encouraging patients to sign up to our Patient Portal**, where they can view detailed records of their hospital treatment, including test results and letters.

An additional challenge we face in recovery is the **condition of our main West Suffolk Hospital building**. The issues with the construction methods used at our, and several other, hospitals have been well publicised recently. Working with structural engineers and independent advisors, our remedial programme is now at full steam; this will see many departments temporarily relocate around the hospital while we install end bearing and failsafe support mechanisms. Work in maternity has completed, and we expect ITU to return to its normal location by the time of the board meeting. Work is also ongoing in antenatal, theatres, and link corridors, with work to begin shortly on F3, F8, and F12. This will inevitably cause some noise and disruption but wherever possible we are scheduling the quietest work at the most sensitive times to minimise the impact on our staff and patients.

To give us further flexibility **our new G10 ward is rapidly taking shape**. Using a modular construction approach, this has been built rapidly and it has been quite something to see it move from go-ahead in February to, we hope, completion in July. We are very grateful to local residents for their understanding for the 24-hour working that has enabled this rapid progress.

Not only will this new ward give us more capacity, it will provide modern facilities of the type our staff and patients deserve, and a taste perhaps of what our **new healthcare facility** will offer in due course. Exactly how it will be configured will be closely informed by our ongoing consultation work with the local community, our ICS partners, and our staff. I would urge everyone to fill out our online survey at www.wsh.nhs.uk/NewHealthcareSurvey and to also consider joining one of our community engagement groups by registering on our website. This is a crucial stage in the delivery of our plans,

as we work towards finalising what we, as a community, need from the new hospital and then working with our architects to put together an outlining planning application towards the end of this year.

Renewal of our culture is as important as renewal of our buildings. We have covered in previous board meetings how our work with colleagues through our local and national staff surveys, as well as learnings from other trusts, are informing our work to ensure an open and honest culture throughout the organisation. An important part of that will be our **new Trust strategy**, which will set out our vision for the future, our priorities and aspirations. We are looking to streamline the strategy to help us focus on a clearer set of ambitions, around a central vision to "Deliver the best quality and safest care for our local community". The strategy will be modelled on a daily basis through **our First Trust values**, and we have begun consulting with staff on what these should be and how they resonate, as a core set of principles/ethics, with every colleague.

Our proposed values retain the existing FIRST framework, but have been updated to reflect where we are as a Trust. They are:

Fairness	We value and prioritise fairness and treat each other appropriately and justly
Inclusion	We are inclusive, appreciating the diversity and unique contribution everyone brings to our organisation
Respect	We respect one another and our patients. We seek to understand each other's perspectives so that we all feel safe and able to express ourselves
Safety	We put safety first for our patients and staff. We seek to learn from our mistakes and create a culture of learning and improvement
Teamwork	We work and communicate as a team. We support one another, collaborate and drive improvements across the Trust and wider local health system

We have already begun to hear from colleagues on the values, and also welcome feedback from our wider Trust community.

One thing we know will change over the life of our new strategy is the local framework under which we operate. The emerging **integrated care system** will replace our current clinical commissioning groups and create stronger links with our partners outside of the NHS. I am delighted therefore that we have been able to appoint **Clement Mawoyo** as director of integrated community health and adult social care at the West Suffolk Alliance, as a joint appointment between the Trust and Suffolk County Council. Clement is currently area director for adult and community services in north Suffolk, and brings with him 20 years' experience in health and social care. Clement will take up post in July on a 12-month secondment.

Within the Trust, we have also welcomed **Paul Molyneux** as **interim medical director**. Paul takes over from Nick Jenkins, who has stepped down from the role for family reasons but remains with us as an emergency department consultant. Paul has been a consultant with us for more than 18 years and most recently was deputy medical director.

I am delighted that we will benefit from his experience, and his passion for improving the quality of care patients receive.

Joining Paul at board level, we have another new face around our currently virtual table. **Chris Lawrence** brings his considerable experience in the NHS, private, and charitable sectors to the Trust as a **non-executive director**. He has recently completed a full term as chair of Hertfordshire Partnership University NHS Foundation Trust, during which time it was rated Outstanding by the Care Quality Commission and named Health Service Journal's Mental Health Trust of the Year.

His career also includes senior positions at Lloyds, Citicorp, and Rothschild, as well as managing director of the London Philharmonic Orchestra. I'm not sure what Chris will make of my Friday night Twitter playlists, but I am very pleased that we will benefit from his critical eye as we continue our Trust's journey of improvement.

We often notice newcomers that little bit more, but as a Trust we also have many dedicated staff that have been with us for many years, and indeed many families with multiple members among our ranks. This, I feel, is testimony to the friendly atmosphere that makes working at West Suffolk so special.

Earlier this month I was honoured to meet **Linda Potts**, whose nursing career started with us back in May 1971 as a student nurse. Over her impressive 50-year career Linda has worked in departments across the Trust, including at West Suffolk Hospital, Newmarket Community Hospital, and is currently at Glastonbury Court.

As with many of our staff, Linda stepped up to help during the pandemic going from her normal 23-hours a week to work an additional 90 hours in March this year. The Trust is extremely grateful for her service, and so are the thousands of people across our community whom she has helped over the last 50 years.

Wherever we can we try to show our appreciation for our staff and what they do for all of us day in, day out – not just on the wards and in clinics, or out visiting patients in their homes - but also our support staff and volunteers who make sure we have the buildings, systems, finance, and environment to deliver great patient care.

So much of what they do is in the small acts of kindness that makes a patient's treatment that little bit easier, or going out of the way to help a colleague. In that spirit we have been pleased to offer staff a little treat in the recent hot weather, in the shape of free ice lollies. For community sites – and to avoid them melting before they've had a chance to be enjoyed – we arranged for fruit baskets to be delivered instead. It's a small gesture, but every one of our staff deserve a million thank yous.

10:15 DELIVER FOR TODAY

10. Operational report

To APPROVE a report

For Approval

Presented by Helen Beck

Trust Board – 25 June 2021

Agenda item:	10			
Presented by:	Helen Beck, Executive Chief Operating Officer			
Prepared by:	Helen Beck, Executive Chief Operating Officer Alex Baldwin, Deputy Chief Operating Officer			
Date prepared:	15 June 2021			
Subject:	Operational Update			
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; an update on current operational pressures and the impact of RAAC remedial work.

Appendix A of this report includes the integrated quality and performance report for May 2021.

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.
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.

Operational update

General activity and COVID

As reported last month we continue to see an increase in ED activity levels consistent with pre-pandemic demand. Average journey time (June to date) is 215 minutes which is a slight increase on May average (209 minutes).

Overall attendances increased 14% between April and May. This is noted in both minors and majors which reflects an increase in acuity. Likewise, there has been an increase in 12-hour length of stay (4 in April compared with 23 in May). There are two primary causes of this – reduced general and acute bed capacity (as previously reported) and delays to assessment for the significant increase in psychiatric attendances we have seen in the last four weeks (80 such attendances in January, 133 in April and 156 in May).

This attendance pattern follows both the regional and national picture.

At the time of writing there are zero patients in the hospital with a confirmed COVID result. There have been single digit numbers at times over the past four weeks and at no time has demand exceeded available capacity for this cohort of patients. We continue to have sufficient ITU capacity despite the decant to F2.

Paediatric activity

It has been recognised that the number of emergency admissions for infants has risen alongside an increase in short-stay admissions for children and young people. The national year on year increase of children presenting to the emergency department is approximately 5% (RCPCH 2021).

At West Suffolk we have seen a 21% increase in paediatric attendances to ED (May 21 compared with July 19). This, combined with an increase in acuity, has resulted in increased admissions to the paediatric ward.

In addition to the increase in attendances we are being advised to expect a peak of unwell children in July and August – national modelling of COVID variants suggest paediatrics will see a rise during this period. Furthermore, PHE data suggests RSV infections are likely to increase and have asked trusts to plan for a range of scenarios. The most likely is an outbreak mid-August with 20-50% increase in RSV cases seen in ED. The worst-case scenario is a larger outbreak with 100% increase in cases.

The environment for paediatrics in ED is currently unsuitable for this volume of increased attendances – both space and facilities are compromised in the current footprint. Therefore, the clinical decision unit (CDU) will be used as an extension to the paediatric ED. The consequence of this decision is that the planned frailty front door service will be temporarily delayed until the Autumn, when it is anticipated that activity will return to normal levels.

In the meantime, the service is reviewing additional options to extend the paediatric footprint in ED. This decision and the clinical and operational impact will be kept under continual review.

RAAC bearing extension and operational impact

We have moved in to the second phase of the bearing extension programme – wards F12, F8 and F3 have been transferred to wards F9, F10 and F4 respectively. Bearing extension on F8 and F3 will be completed by 30 June and by 16 July on F12. Thereafter wards F4, F5 and F14 will decant.

Planning for the full failsafe programme has commenced – this will follow on directly after the completion of the bearing extension programme which will conclude in October.

To date the work is progressing well and with minimal delay. There is obvious disruption to all involved and thanks is shared with all affected staff.

The ITU refurbishment work is also progressing well. A date of 21 June has been set for the service to transfer from F2 and the orthopaedic elective programme will commence from F2 on Monday 28th June.

The theatre failsafe programme remains scheduled to commence at the end of the month. Preparatory work in the theatre stores area is on track, despite the initial unforeseen delay, with worth scheduled in theatres 1-4 initially.

Recommendation

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

Appendix1: EOE activity report 30 05 21 (please note this is the most recently received dataset.

Source: SUS, Monthly Diagnostics (DM01) and Weekly Activity Return (WAR)
Data in this table has not been adjusted.

				Daycases						Ordinary electives					
				4 Week Average (Final data)			Latest week (Provisional)			4 Week Average (Final data)			Latest week (Provisional)		
Prov code	Provider Name	Region	STP	Same weeks in 2019	4 weeks ending: 23 May 2021	as a % of same weeks in 2019	Same week in 2019	w/e 30 May 2021	as a % of same week in 2019	Same weeks in 2019	4 weeks ending: 23 May 2021	as a % of same weeks in 2019	Same week in 2019	w/e 30 May 2021	as a % of same week in 2019
RC9	Bedfordshire Hospitals NHS Foundation Trus	East of England	Bedfordshire, Luton and Milton Keynes S	1,329	1,125	85%	1,371	1,139	83%	171	156	91%	179	178	100%
RGT	Cambridge University Hospitals NHS Founda	East of England	Cambridgeshire and Peterborough STP	1,561	1,558	100%	1,673	1,549	93%	321	268	83%	300	290	97%
RWH	East and North Hertfordshire NHS Trust	East of England	Hertfordshire and West Essex STP	1,324	1,236	93%	1,350	1,152	85%	147	131	89%	154	156	101%
RDE	East Suffolk and North Essex NHS Foundatio	East of England	Suffolk and North East Essex STP	1,897	1,812	96%	1,794	1,692	94%	259	248	96%	244	228	94%
RGP	James Paget University Hospitals NHS Foun	East of England	Norfolk and Waveney Health & Care Partr	667	481	72%	736	459	62%	89	86	97%	66	67	101%
RAJ	Mid and South Essex NHS Foundation Trust	East of England	Mid and South Essex STP	2,295	2,060	90%	2,276	2,181	96%	404	297	74%	383	275	72%
RD8	Milton Keynes University Hospital NHS Foun	East of England	Bedfordshire, Luton and Milton Keynes S	558	584	105%	576	529	92%	74	70	94%	68	74	110%
RM1	Norfolk and Norwich University Hospitals NH	East of England	Norfolk and Waveney Health & Care Partr	1,986	1,665	84%	2,094	1,616	77%	262	181	69%	256	182	71%
RGN	North West Anglia NHS Foundation Trust	East of England	Cambridgeshire and Peterborough STP	1,203	950	79%	1,101	957	87%	226	109	48%	194	90	46%
RGM	Royal Papworth Hospital NHS Foundation Tr	East of England	Cambridgeshire and Peterborough STP	140	220	157%	161	219	136%	116	119	103%	148	106	72%
RQW	The Princess Alexandra Hospital NHS Trust	East of England	Hertfordshire and West Essex STP	462	415	90%	510	410	80%	85	111	130%	64	99	155%
RCX	The Queen Elizabeth Hospital, King's Lynn, I	East of England	Norfolk and Waveney Health & Care Partr	871	442	51%	874	443	51%	119	39	33%	115	40	35%
RWG	West Hertfordshire Hospitals NHS Trust	East of England	Hertfordshire and West Essex STP	909	705	78%	885	695	79%	122	125	102%	134	150	112%
RGR	West Suffolk NHS Foundation Trust	East of England	Suffolk and North East Essex STP	560	493	88%	506	481	95%	74	65	87%	69	63	92%

Source: SUS, Monthly Diagnostics (DM01) and Weekly Activity Return (WAR)
Data in this table has not been adjusted.

				First Outpatients						Follow-up Outpatients					
				4 Week Average (Final data)			Latest week (Provisional)			4 Week Average (Final data)			Latest week (Provisional)		
Prov code	Provider Name	Region	STP	Same weeks in 2019	4 weeks ending: 23 May 2021	as a % of same weeks in 2019	Same week in 2019	w/e 30 May 2021	as a % of same week in 2019	Same weeks in 2019	4 weeks ending: 23 May 2021	as a % of same weeks in 2019	Same week in 2019	w/e 30 May 2021	as a % of same week in 2019
RC9	Bedfordshire Hospitals NHS Foundation Trus	East of England	Bedfordshire, Luton and Milton Keynes S	3,952	3,221	81%	3,533	3,506	99%	7,600	6,607	87%	6,783	7,062	104%
RGT	Cambridge University Hospitals NHS Founda	East of England	Cambridgeshire and Peterborough STP	5,874	5,416	92%	5,349	5,460	102%	7,345	7,949	108%	6,594	7,937	120%
RWH	East and North Hertfordshire NHS Trust	East of England	Hertfordshire and West Essex STP	3,704	3,310	89%	3,708	3,237	87%	7,443	8,577	115%	6,759	7,953	118%
RDE	East Suffolk and North Essex NHS Foundatio	East of England	Suffolk and North East Essex STP	5,084	4,984	98%	4,569	4,616	101%	9,705	8,744	90%	8,621	7,680	89%
RGP	James Paget University Hospitals NHS Foun	East of England	Norfolk and Waveney Health & Care Partr	1,463	1,353	92%	1,406	1,266	90%	2,741	2,823	103%	2,313	2,599	112%
RAJ	Mid and South Essex NHS Foundation Trust	East of England	Mid and South Essex STP	7,004	7,368	105%	6,441	6,576	102%	13,367	14,822	111%	11,590	14,640	126%
RD8	Milton Keynes University Hospital NHS Foun	East of England	Bedfordshire, Luton and Milton Keynes S	3,520	1,859	53%	3,744	1,773	47%	2,531	2,584	102%	2,390	2,241	94%
RM1	Norfolk and Norwich University Hospitals NH	East of England	Norfolk and Waveney Health & Care Partr	4,385	3,819	87%	3,969	3,565	90%	9,614	10,122	105%	8,305	9,697	117%
RGN	North West Anglia NHS Foundation Trust	East of England	Cambridgeshire and Peterborough STP	3,965	2,817	71%	3,296	2,743	83%	5,735	5,493	96%	4,753	4,761	100%
RGM	Royal Papworth Hospital NHS Foundation Tr	East of England	Cambridgeshire and Peterborough STP	128	218	171%	140	186	133%	367	591	161%	440	533	121%
RQW	The Princess Alexandra Hospital NHS Trust	East of England	Hertfordshire and West Essex STP	2,025	2,034	100%	2,105	2,262	107%	2,934	3,830	131%	2,816	3,665	130%
RCX	The Queen Elizabeth Hospital, King's Lynn, I	East of England	Norfolk and Waveney Health & Care Partr	1,529	1,300	85%	1,466	1,140	78%	3,849	2,688	70%	3,649	1,939	53%
RWG	West Hertfordshire Hospitals NHS Trust	East of England	Hertfordshire and West Essex STP	3,346	2,976	89%	3,079	2,816	91%	4,967	4,343	87%	4,063	3,787	93%
RGR	West Suffolk NHS Foundation Trust	East of England	Suffolk and North East Essex STP	2,094	1,712	82%	1,793	1,699	95%	4,676	3,575	76%	4,145	3,313	80%

Source: SUS, Monthly Diagnostics (DM01) and Weekly Activity Return (WAR)
Data in this table has not been adjusted.

				CT Scans						MRI Scans					
				4 Week Average (Final data)			Latest week (Provisional)			4 Week Average (Final data)			Latest week (Provisional)		
Prov code	Provider Name	Region	STP	Same weeks in 2019	4 weeks ending: 23 May 2021	as a % of same weeks in 2019	Same week in 2019	w/e 30 May 2021	as a % of same week in 2019	Same weeks in 2019	4 weeks ending: 23 May 2021	as a % of same weeks in 2019	Same week in 2019	w/e 30 May 2021	as a % of same week in 2019
RC9	Bedfordshire Hospitals NHS Foundation Trus	East of England	Bedfordshire, Luton and Milton Keynes S	1,350	1,203	89%	1,350	1,108	82%	728	583	80%	728	575	79%
RGT	Cambridge University Hospitals NHS Founda	East of England	Cambridgeshire and Peterborough STP	917	1,354	148%	918	1,301	142%	664	635	96%	664	630	95%
RWH	East and North Hertfordshire NHS Trust	East of England	Hertfordshire and West Essex STP	1,239	939	76%	1,239	918	74%	603	431	72%	603	470	78%
RDE	East Suffolk and North Essex NHS Foundatic	East of England	Suffolk and North East Essex STP	1,625	1,356	83%	1,625	1,348	83%	801	651	81%	801	623	78%
RGP	James Paget University Hospitals NHS Foun	East of England	Norfolk and Waveney Health & Care Partr	580	728	126%	580	653	113%	404	365	90%	404	361	89%
RAJ	Mid and South Essex NHS Foundation Trust	East of England	Mid and South Essex STP	2,896	3,021	104%	2,896	2,898	100%	1,185	1,236	104%	1,185	1,234	104%
RD8	Milton Keynes University Hospital NHS Foun	East of England	Bedfordshire, Luton and Milton Keynes S	187	199	106%	186	341	183%	165	119	72%	165	116	70%
RM1	Norfolk and Norwich University Hospitals NH	East of England	Norfolk and Waveney Health & Care Partr	1,724	1,998	116%	1,724	1,936	112%	754	714	95%	754	666	88%
RGN	North West Anglia NHS Foundation Trust	East of England	Cambridgeshire and Peterborough STP	1,411	1,743	124%	1,411	1,736	123%	575	626	109%	575	649	113%
RGM	Royal Papworth Hospital NHS Foundation Tr	East of England	Cambridgeshire and Peterborough STP	83	180	217%	83	180	218%	32	73	228%	31	58	186%
RQW	The Princess Alexandra Hospital NHS Trust	East of England	Hertfordshire and West Essex STP	961	731	76%	961	712	74%	336	339	101%	336	285	85%
RCX	The Queen Elizabeth Hospital, King's Lynn, I	East of England	Norfolk and Waveney Health & Care Partr	468	493	105%	468	437	93%	213	164	77%	214	196	92%
RWG	West Hertfordshire Hospitals NHS Trust	East of England	Hertfordshire and West Essex STP	592	1,016	172%	593	876	148%	257	301	117%	258	242	94%
RGR	West Suffolk NHS Foundation Trust	East of England	Suffolk and North East Essex STP	513	600	117%	513	457	89%	300	246	82%	300	182	61%

Source: SUS, Monthly Diagnostics (DM01) and Weekly Activity Return (WAR)
Data in this table has not been adjusted.

				Colonoscopies						Flexible-sigmoidoscopies					
				4 Week Average (Final data)			Latest week (Provisional)			4 Week Average (Final data)			Latest week (Provisional)		
Prov code	Provider Name	Region	STP	Same weeks in 2019	4 weeks ending: 23 May 2021	as a % of same weeks in 2019	Same week in 2019	w/e 30 May 2021	as a % of same week in 2019	Same weeks in 2019	4 weeks ending: 23 May 2021	as a % of same weeks in 2019	Same week in 2019	w/e 30 May 2021	as a % of same week in 2019
RC9	Bedfordshire Hospitals NHS Foundation Trus	East of England	Bedfordshire, Luton and Milton Keynes S	58	138	239%	58	137	238%	74	45	61%	74	27	37%
RGT	Cambridge University Hospitals NHS Founda	East of England	Cambridgeshire and Peterborough STP	139	97	70%	139	61	44%	26	20	77%	26	20	76%
RWH	East and North Hertfordshire NHS Trust	East of England	Hertfordshire and West Essex STP	78	67	85%	79	63	80%	27	18	65%	28	16	58%
RDE	East Suffolk and North Essex NHS Foundatic	East of England	Suffolk and North East Essex STP	169	188	112%	169	190	113%	50	55	110%	50	55	110%
RGP	James Paget University Hospitals NHS Foun	East of England	Norfolk and Waveney Health & Care Partr	28	66	235%	29	75	261%	62	30	48%	61	18	29%
RAJ	Mid and South Essex NHS Foundation Trust	East of England	Mid and South Essex STP	145	266	183%	145	233	161%	71	82	116%	71	69	97%
RD8	Milton Keynes University Hospital NHS Foun	East of England	Bedfordshire, Luton and Milton Keynes S	40	97	243%	40	81	203%	17	20	114%	18	21	120%
RM1	Norfolk and Norwich University Hospitals NH	East of England	Norfolk and Waveney Health & Care Partr	175	184	105%	175	167	95%	177	68	38%	176	75	43%
RGN	North West Anglia NHS Foundation Trust	East of England	Cambridgeshire and Peterborough STP	116	75	65%	116	9	8%	55	37	68%	55	3	5%
RGM	Royal Papworth Hospital NHS Foundation Tr	East of England	Cambridgeshire and Peterborough STP	0	0	n/a	0	0	n/a	0	0	n/a	0	0	n/a
RQW	The Princess Alexandra Hospital NHS Trust	East of England	Hertfordshire and West Essex STP	20	31	155%	20	17	85%	4	5	117%	4	5	133%
RCX	The Queen Elizabeth Hospital, King's Lynn, I	East of England	Norfolk and Waveney Health & Care Partr	47	40	86%	48	16	34%	14	18	126%	14	7	51%
RWG	West Hertfordshire Hospitals NHS Trust	East of England	Hertfordshire and West Essex STP	1	119	11212%	1	129	10320%	3	52	1791%	3	39	1560%
RGR	West Suffolk NHS Foundation Trust	East of England	Suffolk and North East Essex STP	60	63	105%	60	11	18%	39	27	70%	39	16	41%

Source: SUS, Monthly Diagnostics (DM01) and Weekly Activity Return (WAR) ***Data in this table has not been adjusted.***				Gastroscopies						Cardiology - Echocardiography					
				4 Week Average (Final data)			Latest week (Provisional)			4 Week Average (Final data)			Latest week (Provisional)		
Prov code	Provider Name	Region	STP	Same weeks in 2019	4 weeks ending: 23 May 2021	as a % of same weeks in 2019	Same week in 2019	w/e 30 May 2021	as a % of same week in 2019	Same weeks in 2019	4 weeks ending: 23 May 2021	as a % of same weeks in 2019	Same week in 2019	w/e 30 May 2021	as a % of same week in 2019
RC9	Bedfordshire Hospitals NHS Foundation Trus	East of England	Bedfordshire, Luton and Milton Keynes S	109	153	141%	109	122	112%	245	309	126%	245	264	108%
RGT	Cambridge University Hospitals NHS Founda	East of England	Cambridgeshire and Peterborough STP	175	139	80%	175	87	50%	254	215	85%	254	248	98%
RWH	East and North Hertfordshire NHS Trust	East of England	Hertfordshire and West Essex STP	53	50	94%	53	55	105%	223	274	123%	223	371	167%
RDE	East Suffolk and North Essex NHS Foundatic	East of England	Suffolk and North East Essex STP	125	111	89%	125	112	90%	313	306	98%	313	315	101%
RGP	James Paget University Hospitals NHS Foun	East of England	Norfolk and Waveney Health & Care Partr	27	80	298%	26	86	328%	122	112	92%	121	96	79%
RAJ	Mid and South Essex NHS Foundation Trust	East of England	Mid and South Essex STP	172	223	129%	173	213	123%	816	685	84%	816	646	79%
RD8	Milton Keynes University Hospital NHS Foun	East of England	Bedfordshire, Luton and Milton Keynes S	56	80	142%	56	82	146%	95	99	104%	95	121	127%
RM1	Norfolk and Norwich University Hospitals NH	East of England	Norfolk and Waveney Health & Care Partr	199	173	87%	199	188	95%	267	202	76%	266	200	75%
RGN	North West Anglia NHS Foundation Trust	East of England	Cambridgeshire and Peterborough STP	110	114	104%	110	14	13%	303	239	79%	304	232	76%
RGM	Royal Papworth Hospital NHS Foundation Tr	East of England	Cambridgeshire and Peterborough STP	0	0	n/a	0	0	n/a	55	67	122%	55	75	136%
RQW	The Princess Alexandra Hospital NHS Trust	East of England	Hertfordshire and West Essex STP	14	27	195%	14	18	131%	200	184	92%	200	173	87%
RCX	The Queen Elizabeth Hospital, King's Lynn, I	East of England	Norfolk and Waveney Health & Care Partr	62	48	78%	61	43	70%	149	103	69%	149	373	251%
RWG	West Hertfordshire Hospitals NHS Trust	East of England	Hertfordshire and West Essex STP	4	130	3292%	4	120	3200%	235	243	103%	235	218	93%
RGR	West Suffolk NHS Foundation Trust	East of England	Suffolk and North East Essex STP	104	99	96%	104	27	26%	195	184	94%	195	184	94%

Trust Board Report

Agenda Item:	10 Appendix A			
Presented By:	Helen Beck & Sue Wilkinson			
Prepared By:	Information Team			
Date Prepared:	May-21			
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. Covid datix and Perfect ward Charts have been removed and that they will be presented within other board reports from the Chief Nurse.

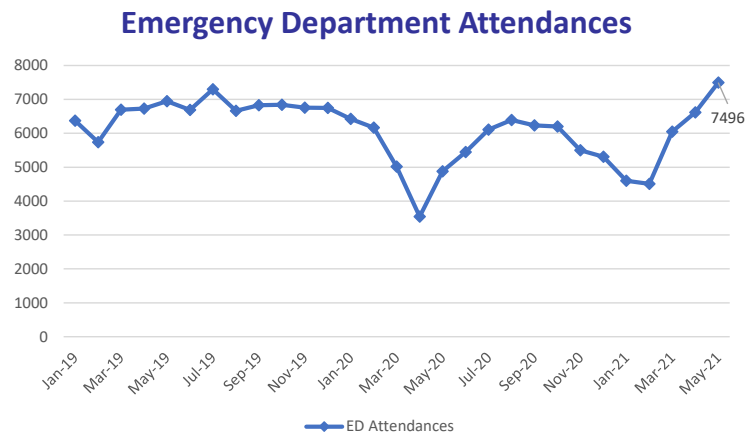
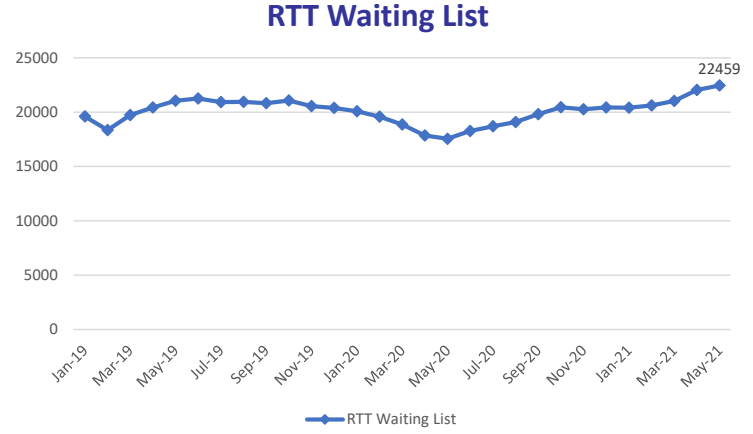
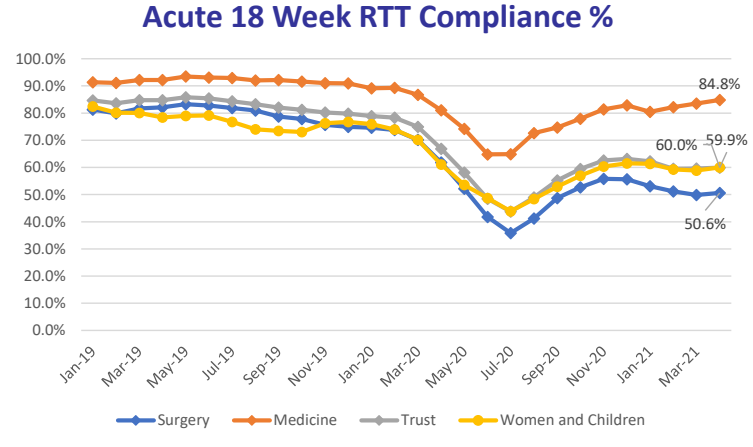
Trust Priorities [Please indicate Trust priorities relevant to the subject of the report]	**Delivery for Today**	**Invest in Quality, Staff and Clinical Leadership**	**Build a Joined-up Future**
	X		

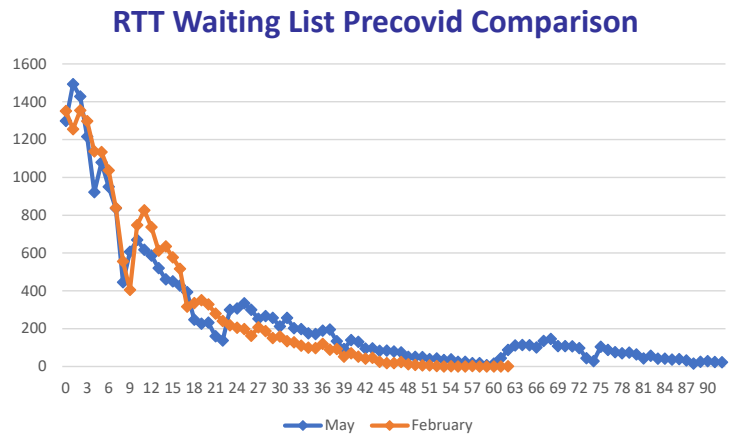
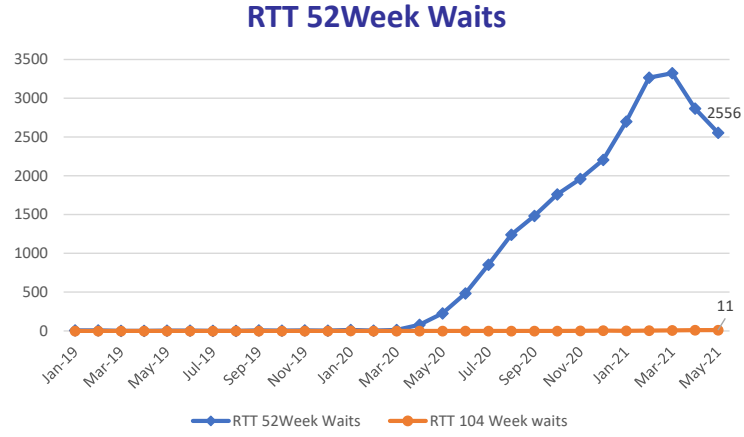
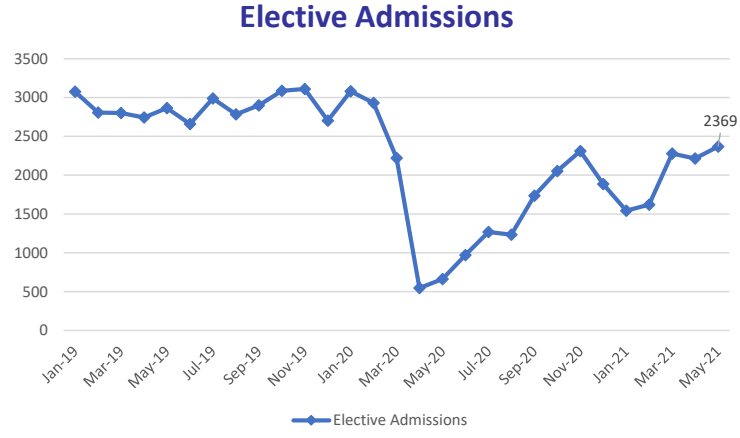
Trust Ambitions [Please indicate ambitions relevant to the subject of the report]	Deliver personal care	Deliver safe care	Deliver joined-up care	Support a healthy start	Support a healthy life	Support ageing well	Support all our staff
		X	**X**				**X**

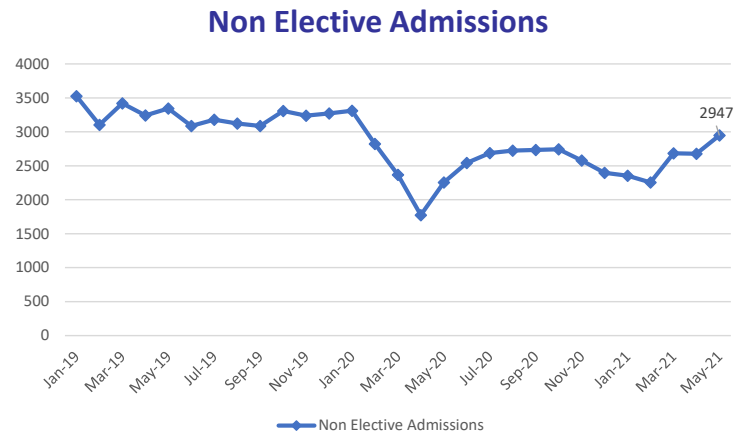
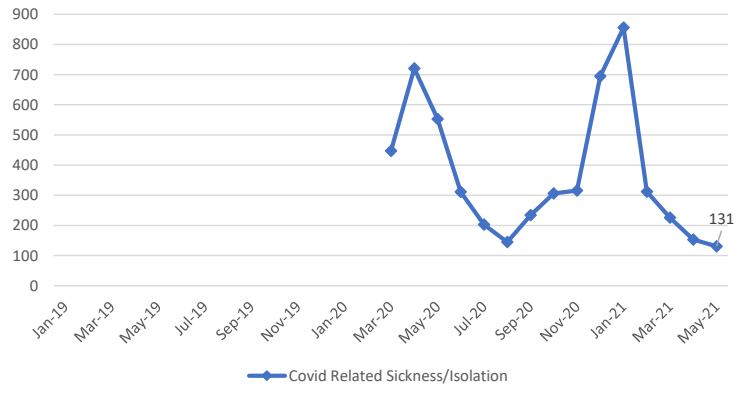
Previously Considered by:	
Risk and Assurance:	
Legislation, Regulatory, Equality, Diversity and Dignity Implications	

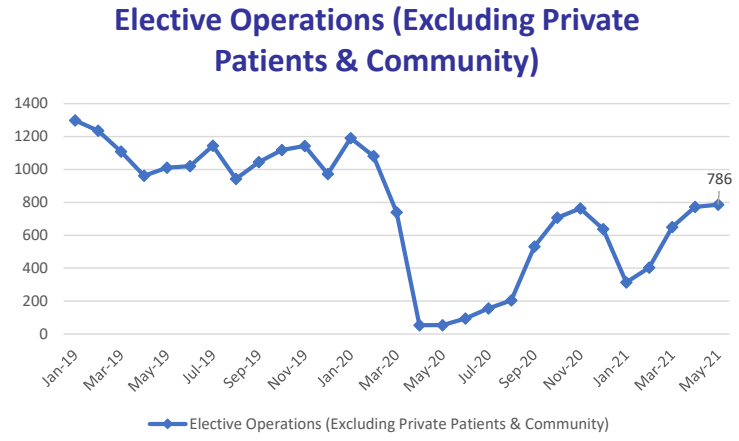
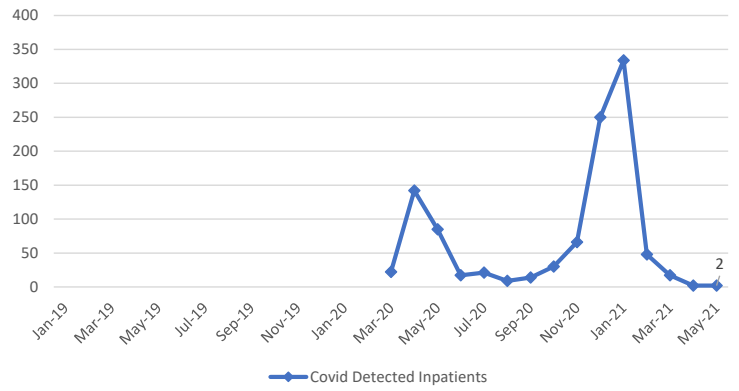
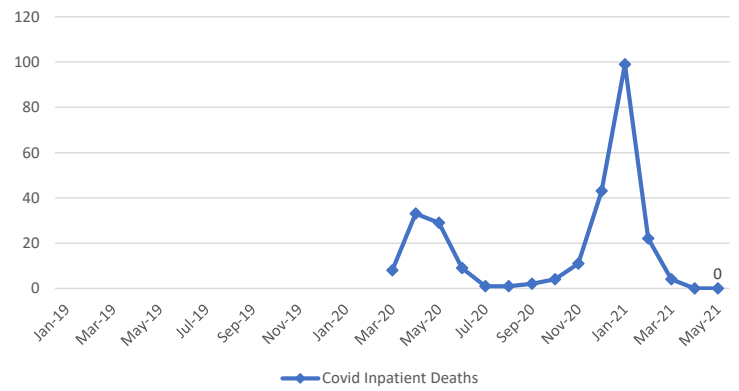
Recommendation:

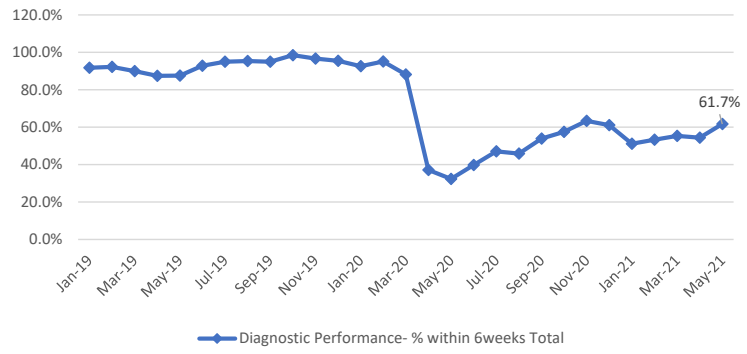
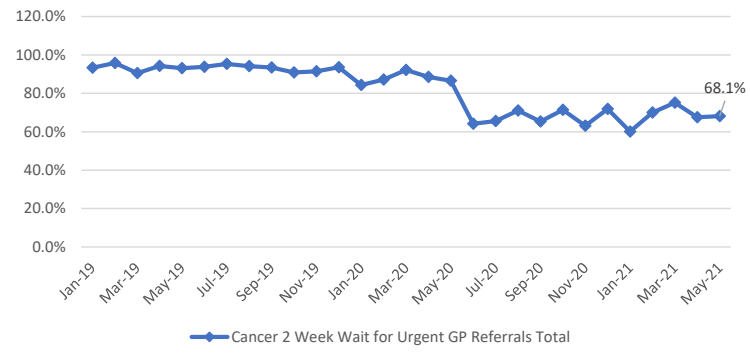
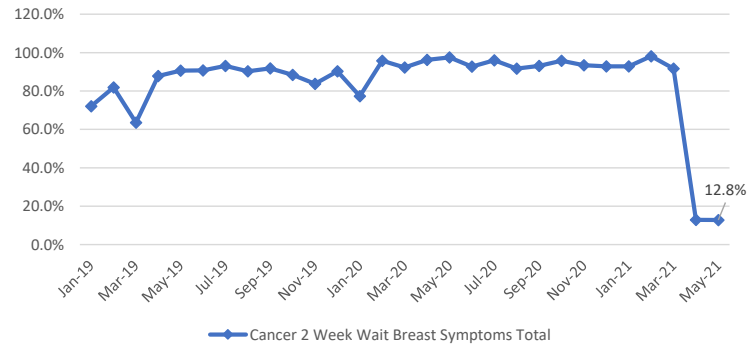
That Board note the report.

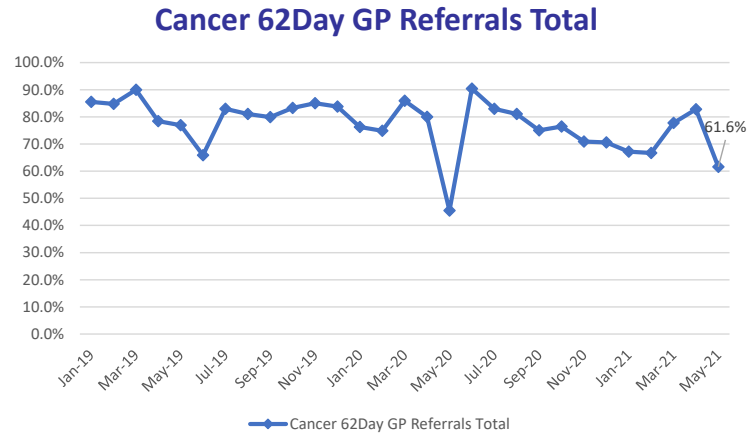
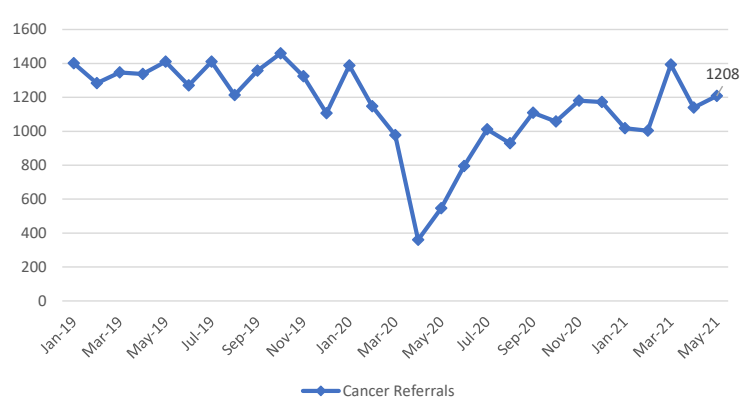
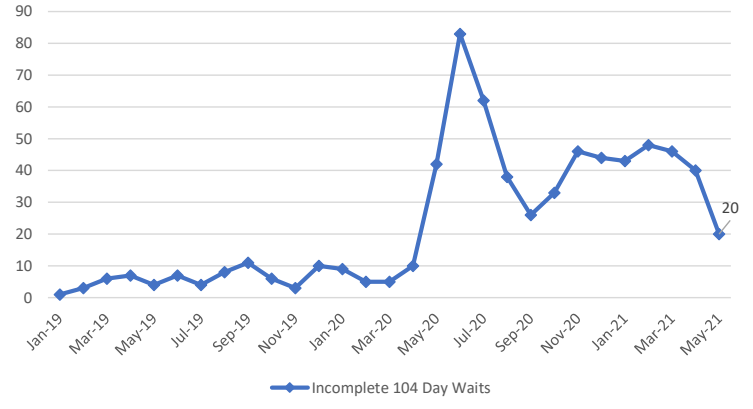
Board Report KPIs	Narratives
	There were 7496 attendances to ED in May 2021, this represents an increase of 882 attendances compared to the previous month of April 2021. This equates to a 13.5% increase. Looking at May's data we have seen an increase in both minor and major attendances of similar proportions. We are also aware that ED attendances are up nationally. We are examining data to determine any themes.
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.	
	Overall waiting list has increased by 700 patients from April, this is mostly due to an increase in patients under 18 weeks as a reflection of an increase in referrals.
A count of the patients on the waiting list for treatment.	
	Medicine compliance continues to improve as expected. Surgery, women's and child and the trust total have all seen a very slight improvement in compliance, this is due to the larger numbers beneath 18 weeks in line with increased referrals and a reduction in the overall patients over 18 weeks. Whilst surgical capacity is a constraint this number is unlikely to improve significantly.
% of patients on incomplete RTT pathways	

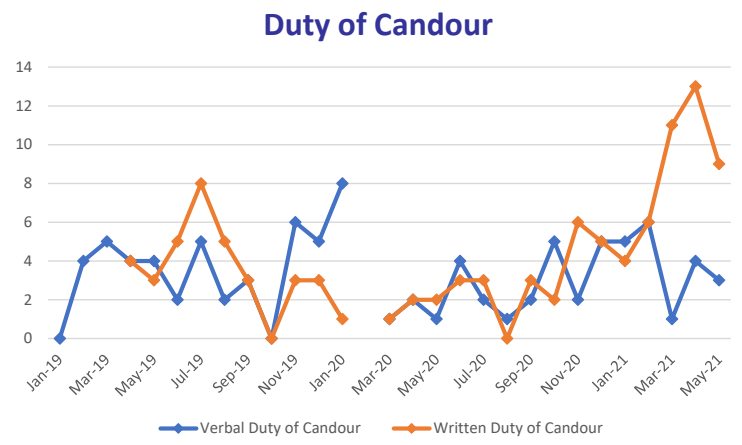
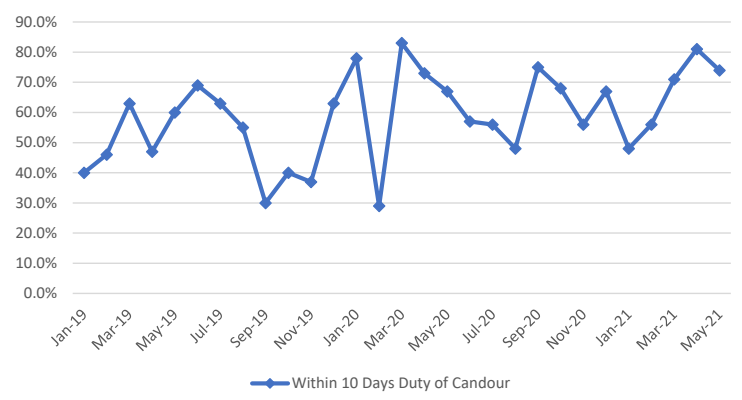
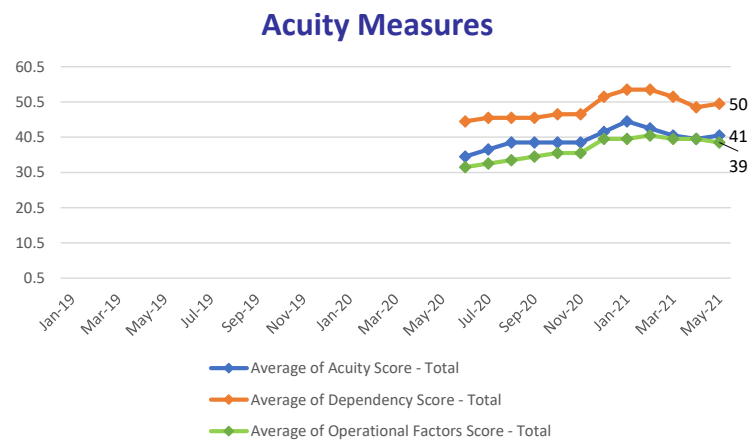
Board Report KPIs	Narratives
	The shape of the waiting list is now fairly similar to that of Pre Covid, with the exception of a much larger tail of patients waiting over 52 weeks, due to surgical constraints, patients are being treated in clinical priority before waiting time priority.
A year on year comparison of the number of patients waiting for treatment.	
	The number of patients waiting over 52 weeks has reduced significantly again this month as the theatre and ward capacity has allowed some longer waiting patients to be treated. There is a risk currently that this position will worsen over the summer whilst capacity is reduced, however there are robust plans within the system to avoid this position worsening.
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.	
	Elective admissions increased again in May 2021, back to November 2020 levels. This will reduce again in June due to theatre constraints.
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.	

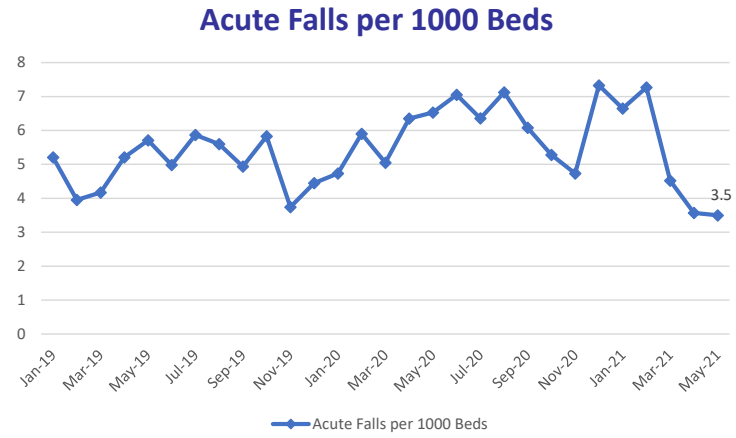
Board Report KPIs	Narratives
	There were 2947 Non-elective admissions in May 21 compared with 2679 in April 21, which represents a 10% increase. Having looked at the data we have seen the following increases in admissions per speciality comparing April to May. Medicine 11%, Surgery 9%, T and O 10%, Obs and Gynae 62% and Paeds 25%. The paeds increase is expected, this has been predicted nationally. The cause of the large increase in Gynae admissions will need to be investigated.
A count of the number of patients who were admitted following an unplanned or emergency episode. This is a local metric used to monitor demand.	
	The Trust's 12-month cumulative (rolling) absence figures at the end of May 2021 was 3.7%, a decrease on March 2021 figures of 3.9%. This downward trend in the cumulative absence figure is likely to continue due to weekly absence levels continuing to reduce.
A measure of staff sickness across the Trust. This includes community staff. This is a local metric to monitor the capacity of our workforce.	
	This chart illustrates the number of sickness episodes related to COVID-19. In May 2021 there were 131 episodes recorded which is a decrease on April 2021 which recorded 153 episodes of COVID-19 related sickness.
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.	

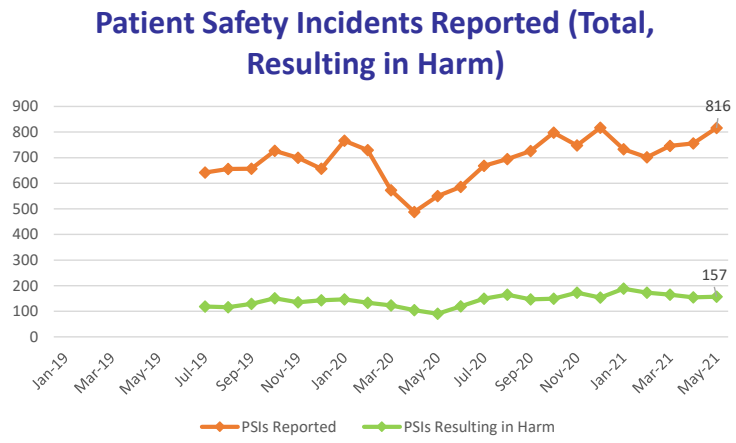
Board Report KPIs	Narratives
	Increase in elective operations in May 2021, to a higher level than was achieved in the last phase of recovery in November 2020. Restrictions in theatre will impact on this recovery, however there are plans to try and mitigate this as much as possible.
This is a count of the number of operations that were carried out. This is a local measure to monitor our productivity and recovery from Covid.	
	There were 2 individual patients admitted during May, who had their first diagnosis of Covid-19. In May the highest number of Covid positive inpatients residing in the trust on any one day was 1.
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.	
	There were 0 patients who died within 28 days of a positive Covid result, in May. These figures are as published by NHSE.
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.	

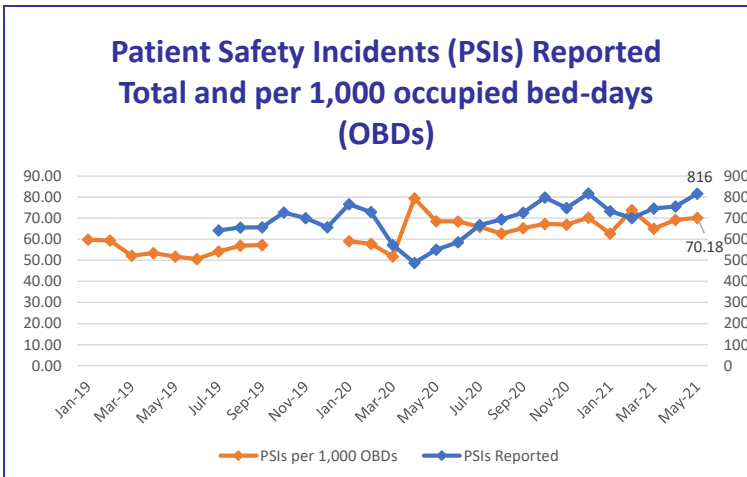
Board Report KPIs	Narratives
Diagnostic Performance- % within 6weeks Total 	Diagnostic performance remains to be a significant challenge in certain areas. Whilst MRI, CT and ECHO's have recovered their position back to achieve the 99% standard, challenges remain in the following: Ultrasound at 42.6% Audiology at 34.9% Urodynamics at 40% Colonoscopy at 36.08% Flexible sigmoidoscopy at 34.37% Cystoscopy at 48% Gastroscopy at 46.08% Trajectories for recovery are in development for Audiology, Urodynamics and Cystoscopy.
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 	Slight improvement in the bottom line performance for 2WW referrals. Breast performance continues to remain a challenge with large referral numbers as well as continued pressure within Upper and Lower GI that is reliant on endoscopy. A full recovery trajectory for 2WW performance is in place.
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.	
Cancer 2 Week Wait Breast Symptoms Total 	Breast performance remains a significant constraint, with very low performance, however whilst the overall position is still low the overall waiting time has reduced to closer to 2 weeks and a recovery trajectory is in place.
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.	

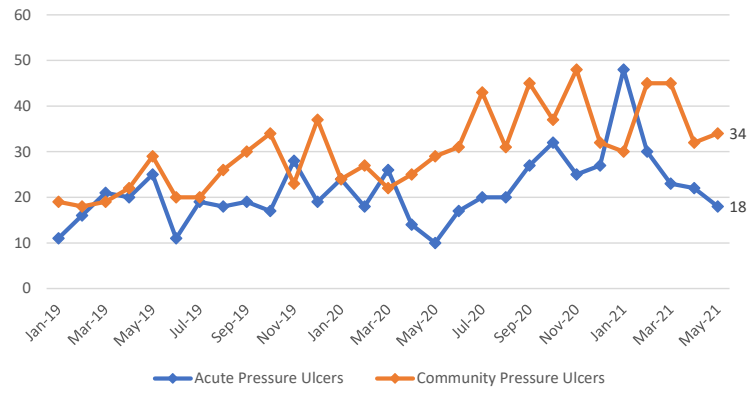
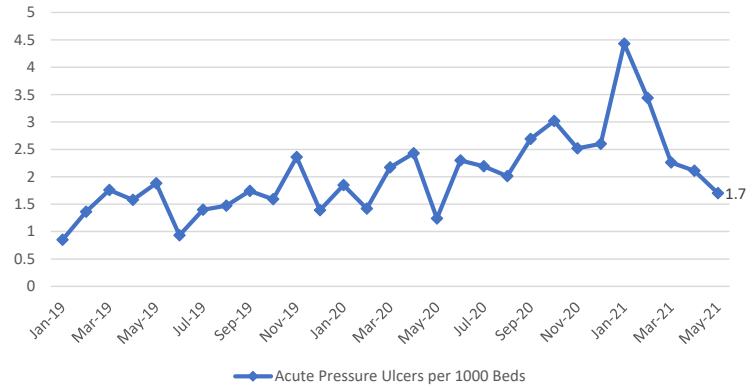
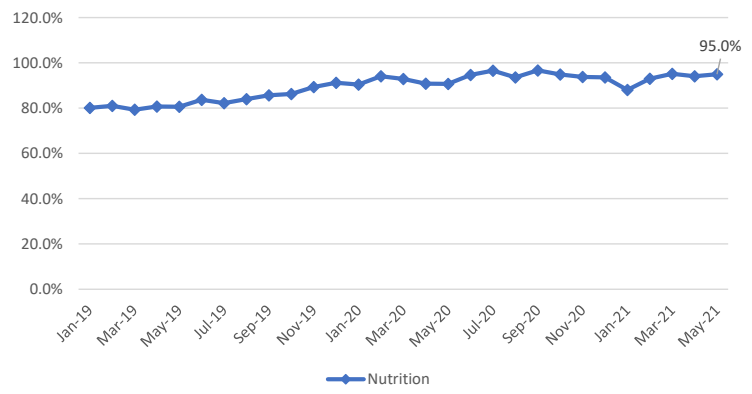
Board Report KPIs	Narratives
	Significant drop in 62 day performance, however this is due to large number of our long waiting patients being treated and working through additional cancer surgery and treatments in May, which is turn has reduced our patients waiting over 104 days.
To measure compliance 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.	
	Two week wait referrals up from April 2021, with larger numbers being received in Breast, Skin and Lower GI.
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).	
	104 day waits reduced by half from April to May, due to additional treatments in May.
A count of the number of patients who have waited longer that 104 days for treatment for cancer from GP referral. This is a national standard and is expected to be 0.	

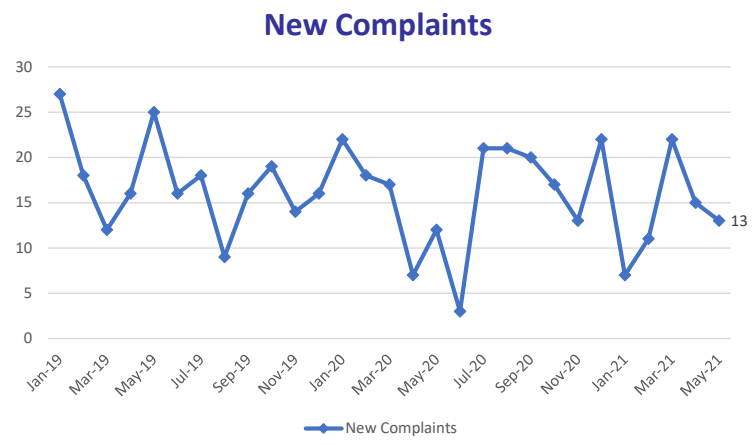
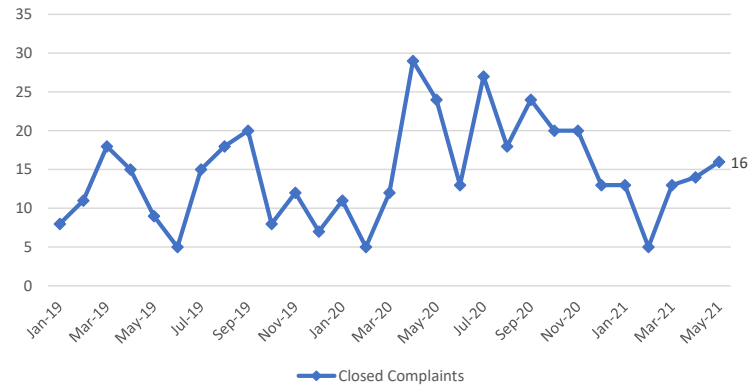
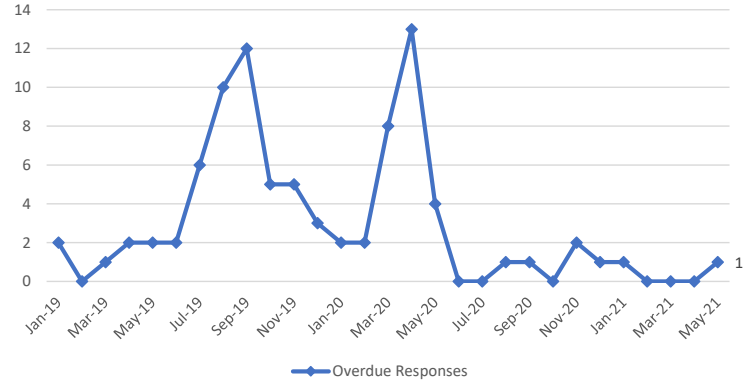
Board Report KPIs	Narratives
	We continue to work through our improvement plan which was presented and discussed at the improvement committee this month
This is a count of the number of verbal and written duty of candour overdue for the reporting month (and earlier) as at the date of report issue	
	
The percentage of cases reported in that month where verbal duty of candour was completed within the nationally required 10 working day timeframe.	
	There has been continued levelling of the acuity and dependency metrics in May, but this mainly due to the ongoing and increased number of closed beds during this period, to facilitate urgent RAAC plank repairs. On review of the metrics, there are several areas which have experienced higher than average acuity and / or dependency which correlates with the anecdotal pressures the wards and departments are continuing to experience. It is notable that despite the bed base being less than it was in June 2020, all the average metrics have increased overall. Dependency and acuity levels have increased slightly during May and is reflective of the anecdotal pressures being experienced by the acute teams. This data is being used in conjunction with the Safe Care data which reviews acuity and dependency levels against nurse staffing levels. This data is reviewed daily at the Safety huddle to support safe nurse staffing across the inpatient areas within 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.	

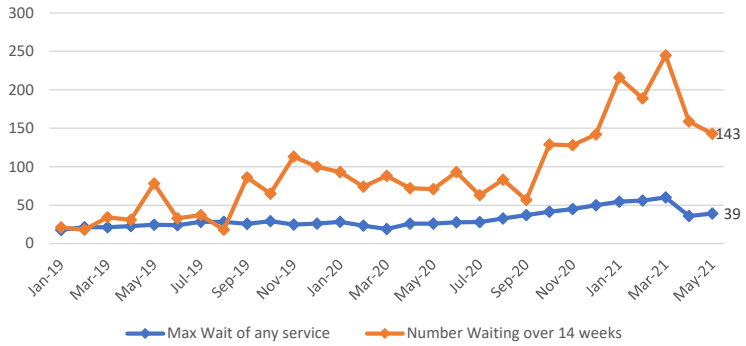
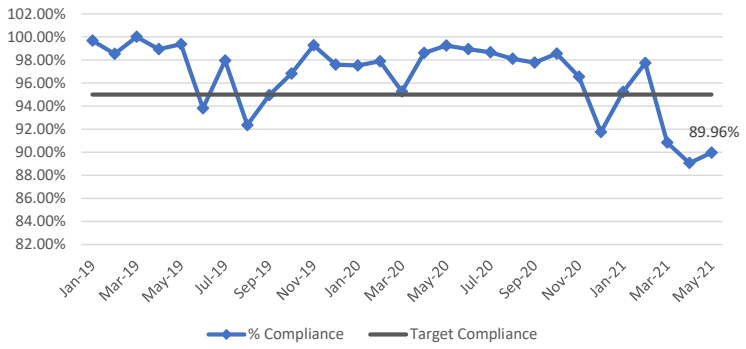
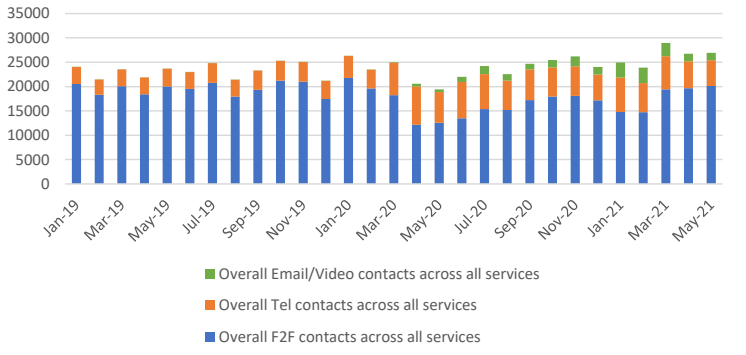
Board Report KPIs	Narratives
	This is now reported in Staffing paper.
A measure of the number of falls in the acute hospital measured per 1000 bed days. Community falls are excluded from this metric.	

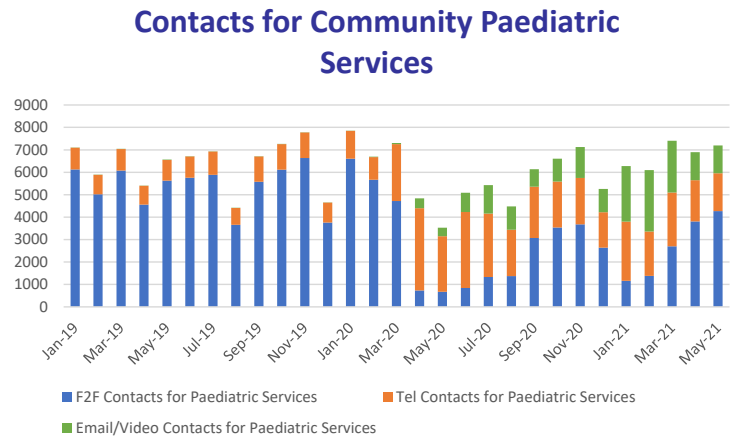
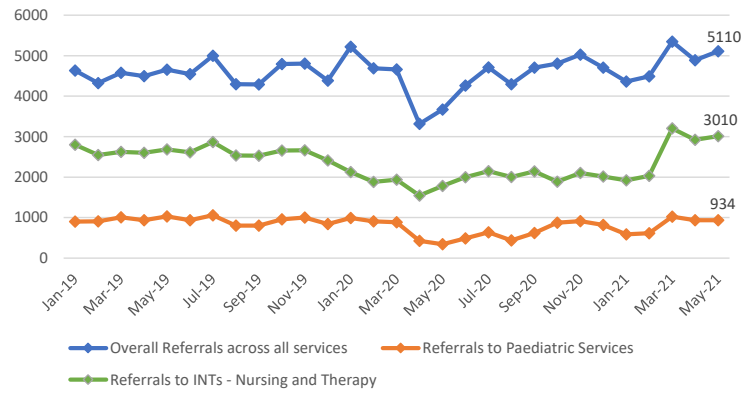
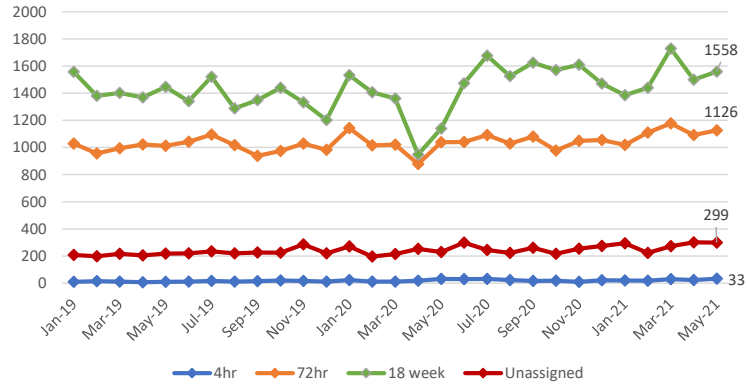
	The number of patient safety incidents reported in May to the highest level since December reflecting the increase in incident reporting in the previous 12 months (excluding the first few months of the pandemic). Higher reporting levels are seen as an indicator of a positive reporting culture and therefore increases in total incidents reported should not necessarily be considered as adverse. The number of incidents resulting in harm remained similar compared to recent months. Pressure ulcers (PUs) and falls remain the main contributor to increased harm. Detail on PU and Falls are reported elsewhere.
A count of the number of patient safety incidents reported in total and those resulting in harm	

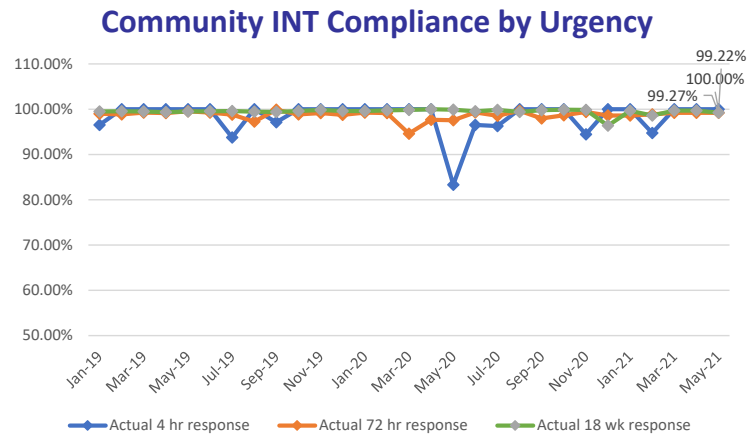
	The incidents reported per 1,000 bed days rose in May but remains within the normal limits of the recent 12 months.
The number of patient safety incidents reported as a percentage of occupied bed days to measure reporting rates	

Board Report KPIs	Narratives
Pressure Ulcers  A count of the number of recorded new pressure ulcers across the Trust. This metric will include those recorded in the acute hospital and community settings	This is now reported in Staffing paper.
Acute Pressure Ulcers per 1000 Beds  A measure of the number of pressure ulcers in the acute hospital measured per 1000 bed days. Community inpatient pressure ulcers are excluded from this metric.	
Nutrition  % of patients with a Malnutrition Universal Screening Tool (Adults)/Paediatric Yorkhill Malnutrition Score (Children) assessment completed within 24 hours of admission	This is now reported in Staffing paper.

Board Report KPIs	Narratives
	13 formal complaints received in May which is still below average compared what we would normally receive pre-Covid. (c21). A trend we have been seeing lately is in regards to communication, with 7 complaints involving communication from providing the incorrect information, patient not listened to and a lack of communication with relatives. We have re-iterated this message through the divisional board meetings to remind staff. We will be reviewing complaints on a quarterly basis to identify themes over longer period and working with ward managers, matrons and members of the divisional boards to reduce repeat complaints.
New formal complaints received and accepted, this counts both West Suffolk Hospital and Community	
	16 complaints closed during May which has allowed us to reduce the total complaints open and allow us to manage complaints even more effectively. Red triaged complaints were reduced in May which allowed us to focus on less complex cases.
Formal complaints signed off by the CEO, this counts both West Suffolk Hospital and Community	
	A legacy complaint which was complex as the consultant had left the trust caused the delay. Although complainant was kept up to date, the timeframe was exceeded. Nevertheless, still a solid number of 93%
Any complaints which were sent outside of the given timeframe and no extension was agreed, this counts both West Suffolk Hospital and Community	

Board Report KPIs	Narratives
Community Non Consultant Led 18week Max Wait  Services covered: Adult SLT, Heart Failure, Neurology Service, Parkinson's Nursing, Wheelchairs, Paediatric Occupational 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.	The number of services with patients waiting over 18 weeks has decreased back to 2 from 3 in May. At the end of May these services were: Paed SLT and Wheelchairs. The maximum wait for each of these services are: Paed SLT - 29 weeks (decreased from 31) Wheelchairs - 39 week (increased from 36 weeks) Paed SLT and Wheelchair services 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. The lack of face to face group work and restrictions in schools etc are having a continued profound effect on Paed SLT activities, as are vacancies within the service. Wheelchairs has a high number of patients who are shielding or just unwilling to have home visits at this time, access to Special Schools and Care Homes has been limited because of COVID, staff numbers have been affected because of COVID and BREXIT has affected the supply of equipment that has been stuck at ports. The number of child breaches may be increasing but the number of handovers is actually increasing significantly.
Community Non Consultant Led 18week Compliance  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	The aggregated % of patients treated within 18 weeks for all community services in May was 89.96% with the lowest individual service being Wheelchairs at 84.31%.
Contacts for ALL Community Services (Adults and Paediatrics)  Activity is counted as a face to face/telephone/email/video contact with a patient/carer/parent which is clinically relevant. This means activity that a clinician carries out which is writing reports, liaising with other healthcare professionals is NOT counted as activity. This is in line with acute systems where there is an assumption that clinicians will carry out related activities that result from contact with a patient.	The total activity for community services has returned to pre-COVID levels and exceeded the values although the ratio of face to face and other means of contact (telephone, video and email) have altered. March, April and May have been exceptionally above the levels of either March, April and May in the last 2 years of 2020 and 2019.

Board Report KPIs	Narratives
	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.	
	Referrals to the majority of the community services has exceeded the levels of March, April and May 2019 and 2020.
There should be one reason per referral, i.e. if a patient is referred in to the INTs for 2 requirements either simultaneously or over time, eg leg ulcer dressing and phlebotomy, then there are 2 referrals.	
	Referrals to the INT services have returned to pre-COVID numbers or exceeded them.
Referrals into the Integrated Neighbourhood Teams have urgencies of Red (within 4 hours), Amber within 72hrs) and Green (within 18 weeks). These contractual urgencies are locally agreed pan Suffolk with the CCG and there is a 98% response target for Red, Amber and Green response times have a 95% threshold (These are local contractual targets)	

Board Report KPIs	Narratives
	The Red, Amber and Green referral targets were all met in April.
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)	

11. Report from 3i Committees: Improvement & Involvement

To APPROVE the report

For Approval

Presented by Susan Wilkinson and Alan Rose

Trust Open Board – 25 June 2021

Agenda item:	11			
Presented by:	Sue Wilkinson, Executive Chief Nurse Alan Rose, Non-executive Director			
Prepared by:	Rebecca Gibson, Head of Compliance and Effectiveness			
Date prepared:	June 2021			
Subject:	3i Committee report: Improvement & Involvement			
Purpose:		For information	X	For approval

Executive summary:

The Trust have recently commenced with a new approved framework for engagement and oversight for quality, safety and improvement. These are known as the 3i committees: Insight, Improvement, Involvement.

The reporting framework for the Board will provide greater emphasis on matters escalated by the committees, people engagement and strategy, and it is proposed that a monthly summary of the 3i committees' activities is prepared and shared with the Board.

This month only improvement and involvement met. Due to the occurrence of the involvement committee the report for this will be given as a verbal update.

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:
To approve the report and contents

Improvement Committee

Context and Approach

The Improvement Committee (IC) forms part of the new 3i committee structure working together with Involvement and Insight.

Meeting highlights

The second meeting of the committee took place on 14th June and focussed on

- Terms of reference and interaction between 3i committees
- Reports from specialists
- Onward scheduling and underpinning structure
- Key risks and potential mitigations
- IPB Decommissioning

The next meeting is scheduled for the 12th July.

Terms of reference (ToR) and interaction between 3i committees

The ToR ensures there is clarity around committee membership, purpose, scope, ways of working, reporting framework and relationship to the other two 3i committees. It is recognised that the IC is in a “development phase” in what is expected to be an iterative process over the coming months.

The meeting discussed the need for a formal pathway of referral and interaction between the three committees Insight, Involvement and Improvement. The meeting considered options such as a monthly Chairs’ forum that might discuss for example how Insight might raise a concern from the intelligence presented that requires a deep dive by Improvement.

It is clear that there is a need to ensure consistency across the 3i leads and an urgent meeting between the non-Exec meeting chairs and Executive leads of all of the committees should take place in the next few weeks prior to the next round of meetings in July (ACTION SW to progress)

There was a note of caution made to ensure that any additional steps do not add any additional bureaucracy / time delays to highlighting and acting upon safety issues.

The need for consistency in the underpinning governance of the 3i was also emphasised.

There is also an important challenge on how the Scrutiny and Audit committees test the accountability of the 3i and seek assurance that the new structures are properly covering off the way that information flows come through and how the Board receives that assurance.

Reports from specialists

The meeting included presentation of the improvement plans from two of the key themes in the wider trust-wide improvement plan (the WSFT One Plan) namely Duty of Candour and the Deteriorating patient.

The draft template previously used to present the Falls Improvement Plan in May has been used for these two subsequent subjects. The May meeting had agreed that this was an effective tool for tracking and monitoring improvement progress. The need to further develop this tool for complex areas such as maternity will be the next challenge that the organisation will need to address.

Duty of Candour – The structure and elements of the plan were agreed as robust but there is a need to define leads and timeframes and an update was requested to the next meeting.

Deteriorating patient – The clinical lead was congratulated on the breadth of work encompassed within this plan and the amount of work clearly in place.

Onward scheduling and underpinning structure

The IC will agree the rolling programme of specialist committee using the PSIRP priorities recognising this will be added to by subjects highlighted for 'out of schedule' prioritisation according to local intelligence and/or escalation from other committees.

A draft future work programme will be proposed and presented to the July meeting

(ACTION – SW with AA+JM)

Initial proposal for the July meeting was to receive an update on Duty of Candour and either infection prevention or pressure ulcers based on which was felt to present the greater risk.

The option for possibly a Maternity update following the Ockendon return might come to July reflecting the enhanced scrutiny that they have been under but also that they do already have a reporting framework to the Board which provides assurance. This will be agreed as part of the work programme sign-off in July.

Key risks and issues

Important mitigations were discussed included

- Need to understand the role of PMO including how best to use the additional resource appointed to as part of the IPB to enable timeliness of the reporting framework
- Need for communication to the wider organisation ensure an understanding of the 3i and the WSFT One plan
- A quality assurance function, possibly by a subgroup
- A central library / repository of the documentary resources associated
- The possibility of using Life QI to capture some of the improvement reporting

IPB Decommissioning

A thorough review and analysis of the existing IPB workstreams and actions was considered at the May meeting to ensure that either completed actions are fully embedded as BAU or next steps are in place for any outstanding items.

The June meeting agreed that from the perspective of this committee this item could be removed from the ongoing agenda of this meeting subject to agreement from the NED chair and Exec leads of all of the 3i.

In the interim it had been agreed in May that three plans on the list would be re-presented for assurance with revised plans to the August meeting (ACTION) which were:

- Pathology
- Clinical audit
- Community pain assessments

12. Finance and workforce report

To ACCEPT the report

For Report

Presented by Craig Black

Board of Directors – 25 June 2021

Agenda item:	12			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	17th June 2021			
Subject:	Finance and Workforce Board Report – May 2021			
Purpose:		For information	x	For approval

Executive summary:

The reported I&E for May is break-even (YTD break-even).

Due to COVID-19 we are receiving income for the period April to September 2021 in line with the period October 2020 to March 2021. This includes reimbursement of all COVID related expenditure (including vaccination costs) and shortfalls against non-clinical income receipts as a result of COVID.

We previously agreed a budget for 2021-22 to deliver a deficit of £10.5m, with a Cost Improvement Programme (CIP) of 1%. However, the funding arrangements for the first half of 21-22 are expected to facilitate a break even position and if we assume this funding continues through the second half of the year we anticipate a break even position for the full year, although it should be noted that this is contingent on these funding assumptions.

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
May 2021 (Month 2)

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

Financial Summary

I&E Position YTD	£12.4m	break-even
Variance against Plan YTD	£0m	on-plan
Movement in month against plan	£0m	on-plan
EBITDA position YTD	£2.9m	on-plan
EBITDA margin YTD	6%	on-plan
Cash at bank	£16.6m	

Executive Summary

- The reported I&E for May is break-even (YTD break-even).

Key Risks in 2021-22

- Costs and income associated with revised activity plan
- Costs associated with increased capacity pressures relating to COVID-19, RAAC planks and winter pressures
- Funding arrangements continue in line with 2020-21
- Delivery of CIP programme

SUMMARY INCOME AND EXPENDITURE ACCOUNT - May 2021	May 2021 Budget £m	May 2021 Actual £m	May 2021 Variance F/(A) £m	Year to date Budget £m	Year to date Actual £m	Year to date Variance F/(A) £m
NHS Contract Income	23.4	23.6	0.2	46.8	46.8	(0.0)
Other Income	3.0	2.6	(0.3)	6.0	5.6	(0.4)
Total Income	**26.4**	**26.3**	**(0.1)**	**52.8**	**52.3**	**(0.4)**
Pay Costs	16.9	17.3	(0.4)	33.7	34.5	(0.8)
Non-pay Costs	8.3	7.6	0.6	16.6	14.9	1.7
Operating Expenditure	**25.1**	**24.9**	**0.2**	**50.3**	**49.5**	**0.9**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA excl STF	**1.2**	**1.4**	**0.1**	**2.5**	**2.9**	**0.4**
Depreciation	0.8	0.7	0.0	1.5	1.5	0.0
Finance costs	0.5	0.6	(0.1)	1.0	1.4	(0.4)
SURPLUS/(DEFICIT)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FINANCE AND WORKFORCE REPORT – May 2021

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 – May 2021

Income and Expenditure Summary as at May 2021

The reported I&E for May is breakeven (YTD break-even).

Due to COVID-19 we are receiving income for the period April to September 2021 in line with the period October 2020 to March 2021. This includes reimbursement of all COVID related expenditure (including vaccination costs) and shortfalls against non-clinical income receipts as a result of COVID.

Summary of I&E indicators

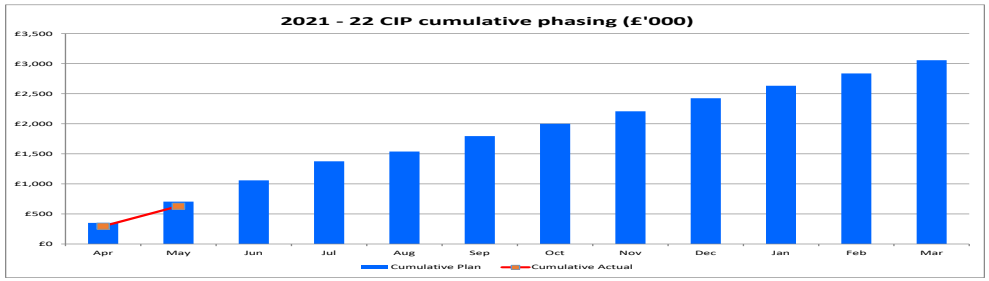
Income and Expenditure	Plan/ Target £000'	Actual/ Forecast £000'	Variance to plan (adv)/ fav £000'	Direction of travel (variance)	RAG (report on red)
In month surplus/ (deficit)	0	0	0	⟺	Green
YTD surplus/ (deficit)	0	0	0	⟺	Green
EBITDA (excl top-up) YTD	6	6	0	⟺	Green
EBITDA %	0.0%	0.0%	0.0%	⟺	Green
Clinical Income YTD	(36,423)	(36,255)	(169)	↑	Green
Non-Clinical Income YTD	(16,344)	(16,065)	(279)	↑	Green
Pay YTD	33,689	34,503	(814)	↑	Green
Non-Pay YTD	19,080	17,817	1,264	↓	Green
CIP Target YTD	705	629	(76)	↑	Green

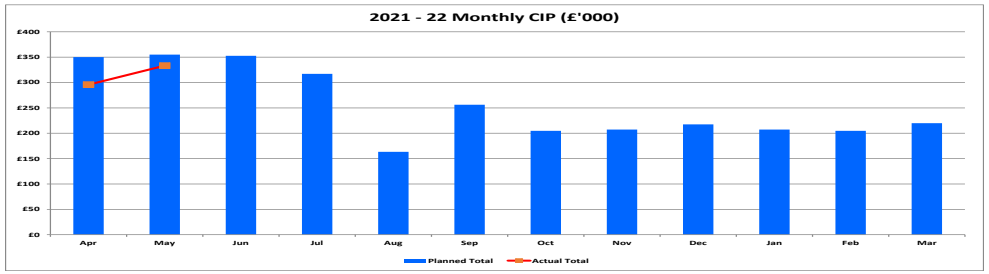
Cost Improvement Programme (CIP) 2021-22

The CIP programme for 2021-22 is £3.1m (1.0%). In the year to May we achieved £629k (23.1%) against a plan of £705k (20.6%). This represents a £76k shortfall.

Division	Divisional Target £'000	YTD Var £'000	Unidentified plan £ YTD	Unidentified plan £ year
Medicine	824	0	0	0
Surgery	550	(1)	0	0
W&C/CSS	554	(47)	0	0
Community	437	2	0	0
E&F	188	(30)	0	0
Corporates	504	0	0	504
Stretch	0	0	0	0
Total	**3,056**	**(76)**	**-**	**504**

Recurring/Non Recurring	2021-22 Annual Plan £'000	Plan YTD £'000	Actual YTD £'000
Recurring			
Outpatients	-	-	-
Procurement	242	24	24
Activity growth	-	-	-
Additional sessions	101	40	40
Community Equipment Service	271	45	48
Drugs	51	-	-
Estates and Facilities	63	13	4
Other	280	51	35
Other Income	147	22	17
Pay controls	28	5	2
Service Review	-	-	-
Staffing Review	36	6	6
Theatre Efficiency	20	2	2
Contract Review	319	53	19
Workforce	-	-	-
Consultant staffing	-	-	-
Agency	-	-	-
Car Park income	75	13	-
Unidentified CIP	504	0	-
Recurring Total	**2,137**	**273**	**196**
Non-Recurring			
Pay controls	99	48	87
Theatre Efficiency	280	114	76
Staffing Review	-	-	-
Other	540	270	270
Estates and Facilities	-	-	-
Non-Recurring Total	**919**	**432**	**433**
Total CIP	**3,056**	**705**	**629**





FINANCE AND WORKFORCE REPORT – May 2021

Trends and Analysis

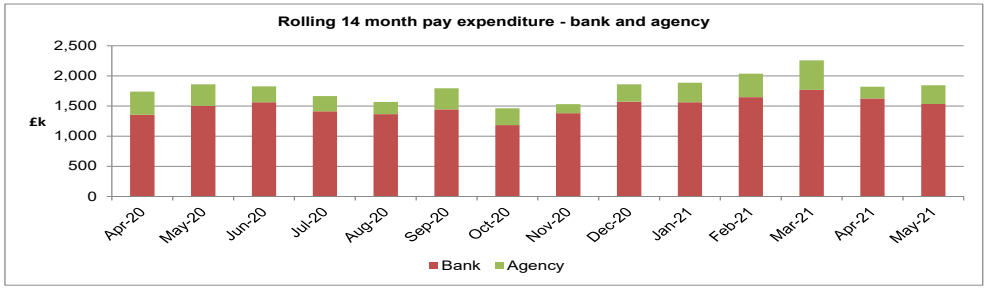
Workforce

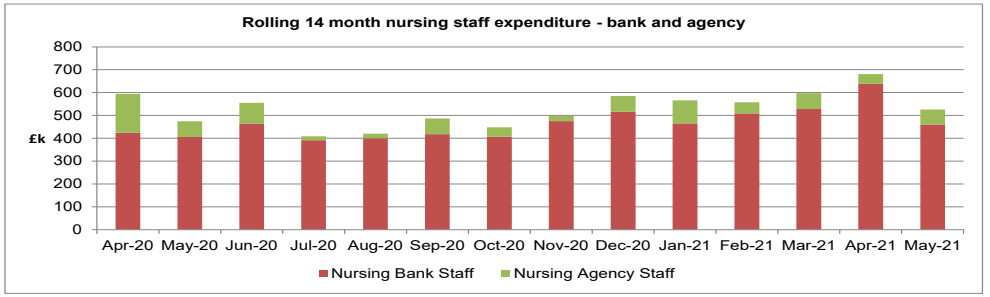
During May the Trust overspent by £0.4m on pay (£0.8m YTD).

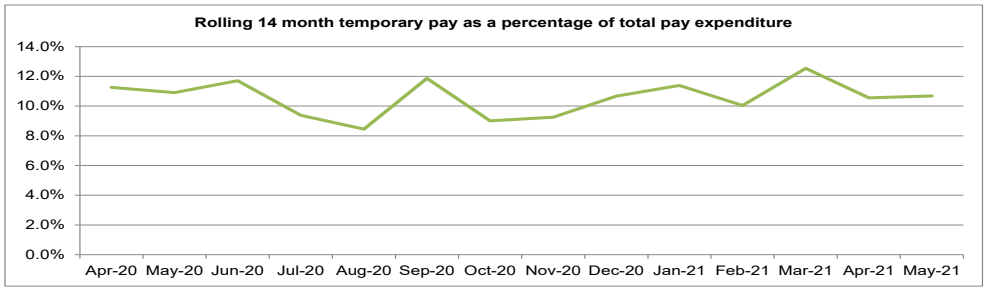
Monthly Expenditure (£)				
As at May 2021	May-21	Apr-21	May-20	YTD
	£000's	£000's	£000's	£000's
Budgeted Costs in-month	16,857	16,832	16,857	33,689
Substantive Staff	15,418	15,422	15,187	30,841
Medical Agency Staff	163	74	237	237
Medical Locum Staff	357	272	262	629
Additional Medical Sessions	276	182	378	458
Nursing Agency Staff	66	43	69	109
Nursing Bank Staff	460	638	406	1,098
Other Agency Staff	79	78	52	158
Other Bank Staff	237	301	189	538
Overtime	106	138	200	244
On Call	98	93	65	191
Total Temporary Expenditure	1,843	1,819	1,858	3,662
Total Expenditure on Pay	17,261	17,242	17,046	34,503
Variance (F/(A))	(405)	(409)	(189)	(814)
Temp. Staff Costs as % of Total Pay	10.7%	10.6%	10.9%	10.6%
memo: Total Agency Spend in-month	309	195	358	504

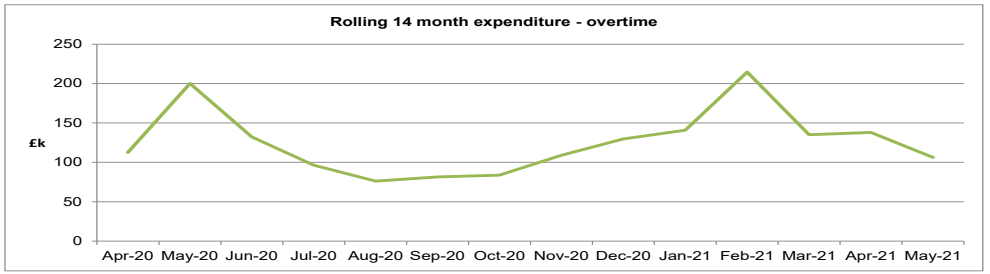
Monthly WTE				
As at May 2021	May-21	Apr-21	May-20	YTD
	£000's	£000's	£000's	£000's
Budgeted WTE in-month	4,365.4	4,361.0	4,365.4	9,971.5
Substantive Staff	4,040.9	4,049.3	3,751.2	8,090.2
Medical Agency Staff	0.0	7.2	18.7	7.2
Medical Locum Staff	30.5	27.4	18.4	57.9
Additional Medical Sessions	6.5	2.9	6.5	9.4
Nursing Agency Staff	0.0	20.0	9.9	20.0
Nursing Bank Staff	112.0	175.5	115.4	287.5
Other Agency Staff	0.0	16.9	10.0	16.9
Other Bank Staff	89.0	118.4	73.2	207.4
Overtime	25.3	35.2	51.4	60.4
On Call	7.1	7.3	5.1	14.4
Total Temporary WTE	270.4	410.8	308.7	681.2
Total WTE	4,311.4	4,460.1	4,059.9	8,771.4
Variance (F/(A))	54.0	(99.0)	305.5	1,200.1
Temp. Staff WTE as % of Total WTE	6.3%	9.2%	7.6%	7.8%
memo: Total Agency WTE in-month	0.0	44.1	38.6	44.1

Pay Costs









FINANCE AND WORKFORCE REPORT – May 2021

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
NHS Contract Income	(9,582)	(9,523)	(59)	(14,542)	(13,768)	(774)
Other Income	(299)	(271)	(28)	(581)	(512)	(69)
Total Income	**(9,880)**	**(9,793)**	**(87)**	**(15,123)**	**(14,280)**	**(843)**
Pay Costs	4,324	4,808	(484)	8,738	9,517	(779)
Non-pay Costs	1,511	1,605	(94)	3,081	3,225	(143)
Operating Expenditure	**5,835**	**6,413**	**(578)**	**11,819**	**12,742**	**(922)**
SURPLUS / (DEFICIT)	**4,045**	**3,380**	**(665)**	**3,304**	**1,538**	**(1,766)**
SURGERY						
NHS Contract Income	(6,511)	(7,298)	788	(10,133)	(9,750)	(384)
Other Income	(199)	(170)	(29)	(398)	(340)	(58)
Total Income	**(6,710)**	**(7,468)**	**758**	**(10,532)**	**(10,089)**	**(442)**
Pay Costs	3,478	3,552	(74)	6,953	7,060	(107)
Non-pay Costs	1,163	1,177	(14)	2,321	2,187	135
Operating Expenditure	**4,641**	**4,730**	**(89)**	**9,274**	**9,247**	**27**
SURPLUS / (DEFICIT)	**2,069**	**2,738**	**669**	**1,257**	**842**	**(415)**
WOMENS AND CHILDRENS						
NHS Contract Income	(2,532)	(2,477)	(55)	(3,839)	(3,552)	(287)
Other Income	(67)	(69)	2	(134)	(136)	2
Total Income	**(2,599)**	**(2,546)**	**(53)**	**(3,973)**	**(3,688)**	**(285)**
Pay Costs	1,488	1,446	42	2,977	2,947	30
Non-pay Costs	152	213	(60)	306	372	(66)
Operating Expenditure	**1,640**	**1,658**	**(18)**	**3,283**	**3,319**	**(36)**
SURPLUS / (DEFICIT)	**959**	**887**	**(72)**	**690**	**369**	**(321)**
CLINICAL SUPPORT						
NHS Contract Income	(526)	(443)	(84)	(1,155)	(938)	(216)
Other Income	(157)	(183)	26	(314)	(302)	(12)
Total Income	**(683)**	**(625)**	**(58)**	**(1,469)**	**(1,240)**	**(229)**
Pay Costs	2,067	2,066	1	4,129	4,084	45
Non-pay Costs	1,014	1,206	(193)	2,026	2,048	(22)
Operating Expenditure	**3,081**	**3,272**	**(192)**	**6,155**	**6,133**	**23**
SURPLUS / (DEFICIT)	**(2,397)**	**(2,647)**	**(249)**	**(4,687)**	**(4,893)**	**(206)**
COMMUNITY SERVICES						
NHS Contract Income	(2,792)	(2,758)	(34)	(5,355)	(5,275)	(79)
Other Income	(1,066)	(973)	(93)	(2,242)	(2,166)	(77)
Total Income	**(3,858)**	**(3,731)**	**(127)**	**(7,597)**	**(7,441)**	**(156)**
Pay Costs	2,741	2,743	(2)	5,395	5,449	(53)
Non-pay Costs	1,174	1,383	(209)	2,326	2,373	(47)
Operating Expenditure	**3,915**	**4,127**	**(212)**	**7,721**	**7,821**	**(100)**
SURPLUS / (DEFICIT)	**(57)**	**(396)**	**(339)**	**(124)**	**(380)**	**(256)**
ESTATES AND FACILITIES						
NHS Contract Income	0	0	0	0	0	0
Other Income	(446)	(258)	(188)	(893)	(489)	(404)
Total Income	**(446)**	**(258)**	**(188)**	**(893)**	**(489)**	**(404)**
Pay Costs	951	1,016	(65)	1,892	2,050	(158)
Non-pay Costs	652	704	(52)	1,304	1,121	184
Operating Expenditure	**1,603**	**1,720**	**(117)**	**3,196**	**3,171**	**26**
SURPLUS / (DEFICIT)	**(1,156)**	**(1,461)**	**(305)**	**(2,303)**	**(2,682)**	**(379)**
CORPORATE						
NHS Contract Income	4,871	5,166	(295)	903	(968)	1,871
Other Income	(6,916)	(6,980)	64	(13,831)	(14,094)	263
Total Income	**(2,045)**	**(1,814)**	**(231)**	**(12,927)**	**(15,062)**	**2,135**
Pay Costs	1,808	1,630	178	3,605	3,396	209
Non-pay Costs	2,473	1,346	1,127	5,008	3,621	1,387
Capital Charges and Financing Costs	1,226	1,339	(113)	2,452	2,839	(387)
Operating Expenditure	**5,508**	**2,976**	**2,532**	**11,065**	**7,017**	**4,048**
SURPLUS / (DEFICIT)	**(3,463)**	**(1,162)**	**2,300**	**1,863**	**8,045**	**6,182**
TOTAL						
NHS Contract Income	(17,072)	(17,332)	261	(34,120)	(34,251)	131
Other Income	(9,151)	(8,903)	(248)	(18,393)	(18,037)	(356)
Total Income	**(26,222)**	**(26,235)**	**13**	**(52,513)**	**(52,288)**	**(225)**
Pay Costs	16,857	17,261	(405)	33,689	34,503	(814)
Non-pay Costs	8,139	7,635	505	16,372	14,946	1,426
Capital Charges and Financing Costs	1,226	1,339	(113)	2,452	2,839	(387)
Operating Expenditure	**26,223**	**26,235**	**(13)**	**52,513**	**52,288**	**225**
SURPLUS / (DEFICIT)	**(0)**	**(0)**	**0**	**(0)**	**0**	**0**

Page 5

Medicine (Sarah Watson)

The division is behind plan in month by £665k (YTD £1.766m).

Clinical income is behind plan by £59k in month and £774k YTD. Activity levels have continued to improve in May with performance against 3 metrics detailed in Table 1 below. This year we have seen a significant and sustained increase in A & E attendances which has led to non-elective activity outperforming both planned activity by 13%, the 2yr average by 24% and average 19/20 activity by 11%.

Outpatient activity in May is behind on all three metrics, and Elective activity is only out-performing the 2yr average. However, it should again be noted that at 89% and 84% respectively, both are ahead of the national expectations for activity recovery (80% of 19/20 activity by the end of M2).

Activity Type	Vs Plan	Vs 24 Mth Avg	Vs 19/20 Avg
Non-Elective	13%	21%	11%
Outpatients	-4%	-6%	-11%
Elective	-12%	4%	-16%

Table 1 - % differences between actual activity and planned activity, average activity over the last 24 months, and the average activity in 19/20. NB: Positive figures = actual activity outperforming, negative figures = actual activity under performing

Excluding clinical income, the division is behind plan by £606k in May (£992k YTD)

Pay costs account for £484k of the monthly variance (£779k YTD), due largely to:

- Consultants (£113k) – The use of locums and additional sessions to cover vacancies and operational pressures.
- Junior Drs (£64k) – Likely due to funding held in Corporate areas, a cross division review of how funding is accounted for in the Trust is underway.
- ED Registrars (£100k) – the reduction in the use of temporary staffing to cover substantive vacancies is a continued area of focus for the division.
- Unregistered Nursing (£87k) – again, this is an area of focus for the division as we move past the pressures caused by COVID.

Non-pay costs are £94k over budget in month.

Surgery (Simon Taylor)

The division is behind plan in month by £669k (YTD £415k adverse variance)

In May, the division continues to improve its activity levels against plan and has seen a positive increase month on month in all activity types. Outpatient activity

improved in month by 6.25%, with significant improvement in Breast Surgery, General Surgery, Plastic Surgery and Vascular Surgery. Non-elective activity in May exceeded plan by 12.3%, with a particular increase in emergency long stay patients within General Surgery and Orthopaedics. Day case activity continues to exceed against plan, by 7.3% in May (2.6% in April), whilst elective inpatient activity has seen an increase month on month from 164 to 209 patients (27.4%) but still remains behind plan by 4.6%.

The division are utilising as much of its available capacity to mitigate the reduction in theatre capacity and the other known constraints from the roof failsafe work. However, in order to deliver the current level of activity, premium costs are being incurred which are reflected in overspends against pay which reported an overspend of £74k in month (£107k YTD). This is expected to continue until all theatres are available and elective bed capacity is restored. Main areas of overspend are:
Anaesthetics (£20k) and General Surgery (£19k) - increased use of additional sessions and locum work to cover the additional theatre work and vacancies.
COVID - £35k – this includes additional staff recruited during COVID to support critical care and are essential to maintaining staffing ratios to support ITU.

Non-Pay expenditure was overspent by £14k in month and £135k underspent YTD reflecting increased activity.

Women and Children's (Michelle O'Donnell)
In May, the Division reported an adverse variance of £72k (£321k YTD)

The Division was £53k (£285k YTD) behind the clinical income plan as non-elective and outpatient activity were lower than plan. It is expected that the recovery work will increase outpatient attendances in future months.

Pay reported a £42k (£30k YTD) favourable variance in-month.

Non-pay reported a £60k (£66k YTD) overspend in-month due to slippage on the Maternity Part Pathway Reduction cost improvement scheme.

Clinical Support (Michelle O'Donnell)
In May, the Division reported an adverse variance of £249k (£206k YTD).

Income for Clinical Support reported £58k behind plan in-month as outpatient radiology, direct access radiology and breast screening activity were lower than plan. It is expected that recovery work will increase activity in future months.

Pay reported a £1k (£45k YTD) underspend in-month. There still several vacant posts in Pharmacy but this has been offset with the use bank staff across the division.

Non-pay reported a £192k overspend in-month (favourable £23k YTD).

Community Services (Michelle Glass)
In May, the Division reported an adverse variance of £249k (YTD £206k).

Income reported £127k under recovery in May (YTD £156k), where elements of the division's income plan that are allocated on a cost and volume basis, continue to be impacted by COVID. It is expected that the recovery work underway will lead to a recovery of income during the first half of the year. Additional confirmed external income, will partially offset this non-recurrent adverse impact in M3 and M4.

Pay reported an adverse variance of £2k in month (YTD £53k). The division has a favourable underlying pay position without COVID costs. Agency staff were used to cover some vacant Therapy roles in Adult Physiotherapy, Occupational Therapy, Dietetics and the Early Intervention Team. In addition, agency staff have been used to provide a peripatetic team of nurses operating across Community Health. The peripatetic resource has been required to meet both a notable increase in demand for community nursing services, as well as to mitigate the impact of reduced clinical capacity, in order to allow more time between patient home visits to don and doff PPE.

Non-pay reported an adverse variance of £209k (YTD £47k). In May, additional community equipment costs above budget allocation were incurred to enable timely hospital discharges, including an increase in same day and out of hours and to support more than a doubling of discharges through Pathway 1 this year. These 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 secured. There has been a stepped increase in activity in Community Health Teams, notably nursing and therapy patient face to face contacts; higher than pre-Covid levels and non-pay spend on dressings and consumables has increased as a result. Additional travel costs were incurred to support the peripatetic team. The position will be further impacted as a result of restoration and recovery of services, as well as managing the impact of additional demand placed on Community teams as a result of the RAAC works; with additional activity managed in the community.

FINANCE AND WORKFORCE REPORT – May 2021

Statement of Financial Position at 31 May 2021

STATEMENT OF FINANCIAL POSITION

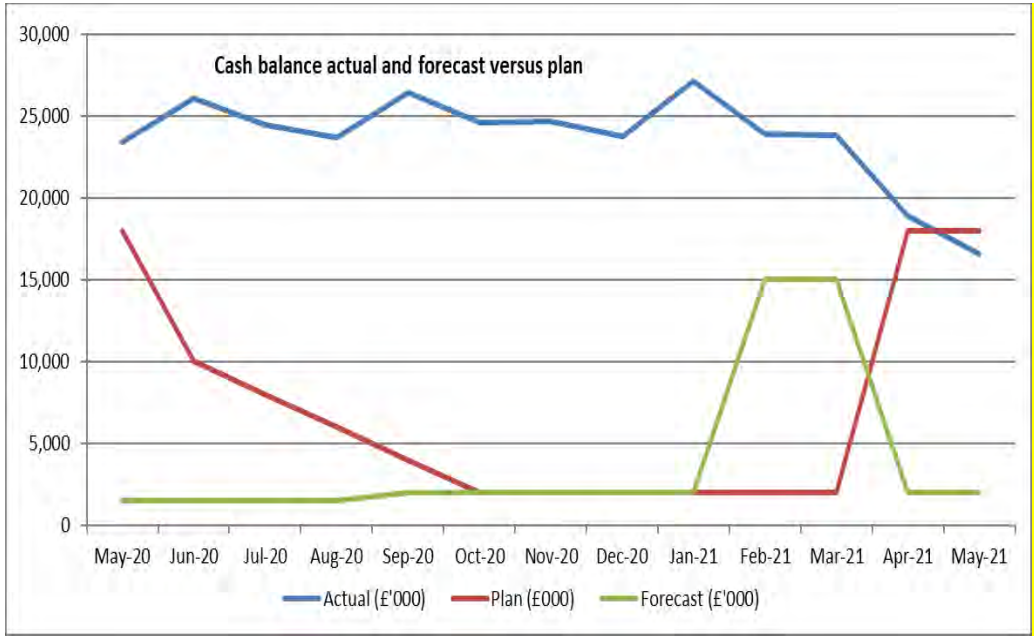
	As at 1 April 2021	Plan 31 March 2022	Plan YTD 31 May 2021	Actual at 31 May 2021	Variance YTD 31 May 2021
	£000	£000	£000	£000	£000
Intangible assets	52,198	54,398	52,398	54,724	2,326
Property, plant and equipment	137,103	168,603	138,603	142,208	3,605
Trade and other receivables	6,341	6,341	6,341	6,341	0
Total non-current assets	**195,642**	**229,342**	**197,342**	**203,273**	**5,931**
Inventories	3,481	3,481	3,481	3,558	77
Trade and other receivables	19,362	19,362	19,362	21,639	2,277
Cash and cash equivalents	23,788	2,006	18,006	16,590	(1,416)
Total current assets	**46,631**	**24,849**	**40,849**	**41,787**	**938**
Trade and other payables	(52,522)	(37,779)	(47,379)	(50,235)	(2,856)
Borrowing repayable within 1 year	(6,439)	(5,500)	(5,500)	(5,524)	(24)
Current Provisions	(46)	(46)	(46)	(46)	0
Other liabilities	(1,357)	(3,357)	(3,357)	(6,304)	(2,947)
Total current liabilities	**(60,364)**	**(46,682)**	**(56,282)**	**(62,109)**	**(5,827)**
Total assets less current liabilities	**181,909**	**207,509**	**181,909**	**182,951**	**1,042**
Borrowings	(47,719)	(43,319)	(47,719)	(48,761)	(1,042)
Provisions	(852)	(852)	(852)	(852)	0
Total non-current liabilities	**(48,571)**	**(44,171)**	**(48,571)**	**(49,613)**	**(1,042)**
Total assets employed	**133,338**	**163,338**	**133,338**	**133,338**	**0**
Financed by					
Public dividend capital	158,650	188,650	158,650	158,650	0
Revaluation reserve	8,743	8,743	8,743	8,743	0
Income and expenditure reserve	(34,055)	(34,055)	(34,055)	(34,055)	0
Total taxpayers' and others' equity	**133,338**	**163,338**	**133,338**	**133,338**	**0**

There has been little movement in the balance sheet against plan and the year end position and the balances are in line with expectations. The capital additions are slightly ahead of plan, however this is due to the profiling of the plan, with a larger amount of capital additions in relation to structure works occurring earlier in the year than anticipated in the plan.

The opening balances shown in the table above remain subject to audit.

Cash Balance Forecast for the year

The graph illustrates the cash trajectory since May 2020. The Trust is required to keep a minimum balance of £1m.



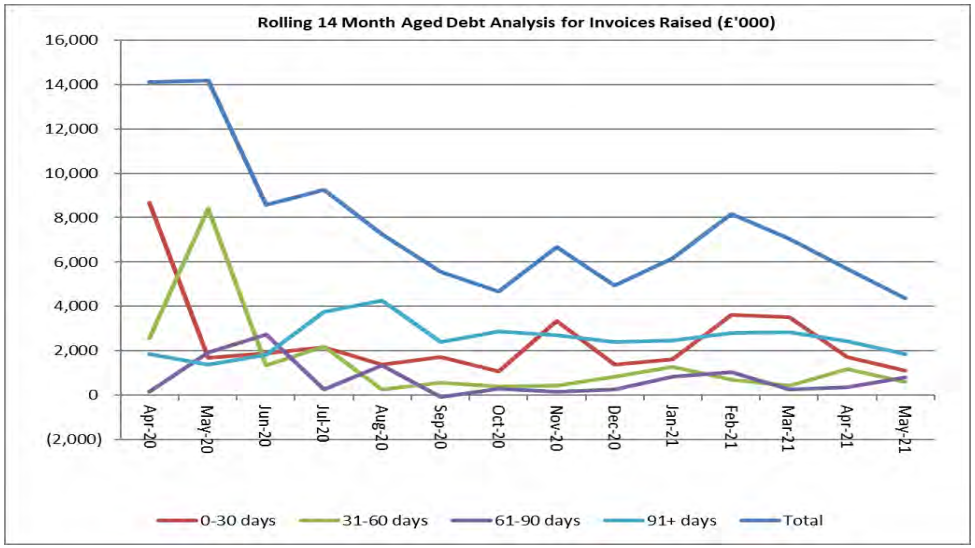
The Trust's cash balance increased significantly during the prior year and continues to be in a strong position into month 2. However the cash position will require rigorous monitoring during 2021/22 as the Trust will no longer be receiving any income in advance as it was in 2020/21 and we need to ensure that the timing of the capital payments is line with capital cash funding due to be received.

Cash flow forecasts continue to be submitted to NHS England every fortnight to ensure that adequate cash reserves are being held within the NHS

FINANCE AND WORKFORCE REPORT – May 2021

Debt Management

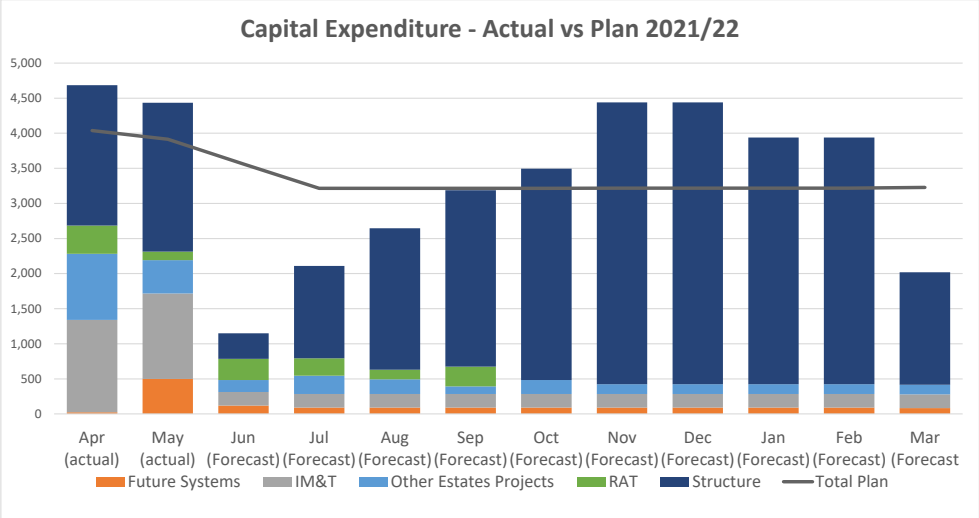
The graph below shows the level of invoiced debt based on age of debt.



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

The overall level of sales invoices raised but not paid has remained stable, with a continuing decrease at month 2. The large majority of the debts outstanding are historic debts, although these are reducing. Over 68% of these outstanding debts relate to NHS Organisations, with 39% 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 and a significant amount of work has been completed in this area to help reduce these historic balances.

Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Forecast £'000	Jul Forecast £'000	Aug Forecast £'000	Sep Forecast £'000	Oct Forecast £'000	Nov Forecast £'000	Dec Forecast £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	Total 2020-21 £'000
Future Systems	24	498	120	90	90	90	90	90	90	90	90	84	1,446
IM&T	1,316	1,219	194	194	194	194	194	194	194	194	194	196	4,477
Other Estates Projects	942	475	170	260	210	110	198	141	141	141	141	137	3,066
RAT	403	120	300	250	137	280	0	0	0	0	0	0	1,490
Structure	1,999	2,122	364	1,314	2,014	2,514	3,014	4,014	4,014	3,514	3,514	1,603	30,000
Total / Forecast	4,684	4,434	1,148	2,108	2,645	3,188	3,496	4,439	4,439	3,939	3,939	2,020	40,479
Total Plan	4,038	3,915	3,561	3,216	3,216	3,216	3,216	3,218	3,218	3,218	3,218	3,229	40,479

The plan figures shown in the table and graph match the plan submitted to NHSI. The 2021/22 Capital Programme has been set at £40.5m with £30m of this relating to structure works.

The prime focus of the Capital Programme is work to ensure the structure of the current hospital site is safe and can continue to be used until the new hospital is built. Within this project there are a number of schemes such as RAAC planks, roof work, electrical and water infrastructure. The other main focus of the programme is the continuation of the Ecare programme. The budget also shows the work on future systems. At this early stage the projects are all being forecast to come in at around the plan figure.

Comfort Break - 10 minutes

11:00 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

13. People and organisational development (OD) highlight report

To APPROVE a report

For Approval

Presented by Jeremy Over

Board of Directors – Friday 25 June 2021

Agenda item:	13			
Presented by:	Jeremy Over, Executive Director of Workforce and Communications			
Prepared by:	Members of the Workforce & Communications directorate			
Date prepared:	17 June 2021			
Subject:	People & OD Highlight Report			
Purpose:	✓	For information		For approval

The People & OD highlight report was established during 2020-21 as 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 month the report provides updates on the following areas of focus:

- Putting You First Awards
- Improving people management culture through more compassionate HR policy frameworks
- National and local People Plan development
- Quarterly NHS staff survey implementation
- WSFT Library and Knowledge Services update
- Consultant appointments

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

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*
		✓					✓

Putting you first

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.

Putting You First – June awards

Sheryl Pidgeon – Ward Manager, F3
Kelly Phillips – Occupational Therapist
Emily Box – Physiotherapist
Nominated by Helen Beard

The team worked tirelessly to plan, prepare and co-ordinate a safe discharge for a patient with very complex needs. Reasonable adjustments were engaged to ensure the patient was fully prepared for discharge and the team went above and beyond, personally taking the patient to her home to settle her in and ensure all her personal needs were met. The team ensured there was full engagement with multiple agencies to ensure the discharge was safe and the individual was fully involved with the plans.

This was an exceptionally complex situation, but everyone involved ensured the patient was put in the centre of all the decisions made.

Danielle Offord, nursing recruitment lead and Harriet Jump, recruitment assistant
Nominated by Angie Manning

Danielle is responsible for the registered nurse and nursing assistant recruitment including the recruitment of our international nurses. NHS England and NHS Improvement funded additional resource to support our nursing recruitment programme this year which enabled us to bring Harriet into the team.

We have received verbal feedback from NHS England and NHS Improvements that we are top in the region for international recruitment and are the only Trust to be on top of our targets.

In addition, we received an email on 19 May from NHS England and NHS Improvement, which states that: "We are delighted to see that you have reached 100% of your HCSW recruitment target as outlined in the Memorandum of Understanding. This is a phenomenal achievement and we would like to take this opportunity to congratulate and thank both you and your teams for all your efforts since the beginning of the HCSW 2020 Programme. Your hard work and commitment to the programme aims has resulted in a significant reduction in HCSW vacancies across the nation with approximately 50% of new recruits being new to the NHS."

We have some of the lowest nursing vacancy rates in the region and this is mainly down to Danielle and Harriet, supported by the general recruitment team and Diane Last's education and training team.

Elizabeth Keegan, SCARC, ICPS

Nominated by Della Chubb

I am the service lead for Suffolk Communication Aid Resource Centre (SCARC) – an Integrated Community Paediatric Services (ICPS) service working with young people 0-25. My colleague Liz recently received an e-mail from a parent to thank her for the kindness and compassion shown to her, as her son was discharged from our service. Her son is very poorly and recently deteriorated, meaning that he could no longer access our equipment to support his communication.

Liz took the time to listen to the parent at a time when she was hurting and grieving for the changes in her son. The recognition we received from them, at a time when she was grieving, is a real testament to Liz's sensitivity and patient care.

Improving people management culture through more compassionate HR policy frameworks – our new disciplinary policy

A central priority over recent months has been co-creation of a new disciplinary policy for WSFT, working in partnership with staff representatives. The overarching purpose being to embed the cultural change we want to see in how the organisation responds when things go wrong and reflect the learning so far from events under scrutiny as part of the rapid review.

Background

As part of the review of our people practices, and the need identified by our CQC inspection to improve our culture we looked to other parts of the NHS and their experience of changing organisational culture; specifically, in relation to how we respond when things go wrong – typically incidents that might result in an investigatory process and/or HR process. Specifically we heard from Mersey Care NHS Trust about their 'just and restorative culture' journey, through which they have transformed and modernised their HR policy framework.

In addition to this, the NHS has written to Trusts asking that we all learn lessons from the tragic event that occurred at a London NHS trust by improving our people practices, and sharing a model policy for comparison purposes.

Progress to date

A review of priority HR policies has been undertaken, starting with the former Disciplinary Policy, with a change of emphasis on pre-investigation and informal resolution and learning, with language used reflective of a supportive, kind and compassionate approach. Agreement of this policy and commitment to the just, learning and restorative approach has set the template for the review and development of other HR policies and the template correspondence that sit alongside each process, to ensure that the tone and language is balanced and supportive to the individual and their well-being. Integral to the change is the role of *incident and learning reviewer* and an agreed feedback mechanism for capturing learning recommendations.

Additional information

A pre-investigation incident and learning review form (based on the Mersey Care 4 step process) sits alongside HR policies and is being used at the outset to review all employee relations cases to determine whether it is appropriate for the case to be dealt with formally, with the objective that the best outcome, where possible, is informal resolution.

This approach is being promoted and reflected in coaching conversations with managers in relation to the management of employee issues, supported and enabled by our investment in HR professionals embedded within our divisions and corporate services.

Anonymised monthly oversight of employee relations cases is now being provided to the Board to provide visibility and assurance of progress and learning.

Recommendation

The new proposed policy is attached Appendix A, which has been developed and agreed in partnership with our union colleagues. The Board is asked to endorse the policy and approve its introduction and implementation.

National and local People Plan development

Last month an update was provided to the Board with an overview of the work that is ongoing to create a broader, stronger, longer-term People Plan for West Suffolk that reflects the culture we want to develop across West Suffolk, based on the experience, wishes and involvement of our staff.

A revised national framework and deliverables for the NHS People Plan has been published by NHS England. Set within the context of what was achieved during the pandemic, it sets out clear deliverables for 2021/22 for individual organisations, local systems and the national team respectively, grouped around four key deliverables.

It is proposed that the national and WSFT priorities are assimilated, to enables us to join up local and national priorities into one plan. These are set out in the attached table as twelve goals and will form the basis of our plan. This will be overseen through the Involvement Committee and various staff stakeholder and representative groups.

The key question is whether the draft goals capture all of our people priorities for 2021/22 and feedback is welcome from colleagues to that end.

National priority	Local priority	Draft Goals
1. Looking after our people	Recovery	1a – support our people to recover and promote pro-active health and well-being
	Line management	1b – grow supportive line management for all staff, which prioritises their well-being
	Well-being	1c – develop organisational well-being services that meet staff's needs

2. Belonging at WSFT and in the NHS	Freedom to Speak Up	2a – support all staff to safely speak up and raise concerns, with confidence
	Culture	2b – develop an inclusive, just and compassionate culture
	Inclusion	2c – address inequalities and the concerns of minority staff groups
3. New ways of working and delivering care	Flexible working	3a – promote and embed remote and flexible working
	New roles	3b – develop new and redesigned roles
	Future system	3c – developing the people plans for our future system
4. Growing for the future	Workforce development	4a – recovering ETD and career pathways to support staff development
	Workforce supply	4b – recruitment and resourcing plans to address key risks
	System-working	4c – contribute to workforce development across the ICS as a system partner

Implementation of a quarterly staff survey for the NHS

We understand that work to take forward the commitment to establish a quarterly staff survey for the NHS will come to fruition over the summer. The purpose of this will be to more frequently track staff engagement (using the nine questions from the Engagement theme in the NHS Staff Survey), in line with the commitment in the People Plan 2020/21. This will replace the staff Friends and Family Test.

For reference the nine questions focus on the extent to which staff agree with the following:

1) I look forward to going to work
2) I am enthusiastic about my job
3) Time passes quickly when I am working
4) There are frequent opportunities for me to show initiative in my role
5) I am able to make suggestions to improve the work of my team / dept
6) I am able to make improvements happen in my area of work
7) Care of patients is my organisation's top priority
8) I would recommend my organisation as a place to work
9) If a friend or relative needed treatment I would be happy with the standard of care provided by my organisation

In the most recent full staff survey, our people gave WSFT a combined score of 7.2 out of 10 for this theme (within a range of 6.4 to 7.6 for our benchmark group), a reduction from 7.5 in 2019.

WSFT Library and Knowledge Services update

Throughout the pandemic, the WSFT Library remained open and staffed and the enquiry service was available to all staff. The service has continued to be well used during the last year and currently there are almost 2600 active library users registered.

- 943 colleagues (around 20% of staff) have an NHS OpenAthens account that allows access to all online resources the Library subscribes to. Over 120 of these were created during the peak of the pandemic.
- "Knowledgeshare" is an evidence-alerting service which delivers links to full text articles in the users' areas of interest every two weeks. We offer this as part of Library membership and over 1000 staff have registered for the service. More than 100 of these were registered between March and December 2020.
- 74 evidence searches were carried out by the library team for WSFT staff in the 12 months from April 2020. The majority (67) were to support clinical decision-making.

Recent Consultant Appointments

Post: Consultant Microbiologist
Interview: 8 June 2021
Appointee: Dr Daniel Greaves
Start date: 6 December 2021

Current post: Consultant Microbiologist: Cambridge University Hospitals NHS FT
2020 to present

Previous Position:
May 2015 – Jan 2020
Clinical Research Fellow and Honorary Specialty Registrar, Jeffrey Cheah Biomedical Centre, Cambridge Biomedical Campus

Post: Consultant Microbiologist
Interview: 8 June 2021
Appointee: Dr Michelle Toleman
Start date: TBC

Current post: Medical Microbiology Trainee: Cambridge University Hospitals NHS FT
June 2020 to present

Previous Position:
July 2018 – June 2020
Medical Microbiology Trainee: North Bristol NHS Trust

Trust Policy and Procedure **Document Ref. No: PP(17)040**

MANAGING CONDUCT AND EXPECTED STANDARDS POLICY & PROCEDURE

For use in:	**All Areas of the Trust**
For use by:	**All Staff**
For use for:	**In the Managing Conduct and Expected Standards Process**
Document owner:	Executive Director of Workforce & Communications
Status:	Draft

Purpose of this Document

To provide a framework to enable the Trust to appropriately, fairly and compassionately manage and support colleagues who do not meet the expected standards of conduct required by the Trust

Contents **Page No.**

1. Introduction and Scope

1.1 The West Suffolk NHS Foundation Trust Managing Conduct and Expected Standards Policy is based on the principles of a 'Just Culture', where we will look to ask 'What went wrong' rather than placing blame on the individual. The aim of this policy and process is to ensure that conduct concerns are properly assessed to ensure a full and thorough understanding of the issues raised. The process is also designed to help and encourage all colleagues to achieve and maintain acceptable standards of conduct. This Policy aims to provide consistent and fair treatment for all, and demonstrates our commitment to helping colleagues improve and learn from mistakes and incidents that may occur.

1.2 This policy has been developed in consultation with the Trust's recognised trade unions and is in accordance with the ACAS Code of Practice on disciplinary and grievance procedures.

1.3 The West Suffolk NHS Foundation Trust supports a culture of fairness, openness and learning and this policy is designed to ensure colleagues feel confident to speak up when things go wrong, rather than fearing blame. An objective and prompt examination of the issues and circumstances should be carried out to establish whether there are truly grounds for a formal investigation and/or for formal action. Where support, guidance or informal management would be a more appropriate and productive outcome, this should be pursued. Mediation should always be considered for early resolution, where appropriate.

1.4 It is the intention of this policy to ensure that the trust deals with all conduct issues compassionately and appropriately. The trust will seek restorative action wherever possible, rather than seeking to blame individuals or issue punitive sanctions.

1.5 Managers will ensure that all action taken under this policy and procedure is reasonable and proportionate. At an early stage, colleagues will be told why action is being considered and they will be given the opportunity to respond to allegations before decisions about formal sanctions are taken.

1.6 A learning review (Appendix C) will be carried out following any action under this policy, whether informal or formal. This will be to ensure recommendations regarding improvement of internal processes or mitigation of risk are acted on and implemented promptly.

1.7 The procedure applies to all colleagues employed under a Contract of Service by the West Suffolk NHS Foundation Trust, (hereinafter referred to as the Trust).

Nothing in this agreement affects the rights of Medical and Dental colleagues under their terms and conditions of employment, in particular, the procedures relating to "Maintaining High Professional Standards in the NHS" Please see PP019 Disciplinary Framework for Doctors and Dentists.

Matters relating to personal misconduct of Medical and Dental colleagues will be dealt with in accordance with the Managing Conduct and Expected Standards Policy and Procedure please see PP019 Section III.

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

1.9 A formal conduct review under these procedures against an accredited Union Steward or Branch Official will not take place before a full time official of the union concerned has been advised of the circumstances and has had reasonable opportunity to make representation on behalf of the steward. If an accredited Health and Safety representative has breached Health and Safety regulations a full time official of the union should be advised and given opportunity to make representation before action is taken.

1.10 Where allegations concern the safeguarding of children or vulnerable adults, the Trust's Safeguarding lead must be notified without delay.

1.11 This policy should be read in conjunction with The Trust Expected Standards.

1.12 No formal action will be taken against a colleague until the case has been investigated in accordance with this policy.

1.13 At all stages of formal procedure a colleague will have the right to be accompanied by a representative of a union, colleague organisation, professional organisation (hereinafter referred to as "Union") or by a colleague acting in a non-professional capacity. The colleague/Union Representative will be entitled to paid time off to attend any meetings under this procedure. If the Union Representative is not employed by the Trust they must provide evidence from their trade union that they have been certified as competent to accompany a colleague. The companion/Union Representative will be allowed to address the hearing/meeting in order to:

- put the colleague's case
- sum up the colleague's case
- respond on the colleague's behalf to any view expressed at the hearing.

1.14 In exceptional circumstances, and with the prior agreement of the HR representative supporting the process, the colleague will not be required to be present at meetings/hearings which are part of the formal Managing Conduct and Expected Standards procedure. The colleague would still have an opportunity to provide a written submission or send a delegate, where this is deemed appropriate.

1.15 No colleague will be dismissed for a first incident, where expected standards have not been met, except in the case of gross misconduct, when the penalty may be dismissal without either notice or payment in lieu of notice (i.e. summary

dismissal). This would only be in the case where no other sanction can be considered reasonable.

1.16 This procedure may be implemented at any stage if the colleague's alleged misconduct warrants such action, but in all cases must be preceded by a pre action review and investigation.

1.17 This procedure does not form part of any colleague's contract of employment and it may be amended at any time. We may also vary this procedure, including any time limits, as appropriate in any case.

1.18 Where a colleague's ability to do their job is affected by a lack of skill or knowledge, or ill health, this will be managed by following the Supporting Performance Improvement policy or the Improving Health, wellbeing and attendance policy.

1.19 Proactive consideration must be given as to whether the subject of any informal or formal conduct action has previously spoken up or raised concerns relating to the allegations, and whether this has any impact on the process. Colleagues must not be negatively impacted for speaking up and honest feedback should be encouraged so the Trust can learn from incidents and improve our processes.

2. Informal Stage

2.1 Where at all possible, and where appropriate, allegations where expected standards have not been met should be dealt with informally by the Supervisor/Head of Department. The Pre incident review form must be used to assess the circumstances and to determine the appropriate course of action. This will be carried out by HR and a relevant manager, in line with the principles of our just and learning culture.

2.2 If it is determined that the allegations can be managed informally, the manager will carry out some initial fact finding and meet the colleague to establish their version of events. The manager may also meet with other relevant individuals to get a thorough understanding about what has happened. Once the facts of the situation are understood, restorative action should be taken to ensure conduct does not fall below expected standards again, and also to address any organisational processes that may have led to the incident occurring in the first place.

2.3 This may involve a range of action from counselling, mediation and additional training/ re-training. This may also include firmer action to advise that if conduct falls below the expected standards again, more formal action may have to be considered.

2.4 The colleague may request a Union Representative or Work colleague who is not acting in a legal capacity to be present. The employee should be encouraged to request support and this should not be unreasonably refused. Managers are reminded that the early involvement of a Union Representative can help with the prompt resolution of any complaint or concern

2.5 Following this process, a learning review will be undertaken by the manager with support from HR, to make recommendations on why the incident happened and how we can review our processes to ensure that we can mitigate against it happening in the future. (Appendix B)

2.6 Learning recommendations will be shared with the colleagues involved in the case, and possibly shared and implemented with the wider organisation where appropriate and where this would result in service improvements.

2.7 In some cases, where the Trust considers that formal action is not appropriate, it may decide instead that a jointly agreed independent mediator may help solve disagreements over conduct issues. An independent mediator, for example trained colleagues or external support from ACAS, will not take sides or judge who is right, but can help the parties reach their own agreement where the colleague and the Trust are unable to solve the disagreement alone. The mediator may also recommend a way forward, if both parties agree that they want this.

3. FORMAL PROCEDURE

There may be situations where informal action has not brought the required improvement, where expected standards are repeatedly not met, or where the nature of the allegation is so serious it can't be considered for informal action. In these circumstances, it may be appropriate for the formal procedure to be implemented. This should only be considered where all appropriate informal action has been explored and there are still concerns regarding a colleagues conduct. Where it is decided that further investigation and/or formal action is appropriate, this must be approved by the Deputy Director of Workforce, or a nominated deputy if they have previously been involved in the case. This decision will be based on the information submitted on the pre incident review form. Formal action must only be taken where there is no other alternative, and this will be continuously reviewed throughout any formal process. In the event of formal action being deemed necessary, it is essential that affected colleagues are treated with dignity, kindness and compassion, regardless of the circumstances of the case

Appropriate managers designated to take formal action may be seen at Appendix 'A'.

3.1 Action to be taken prior to a Conduct Hearing

3.1.1 Investigation

Prior to formal action being taken the facts of the case must be investigated. Terms of reference will be agreed by the commissioning manager to support the learning reviewer. Where possible an agreed set of statements and minutes should be available following the investigatory process.

Investigations should be conducted by an appropriate, neutral manager who has been trained in undertaking investigations, supported by an HR representative. This manager will be known as the learning reviewer. For the purpose of minute taking, an investigatory interview may include secretarial support. In some cases

the secretary may use a digital recorder to capture the full detail of the interview and destroy the recording once the transcribed minutes have been agreed.

Any investigation should:

(a) Obtain all available information about the allegation, including written statements, using Incident Forms and Written Statements wherever possible.
(b) Advise the colleague concerned, at the earliest possible stage, of what is happening and the reasons. The point at which this occurs will depend on a number of factors, including the amount of information available. Some investigations will be kept confidential, e.g. where the police are conducting a criminal investigation. The colleague should also be advised of all support available to them at this earliest stage
(c) Managers, colleagues and their representatives must make every effort not to unreasonably delay meetings.

3.2.2 Agreed Outcome

At any stage during an investigation or prior to a conduct hearing, the colleague may accept fair accountability and insight for the allegations against them and propose a discussion of an agreed outcome instead of continuing the conduct investigation and/or hearing.
The Trust may agree to, or if appropriate offer, any such discussion wholly at its discretion. Any such agreement or offer to discuss shall be wholly without prejudice to the right to proceed to a conduct hearing and any sanction at that hearing.
At such a discussion, an outcome will only be agreed if the colleague accepts fair accountability and insight for the allegations and proposes a sanction and/or other arrangements for example, an improvement/development action plan to be signed by all parties which the Trust is willing to agree to.

3.2.3 Action if Colleague is a Union Representative

If the colleague concerned is a Trade Union Steward or Branch Official or, in the case of a breach of Health and Safety Rules, a Health and Safety Representative, there is a requirement to inform the full time officer of the relevant Union that the formal procedure is to be implemented. (See paragraphs 1.6 and 1.11). This will normally be undertaken by the Human Resources Department.

3.2.4 Involvement of Union Representative during Investigation

During investigations and investigatory interviews, colleagues may request a Union Representative or work colleague to be present. Managers are reminded that the early involvement of a Union Representative or work colleague can help with the solution of the problems. The representative/ work colleague should be

allowed the opportunity to confer with the colleague during any investigatory meeting, but has no right to answer questions on the colleague's behalf.

3.2.5 Informing Colleague of Allegations and Date of Conduct Hearing

(a) Once the investigation is completed, the learning reviewer will produce a factual investigation report for submission to the commissioning manager, outlining whether they feel there is a case to answer based on the evidence collated. At this stage, the decision to proceed to a formal investigation will be reviewed by the commissioning manger, with support from the HR representative, to ensure that this is still appropriate, and whether informal interventions would be more suitable. If it is decided to proceed formally the colleague must be informed of the allegations in writing, detailing the following as appropriate:

(i) Nature of allegations
(i) Date and time of alleged incident(s).
(ii) Location of incident(s).
(iii) Other colleagues or patient(s) involved in the incident(s). (n.b. It will not be appropriate to detail the full names of patients as initials will normally suffice)
(iv) West Suffolk NHS Foundation Trust property involved.
(v) West Suffolk NHS Foundation Trust Expected Standard(s) not met.
(vi) Date, time and location of conduct hearing.
(vii) Their right to bring a representative and witnesses to the conduct Hearing.
(viii) Copies of statements. (See (d) and (e) below).

(b) The colleague must be given a minimum of 14 calendar day's notice of the conduct Hearing to allow time for consultation with any representative or witnesses that have been requested to be present at the hearing.
(c) The formal notice to the colleague of conduct allegations should be issued by the Hearing Chair.
(d) Statements and other papers relevant to the case should be given to the colleague with the notice of allegations or as soon as possible after its issue in order to allow the colleague maximum time to prepare their explanation.
(e) If the issue of documents would involve a potential breach of confidentiality, a copy of the relevant records may be given to the colleague or a named representative, redacted if required, who would carry personal responsibility for the maintenance of confidentiality. These documents must be returned at the end of the formal procedure if the colleague is not appealing or, if there is an appeal, at the end of the appeal procedure. When the documents are issued the responsibilities involved will be made clear.
(f) The colleague or the Union Representative (if applicable) should submit Staff Side witness statements, with the names of witnesses

who will be in attendance at the conduct hearing, to Hearing Chair, prior to the conduct hearings.

(g) None of the above prevents new information arising during the course of the conduct hearing being considered, though this may necessitate an adjournment for an appropriate period.

3.2.6 The amount of time between identification of the alleged breach of expected standards, the preliminary investigation and notification to the colleague must be kept to a minimum. The HR support for the learning reviewer will be given responsibility for ensuring that there are no avoidable delays in the process.

3.2.6 A separate member of the HR department will be assigned as additional support for the colleague who is facing conduct allegations, to provide support and guidance on the process.

3.2.6 If the colleague takes sick leave as a result of the formal process the HR representative supporting the process should make a referral to Occupational Health to determine if the colleague is well enough to attend a conduct hearing.

3.3 The Conduct Hearing

The aim of the Conduct Hearing is to establish all the facts available regarding the allegations, giving every opportunity for the colleague to state their case.

Different circumstances will determine how conduct hearings are run but the following guidelines should be considered

3.3.1 Arrange a quiet place with adequate seating for the hearing where there will be no interruptions.

3.3.2 Allow sufficient time to hear all the facts.

3.3.3 An HR representative should be present on the hearing panel to provide professional advice, assist and facilitate the proceedings.

3.3.4 Confidential arrangements, acceptable to all parties, should be made for notes to be taken.

3.3.5 Allegations involving professional matters

If the allegations involve Professional or procedural matters about which the Hearing Chair is not qualified to judge, a senior member of that profession or expert in the procedures involved should be requested to attend the Conduct Hearing and provide professional advice to the Hearing Chair

3.3.6 Witnesses

Ensure witnesses are available at the hearing wherever possible. Attendance in person is preferred, but where this is not possible,

alternatives should be considered. Witnesses will be required to make written statements, prior to the conduct hearing. Statements may be submitted by a witness unable to attend the Conduct Hearing, but it must be accepted that they are documents which have not been subject to challenge.

3.3.7 Procedure at Hearing

(a) At the commencement of the Conduct Hearing, introduce those present to the colleague and explain why they are there.
Explain the purpose of the hearing, how it will be conducted and the possible outcomes.
If the colleague and/or their representative does not attend the Conduct Hearing the reason must be ascertained if at all possible. If the circumstances were beyond the colleague's control, e.g. illness, the Hearing Chair must arrange another meeting. If the meeting is rearranged and the colleague fails to attend a second time, without good reason, the Hearing Chair is entitled to make a decision in the colleague's absence. Occupational Health may at this point be asked to assess whether the colleague is fit to attend the meeting, if concerns have been raised.

(b) The learning reviewer who conducted the preliminary investigation will normally present the management case and asked to detail the allegations and present the evidence, including the calling of witnesses. The colleague and/or their representative, the Hearing Chair and others advising them must be given the opportunity to question the witnesses and manager presenting the case.

(c) The colleague and/or their representative must be given an opportunity to present their case and call relevant witnesses. The Manager who presented the allegations, the Hearing Chair and others advising him/her, must be given opportunity to question the colleague and the witnesses.

(d) The manager presenting the allegations should summarise the Management case.

(e) The colleague or their representative should summarise their case.

(f) Inform the colleague the Hearing will be adjourned to consider all the information given before a decision is reached. If there is need to check certain facts, explain how this will be done and that if new facts emerge a decision will be made after discussion with the individual or their representative as to whether the hearing needs to be reconvened.

(g) During the hearing be prepared to adjourn to allow consideration of new documentation or to allow an emotionally distressed colleague a short time to recover.

3.4 Support for the Colleague

Being subject to allegations of misconduct can be very upsetting and stressful for any affected colleagues. It is important throughout the procedure for the colleagues line manager to keep talking with both the colleague and any other colleagues affected. Clear, regular and confidential communication can help make sure colleagues are kept informed of what is happening, have the opportunity to ask questions and can avoid stress and other mental health issues. The following additional support is also available where appropriate

(i) Where there are concerns about a colleague's health or wellbeing, Occupational Health advice will be obtained.
(ii) Care First are available to offer counselling and emotional support to any colleague affected by matters covered by this policy, and they can be contacted on 0800 174 319 (Freephone)
(iii) Any colleagues under investigation will be able to contact a designated HR support, should they need any additional support during the course of the investigation. This will be a separate HR representative to the one who will be supporting the learning reviewer with the investigation.
(iv) Counselling and support from the colleague wellbeing service

Further details on support available for colleagues can be found on the intranet or by contacting HR or your line manager. Please see Appendix D for further information.

4. FORMAL ACTION

4.1 The Hearing Chair should decide if a conduct sanction is appropriate taking the following into consideration.

(i) whether the Managing Conduct and Expected Standards Policy indicates what action will result from the particular misconduct;
(ii) Whether informal or restorative action is appropriate.
(iii) the action taken in similar cases in the past;
(iv) any special circumstances which might make it appropriate to lessen the severity of action which should be taken;
(v) whether the behaviour was deliberate or accidental;
(vi) the colleague's conduct record, general employment record, position and length of service;
(vii) whether the action proposed is reasonable in view of all the circumstances.
(viii) To proceed to a hearing where dismissal may result, approval must be obtained from a HR Representative after careful consideration of the evidence gathered to date.

4.2 Conduct Sanctions

4.2.2 Stage 1 - First Written Warning

In the case of a serious breach of expected standards, or if a further offence occurs similar to or for which informal action is still current, a **First Written Warning** will be given. The warning will be confirmed in writing and kept on the colleague's personal file but will be disregarded after 12 months subject to satisfactory conduct and performance.
The colleague will be informed of the standards expected and action to be taken by the colleague and employer to achieve and monitor the improvement required. Failure to achieve the standard required may result in further action.

4.2.3 Stage 2

(a) Final Written Warning

This stage may be imposed in the following circumstances:

(i) where a colleague has received a previous written warning for a similar offence which is still current;
(ii) where misconduct is considered not to be serious enough to justify dismissal but serious enough to warrant only one written warning which will be both the first and final.

The warning will be confirmed in writing and kept on the colleagues personal file for a minimum of 12 months, up to a maximum of 24 months, at the discretion of the hearing panel. The warning will be disregarded after this time period has expired, subject to satisfactory conduct and performance. The colleague will be informed of the standards expected and action to be taken by the colleague and employer to achieve and monitor the improvement required. Failure to achieve the standard required may result in dismissal.

(b) Reduction in Pay Band or Transfer to Suitable Alternative Employment

In certain circumstances and as an alternative to dismissal, it may be appropriate to reduce a colleague's pay band or transfer them to suitable alternative employment either on a permanent basis or a specified period during which retraining would be given and then the position reviewed. In such cases the colleague would receive the salary and conditions of the new post, without protection.

4.2.4 Stage 3 - Dismissal

If conduct remains unsatisfactory or if the offence constitutes gross misconduct, dismissal will normally result. Except in cases of gross misconduct, dismissal will be with notice. Cases of gross misconduct may result in summary dismissal, i.e.

dismissal without notice. Dismissals may be reported to the relevant professional body as appropriate.

4.2.5 Referral to a Professional Body

If the outcome is likely or proposed to be referred to a professional body, this must be discussed with the relevant professional lead prior to making the referral.

4.2.6 Time Limits

The above sanctions specify time limits where appropriate. There may exceptionally be occasions where the periods specified are not suitable.

When a colleague's conduct is satisfactory throughout the period the warning is in force, only to fall below expected standards very soon after, a pattern may emerge that there is evidence of abuse. In such cases the colleague's previous conduct record should be borne in mind when deciding if a longer time limit should be applied.

Exceptionally there may be circumstances where the misconduct is so serious, verging on gross misconduct, that it cannot realistically be disregarded for future conduct purposes. In such circumstances it should be made very clear that the final written warning can never be removed and that any recurrence will lead to dismissal.

4.2.7 Action taken at end of Time Limit

Records of formal action taken will be disregarded after the specified period but will not be removed from the colleague's personal file.

4.3 Failure to Attend the Hearing

In the circumstances where the colleague fails to attend the Conduct Hearing, the Hearing Chair will arrange an alternative date (if appropriate). However, if the colleague fails to attend the second hearing, without reasonable justification, the Hearing Chair will have the authority to hold the hearing in the colleagues absence, and consider a retrospective dismissal date or any other formal action. The dismissal or any other form of formal action therefore would be effective from the date of the original hearing.

4.4 Notifying the Decision

The colleague should, whenever possible, be informed verbally of any action to be taken. This should be done as quickly as possible. If further investigations have taken place during an adjournment, the colleague should be told of the outcome of these and the Conduct Hearing re-convened, in order to allow the colleague the opportunity to challenge any new evidence.
In cases of Formal Written Warning/Final Written Warning, Reduction in Pay Band/Transfer to Suitable Alternative Employment, Dismissal with notice and Summary Dismissal, the decision will be put in writing to the colleague within

seven calendar days of the Conduct Hearing, together with notification of their rights of Appeal. Mediation should be considered following any formal action, where appropriate

5. PRECAUTIONARY SUSPENSION (WITH PAY)

Precautionary suspension is not a conduct sanction and should only be used where necessary and where alternative options, e.g. temporary suspension from specific duties are not feasible. It may be appropriate in the following circumstances:

(a) Apparent serious misconduct requires investigation and the suspension is required for the period of investigation if it is felt that the colleague's continued presence at work would interfere with the investigation process.

(b) The action complained of, if substantiated, would constitute gross misconduct and it is considered inappropriate for the colleague to remain on West Suffolk Hospital premises pending a Conduct Hearing.
The colleague should be suspended on full pay by a senior manager for the shortest period possible. This should be reviewed every 30 days as a minimum. The colleague should be told the reason for suspension. Written confirmation of suspension must be sent within 5 calendar days.

NB. Suspension due to failure to be registered or have a licence is normally without pay, as it is the individual's responsibility to register or hold a qualification. In such cases, there must be a meeting with the colleague concerned (and representative) to allow full consideration of the facts and the colleagues explanation.

6. Appeal Procedure

6.1.1 Colleagues may appeal against any formal action. Possible grounds for an appeal include the following:

6.1.1.1 New evidence coming to light;

6.1.1.2 The reasonableness of the penalty imposed; and/or

6.1.1.3 Procedural irregularities during the investigation or hearing which had a material impact on the outcome of the case.

6.1.1 Depending on the circumstances, the Trust may choose to entirely re-hear the matter at appeal, or simply review of the fairness of the original decision in light of the appeal.

<u>Lodging an Appeal</u>

6.1.1 An appeal must be lodged within **14 calendar days** of receiving the written decision. The letter from the colleague should state the ground(s) of appeal relied upon and the specific reasons for this.

Notification of an Appeal Hearing

6.1.1 An appeal hearing should usually be heard within **four weeks** of receipt of the appeal. If this is not possible due to panel availability, or further investigation is required, the colleague should be notified and a new date set as soon as possible.

6.1.1 The colleague should normally be given **14 calendar days** notice in writing of the date of the appeal hearing. The letter should confirm the date, time and venue of the hearing and the names of the panel. The colleague should also be reminded of their right to be accompanied. If the colleague or representative is not available on the appeal hearing date a new date will be agreed as soon as possible.

6.1.1 Any statements of case or documents relevant to the appeal or names of witnesses should be exchanged and provided to the appeal Chair not less than **nine calendar days** before the appeal hearing.

Procedure at the Appeal Hearing

6.1.1 The appeal panel should comprise of a senior manager as Chair, an HR Representative and a Professional Adviser/Clinical Lead if appropriate. The Chair should have authority to decide the appeal as per Appendix A. The chair of the original conduct hearing will also attend to present the management case.

6.1.1 The procedure of the appeal should be similar to the procedure at a Conduct Hearing above.

6.1.1 The decision of the Appeal panel will be final and may:

6.1.9.1 Confirm the original decision;
6.1.9.2 Revoke the original decision; or
6.1.9.3 Substitute a different penalty.

6.2 Criminal Allegations

6.2.1 Where an colleague 's conduct is the subject of a criminal investigation, charge or conviction, the Trust will investigate the facts before deciding whether to take formal action and put the colleague on suspension.

6.2.1 The Trust will not usually wait for the outcome of any criminal prosecution before deciding what action, if any, to take. Where the colleague is unable or has been advised not to attend a conduct hearing or say anything about a pending criminal matter, the Trust may have to take a decision based on the available evidence.

6.2.1 A criminal investigation, charge or conviction relating to conduct outside work may be treated as a formal conduct matter if the Trust considers that it is relevant to the colleague's employment.

7 MONITORING AND REVIEW

This policy and procedure will be monitored and reviewed annually by the Executive Director of Workforce and Communications, and where necessary, changes will be made in consultation with the Policy Working Group and Trust Council.

Author(s):	HR & Communications
Other contributors:	Union Representatives
Approvals and endorsements:	Trust Council
Consultation:	Trust Council
Issue no:	6
File name:	
Supercedes:	Disciplinary policy and procedure PP(14)040.
Equality Assessed	
Implementation	
Monitoring: (give brief details how this will be done)	Implementation, compliance and effectiveness of this policy will be monitored by Trust Council. 100% of any requests received into the HR Directorate will be handled in line with the policy and will be recorded by the on the HR database.
Other relevant policies/documents & references:	PP053 Expected Standards PP019 Disciplinary Framework for Doctors and Dentists.
Additional Information:	None

APPENDIX A

LEVELS OF AUTHORITY TO AWARD FORMAL SANCTIONS AND HEAR APPEALS

Formal Sanction	Minimum Level of Manager Authorised to Award Sanction	Appeal To
First Written Warning	Service Managers Head of Department Local Area Managers Integrated Therapies Manager Integrated Community Paediatric Services Leads	Senior Operations Managers Head of Department Local Area Managers Heads of Nursing Integrated Therapies Manager Integrated Community Paediatric Services Leads
Final Written Warning	Senior Operations Managers Assistant Directors Associate Director of Operations Deputy Directors Business Manager Estates and Facilities Development Manager Estates and Facilities Local Area Managers Deputy Chief Operating Officer Associate Director of Integrated Community Paediatric Services Integrated Therapies Manager	Assistant Directors Associate Director of Operations Deputy Directors Business Manager Estates and Facilities Development Manager Estates and Facilities Local Area Managers Deputy Chief Operating Officer Associate Director of Integrated Community Paediatric Services Integrated Therapies Manager
Dismissal	Senior Operations Managers Assistant Directors Associate Director of Operations Deputy Directors Business Manager Estates and Facilities Development Manager Estates and Facilities Local Area Managers Deputy Chief Operating Officer Associate Director of Integrated Community Paediatric Services Integrated Therapies Manager All Directors and CEO	Assistant Directors Associate Director of Operations Deputy Directors Business Manager Estates and Facilities Development Manager Estates and Facilities Local Area Managers Deputy Chief Operating Officer Associate Director of Integrated Community Paediatric Services All Directors and CEO

Reduction in Grade/Transfer to SAE	Senior Operations Managers Assistant Directors Deputy Directors Business Manager Estates and Facilities Development Manager Estates and Facilities Associate Director of Integrated Community Paediatric Services Local Area Managers Deputy Chief Operating Officer Integrated Therapies Manager All Directors and CEO	Assistant Directors Deputy Directors Business Manager Estates and Facilities Development Manager Estates and Facilities Local Area Managers Associate Director of Integrated Community Paediatric Services Integrated Therapies Manager Deputy Chief Operating Officer All Directors and CEO

Notes; -

- Directors and the Chief Executive have the authority to award formal sanctions and hear appeal at all levels

Where the Chief Executive is the dismissing officer then an appeal would be heard by the Chairman.

NHS
West Suffolk
NHS Foundation Trust

APPENDIX C

Learnings & Recommendations following Investigations and/or Hearings

Please detail any learnings, recommendations or feedback below following the completion of each investigation/hearing:

Colleagues Name: _____

Job Title: _____

Department: _____

Case Reference Number: _____

Individual:

Relevant Department/Team:

Investigation Manager and Commissioning Manager:

HR:

Wider Organisation:

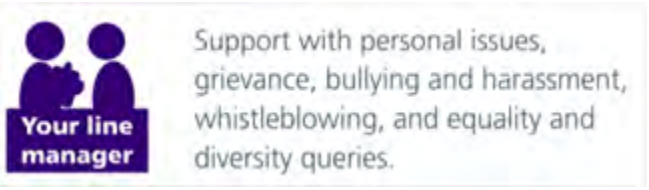
Completed by: _____ **Review Date:** _____

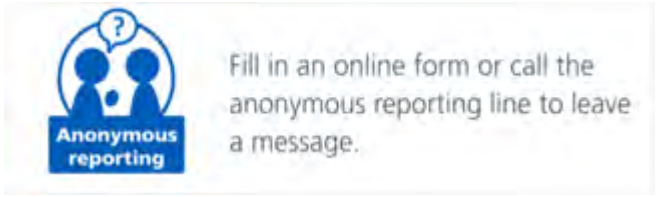
Employee Relations Database updated ☐

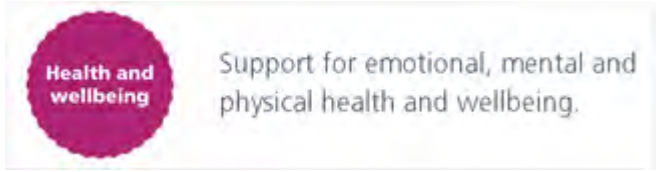
Appendix D

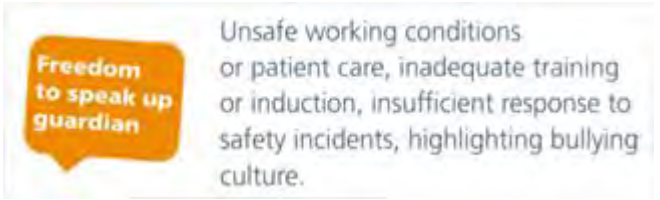
Colleague Support

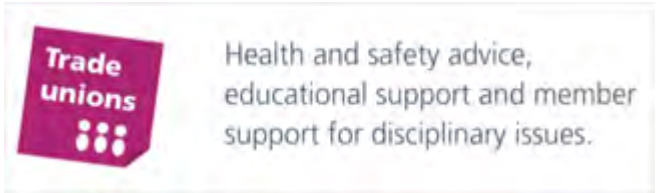
There are many sources of support and advice available whatever the difficulty you are facing, whether it's at work or at home. Please visit http://staff.wsha.local/Intranet/Documents/Q-Z/StaffSupporters/Staffsupporters.aspx to find out more about the support each service can offer

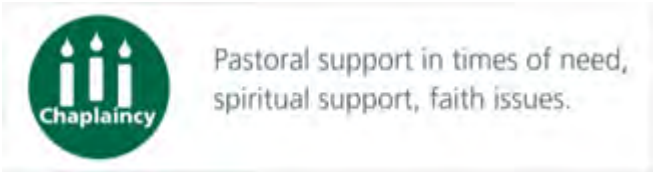


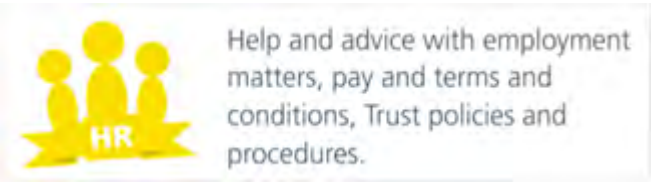


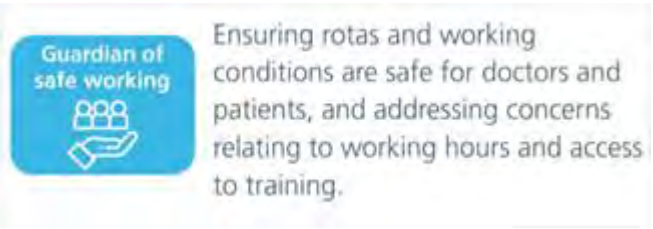


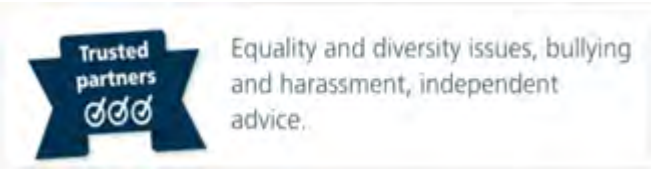


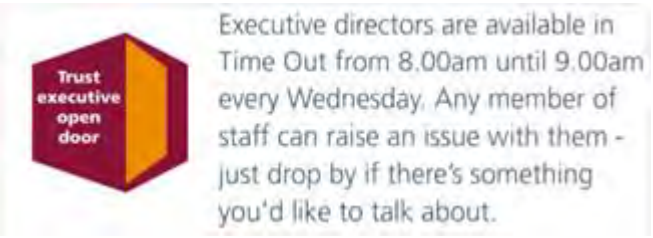


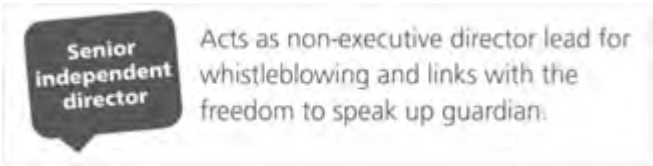












Further information can be found on the Trust intranets. Expert advice and information is also available from other Trust teams including the health, safety and risk office, postgraduate medical education team and governance support. The HR and people services team can also provide information about all staff supporters - call a member of the team on 01284 713528 (ext. 3528) or visit the department at Quince House, West Suffolk Hospital.

14. Medical Revalidation Annual Report

To RECEIVE the report

For Approval

Presented by Paul Molyneux and Katherine Rowe

Trust Board – 25 June 2021

Agenda item:	14			
Presented by:	Dr Paul Molyneux and Dr Katherine Rowe			
Prepared by:	Dr Katherine Rowe – Appraisal Lead			
Date prepared:	17 June 2021			
Subject:	Responsible Officer Annual Report: Medical revalidation			
Purpose:	✓	For information		For approval

Executive summary:

Boards have statutory duties in respect of medical appraisal and revalidation, and are required to receive an annual report from the appointed Responsible Officer.
The Annual Report outlines the trust position as of June 2021, updates the board on recent development in appraisal and revalidation and asks for confirmation that it is satisfied the West Suffolk NHS Foundation Trust is compliant with current regulations.
Key developments in the 2020-21 report were:

1. Formal notification of suspension of appraisal and revalidation in March 2020 by the General Medical Council with immediate effect
2. Restarting of appraisal and revalidation in October 2020
3. Stepping down of the Responsible officer (Dr Nick Jenkins) in June 2021 and appointment of interim medical director and Responsible officer (Dr Paul Molyneux)
4. Retirement of appraisal and revalidation support manager (Janet Rolph) and appointment of Lorna Watson
5. Appointment of interim Appraisal lead and deputy RO June 21 (Dr Katherine Rowe)

The report highlights areas where progress has been made and areas for ongoing development.

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*
		X	X				X

Previously considered by:	**N/a**
Risk and assurance:	
Legislation, regulatory, equality, diversity and dignity implications	
Recommendation: The Board are asked to accept the Annual Report, note the contents and approve it for submission to the higher-level Responsible Officer. The Board are asked to approve the statement of compliance confirming that the West Suffolk NHS Foundation Trust is compliant with relevant legislation and regulations.	

Background

Medical revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care to patients, improving patient safety and increasing public trust and confidence.

Appraisal represents a mechanism of ensuring that clinicians within a designated body are 'fit to practise' and aligned to the core values of the General Medical Councils (GMC) guidance 'Good Medical Practise' (GMC, 2020).

Provider organisations have a statutory duty to support their responsible officer in discharging their appraisal and revalidation duties under the Responsible officer regulations, and it is expected that provider boards will oversee compliance by:

- Ensuring that the designated body has a robust and transparent appraisal and revalidation process that is supportive of the legislation
- That the process demonstrates equality and inclusion for all its users
- Monitoring the frequency, quality and timeliness of medical appraisals in their organisation
- Confirming that there are effective and robust systems in place for the governance of their clinicians
- Confirming that clinicians seek regular feedback from colleagues and patients and that the designated bodies systems are supportive of this occurring
- Ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work due to be performed.
- That the Medical Practise Information Transfer forms (MPIT) are utilised effectively and responsibly not only for doctors entering their designated body, but also to those leaving.

Governance arrangements

Individual clinicians are responsible for ensuring they undertake a timely annual appraisal and have a prescribed connection with a designated body. The Responsible Officer (RO) is responsible for evaluating 1) the clinician's fitness to practise via the appraisal and revalidation process, and 2) the clinician's performance via outputs from line managers during annual job planning meetings.

The responsible officer needs to make a revalidation recommendation regarding the fitness to practise for each individual clinician (within their designated body) via GMC connect in a timely fashion prior to their revalidation date every five years. Trust boards have a responsibility to ensure that the RO is provided with adequate resources to fulfil this statutory function.

Each clinician has a fixed appraisal month and in line with the trust Medical appraisal policy their appraisal should be completed by the end of the fixed appraisal month. In line with other organisations, failure to complete the appraisal within those three months counts as a 'missed appraisal'. Individuals whom have contacted the RO or appraisal lead and whom have a compelling reason agreed by the RO or appraisal lead in which they are or were unable to complete their appraisal will have their appraisal recorded as an 'agreed postponement'.

The GMC has developed a formal mechanism for managing non-engagement through a non-engagement concern letter. If the RO notifies the GMC of non-engagement, as set out in their criteria, the GMC will put the doctor under notice. If sufficient progress is not made by the doctor to engage in appraisal, the GMC may bring forward the revalidation date to allow the RO to submit a revalidation recommendation of non-engagement. If a recommendation of non-engagement is made by the RO, the GMC will begin the process of determining whether the individual should lose their license to practise.

Within the 2020/21 appraisal year the NHS moved to incident level 4 of NHS England's Incidence Response Plan (NHS, 2017) due to the Covid-19 pandemic necessitating Command and Control leadership and a co-ordinated response with local commissioners. In line with this RO's were notified in March 2020 that both appraisal and revalidation would be suspended with immediate effect.

In October 2020 appraisal and revalidation restarted, with a new theme that had a lesser requirement for supportive information and a greater emphasis on continuous professional development and wellbeing.

The status of every doctor with regards to their appraisal and revalidation timing is continually reviewed by the appraisal and revalidation team. However automated mechanisms via allocate to remind the doctors of their upcoming appraisal or overdue appraisals to support sufficient notice to complete and submit their appraisal documentation have been turned off since March 2020.

Annual appraisal process

- The clinician (appraisee) prepares their portfolio which includes the full scope of their professional activities and the governance information associated with these activities
- An assessment by the appraiser of their scope of work, continuous professional development, patient outcomes, complaints and incidents, feedback, health and probity
- From October 2020 onwards, a wellbeing section has also been added
- A review of the personal development plan from the previous year, achievements and challenges, and the development of a new PDP to address the learning needs and career development of the doctor
- Declarations by the appraisee and the appraiser that the doctor continues to practice in line with the values and obligations set out in the GMC '*Good Medical Practice Framework'* (GMC, 2017)
- An appraisal summary which describes how the appraiser has evaluated the doctor against their professional roles, and what topics were discussed.

The trust submits quarterly information to NHS England about appraisal activity including whether the Responsible Officer has sufficient resources to undertake the role, and also submits an Annual Organisational Audit (ORSA).

Responsible Officer

In June 2021 Dr Paul Molyneux took over the role of interim Medical director and interim responsible officer for West Suffolk Hospital. Prior to this Dr Molyneux was the deputy RO and appraisal lead. He has undertaken responsible officer and case investigator training.

Medical Appraisal Lead

In June 2021 Dr Katherine Rowe took over the role as interim Appraisal lead and deputy RO. She has previously been the appraisal lead and deputy RO for Mid Essex Hospital 2016-2019. During this time, she had undertaken RO training and regularly attended lead appraiser meetings arranged by NHSE/I and the GMC.

AO report

	Appraisee Doctor Type	No. Prescribed Connections	Completed Appraisal (1a)	Completed Appraisal (1b)	Approved Incomplete or missed appraisal (2)	Unapproved Incomplete or missed appraisal (3)	Total
1	Consultant	241	34	38	105	64	241
2	Other doctors with a prescribed connection to this designated body	5	1	0	1	3	5
3	Staff grade, associate specialist, specialty doctor	33	3	5	16	9	33
4	Temporary or short-term contract holders	188	3	13	37	135	188
5	Uncategorised	8	0	0	0	8	8
	Total	475	41	56	159	219	475

Description of terms

1 a) The appraisal meeting occurred within the appraisal year, has taken place within 3 months preceding the appraisal due date and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting.

1 b) Completed appraisals that do not meet one or more of the above criteria.

2) Appraisal incomplete/missed but approved by RO; reason given 'Appraisal deferred – Covid-19'.

3) Appraisal incomplete/missed but not approved by RO

Summary

- 41 doctors (8.6%) met criteria for a 1a appraisal
- 56 (11.8%) met criteria for a 1b appraisal
- 159 (33.5%) doctors had an approved incomplete/missed appraisal
- 219 doctors (46%) of doctors had an unapproved, incomplete or missed their appraisal in the appraisal year
- The largest population within West Suffolk hospital who had missed their appraisal were temporary or short-term contract holders

- There remain 23 overdue appraisals from the appraisal year 2020/21 with a delay range of 4 – 287 days (average 145 days)
- There are 2 appraisals that are incomplete (taken place but not signed off) – overdue to 89 and 97 days respectively
- Further break down of category 3 unavailable for current report

While the summary figures for category 3 are higher than in previous years, this reflects the suspension of appraisal from March to October 2020 and phased re-introduction between October 2020 and March 2021.

It is anticipated that now that the appraisal process has been fully restarted the figures for completion will improve. The appointment of a new Lead Appraiser and Appraisal Administrator last month has necessarily created a challenge in the transition period and it will take time to review all appraisals identified on the Allocate system as incomplete to confirm whether or not this is correct.

This will take some time to work through; it is proposed to bring a further report to the Board with a detailed breakdown of these figures in three months' time.

Progress in 2020-2021

- Appraisal portfolio within Allocate established amongst clinicians and support staff at West Suffolk Hospital
- Wellbeing survey incorporated within allocate
- Patient feedback collated by appraisal team
- 2 new appraisers appointed

Development plans for appraisal year 2021- 2022

- Weekly review of overdue/missed or incomplete appraisals
- Appraisal quality review using standardised ASPAT appraisal template to allow feedback to individual appraisers
- Ensure appraisers receive feedback from the appraisee's
- Receive formalised feedback from the lead appraiser to ensure that individual appraisers meet the need of the appraisee's and is supportive of fulfilment of the RO's responsibilities
- Updated medical appraisal policy to support transparency of the non-engagement process, revalidation decision making and portfolio confidentiality
- Update revalidation decision making group to ensure greater diversity of members (in particular SAS doctors)
- Turning on of automated reminder mechanisms for appraisal via allocate
- Ensuring allied health professionals within West Suffolk Hospital are supported with the same opportunities for robust governance, appraisal and revalidation as doctors
- Increasing training for appraisal for appraisee's at West Suffolk Hospital – in particular to capture the short-term contract holders

References

1. General Medical Council (2020) Good Medical Practise. [Online]. Available here. [Accessed: 10th June, 2021].
2. NHS England (2017) Incidence Response Plan (national) Emergency Preparedness, Resilience and Response. [Online]. Available here. [Accessed: 10th June, 2021].

15. Quality and safety reports

To APPROVE the reports

Presented by Susan Wilkinson and Paul Molyneux

15.1. Maternity services quality & performance report

For Approval

Trust Open Board – 25th June 2021

Agenda item:	15.1			
Presented by:	Sue Wilkinson, Executive Chief Nurse/ Karen Newbury, Head of Midwifery			
Prepared by:	Karen Newbury – Head of Midwifery / Rebecca Gibson Head of Compliance & Effectiveness			
Date prepared:	June 2021			
Subject:	Maternity quality & safety performance report			
Purpose:	X	For information		For approval

Executive summary:

This report presents a 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:

- eCare go live
- Strategy update
- Maternity improvement plan
- Audit of Consultant led ward rounds (Annex A)
- Audit of women's involvement in Decision making during pregnancy (Annex B)
- Audit of Compliance with Reduced Fetal Movements Best Practice Guidance (Annex C)
- Audit of Risk Assessment for Pregnant women (Annex D)
- Audit of women with a BMI >35 (Annex E)
- Audit of women with Complex Pregnancies Having a Named Consultant, early referral and Management Plan in place. (Annex F)
- Annual report on Midwifery Workforce (Annex G)
- Safety champion feedback from walkabout/virtual session
- National Staff Satisfaction Survey Results
- Service user feedback
- External assurance and oversight
- National best practice publications and local HSIB reports
- Reporting and learning from incidents
- Maternity Clinical and Quality dashboard (Annex A) Data incomplete, please see below

eCare go live

Issues regarding data collection are on-going. The majority of issue due to workflow and user input. eCare team working closely with maternity and Information teams to change workflows, focus training and undertake data corrections/cleansing.

In the meantime, the information team are unable to provide the same level of reporting until all of these issues have been resolved. Business case required for digital support in maternity, job description for digital midwife written and awaiting evaluation.

Quality and Safety Framework / Strategy update

The Maternity Quality and Safety Framework includes all aspects of Clinical Governance and reflects the Trust's overarching policies and processes. It is now been approved by the directorate and awaiting date to present to the new Insight Committee for formal approval.

Maternity improvement plan including Ockenden

The maternity Improvement Board receives the updated Maternity improvement plan on a monthly basis. This has been created through an amalgamation of the original CQC improvement plan with the wider requirements of Ockenden, HSIB, external site visits and self-assessment against other national best practice (e.g. MBRRACE, Each Baby Counts, UKOSS).

Submission of Ockenden compliance supporting evidence due by the end of June 2021. The following reports will be submitted and a more detailed overview will be given at the closed board.

Audit of Consultant led ward rounds (Annex A)
The Trust has made significant progress towards safer care by introducing the twice daily ward rounds 7 days a week.

However, the recommendation of a day and night round is not completely fulfilled as the second ward round is not taking place during what would be considered to be 'night' time.

Currently due to a shortage of obstetric registrars, some of the consultant obstetricians are resident as the on-call registrar overnight during the week. It could be argued therefore that a consultant undertakes the ward round at 20.00 each weekday. However, the consultant on call who is not present at that time is not involved in the unilateral decisions that are being made about the women at that time.

Audit of Women's Involvement in Decision Making during Pregnancy and Respect for the Decisions they make (Annex B)
The audit results demonstrate that the staff within the maternity service at WSH involve women in decisions about their care and this is documented. It also demonstrates that when women make choices outside the guidance, the discussions are documented and a care plan is agreed with her respecting her wishes.

Audit of Compliance with Element 3 of Saving Babies Lives Care Bundle version 2 (SBLCBv2)-Reduced Fetal Movements Best Practice Guidance (Annex C)
This audit demonstrates that documentation of information on fetal movements in pregnancy by 28 weeks is still below that which we should expect. There is further work required to increase compliance for our women out of area, this is likely to be due to different documentation systems and capturing the data However we are exploring this with our community teams to clarify the position.

Once identified, women are having appropriate fetal monitoring using an electronic recording (Dawes Redman).

Audit of Risk Assessment for Pregnant Women at each Contact, place of birth and care pathway documented and Personalised Care Plan in place (Annex D)
The audit results demonstrate that improvements in documentation of risk assessments are required. During the audit period the maternity information system was changed and a space for a risk assessment at each contact is not currently in place. This is being addressed and will help to improve compliance in the future.

Although the care plans and discussions are not always documented fully in the correct areas of the records, there are examples of good documentation of care and care planning and discussions with women.

The risk assessment process for the birthing unit is robust and enables a safe level of care to be provided to mothers and babies.

Audit report – women with a BMI>35 at booking being offered serial growth scans in line with SBLCBv2 (Annex E)
Findings show that compliance with the referral for a higher risk pathway and serial scans is met to a high standard. Once referred, serial growth USS were undertaken as required 95% of the time.

Whilst this standard has dropped slightly from the last audit, compliance is still high. Further work is required to improve to 100% and will be captured in the maternity improvement plan

Audit of women with Complex Pregnancies Having a Named Consultant, early referral and Management Plan in place (Annex F)
The audit results demonstrate exceptional compliance with this area of care. Whilst the numbers of women are small, the specialist input is timely and there is evidence of MDT involvement. A Standard Operating Procedure (SOP) has been written to describe in detail the processes underpinning this aspect of care of women. Once the Maternal Medicine Centres are set up, the referral processes will be updated.

Annual report on Midwifery Workforce (Annex G)
The maternity service has taken steps to ensure the recommendations form the BR+ report have been analysed and actions have been taken to address the findings.

Covid-19 has impacted significantly on the midwifery service this year, making it difficult to develop systems, processes and new ways of working to improve care and there remains a need to embed the monitoring processes to ensure information on staffing levels, vacancies, acuity, safety and workload are recorded accurately and in a timely way.

The introduction of Continuity of Carer will change current practices significantly and further roll out has been suspended to ensure safe staffing levels have been maintained. Future monitoring will need to ensure new systems and processes are monitored robustly to ensure safe standards of care and safety are maintained

Safety Champion Walkabout feedback
The Board-level champion undertakes a monthly walkabout in the maternity and neonatal units. Staff have the opportunity to raise any safety issues with the Board level champion and if there are any immediate actions that are required, the Board level champion will address these with the relevant person at the time. Individuals or groups of staff can raise the issues with the Board champion.

the Safety Champion Walkabout took place on 26/05/2021. Issues raised by staff included implementation of eCare, staffing shortages on Neo-Natal Unit (NNU) due to sickness and on-going shielding, equipment on NNU, roof works on F11 and lack of office space in antenatal clinic. The equipment issue has now been resolved and staff are more assured regarding the roof work. The Safety Champion took the opportunity to ask staff if they were aware of what to do if a baby was abducted and all staff asked were able to explain the process.

Concerns raised from previous walkabouts are captured on the Safety Champion action plan until actions complete.

National Staff Satisfaction Survey Results
The National Staff Satisfaction Survey results were published in March 2021. On the back of the results, key elements of the survey were used to form a targeted questionnaire to band 5 & 6 midwives in April 2021. The division is keen to develop further action points by listening to staff in more detail and are looking for participants to join in departmental focus groups run by a manager from a different department, due to commence end June 2021.

Service User feedback via F&FT and maternity Facebook page
The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It's a quick and anonymous way to give views after receiving NHS care or treatment.
In May, the maternity service received 16 FFT returns. 100% of women would recommend our service.

External assurance and oversight
Following visits from the CCG in February and the CQC in April, the overarching Maternity

improvement plan is being updated to incorporate the findings of both. The draft CQC report has been received for factual accuracies and reflects the high-level findings and immediate actions shared at the time of the visit.

National best practice publications and local HSIB reports
MBRRACE-UK provides a national reporting framework for the surveillance and investigating the causes of maternal deaths, stillbirths and infant deaths. Since the last Maternity Board report, no new reports have been issued (reports can be found at https://www.npeu.ox.ac.uk/mbrrace-uk/reports)

HSIB have now issued a number of maternity national learning reports. These collate the learning from multiple investigations and require consideration of their content alongside those issued for WSFT specific cases. National reports are more likely to contain safety recommendations for national bodies (e.g. the CQC) but the impact of these national recommendations will be relevant locally. To date HSIB have issued 12 local reports for WSFT cases and the outcome of these have been presented locally in Maternity as well as within the Board quarterly quality & learning report. Maternity MBRRACE and HSIB action plans form part of the wider Maternity quality & safety improvement plan and will be monitored locally and via the new Improvement committee.

Reporting and learning from incidents
An external thematic review which will review all maternity's serious incidents including HSIB cases has now been agreed by NHSE to be for the last year and not the last two years. A panel have been commissioned and terms of reference have been agreed. The panel are now able to progress with the review. The timeframe for completion has provisionally been given as eight weeks.

The updated PSIRF framework required the agreement of a local patient safety incident response plan (PSIRP). This includes a Maternity section (within the main PSIRP) which sets out the reporting, investigation and external notification pathways for all incidents (not just those previously categorised as 'red' or 'an SI').

A sub-set of these are reported in the closed board 'PSIRF, 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 incidents reported to HSIB in May however there was one serious incident for local review which will be discussed in the closed board paper.

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 March due to changing from one IT system to another (eCare) the data is incomplete for this month. Until the new system is fully embedded it is anticipated there will be a delay in data reports.

The **Quality Dashboard** is also included. This gives 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. Longer term the plan is to move from RAG rating to a more SPC / 'plot the dots' style of reporting in line with the national NHSI model.

Indicators	Narrative
Grade 2 section decision to delivery time	Out of 22 grade II sections, 8 were delayed – 3 of these by 10 mins or less. 1 case admitted to Neonatal Unit, but this due to GA. All other cases no adverse outcomes. Ongoing QI project
Appraisal completion	This has been addressed and compliance reaches standard

Indicators	Narrative
Mandatory training	Escalated to line managers to support compliance
Fetal monitoring training	Previously annual compliance. Changed to monthly in Jan 2021. Previous annual cut off point mid-June therefore dip in compliance for May due to staff thinking they had till mid-June to complete.
Equipment checks	Addressed with ward mangers/team leads
Supernumerary status of Labour Suite co-ordinator	Awaiting final Band 7 to complete induction – started in May 2021
Documentation audits	Change IT system impacted compliance. Review underway and improvement seen.
Swab counts compliance	Substantial drop in compliance. Immediate action taken, email sent to all, Message of the week and matron/HOM spot checks in place and addressing with individuals.

The Birthing Unit has had a reduction of overall compliance this month, this is due to the staff being pulled to work on the labour suite and therefore no staff on the birthing unit to complete checks etc. pain scores for the birthing unit will predominantly be n/a as women are in labour, non-compliance due to labour status not being documented.

LMNS Perinatal Quality Oversight Highlight Report

A new highlight report has been introduced across the region to enable LMNS (Local Maternity & Neonatal Systems) to demonstrate individual Trust's positions on key elements of safety and quality. The highlight report will enable comparison across the LMNS and to share learning. Unfortunately, as the report is still undergoing monthly adaptations region are not in a position to publicly share the LMNS data.

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 April 2021 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. It should be noted that the Ockenden review and essential actions include a degree of overlap with the CNST scheme and therefore progress with one will aid the other.

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 – Audit of Consultant led ward rounds

Annex B - Audit of Women's Involvement in Decision Making during Pregnancy and Respect for the Decisions they make

Annex C – Audit of Compliance with Element 3 of SBLCBv2- Reduced Fetal Movements Best Practice Guidance

Annex D – Audit of Risk Assessment for Pregnant Women at each Contact, place of birth and care pathway documented and Personalised Care Plan in place

Annex E – Audit report – women with a BMI>35 at booking being offered serial growth scans in line with SBLCBv2

Annex F- Audit of women with Complex Pregnancies Having a Named Consultant, early referral and Management Plan in place.

Annex G Annual Report on Midwifery workforce

Annex H –Quality Dashboard only due to delay in provision of data

West Suffolk NHSFT			
Maternity QUALITY TOPIC	2021		
STAFF SUPPORT & DEVELOPMENT			
Appraisal completion	Standard	April	May
Midwives Hospital % in date	90%	96%	91%
Midwives Community & ANC % in date	90%	99%	97%
Support Staff Hospital % in date	90%	90%	88%
Support Staff Community & ANC % in date	90%	89%	94%
Medical Staff (Consultant) % in date	90%	82%	80%
Mandatory Training Overview	Standard	April	May
Midwives: % compliance for all training	90%	97.7%	98.7%
Midwives: % compliance with PROMPT training	90%	100.0%	100.0%
Midwives: % compliance with GAP training	90%	86.0%	78.0%
Midwives: % compliance with Safeguarding Children training	90%	99.0%	100.0%
Midwives: % compliance with Fetal Monitoring training	90%	86.3%	56.3%
ANC Midwives: % compliance with Fetal Monitoring training	90%	100.0%	85.7%
MCA: % compliance for all training	90%	93.0%	93.1%
MCA: % compliance with PROMPT training	90%	89.5%	90.0%
MCA: % compliance with Safeguarding Children training	90%	100.0%	100.0%
Obstetric Medical Staff: compliance with PROMPT training	90%	90.6%	90.3%
Obstetric medical staff: % compliance with GAP training	90%	83.0%	80.0%
Obstetric Medical Staff: compliance with Safeguarding Children training	90%	90.0%	92.0%
Obstetric Medical Staff: % compliance with Fetal Monitoring training	90%	82.6%	91.7%
Anaesthetic compliance with PROMPT training	90%	57.9%	70.0%
Theatre staff compliance with PROMPT training	90%	87.5%	88.4%
Sonographer: % compliance with GAP training	90%	86.0%	94.0%
EQUIPMENT SAFETY			
Checking of Emergency Equipment	Standard	April	May
Labour Suite: Adult Trolley	100%	93%	100%
Labour Suite: Resuscitaires		97%	96%
Ward F11: Adult Trolley		97%	94%
Ward F11: Resuscitaire		97%	100%
MLBU: Resuscitaires	100%	100%	90%
Community: Emergency Bags		94%	97%
Checking of Fridge Temperatures	Standard	April	May
Labour Suite	100%	97%	100%
Ward F11		90%	100%
MLBU		100%	90%
ANC		85%	100%
Ambient Room Temperature (where medication is stored)	Standard	April	May

Labour Suite	100%	97%	100%
Ward F11		90%	100%
MLBU		100%	90%
ANC		85%	100%
Checking of CD's	Standard	April	May
Labour Suite	100%	100%	97%
Ward F11		100%	100%
MLBU		100%	90%

MONTHLY QUALITY & SAFETY AUDITS:

	Standard	April	May
Supernumerary Status of LS Coordinator	100%	93%	96%
1-1 Care in Labour	100%		
MW: Birth Ratio	1:28		
No. Red Flags reported		5	1
DOCUMENTATION & CARE AUDITS	Standard	April	May
Compliance with MEOWS completion	100%	97.40%	97.60%
Compliance with NEWTT completion	100%	95%	93%
Carbon Monoxide Monitoring			
Smoking at booking recorded	95%	100%	95%
Smoking at 36 weeks recorded	95%	80%	85%
Compliance with DV questions			
Antenatal period	100%	100%	100%
Postnatal period	100%	73%	70%
Swab Count Compliance			
Birth	100%	91%	60%
Suturing	100%	96%	53%
Compliance with completing WHO checklist @ CS	95%	94%	94%
Recording of Pain Score			
Labour Suite	100%	98%	100%
Triage		82%	96%
MLBU		100%	82%
Ward F11		99%	100%
MDAU		72%	

Completed Drug chart information: weight and allergies	100%	100%	100%
Fresh Eyes			
Labour Suite	100%	63%	50%
Fresh Ears			
MLBU	100%	100%	100%
Epidural response <30 min	90%	awaiting data	
Breast Feeding			
Total women delivered who breastfed their babies within the first 48 hrs	80%		
Unicef baby friendly audits	10, 8, 6	N/A	N/A
LSCS decision to delivery time met			
Grade I LSCS	95%	100.0%	100.0%
Grade 2 LSCS	80%	74.0%	64.0%
New for January 2021			
Neonatal Outcomes			
Mag Sulfate for preterm infants		3 of 5	
Pre-term infants birth in right place			
Continuity of Care Outcomes			
Women Booked onto the continuity pathway	Number		
Women who received CoC inc delivery of care (Of all WSH women)	Number		
	>31%		
Governance			
Oututstanding Datix (last day of the month)		2	2
Out of date guidelines		2	2
Number of serious incidents		1	0
Weekly hours of dedicated consultant cover on LS	>60	Discontinued	Discontinued

GREEN	= Standard or above	AMBER	≥5% below standard	RED	> 5% below standard

West Suffolk NHS
NHS Foundation Trust

Consultant Ward Rounds - High risk women admitted to Labour Suite

Woman and Children Health Division

Gill Walsh
Senior Midwifery Matron for Inpatient services

Project Team

Name: Gill Walsh	Title/grade: Senior Midwifery Matron for inpatient services

24.05.2021

Report status – Approved

Background/Rationale

This audit is being undertaken following the introduction of Consultant ward rounds on our Labour Suite at West Suffolk Hospital. A service improvement (SI) was implemented following 2 HSIB investigations reports which commented on the absence of senior obstetric review. Following these recommendations, the Ockenden Report (2020) was released in December 2020 and clearly corroborated the perspective that senior obstetric ward rounds are an important aspect of a strong safety culture within a maternity service.

Aim

To confirm adherence to the newly implemented standards of twice daily ward round by the consultant on call, to ensure women receive regular senior review of their care plans. Furthermore, to ascertain if the SIP communicated by a Senior Obstetrician for the same standard has been embedded.

Objectives

To ensure adherence to newly implemented standard of twice daily ward rounds as per MAT0064 Handover of Care

Standards

Adherence to MAT 0082 Handover of Care twice daily ward rounds by the On-Call Consultant Obstetrician.
http://staff.wsha.local/Intranet/MaternityGuidelines/docs/MAT-0082---Handover-of-Care-Dec2020.pdf

Service improvement initiative by senior consultant following a learning investigation by the HSIB and further learning from a serious incident on the labour suite highlighting the need for senior face to face. SIP standards outlined in email by KC.

No.	Standard	Target %	Exceptions	Definitions
1.	Consultant led face to face ward round twice daily 7 days a week of all high-risk women on Labour Suite	100%	Women undergoing elective LSCS who will be seen on admission by the surgeon Women who are admitted to, and deliver on the MLBU. Postnatal women not requiring review.	

Methodology

This is audit is being undertaken by the author of this document in her role as the Senior Midwifery Matron for Inpatient services. The findings of the audit will inform as to the success or the challenges of this service improvement and to offer assurance to the HSIB and CCG that actions arising from external investigations have been suitably addressed and also as evidence to support our implementation of the actions from the Ockenden report.

This audit was a simple snap shot retrospective review of all women who were admitted to Labour suite between 01/04/21 and the 14/04/21. Data was retrieved from the patient's hospital maternity records via eCare for admissions between 1st and the 14th April. The data was collected and analysed, and the report compiled by the author of this document.

Results

No.	Standard	Target %	Findings		Comments
			n	%	
1.	Consultant led face to face ward rounds twice daily for all high-risk inpatients on Labour Suite	100%	43/45	96%	43 women received the consultant ward round appropriately 2 women did not have a review when indicated. 7 women excluded due to not meeting the criteria for ward rounds (MLBU, elective LSCS and uncomplicated postnatal not requiring review)

Conclusions

- 52 sets of notes were audited, 7 excluded.
- 43 women who were present on labour suite during the ward rounds received all reviews as set out in MAT 0082. All women had written documentation by the consultant or scribed by the registrar to support this.
- 1 woman received a face to face review in the morning of admission, did not have a review in the evening- no reason was documented.
- 1 woman received a face to face review in the morning of admission but did not have a review in the evening. The reason documented was high acuity. As this woman was admitted to F11 for a prolonged period a management plan was made by the consultant during the day shift on F11.
- 17 women were on Labour suite for both the morning and the evening ward rounds and received comprehensive reviews.
- 26 women were present for one ward round and were either transferred to F11 or discharged home prior to the second ward round therefore not required.
- The majority of reviews showed very good examples of robust well documented reviews by consultants outlining care plans.

- The morning face to face consultant labour ward round appears to be well embedded, there was good evidence of compliance (100%).

- 2 women who required an evening consultant review did not receive one. Two of these women were high risk and whose care was complicating, neither had a poor outcome.

Recommendations

- Significant improvements seen in this audit from the previous which shows twice daily ward rounds are well embedded within the maternity service. This has expanded now that consultant job plans have been reviewed so that at the weekend women are also reviewed twice daily by a consultant.

- Consideration should be given to consultant led ward rounds on the antenatal/postnatal ward. This would capture those inpatients whose labour commences following the evening ward round and birth prior

- Continue to audit to gain a greater understanding and assurance.

- An obstetric review template is now used on eCare which captures who is present on ward rounds to provide assurance that they are MDT. However, there was evidence this was not always used.

Learning Points

- Real time audit would provide richer data to ensure the quality of the handover.

References

Ockenden d, 2020, Maternity Services at the Shrewsbury and Telford Hospital NHS Trust

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/943011/Independent_review_of_maternity_services_at_Shrewsbury_and_Telford_Hospital_NHS_Trust.pdf [Accessed 04.01.2021]

Action Plan

Project title	Consultant Ward Rounds - High risk women admitted to Labour Suite

Action plan lead	Name: Gill Walsh	Title: Senior Midwifery Matron-Inpatient Services	Contact:gillian.walsh@wsh.nhs.uk

Ensure that the recommendations detailed in the action plan mirror those recorded in the "Recommendations" section of the report. The "Actions required" should specifically state what needs to be done to achieve the recommendation. All updates to the action plan should be included in the "Comments" section.

Recommendation	**Actions required** *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Comments/action status** *(Provide examples of action in progress, changes in practices, problems encountered in facilitating change, reasons why recommendation has not been actioned etc)*
Reminder to obstetric teams about using the eCare MDT ward round handover template.	Email	Immediate	G Walsh (GW) / K Croissant (KC)	
Ensure MDT aware of 7 day a week ward round requirements.	Email	Immediate	GW	
Reconsider how women on the antenatal and postnatal ward will be reviewed	Discussion and proposal written	31/7/21	KC	
Review timing of evening ward rounds to encompass evening/night time	Discussion and proposal written	31/7/21	KC/R Ayyamuthu (RA)	
Re-audit to monitor consistent compliance	Re-audit	31/7/21	GW/KC	

Review date	Date of Admission	Admitted from;	Time of admission to LS	Time of delivery	Reviews - comment
01/04/21	31/03/21	Home	19:49	N/A	Postnatal readmission- 3x daily reviews for duration of admission
01/04/21	01/04/21	F11	16:15	16:04 (02/04/21)	Comprehensive ward round

02/04/21	31/03/21	Home	19:49	N/A	Comprehensive ward round x2 (am/pm)
02/04/21	01/04/21	F11	16:15	16:04 (02/04/21)	Comprehensive ward round x2 (am/pm)
03/04/21	03/04/21	Home	04:38	10:25	Comprehensive ward round x1 (am only as on ward pm)
03/04/21	03/04/21	F11	12:06	17:54	Comprehensive ward round (pm only)
03/04/21	03/04/21	F11	23:33	11:01 (04/04/21)	Comprehensive ward round (am and pm)
03/04/21	03/04/21	Home	02:47	N/A	Triage only-excluded
04/04/21	04/04/21	F11	18:09	21:26	Rapid delivery- no review required
04/04/21	04/04/21	F11	19:25	03:36 (06/04/21)	Twice daily comprehensive ward rounds while in labour (and additional reviews as required)
04/04/21	04/04/21	Home	10:00	13:44	Comprehensive review am only as then on ward
05/04/21	04/04/21	F11	19:25 (04/04/21)	03:36 (06/04/21)	Twice daily comprehensive ward rounds while in labour (and additional reviews as required)
05/04/21	04/04/21	F11	23:45 (04/04/21)	10:05 (05/04/21)	Comprehensive ward round (pm and am)
05/04/21	05/04/21	F11	16:40	21:59	Pm ward round completed
05/04/21	05/04/21	F11	17:19	17:34	Rapid delivery- PN for early discharge- no review required
06/04/21	06/04/21	Home	01:57	09:20	Comprehensive ward round (am)
06/04/21	06/04/21	F11	08:22	00:54 (07/04/21)	No am ward round completed, only pm done. Transferred after morning ward round.
06/04/21	06/04/21	Home	04:39	10:03 (07/04/21)	Comprehensive ward round (am and pm x2)
06/04/21	06/04/21	F11	17.14	02.15 (07/04/21)	Comprehensive ward round (pm x2)
06/04/21	06/04/21	Home	13:49	22:34	Comprehensive ward round (pm)
06/04/21	06/04/21	F11	20:47	07:18 (07/04/21)	Comprehensive ward round (pm)
07/04/21	06/04/21	F11	08:22	00:54 (07/04/21)	PPH- appropriate ward round review (am)-transferred to F11 pm
07/04/21	06/04/21	Home	04:39	10:03 (07/04/21)	Reviewed on am ward round, to ward F11 pm
07/04/21	06/04/21	F11	20:47	07:18 (07/04/21)	Delivered without complication therefore no review required

07/04/21	07/04/21	Home			Elective c/s-not included
07/04/21	07/04/21	F11	16:50	23:44	Comprehensive ward round (pm)
07/04/21	07/04/21	F11	11:31	21:25	Comprehensive ward round (pm) x3
08/04/21	08/04/21	F11	05:40	15:05	Comprehensive ward round (am)
08/04/21	08/04/21	F11	02:35	19:17	Comprehensive ward round (am and pm)
08/04/21	08/04/21	Home	15:40	17:59	Comprehensive ward round (pm)
09/04/21	09/04/21	F11	05:54	06:21	Postnatal review on am round as rapid delivery
09/04/21	09/04/21	Home	03:15	19:25	Comprehensive ward round (am and pm)
09/04/21	09/04/21	F11	14:39	02:27 (10/04/21)	Comprehensive ward round (pm)
09/04/21	09/04/21	F11	14:14	12:24 (10/04/21)	Comprehensive ward round (am and pm)
09/04/21	09/04/21	F11	20:35	N/A-AN admission	Comprehensive ward round (am and pm)
10/04/21	10/04/21	F11	04:58	23:16	Comprehensive ward round (am and pm)
10/04/21	10/04/21	Home	07:45	10:47	Comprehensive ward round (am)
10/04/21	10/04/21	F11	07:57	00:35 (11/04/21)	No pm ward round completed, only am done. No reason documented.
10/04/21	10/04/21	F11	20:49	09:52 (11/04/21)	Comprehensive ward round (am and pm)
11/04/21	11/04/21	F11	06:46	22:57	Comprehensive ward round (am and pm)
11/04/21	10/04/21	F11	20:49 (10/04/21)	09:52	As above, postnatal- no r/v required
11/04/21	11/04/21	F11	13:51	12:52 (12/04/21)	Comprehensive ward round (am and pm)
12/04/21	12/04/21	Home	14:31	N/A	Admission to LS to commence IOL for partner to be present-WR not indicated
13/04/21	13/04/21	Home	02:19	13:26	Comprehensive ward round (am)

13/04/21	13/04/21	MLBU	02:30	11:53	Comprehensive ward round (am)
13/04/21	13/04/21	Home	08:35	N/A-AN admission	Comprehensive ward round (am)
13/04/21	13/04/21	Home	20:19	20:47	Rapid delivery- review post-delivery for retained placenta
13/04/21	13/04/21	F11	20:23	10:26 (14/04/21)	No pm ward round completed, only am done. Documented that acuity high and plan made on WR on F11.
14/04/21	13/04/21	F11	01:45	N/A-AN admission	Comprehensive ward round (am)
14/04/21	13/04/21	F11	20:23 (13/04/21)	10:26 (14/04/21)	Postnatal- no review required
14/04/21	14/04/21	F11	20:12	12:19 (15/04/21)	Comprehensive ward round (am and pm)
14/04/21	14/04/21	F11	20:37	05:47 (15/04/21)	Comprehensive ward round (pm)

West Suffolk NHS
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Audit of Women's Involvement in Decision Making During Pregnancy and Respect for the Decisions they make

June 2021

Women and Children's Health
Report author: Beverley Gordon, Project Midwife

Report status – Approved

Background/Rationale

The aim of this audit focuses on the women being involved in all the decisions made about their care options and management plans and when they chose a pathway for care that is outside the guidance, that their wishes are respected and an acceptable plan is made with their agreement.
In December 2020, The Ockenden report of Maternity Services at the Shrewsbury and Telford NHS Trust was published. A number of Immediate and Essential recommendations were made and actions required to implement safety mechanisms.
The evidence required to ensure that these recommendations have been implemented within maternity units is needed to assure women, their families and NHS England that each Trust has addressed any safety issues and provide.
The specific questions that this audit answer are:

Q41 Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care

Q42 Women's choices following a shared and informed decision-making process must be respected

Aim

The audit aims to determine if women are involved in decision making and if they chose a care pathway which is outside the local and national best practice guidance, it is clear that their wishes have been respected and a documented plan of care is agreed with them.

Evidence of improvements will be shared with the Maternity Safety Champions, Trust board and the Local Maternity and Neonatal Services (LMNS) demonstrating continuous improvements in the process and outcome measures.

Objectives

To review the records of women to ascertain their involvement in decisions about their care.

Standard

The standard and compliance for this audit is set as a local target of ≥ 75% for documentation that women are involved in decision making and that their choices are respected.
The guidance for risk assessment in pregnancy, information being given to women to enable them to make an informed choice and other specific guidelines relating to maternal, fetal and neonatal factors are used in order to provide women with the best evidence to support them. Women who request care outside of guidance are referred for discussion at the weekly MDT forum.

No.	Standard	Target %
1.	Evidence of women being involved in decision making	≥75%
2.	Evidence that women's choices following a shared and informed decision-making process are respected	≥75%

Methodology

The records of 67 women who had given birth from January 2021 were reviewed and information obtained to establish if there is evidence that they were involved in decisions about their care.
Out of these 67 women, it was identified that 15 women requested care outside the local and national guidance and the outcomes for these women was reviewed in detail.

Results

No.	Standard	Target %	Findings		Comments
			n	%	
1.	Involvement in decision making	≥75%	63	94%	
2.	Requested Care outside of guidance – evidence that wishes respected and management plan agreed with the woman	≥75%	15	100%	

Discussion

During the audit period, it is clear that there is a very high standard of documented evidence that women are involved in decision making. Also, when women request care outside guidance there is evidence that there has been a discussion on the risks and benefits of the requested care. In some cases, this has resulted in a compromise being reached or the woman changing her mind. In other situations, some women have chosen to continue with their choice of care pathway. One woman transferred her care to another unit, one woman gave birth unattended but the outcome was good, and 2 women had post-delivery complications which required urgent admission. Other than these 2 women who needed additional treatment and in-hospital stay, there were no other complications or adverse outcomes recorded.

Conclusion

The audit results demonstrate that the staff within the maternity service at WSH involve women in decisions about their care and this is documented. It also demonstrates that when women make choices outside the guidance, the discussions are documented and a care plan is agreed with her respecting her wishes.

Recommendations

The results of the audit should be shared with the maternity and neonatal teams and discuss the individual cases as to whether there are any other improvements to be made and how these high standards are maintained.

This audit should be repeated and form part of the annual audit plan.

References

Mothers and Babies Reducing Risk through Audits and Confidential Enquiries across the UK – MBRRACE UK – Perinatal surveillance and Confidential Enquiries

National Maternity Review: BETTER BIRTHS Improving outcomes of maternity services in England A Five Year Forward View for maternity care NHS England 2016

Ockenden Report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford NHS Trust (December 2020)

Action Plan

Project title	Pregnant women involved in decision making and wishes respected

Action plan lead	Name: Karen Green	Title: Clinical Quality and Governance Matron	Contact:3275

Recommendation	Actions required	Action by date	Person responsible	Comments/action status
Share results of this audit	Presentation of the audit at the Clinical Audit and Education meeting	September 2021	Jane Lovedale	
	Include in Risky Business	September 2021	Sarah Paxman	
	Maternity and Gynaecology Quality and Safety Group Maternity Safety Champions meeting HOM Board report LMNS Board agenda	September 2021	Karen Newbury	
Re audit annually	Undertake repeat audit on an annual basis	May 2022	Jane Lovedale	Add to audit plan

Audit of Compliance with Element 3 Reduced Fetal Movements Best Practice Guidance

June 2021

Audit completed by: Karen Green, Clinical Quality and Governance Matron

Background/Rationale

This audit is to assess against the Saving Babies Lives Care Bundle (SBLCB v2 March 2019) Element 3: Raising awareness amongst pregnant women of the importance of reporting reduced fetal movements (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM.

Aim

To ensure that women are offered information on monitoring fetal movements in pregnancy by 28 weeks and know who to contact if they have concerns.

Objectives

To ascertain that women are receiving the information they need to be able to identify and report RFM in accordance with SBLCBv2:

3.1 Information from practitioners, accompanied by an advice leaflet (for example, RCOG or Tommy's leaflet) on RFM, based on current evidence, best practice and clinical guidelines, to be provided to all pregnant women by 28+0 weeks of pregnancy and RFM discussed at every subsequent contact.

3.2 Use provided checklist to manage care of pregnant women who report RFM, in line with national evidence-based guidance (for example, RCOG Green-Top Guideline 5737).

Standards

No.	Standard	Target %	Exceptions	Definitions
1.	Percentage of women booked for antenatal care who had received leaflet/information by 28+0 weeks of pregnancy.	A threshold score of **80%** compliance should be used to confirm successful implementation. If the process indicator scores are less than **95%** Trusts must also have an action plan for achieving >95%.	Women decline information	Information will usually be in written information in a language that women can understand. Information will be available on websites and information boards and other media forums.
2.	Percentage of women who attend with RFM who have a computerised CTG.	A threshold score of **80%** compliance should be used to confirm		

		successful implementation. If the process indicator scores are less than **95%** Trusts must also have an action plan for achieving >95%.		

Methodology

Audit of 20 consecutive women who attended MDAU with reduced fetal movements from 1/2/21 until 8/2/21 when 20 cases reached.

Results

No.	Standard	Target %	Findings		Comments
			n	%	
1.	Women receiving the reduced fetal movement leaflet by 28/40 75% - Compliance not reached	1. >80% 2. >95%	15/20	75%	Theme OOA non-compliance - Action = improve cross border working and communicate expectations
2.	Women attending MDAU and receiving a Dawes Redman CTG	1. >80% 2. >95%	20/20	100%	

Presentation/Discussion

The results will be presented to the Maternity and Gynaecology Quality and Safety Group for information and monitoring. The Maternity Safety Champions will review this as part of the overall compliance with the 5 elements of Saving Babies Lives Care Bundle v2 and reporting to the Trust Board via the Head of Midwifery's and MSC monthly reports on Maternity Risk and Governance, Quality and Safety. This will also be part of the submission of the SBL survey

reports to the Regional Maternity Clinical Network Quality Improvement Manager and as part of the highlight report to the Local Maternity and Neonatal Services (LMNS) Board. They will also be shared with neighbouring Trusts where non-compliance has been identified in order to improve practice and documentation.

Conclusions

This audit demonstrates that documentation of information on fetal movements in pregnancy by 28 weeks is still below that which we should expect. There is further work required to increase compliance for our women out of area, this is likely to be due to different documentation systems and capturing the data, however we are exploring this with our community teams to clarity to position.
Once identified, women are having appropriate fetal monitoring using an electronic recording (Dawes Redman).

Learning Points

Different practices and information systems in other Trusts may lead to poor compliance with standards either by documentation errors or practice issues. It is important that these are discussed at LMNS Board meetings and at Regional Perinatal Quality Forums.

Recommendations

As compliance falls below an acceptable standard, the audit of information sharing will need to be repeated after the team leaders for these areas have been requested to update the local matron for community services on any barriers to compliance. This audit should be part of the annual audit plan to ensure that compliance is maintained at a high level, along with other elements of SBLCB v2.

References

Maternity incentive scheme – year three: Conditions of the scheme: Ten maternity safety actions with technical guidance **Revised safety actions - updated March 2021**

Mothers and Babies Reducing Risk through Audits and Confidential Enquiries across the UK – MBRRACE UK – Perinatal surveillance and Confidential Enquiries

Ockenden Report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford NHS Trust (December 2020)

Royal College of Obstetricians and Gynaecologists (2013). RCOG Green-Top Guideline 31: The Investigation and Management of the Small for Gestational Age Fetus. London: RCOG. Available from: https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg31/

Royal College of Obstetricians and Gynaecologists (2011) RCOG Green-Top Guideline 57: Reduced Fetal Movement. London: RCOG. Available from: https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg57/

Saving Babies' Lives Version Two A care bundle for reducing perinatal mortality March 2019

Woman and Children Health Division

West Suffolk NHS
NHS Foundation Trust

Action Plan

Project title	Audit of Information given to women regarding fetal movements by 28 weeks and compliance with electronic CTG for RFM

Action plan lead	Name: Karen Bassingthwaighte	Title: Antenatal and Community Senior Matron	

Recommendation	Actions required	Action by date	Person responsible	Comments/action status
Discussion with neighbouring Trusts regarding documentation and information sharing	Discuss team to team leaders and at LMNS and Safety Forums	31/7/21	Antenatal and Community Senior Matron	
Quarterly audits until compliance is raised to >95% then annual audits	Add to audit plan and re-audit	30/9/21	Clinical Quality and Effectiveness Midwife	Part of audit plan
To establish a robust process and a fail-safe to ensure all women receive access to the RFM leaflet by 28 weeks.	The Hub will include RFM leaflet link when sending out initial information to women following booking	30/09/21	Antenatal and Community Senior Matron	

West Suffolk NHS
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Item 15.1 Annex D

Audit of Risk Assessment for Pregnant Women at each Contact, place of birth and care pathway documented and Personalised Care Plan in Place

June 2021

Report written by Beverley Gordon, Project Midwife
Women and Children's Health

Report status – approved

Background/Rationale

The aim of this audit focuses on determining whether there is a documented risk assessment at each antenatal contact and ensure that the place of birth and any developing conditions or complications taken into consideration when making and recording a personalised care and support plan.
In December 2020, The Ockenden report of Maternity Services at the Shrewsbury and Telford NHS Trust was published. A number of Immediate and Essential recommendations were made and actions required to implement safety mechanisms.
The evidence required to ensure that these recommendations have been implemented within maternity units is needed to assure women, their families and NHS England that each Trust has addressed any safety issues and provide.

The three key questions to be answered within this audit are:

Q30 All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional

Q31 Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

Q33 A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.

Aim

The audit aims to determine if women are being risk assessed for complications of pregnancy at each contact and where required, a change to place of birth or lead professional is considered and documented. Where there are discussions around place of birth and lead professional, this should be formalised into a personalised care and support plan.

Evidence of improvements will be shared with the Maternity Safety Champions, Trust board and the Local Maternity and Neonatal Services (LMNS) demonstrating continuous improvements in the process and outcome measures.

Objectives

To review the documentation of risk assessments during pregnancy and the resulting personalised care plans put in place to meet the needs of the woman and her baby.

Standard

The standard and compliance for this audit has been set locally and a target of ≥75% compliance has been set as an initial standard. Once this has been consistently achieved, the target for compliance will be raised further.

Place of Birth risk assessment

There is a review of the woman and baby's wellbeing at each antenatal assessment which may result in a change of lead professional and/or place of birth. However, the women's place of birth preference is discussed formally at 34-36 weeks in pregnancy by community or antenatal clinic midwives. This referral provides the opportunity to robustly risk assess the women's medical and obstetric risk factors (or the absence of them). West Suffolk Hospital

does not have a central triage for labour assessment, women are triaged either on Labour Suite or the co-located MLBU. While telephone triage can be useful in risk assessing women, the 34-36-week referral ensures that there is a robust risk assessment of pre-existing and new onset risk factors and so women who are declined have time to prepare for a birth experience in a different environment. Referrals were generated by community Midwives and ANC midwives for place of birth. The Midwife Led Birthing Unit (MLBU) ward manager maintains a database to assess outcomes for women's place of birth who were assessed as suitable for MLBU at 34-36 weeks.

A local Standard Operating Procedure (SOP) outlining these standards has been developed for risk assessment at each contact and future audits will be based on the standards within the SOP.

No.	Standard	Target %
1.	Risk assessment recorded at each contact	≥75%
2.	Risk assessment includes ongoing review of the intended place of birth, based on the developing clinical picture and the woman's wishes	≥75%
3.	Personalised care and support plan in place	≥75%

Methodology

The requirement was to audit the records of at least 1% of women who had given birth since January 2021 to establish that the risk assessment process is embedded at each contact, there is evidence that this review includes place of birth, and that an audit of 5% of women demonstrates that there is a personalised care and support plan recorded.
67 women's records were audited. This represents around 7% of the births since 1/1/21.

In addition, records of 30 women referred to the MLBU for intrapartum care in March, consecutively by EDD were reviewed for evidence of the formal 34-36-week risk assessment

Results

No.	Standard	Target %	Findings		Comments
			n	%	
1.	Risk assessment at each contact	≥75%	21	31.3%	
2.	Place of birth and lead professional discussed and changes to plan of care	≥75%	26	39%	25% were considered not applicable
2a	34-36-week risk assessment for place of birth MLBU	≥75%	30	100%	Evidence of risk assessment and referral if declined antenatally or transferred in labour if there were complications.
3.	Personalised care plan in place	≥75%	50	74.5%	This included evidence of birth plans and discussions that were documented in the narrative in the records as well as in the formal PCSP section of the records.

Results broken down for each element

1. ANTENATAL RISK ASSESSMENT AT EACH CONTACT		
Compliance	**Number**	**Percentage**
< 25%	**8**	**11.9%**
≥ 25%	**15**	**22.3%**
≥ 50%	**23**	**34.3%**
≥ 75%	**21**	**31.3%**

2. Place of Birth risk assessed and documented		
Yes	**No**	**N/A**
26 (39%)	24 (36%)	17 (25%)

2a. Place of Birth risk assessed for MLBU – 30 women				
Yes	**Declined for MLBU at 34-36 wks.**	**Referred for CLC prior to labour**	**Transferred in Labour**	**Birth on MLBU**
30 (100%)	3 (10%)	13(43%)	5(17%)	9 (30%)

3. PCSP documented	
Yes	**No**
50 (74.5%)	17(25.5%)

Discussion

The results of the risk assessment being formally documented at each antenatal contact is disappointingly low at this stage. This does not demonstrate embedding of the process for risk assessment. However, there is evidence that when there is a changing clinical situation, the staff recognise this and refer the women accordingly.

The compliance for recording place of birth as part of the risk assessment at each contact is not embedded but it is clearly documented where there is a need for a change of place of birth due to a changing clinical situation.

The risk assessment of women requesting birth on MLBU is robust and some women are excluded as complications develop during the pregnancy and on admission and some women are transferred in labour. The most common reason for transfer prior to labour is when induction of labour is required. This ensures that women are not giving birth in a low risk area when they have a need for a higher level of care and monitoring.

The documentation of a personalised care and support plan is just below the 75% standard. For the purposes of the results, where it is clear that a personalised plan has been made, even if it is not recorded in the formal area of the records, this has been recorded s compliant.

Conclusion

The audit results demonstrate that improvements in documentation of risk assessments are required. During the audit period the maternity information system was changed and a space for a risk assessment at each contact was not available. This is being addressed and will help to improve compliance in the future.

Although the care plans and discussions are not always documented fully in the correct areas of the records, there are examples of good documentation of care and care planning and discussions with women

The risk assessment process for the birthing unit is robust and enables a safe level of care to be provided to mothers and babies.

Recommendations

The results of the audit should be shared with the maternity teams to discuss and identify where improvements should and can be made.

Once the maternity information system has been updated, this audit should be repeated.

The SOP for risk assessment and the risk assessment process it describes should be embedded in practice.

References

Mothers and Babies Reducing Risk through Audits and Confidential Enquiries across the UK – MBRRACE UK – Perinatal surveillance and Confidential Enquiries

National Maternity Review: BETTER BIRTHS Improving outcomes of maternity services in England A Five Year Forward View for maternity care NHS England 2016

Ockenden Report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford NHS Trust (December 2020)

Action Plan

Project title	Pregnant women having a risk assessment at every contact, risk assessment and documentation regarding place of birth and personalised care plan in place

Action plan lead	Name: Karen Green	Title: Clinical Quality and Governance Matron	Contact:3275

Recommendation	Actions required	Action by date	Person responsible	Comments/action status
Update MIS system	Ecare to be updated to allow for risk assessment at each contact	30/9/21	IT/Ecare	
Share results of this audit	Presentation of the audit at the Clinical Audit and Education meeting	30/9/21	Jane Lovedale	
	Disseminate and embed the risk assessment SOP in practice	30/9/21	Karen Bassingthwaighte	
	Include in Risky Business	30/9/21	Sarah Paxman	
	Maternity and Gynaecology Quality and Safety Group Maternity Safety Champions meeting HOM Board report LMNS Board agenda	30/9/21	Karen Newbury	
Re audit in 6 months	Undertake repeat audit in 6 months on a minimum of 50 cases and if results are	May 2022	Jane Lovedale	Add to audit plan

	satisfactory, move to annual audit			

West Suffolk NHS
NHS Foundation Trust

Audit report - Women with a BMI >35 at booking being offered serial growth scans in line with Saving Babies Lives Version 2

Women and Children's Health
Maternity Services

Project Team

Name Karen Green……..	Role…Clinical Quality and Governance Matron

Date May 2021

Background/Rationale

Saving Babies Lives Care Bundle Version 2 (SBLCB v2) has been produced to build on the achievements on version 1. While version 2 of this document continues to focus on the risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction, it does so by focusing more attention on pregnancies at higher risk of fetal growth restriction (FGR).

This audit focuses on the surveillance for FGR in women with a BMI >35. Obesity is arguably the biggest challenge facing maternity services today. It is a challenge due to almost one in five of pregnant women being in this category. Surveillance for FGR for women with a BMI <35 is undertaken by midwives through fundal height measurement. This method is not suitable for women whose BMI exceeds 34.9. Serial US are required at 32, 36, and 39 weeks gestation to ensure that the fetal growth remains within normal limits.

Aim

To seek assurance that we have appropriate local guidance that supports the recommendations in SBLCB v2, and that the appropriate FGR surveillance is offered to women with a BMI >35. For further assurance scheduling and attendance of these serial USS was audited to ensure that the referral and communication processes were effective

Standards

The audit standards are included within the Maternity Clinical Guidelines:

MAT0005 'Prevention, detection and management of small for gestational babies '
MAT0014 'Care of Women with Obesity in Pregnancy'

No.	Standard	Target %	Exceptions	Definitions
1.	Women with a BMI of >35 will be referred for a higher risk pathway and serial growth ultrasound scans will be organised from 32 weeks.	>80% for embedding of guidance >95% for satisfactory standard	Woman who decline or scans not available	
2.	Serial growth scans were scheduled and attended by this cohort of women from 32 weeks	>80% for embedding of guidance >95% for compliance	None unless woman did not attend for individual reasons	

Methodology

40 women with a BMI >35 at booking, were identified though the maternity system. Records were reviewed for referral and scans undertaken.

Results

No.	Standard	Target %	Findings		Comments
			n	%	
1.	Women with a BMI of >35 at booking were referred to a high-risk pathway with serial scans from 32 weeks.	>80% 1st >95% 2nd	39/40	97.5%	100% last year
2.	Serial growth scans were scheduled and attended by this cohort of women	>80% 1st >95% 2nd	38/40	95%	100% last year

Presentation/Discussion

The results show that the standard has slightly reduced from the 2020 audit but have still been maintained at 95% and above. Some restrictions have been placed on scanning schedules in the last year and there were rapid and frequent changes to guidance during the pandemic.
Moving forward, the scanning services should be more stable and compliance will improve again.
The results of this audit will be submitted as part of evidence against the Trust's SBL ambition and will be shared with staff at the Maternity and Gynaecology Quality and Safety Group, Maternity Safety Champions Group and as part of the Divisional Board report for Maternity Quality and Governance.

Conclusions

Findings show that compliance with the referral for a higher risk pathway and serial scans is met to a high standard. Once referred, serial growth USS were undertaken as required 95% of the time. Whilst this standard has dropped slightly from the last audit, compliance is still high. Further work is required to improve to 100%

Recommendations

Feedback results to staff groups in all areas.
Ensure the current guidelines for scan schedules are embedded in practice and any changes disseminated to all relevant staff groups.
Re-audit in 1 year as part of the audit plan

Learning Points

Risk assessment at each contact will ensure that if the previous indications for growth scans have been missed, this can be picked up and rectified at any stage.

References

National Guidance

Saving Babies Lives Care Bundle version 2 March 2019
RCOG Small for Gestational Age (green top guideline)

Trust Maternity Clinical Guidelines

MAT0005 'Prevention, detection and management of small for gestational babies '
MAT0014 'Care of Women with Obesity in Pregnancy'

Action Plan

Project title	Women with a BMI >35 at booking being offered serial growth scans in line with Saving Babies Lives Version 2

Action plan lead	Name: Karen Green	Title: Clinical Quality and Governance Matron	Contact: 3219

Recommendation	Actions required	Action by date	Person responsible	Comments/action status
Staff awareness of the findings of the Audit	Present results at Maternity Risk and Governance Group, Maternity and Gynaecology Quality and Safety Group; Maternity Safety Champions, and through HOM Quality report.	31/7/21	K Green, Clinical Quality and Governance Matron	
	Share on Maternity Risky Business Newsletter	31/7/21	S Paxman, Clinical Risk Midwife	
Re-audit to establish that guidance is embedded and care is appropriate and effective	Add to annual audit plan	31/7/21	K Green, Clinical Quality and Governance Matron	Add to audit plan

West Suffolk NHS
NHS Foundation Trust

Audit of Women with Complex Pregnancies Having a Named Consultant Early Referral and Management Plan in Place
June 2021

Women and Children's Health

Jane Lovedale, Midwife, Maternity Quality and Safety

Report status – Approved

Background/Rationale

The aim of this audit focuses on the optimisation of care for women with complex pregnancies relating to maternal medicine. In December 2020, the Ockenden report was published. One element of this was that women with complex problems in pregnancy – either at the start or deteriorating during pregnancy – have not always had appropriate input, management and specialist input into their care. It is essential that women with additional medical concerns have a robust pathway of care overseen by senior specialists and have a management plan which has been discussed and agreed with the woman.
At this time, maternal medicine centres have not yet been established in this region. However, WSH have built on an established weekly multidisciplinary (MDT) forum whereby all women with complex pregnancies have a referral to this weekly forum and a plan is made as a result of the discussions as to whether additional specialist input is needed either locally or at a tertiary centre. In additional, a Maternal Medicine MDT forum has been set up with a specialist Maternal Medicine lead at a neighbouring tertiary centre. These forums are held fortnightly usually and the women who have been discussed at the local MDT meetings are also discussed at the forum. Some women are discussed at the MDT forum more than once.

This audit is based on women who have been identified as having a complex medical condition at the maternity booking appointment or at any point during the pregnancy or birth. The results of this audit will be submitted as evidence of progress towards compliance with Ockenden Immediate and Essential Actions Q24-26.

Q24
Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

Q25
Women with complex pregnancies must have a named consultant lead

Q26
Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team

Aim

The audit aims to determine if complex women have early referral, and sufficient input and oversight from senior obstetric and specialist involvement at every stage to avoid harm to the women and their babies which will impact on the future health and wellbeing of the family. Evidence of improvements will be shared with the Maternity and Gynaecology Quality and Safety Group, Maternity Safety Champions, Trust Board and the Local Maternity and Neonatal Services (LMNS) demonstrating continuous improvements in the process and outcome measures.

Objectives

To review the pathways in place for women with complex pregnancies to ensure that these are embedded in practice and women have appropriate care.

Standard

No.	Standard	Target %
1.	Met criteria for referral for maternal medicine input	>95%
2.	Named consultant for women with complex pregnancy	>95%
3.	Early referral for specialist input	>95%
4.	Management plan documented and agreed with the woman	>95%

Methodology

The standard set for this audit was for more than 95% of women to have met the standard. The women were identified from risk assessments at booking and MDT referral forms and documentation of discussions. There were 6 women included in the audit. Three of the women had a condition diagnosed in pregnancy which required input from specialists; 2 of these women went on to have a tertiary referral along with a woman who had a pre-existing condition at her booking appointment.
67 records were reviewed as part of the risk assessment of pregnant women. This included the 6 women who were referred to MDT.

Results

No.	Standard	Target %	Findings		Comments
			n	%	
1.	Women have been risk assessed appropriately and referred to the maternal medicine MDT when indicated	>95%	6/6	100%	6 out of the 67 women were identified as needing discussion at the MDT forum. All of them were referred to MDT.
2.	Met criteria for referral for maternal medicine input	>95%	6/6	100%	
3.	Named consultant for women with complex pregnancy	>95%	6/6	100%	
4.	Early referral for specialist input	>95%	6/6	100%	3 women transferred to tertiary centres for care. 3 women diagnosed with a condition during pregnancy. One woman had a pre-existing condition and was referred to a tertiary centre at booking.
5.	Management plan documented and agreed with the woman	>95%	6/6	100%	

Discussion
Women were risk assessed appropriately and referred to the MDT forum when indicated. Six women met the criteria for complex pregnancies; all 6 were managed appropriately once the complexity of the pregnancy was diagnosed. All of the women had a named consultant.
With the introduction of the new maternity system, the named consultant can change if the woman is seen by another consultant. However, steps are being taken to address this and revert back to the named maternal medicine consultant.

Conclusion
The audit results demonstrate exceptional compliance with this area of care. Whilst the numbers of women are small, the specialist input is timely and there is evidence of MDT involvement. A Standard Operating Procedure (SOP) has been written to describe in detail the processes underpinning this aspect of care of women. Once the Maternal Medicine Centres are set up, the referral processes will be updated.

Recommendations
Share results with staff
Embed processes in the SOP
Re-audit annually against the standards in the SOP

References
Healthcare Safety Investigation Branch (HSIB) Maternity investigations of Each Baby Counts and selected MBRRACE cases, maternal deaths.

Maternity incentive scheme – year three: Conditions of the scheme: Ten maternity safety actions with technical guidance **Revised safety actions - updated March 2021**

Mothers and Babies Reducing Risk through Audits and Confidential Enquiries across the UK – MBRRACE UK – Perinatal surveillance and Confidential Enquiries

National Maternity Review: BETTER BIRTHS Improving outcomes of maternity services in England A Five Year Forward View for maternity care NHS England 2016

Ockenden Report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford NHS Trust (December 2020)

Action Plan

Project title	Women with complex medical conditions in pregnancy

Action plan lead	Name: Karen Green	Title: Clinical Quality and Governance Matron	Contact:3275

Recommendation	Actions required	Action by date	Person responsible	Comments/action status
Share results of this audit	Presentation of the audit results at Maternity and Gynaecology Quality and Safety Group Maternity Safety Champions meeting HOM Board report LMNS Board agenda	30/9/21	Karen Green Karen Newbury	
	Include in Risky Business	30/9/21	Sarah Paxman	
Re audit in 12 months	Undertake annual audit	31/5/22	Clinical Quality and Effectiveness Midwife	Add to annual audit plan

Item 15.1 Annex G

West Suffolk NHS Foundation Trust
Women and Children's & Clinical Support Services Division

MATERNITY SERVICES
Midwifery Staffing Report

Report Title:	Annual Report on Midwifery Workforce – April 2021
Report for:	Information and approval
Report from:	Head of Midwifery
Lead for safety action:	Head of Midwifery
Report authors:	Karen Newbury Christine Colbourne
Frequency of report:	Annual information report for Trust Board
Date of this report:	12 April 2021

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

An action plan that outlines the required activities to achieve the required standards is included in Appendix 1 and this also provides evidence against the Year 3 Maternity Incentive Scheme (MIS) Safety Action 5. This action plan will be monitored at the Women's Health Governance Group and Women's and Children's Divisional Board and progress reports will be presented for discussion and ratification at the meetings held in May each year.

The report and action plan will then be submitted for inclusion on the Trust Board agenda in June 2021 where progress will be overseen and verified by the Trust Executive.

Background:
In 2015, The National Institute for Health and Care Excellence (NICE) published the guideline 'Safe Midwifery Staffing for Maternity Settings' (NG4). This document was developed in response to findings from key national enquiries into care in England in particular the Francis report (2013) and Keogh Review (2013).

Updated in 2019, the guideline aims to improve maternity care by giving advice on monitoring staffing levels and actions to take if there are not enough midwives to meet the needs of women and babies in the service.

The guideline covers safe midwifery staffing in all maternity settings including at home, in the community, in hospital inpatient and outpatient settings, irrespective of whether care is led by midwives or obstetricians. Written to be used by all staff involved in the provision of maternity care, the guideline offers recommendations in relation to required organisational needs, on setting the midwifery establishments, how to assess the difference between the number and skill mix of midwives needed and the number of midwives available and ongoing monitoring and evaluation of midwifery staffing requirements.

In 2018 NHS Resolution introduced a maternity incentive scheme to support the delivery of safer maternity care. Comprising a total of 10 Maternity Safety Actions, safety action 5 focusses on midwifery staffing and asks if the Trust can demonstrate an effective system of midwifery workforce planning to the required safe standards. A report based on these standards was submitted to the Trust Board in November 2020.

In March 2021 revised safety actions were published updating the standards to include required evidence on the impact of Covid-19 on staffing levels. Responses to these are included in this report. There has also been an update to the frequency of submitting a report to the Trust Board, with maternity services now having to report on midwifery staffing annually as a minimum. The report submitted in November 2020 satisfies the compliance requirement but moving forward the service has opted to submit a report to board in June each year, so this report brings that in line for future years.

This provides detail of the minimum evidential requirements needed to meet the standard of Safety Action 5 contained within the Maternity Incentive Scheme and contains information on:

- BirthRate Plus assessment, including any action plans and progress arising from any identified deficits.
- Status of the labour suite co-ordinator in relation to being supernumerary.
- Provision of 1-1 care in labour.
- Midwife to birth ratio
- Monitoring of Red Flags in relation to midwifery staffing.
- Details of planned versus actual midwifery staffing levels.
- The BirthRate intrapartum acuity tool (app)
- Details of the specialist midwives employed.
- Impact of Covid-19 on midwifery staffing:
    - Were staffing levels affected by the changes to the organisation to deal with Covid-19?
    - How has the organisation prepared for sudden staff shortages in terms of demand, capacity and capability during the pandemic and for any future waves.

1. BirthRate Plus assessment

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

Following Care Quality Commission inspection September 2019, the Trust have invested significantly in maternity services, by increasing the establishment of band 7 midwives. The impact of this is described in more detail in sections 2 & 7 below.

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

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

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

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

The staff budgets for 2021/22 are currently being finalised and review across the year has led to the development of a deputy Head of Midwifery post which will be funded from April 2021.

The service has a successful recruitment programme and the majority of midwife posts have been appointed into based on the current establishments. A rolling programme for recruitment is planned and joint recruitment with the LMNS is currently in place across Suffolk and North Essex.

Student numbers have been increased to enable the service to meet demands as the establishment increases in line with practice/service developments.

Significant work has been undertaken with the LMNS on the staffing requirement to fully implement the continuity of care agenda in order to meet the recommendations outlined in Better Births[1]. At the time of this report, formal confirmation of required midwife, midwifery support and administration posts is awaited, although the service remains optimistic that these will be approved.

2. Status of the labour suite co-ordinator in relation to being supernumerary

Safer Childbirth (RCOG 2007) states that each labour ward must have a rota of experienced senior midwives as labour ward shift coordinators, supernumerary to the staffing numbers required for one-to-one care to ensure 24-hour managerial cover. It defines their role as being pivotal in facilitating communication between professionals and in overseeing appropriate use of resources. The lack of a supernumerary labour suite coordinator has also been identified as a contributory factor in many cases of maternal and perinatal morbidity and mortality which have been reported at national forums. The role of labour suite coordinator is nationally recognised as being at Band 7.

[1] Better Births. Improving outcomes of maternity services in England. (NHS England 2016)

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

The additional funding has enabled the service to plan to have 2 band 7 midwives on duty each day and night shift, 7 days a week. The bleep carrying band 7 will not be based in any particular clinical area but will offer oversight and supervisory/operational support to the entire team, to enable the labour suite co-ordinator to focus on her role and be supernumerary.

Monitoring of the supernumerary status of the labour suite coordinator is now established and reported monthly on the service Quality Dashboard.

Date	% compliance
April	100%
May	100%
June	No data
July	84%
August	74%
September	No data
October	83%
November	70%
December	91%
January	90%
February	92%
March	94%

The BirthRate Plus® app for acuity has been introduced. Whilst confidence in the data provided is growing, the service chooses to validate supernumery status through recording at the daily safety huddle and audit this monthly.

3. Provision of 1-1 care in labour

NICE published a Quality Statement on 1-1 care in 2015 (QS105 Intrapartum Care; updated 2017) which states that women in established labour have one-one care and support from an assigned midwife. Established labour is defined as the presence of regular painful contractions and progressive cervical dilatation from 4cm.

For service providers, one-one care in labour means that a woman in established labour is cared for by a midwife who is just looking after her. She might not have the same woman for the whole labour, but the service needs to ensure there are enough midwives on duty every 24-hour period to enable this to happen.

Monitoring of this standard was undertaken using the maternity clinical information system Euroking and since its implementation in March 2021, e-Care will provide this data. Midwives enter the information as part of their delivery records and this information is collated monthly and reported on the service dashboard.

Date	% compliance
April	97.4%
May	100%
June	100%
July	100%
August	100%
September	99.5%
October	100%
November	100%
December	100%
January	100%
February	100%
March	No data

4. Midwife to birth ratio

The monthly midwife to birth ratio is calculated using information from both e-roster for staffing and Euroking for activity. The service has recently introduced a new maternity system E-Care and this will provide activity information from April 2021.

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

The BirthRate Plus funded establishment gives an overall achievable ratio of 27 births to 1 wte MW. The service has set a ratio of 1 wte to 28 births as the standard to be achieved, which is in line with national standards.

MW to Birth Ratio Standard = 1:28	
Date	Ratio
April	1:26
May	1:26
June	1:27
July	1:30
August	1:27
September	1:31
October	1:31
November	1:27
December	1:25
January	1:29
February	1:27
March	No data

Compliance with the MW: birth ratio is generally good. Where compliance has been less than the service standard of 1:28 the predominant reason is availability of staff due to shielding, self-isolation and sickness due to Covid-19.

This data is recorded on the quality dashboard and is monitored monthly at the Maternity Quality and Safety Group.

5. Monitoring of Red Flags in relation to midwifery staffing

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

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

Two new red flags have been introduced relating to the Covid-19 pandemic within the MIS safety actions.

Redeployment of staff to other services/sites/wards based on acuity
Covid -19: staff absences due to illness/isolation/shielding/symptoms

Information on these specific red flags is included in section 9.

The number of red flags submitted via the service reporting system over the last 12 months is as follows:

Number of Red Flags reported each month	
Date	Number
April	0
May	0
June	3
July	4
August	2
September	1
October	14
November	12
December	12
January	4
February	6
March	1

The number of red flags each month is recorded on the quality dashboard and is monitored at the Maternity Quality and Safety Group meeting.

Over the year there have been several submissions investigated as Red Flags. On closer review, not all of the submissions have technically fulfilled the criteria of the Red Flag definitions as above but have still been investigated and demonstrate the maternity services commitment to high quality care even if this not directly as a result of midwifery staffing issues. Some of the Red Flag's highlighted, can be due to other reasons as the following list highlights below.

- 17 reported delays in continuation of induction of labour due to high activity on labour suite – these can be partly due to staffing and partly to do with workload and available space.
- 17 reported occasions where the labour suite co-ordinator was not supernumerary for the whole shift – this may not be directly related to midwifery staffing
- 3 occasions where there were delays in administering medication.
- 2 occasions where there were delays in performing category 2 emergency caesarean section. – this may not be directly related to midwifery staffing
- 2 episodes where observations of vital signs were delayed.
- 1 occasion where there was delay in transfer to theatre for repair of 3rd degree perineal tear.
- 1 occasion where 1-1 care in labour was not provided.

Action is needed to remind staff what criteria is included for a Red Flag, so that these are investigated and reported appropriately.

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

6. Details of planned versus actual midwifery staffing levels

The service currently publishes the daily record of the number of staff on duty against the minimum staffing levels expected in each clinical area. E-Roster gives more detailed information on the numbers of staff on duty, absences, and unfilled shifts but data extraction from E-roster is currently under review in light of the rollout of continuity of care.

Whilst the service is currently unable to produce actual fill rates the Head of Midwifery retains information monthly on the wte number of registered midwife shifts that have not been filled:

Number of RM shifts not filled each month		
Month	WTE	Total Shifts
October	5.91	18
November	5.20	16
December	8.04	25
January	9.04	28
February	10.40	32
March	9.88	31

7. The BirthRateplus intrapartum acuity tool (app)

The service secured funding and introduced the BR+ app in October 2020. This intrapartum app assists the service to determine the acuity of the women being cared for. Acuity is described by BirthRate Plus as 'the volume of need for midwifery care at any one time based on the number of women in labour and their degree of dependency'. Data on women's clinical need and the number of available midwives is inputted into the system every 4-hours by the labour suite coordinator or the unit bleep carrier.

A positive acuity score reassures the service that the staffing is adequate to meet the clinical needs of the women on labour suite at that time and to manage any unexpected admissions or transfers from the ward, whilst a negative score highlights potential issues that will need action and possible escalation. Additional advantages of the BirthRate app will be that it will give information on the supernumerary status of the labour suite coordinator in addition to collecting data on the red flags.

Embedding the BR+ app has proven to be challenging and the service has yet to achieve full compliance with completion of data on the app. This has resulted in the information and data reports produced from the app not helping to inform staffing requirements and accurately monitor the supernumerary status of the labour suite coordinator. The commitment to input the data is high amongst the team, but the impact of staff shortages has led to gaps in completion of the data every 4 hours, and incomplete information on acuity and staffing needs being produced.

8. Specialist Midwives in post

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

The funded establishment for Band 7 specialist MW post is totalled as 8.40 wte and the following are in post:

- 1.20 wte antenatal and newborn screening midwives (2 x 0.60)
- 1.96 wte practice development midwives. (1 x 1.00, 1 x 0.80)
- 1.80 wte Clinical risk midwives. (1 x 1.00, 1 x 0.80)
- 1.00 wte clinical and Quality Assurance midwife
- 0.40 wte fetal monitoring midwife.
- 0.80 wte bereavement midwife
- 0.60 wte safeguarding midwife.
- 0.53 wte diabetes midwife

In addition, external funding is provided to employ 0.80 wte MW for vulnerable women particularly with mental health issues (funded externally) and the service assigns 1 wte to the PMA function where a team of 5 midwives share this role and participate in a roster to ensure the availability of PMA support is available for midwives.

A band 7 Clinical Practice Facilitator post of 0.60 wte is externally funded by HEE.

The funded establishment for band 6 specialist midwives is 1.75 wte and this comprises:

- 0.60 wte infant feeding midwife
- 0.80 wte smoking cessation midwife externally funded for one year.

- Clinical practice facilitator 0.60 wte, part funded by HEE.

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

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

9. Impact of Covid -19 on midwifery staffing:
    a. Were staffing levels affected by the changes to the organisation to deal with Covid-19?

    The midwifery workforce has been impacted by Covid-19, mostly through staff sickness, shielding and the need to isolate. No midwifery or support staff have been redeployed to other areas in the Trust.

    In total 6.22 wte midwives have been shielding during the extended periods of lockdown since March 2020 to 31st March 2021 and 3.82 wte support staff.

    The midwifery staffing levels have been significantly impacted by the effects of Covid-19. The establishments are set to include allowances of 22% for staff absences, which under normal circumstances would enable most shifts to be covered for staff training and sickness absence.

    b. How has the organisation prepared for sudden staff shortages in terms of demand, capacity and capability during the pandemic and for any future waves.

    The service does not use agency midwives or support staff. There is an escalation plan in place, and this is used at times of staff shortage and heightened activity. This has resulted in specialist and management staff being asked to undertake clinical work with their other regular work being put on hold. This is not sustainable over a long period of time.

    The service is reviewing the skill mix on the postnatal wards and is considering the introduction of nurses to care for mothers and babies in the postnatal period. This will provide a longer term solution to any shortages of midwives.

    Maternity Support Worker roles and functions are also being reviewed with a view to strengthening the clinical workforce with appropriately trained and competent band 3 and 4 staff.

10. Conclusions

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

Covid-19 has impacted significantly on the midwifery service this year, making it difficult to develop systems, processes and new ways of working to improve care and there remains a need to embed the monitoring processes to ensure information on staffing levels, vacancies, acuity, safety and workload are recorded accurately and in a timely way.

The introduction of Continuity of Carer will change current practices significantly and further roll out has been suspended to ensure safe staffing levels have been maintained. Future monitoring will need to ensure new systems and processes are monitored robustly to ensure safe standards of care and safety are maintained.

The action plan in appendix 1 has been updated and progress against this will be monitored quarterly at the Maternity Quality and Safety Group. A report on progress and to meet compliance with future Maternity Incentive Scheme standards will be submitted annually.

Appendix 1 Action Plan

Action Plan Lead:	Name	Role Title:	Contact:
HOM	Karen Newbury	HOM	Karen.newbury@wsh.nhs.uk

RECOMENDATION		ACTIONS REQUIRED	ACTION BY DATE	PERSON RESPONSIBLE	COMMENTS/ACTION STATUS
1.	The funded establishment against vacancies to be monitored monthly	Monitor establishment versus vacancies monthly via the current vacancy control processes.	On-going monthly	HOM	April 2021: Continues to be monitored and recruitment processes initiated once agreement has been given.
		More streamlined approach to recruitment: the authorisation of the VAF to progress recruitment processes is often delayed, leading to an unacceptable lag between staff leaving and new ones joining.	As soon as possible	HR and Finance Teams	
2.	Implementation of BR+ acuity app in Q3.	Use of app to monitor staff in post against funded establishment each month alongside proactive vacancy management.	To be implemented by 31/10/20 and results monitored monthly on an ongoing basis.	Band 7 MW's in the unit	Implemented October 2020: Complete
		Increase number of staff able to use the BR+ App.		Matron: IP services Ward Manager: Labour Suite Band 7 MW	All labour suite co-ordinators and bleep holders have completed training.

		Embedding of the app is needed to ensure robust and reliable data is produced monthly.	End of Q2 September 2021	Matron: IP services Ward Manager: Labour Suite Band 7 MW	
3.	Monthly monitoring of 1-1 care in labour	1-1 care in labour compliance will continue to be monitored monthly through e-Care and reported on the service quality dashboard.	On-going monthly	Risk and Governance Team	
4.	Midwife to birth ratio to be maintained at or below 1:28	The MW to birth ratio will continue to be monitored and reported monthly on the service quality dashboard.	On-going monthly	Risk and Governance Team	April 2021: Compliance dipped below 1:28 4 months in last year due to impact of Covid-19.
5.	Embed methodology for reporting and reviewing red flag incidents	Red Flags will continue to be monitored through the daily safety huddle until the implementation of the BirthRate Acuity App when the Red Flags will be reported through this tool.	On-going monthly	All maternity staff Risk and Governance Team	
		Ensure Datix incident reports are submitted with themes and trends monitored and highlighted by the maternity risk team.	On-going monthly	Matrons Ward Managers Community Team Leaders	
		Refresh maternity staff with Red Flag criteria to ensure appropriate reporting	May 31st 2021	Risk and Governance Team Matrons	**Complete**

6.	Enable accurate electronic recording of planned versus actual staffing on E-Roster	Review rules and templates on E-Roster to enable the system to generate accurate reports on planned versus actual staffing levels. The service should move towards having report production with accurate data by Q3 2021/22	Reporting in place by 31/01/21: Revised to 30/9/2021	Matron IP services. Ward Managers	Delayed due to adaptations required due to introduction of continuity of carer.
7.	The service will continue to monitor the roles of specialist MW at WSH and make recommendations for change or additional posts as clinical care requirements are monitored for variations.	Monthly and quarterly reports on activity levels and use of escalation to provide safe care.	On-going monitoring monthly and report quarterly	Deputy HOM (once in post) & Matrons	
9.	Ensure escalation policy is fit for purpose and implemented fairly and equitably with the details of escalation for Continuity of Carer teams when these are in place.	Update the escalation policy to ensure this is fit for purpose. Once updated, a review of table-top exercise should be undertaken. To include the first stage of implementation of Continuity of Carer	30/11/20: Revised Document to be ready for ratification at Women's Health Governance Group meeting in July 2021	Risk and Governance Team	**Now completed.**
10.	Review staffing levels once Continuity of Carer is implemented to ensure safe standards of care are maintained	Review all methodology of monitoring safe staffing levels and acuity when continuity of carer teams are implemented and established. Service has had agreement to employ the required MW to implement continuity of carer. This will be phased in over the next 12 months.	Currently no published dates. Service will work in partnership with LMNS and CCG to progress with implementation as recommended	HOM Matrons LMNS CCG	April 2021: Implementation of CONTINUITY OF CARER model has been delayed due to Covid -19. Further information awaited.

15.2. Infection prevention and control assurance framework

For Approval

Board of Directors – 25 June 2021

Item No.	15.2			
Presented by:	Sue Wilkinson Exec Chief nurse			
Prepared by:	Rebecca Gibson – Head of Compliance & Effectiveness			
Date prepared:	June 2021			
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*.

This month's report contains

- Dashboard
- Audit update

The infection prevention team are currently undertaking a retrospective audit of Day 3, Day 5-7 and Day 13 swab compliance. This will be presented to the trust's Nursing, Midwifery and AHP clinical council (NMCC) in July. Prior to this presentation the findings will be shared with the heads of nursing and matrons who will be asked to consider recommendations when/if non-compliance is found. Re-audit timeframes will be dependent on the national picture with regard to a 'third wave' and will form part of the trust's IPC local audit programme.

Having now completed all the investigations of outbreaks and clusters, the team are now working through the nosocomial cases that were recorded outside of these outbreaks. These are being followed up on a case by case basis.

**Local systems must assure themselves, with commissioners, that a trust's infection prevention and control interventions (IPC) are optimal, the Board Assurance Framework is complete, and agreed action plans are being delivered and review system performance and data; offer peer support and take steps to intervene as required.*

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

Trust priorities	**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 for assurance	

Measure	Time period reported	Data		
		Previous	Last period	This period
Nosocomial C19 (probable + definite)	May 21	0	0	0 →
Staff work-related C19 cases reported to RIDDOR	May 21	0	0	See below
Incidents relating to C19 management	May 21	21	16	19 ↑
Admissions swabs within 24 hours of DTA	May 21	97%	97%	96% ↓
C19 clusters / outbreaks	May 21	0	0	0 →
Staff sickness / absence due to C19	May 21	226	131	↓

Associated charts / tables / narrative

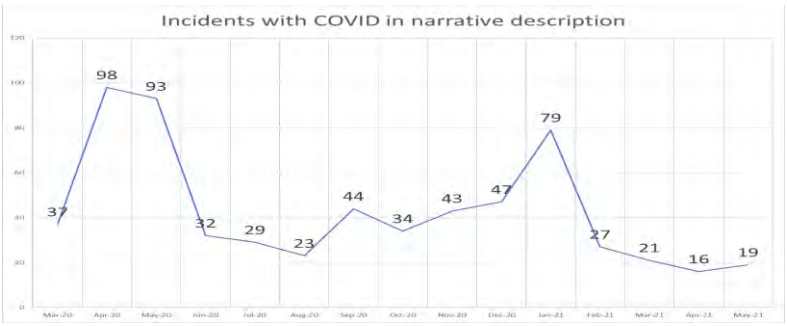
C-19 admission swabs

The total number of patients swabbed in May rose considerably with an increased throughput in the hospital.

Despite this compliance was maintained at a similar level to previous months with 95% of patients having a swab taken within 24 hours of the DTA in May and 96% in total.

64 patients (4%) did not have a record of having a swab taken in this episode.

Inpatient swabs The updated NHSE IPC BAF requires oversight of the requirements for emergency admissions who test negative on admission to be retested on day 3 of admission, and again between 5-7 days post admission. eCare cannot produce an automated report to allow this to be monitored so, (as detailed in the introduction), the IPC team are undertaking a spot-check audit of a sample of patients with a length of stay >9 days who were Covid negative on admission (and previous 90 days) to ascertain the appropriate swabbing regime was adhered to. In order to get a wide view of compliance across the different ward types; this audit is being undertaken for a sample of medical and surgical wards.



The number of **incidents relating to C-19** recorded in May remained similar to recent months.

All 19 May reported incidents were green

Staff work-related C19 cases reported to RIDDOR

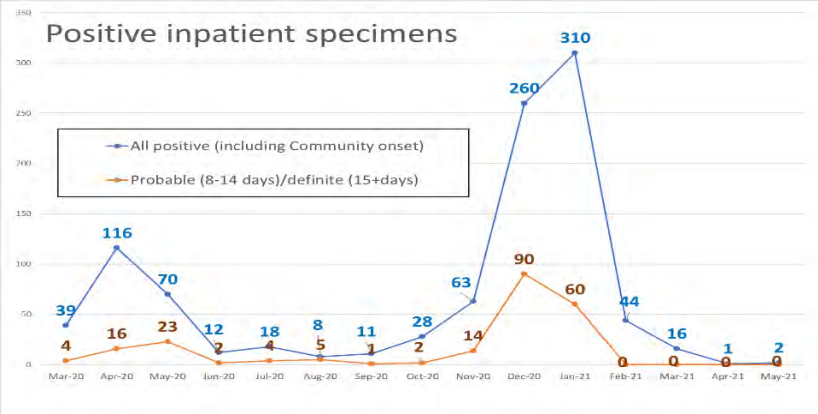
There had been no cases reported to RIDDOR since the reporting requirements changed in spring 2020. This may change as the recently completed investigation in to the staff cluster on F7 in late 2020 identified the potential that a breach in PPE may have contributed to this, although it was recognised that there was also a high prevalence of COVID-19 in the community at that time.

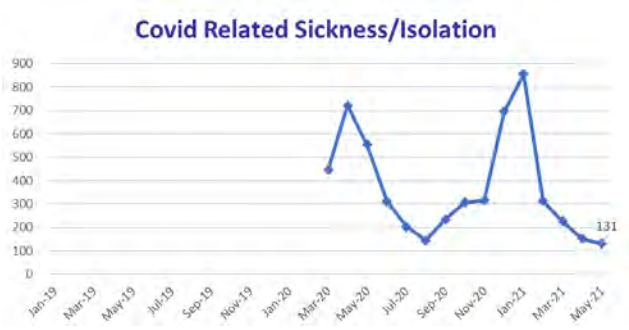
The investigation found occasions when staff were not able to don full PPE before attending a confused and therefore non-compliant patient to prevent injury from falling or to prevent them from leaving to enter a non-COVID ward. This made it difficult for staff to apply full PPE in a timely manner. The RIDDOR reporting requirements for the relevant staff members are being ascertained and this will have the impact of increasing the cases reported total.

Nosocomial (Hospital-Onset) C19

[*definition based on first positive specimen (swab date) X days after admission]*

There were no cases identified as probable/definite in May. This mirrors the decrease in community prevalence over the same period.





Sickness / isolation

Reported within the IQPR this provides 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.

In May 2021 there were 131 episodes recorded, a continued decrease from April (153 episodes). This matches the wider community picture in West Suffolk

15.3. Nursing staffing report

For Approval

Trust Board – 25 June 2021

Agenda item:	15.3			
Presented by:	Susan Wilkinson, Executive Chief Nurse			
Prepared by:	Daniel Spooner Deputy Chief Nurse			
Date prepared:	June 2021			
Subject:	Quality and Workforce Report & Dashboard – Nursing May 2021			
Purpose:	X	For information		For approval

Executive summary:

This paper reports on safe staffing fill rates and mitigations for inpatient areas for May 2021. It complies with national quality board recommendations to demonstrate effective deployment and utilisation of nursing staff. The paper identifies how planned staffing levels were achieved and the resulting impact of these staffing levels. It will go onto review vacancy rates, nurse sensitive indicators, and recruitment initiatives.

Highlights

- Overall Trust fill rates continue to be above 90%
- Turnover rates improved within Nursing Assistant staff group
- Nurse sensitive indicators improved in this month
- Total registered nurse vacancy rate improved this month, small increase seen within the inpatient setting (0.1%)

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

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

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

Recommendation:

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

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

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 May 2021.

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 May 2021 within the data submission deadline. Table 1 shows the summary of overall fill rate percentages for these months and for comparison the previous four months.

	Day		Night	
	Registered	Care Staff	Registered	Care staff
Average fill rate for January 2021	92%	78%	94%	94%
Average fill rate for February 2021	96%	86%	97%	101%
Average Fill rate for March 21	98%	87%	95%	99%
Average Fill rate for April 21	93%	96%	97%	110%
Average Fill rate for May 21	96%	96%	98%	108%

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

Highlights

- Fill rates remain favourable and above 90% as a Trust
- Highest fill rates for NAs this month reflecting the recruitment drive and additional induction in March
- Overfill of NA attributed to increase need of 1:1 care overnight

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

In December the Trust began to see an increase in admission of Covid 19 positive patients and also an increase in community prevalence of Covid 19 infections within Suffolk and these pressures continued into January. Sickness rates for nursing and support staff has reduced slightly compared to the previous month and is consistent with levels seen during the summer when community presence of Covid 19 had also reduced. This is the lowest combined sickness rate since June 2020

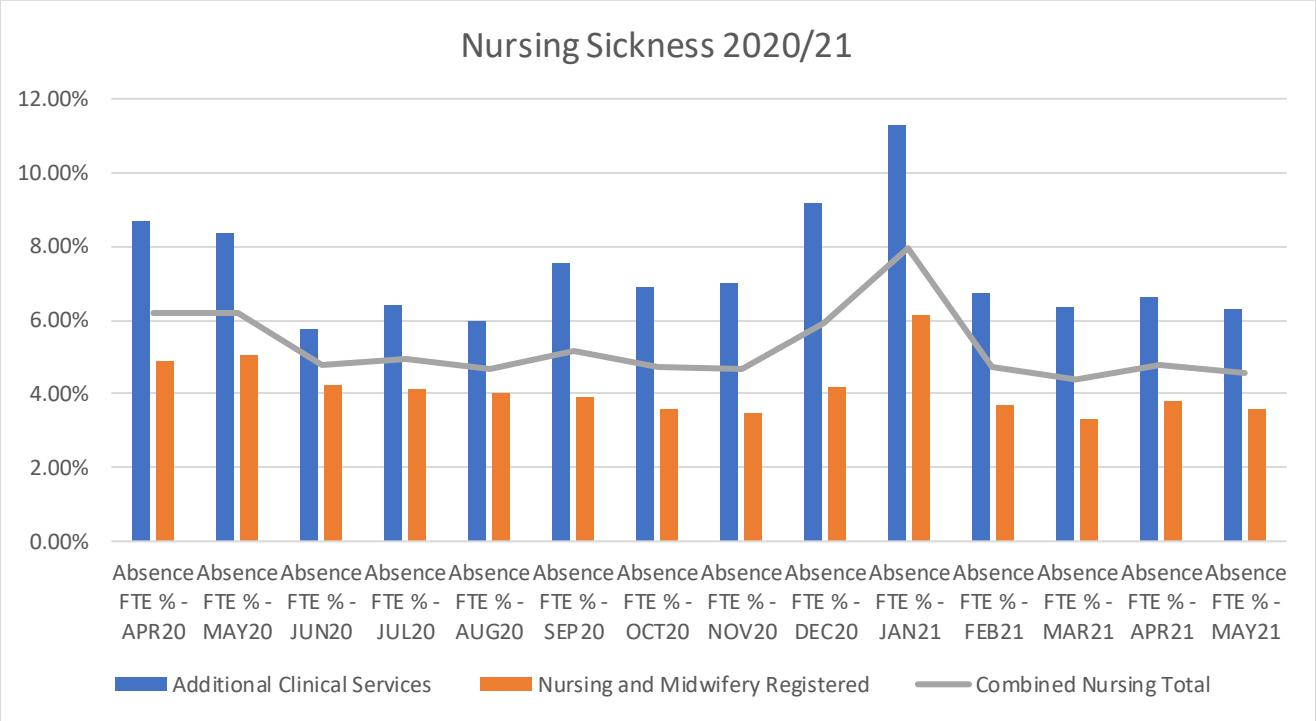


Chart 2.

	Oct	Nov	Dec	Jan 21	Feb 21	Mar 21	April 21	May 21
Unregistered staff (support workers)	6.92%	7.00%	9.16%	11.31%	6.71%	6.34%	6.61%	6.28%
Registered Nurse/Midwives	3.57%	3.47%	4.16%	6.13%	3.67%	3.34%	3.79%	3.60%
Combined Registered/Unregistered	**4.72%**	**4.69%**	**5.92%**	**7.95%**	**4.71%**	**4.39%**	**4.77%**	**4.55%**

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). Despite sickness being reasonably static, self-isolation is at the lowest since April 2020 in both RNs and NAs

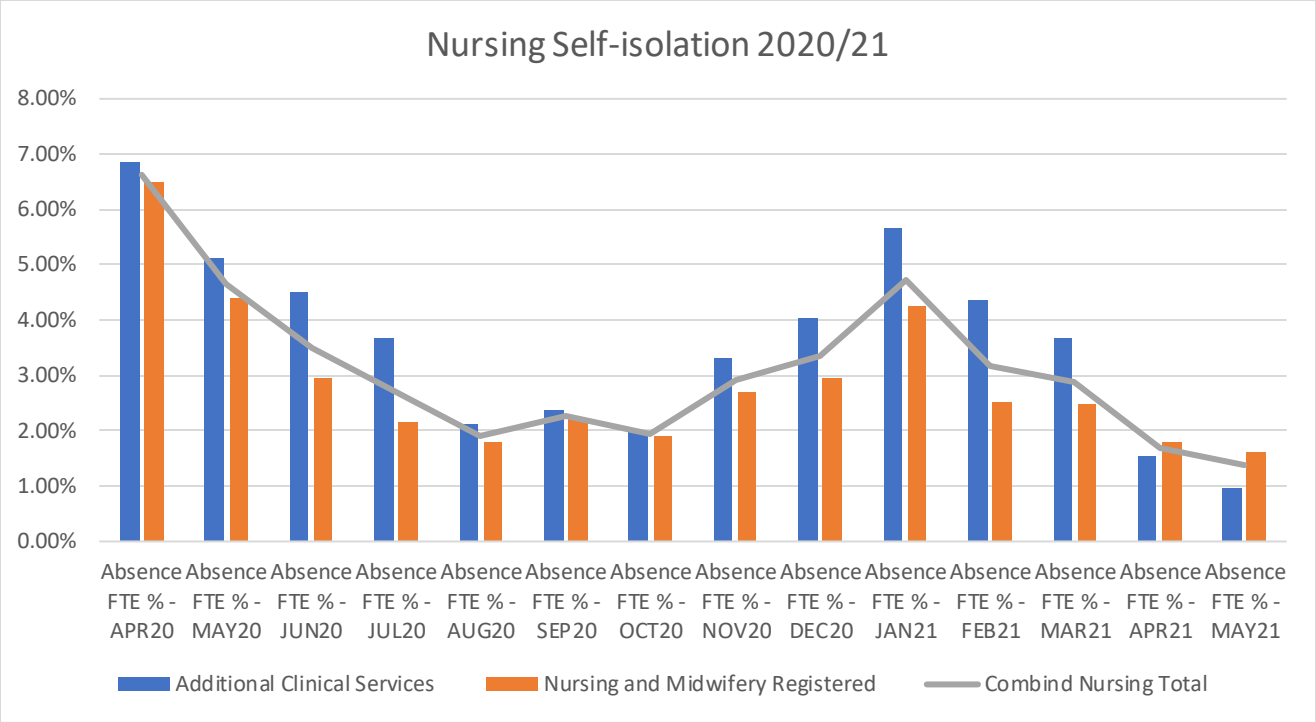


Chart 3

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. In recent months ward relocations and structural repair have challenged flow and staffing. In this report period the following wards were relocated and closed due structural repair.

- F9 moved to G5. F9 closed
- ITU moved to smaller footprint of F2
- F10 closed for repair works, staff supporting vacancies within medicine.

6. Recruitment and retention

Vacancies: Registered nursing (RN/RW):

- Overall WTE establishment for inpatient RNs decreased slightly this month however, the vacancy percentage has reduced from 11.2 % to 10%. This is driven by a reduction in budgeted establishments (winter ward, continuity care)
- Overall vacancy percentage for RNs (inpatient and all others) is 7.9%, an increase of 0.1% from last month.

	Ward Nursing	Sum of Actual Period 9 (Dec)	Sum of Actual Period 10 (Jan)	Sum of Actual Period 11 (Feb)	Sum of Actual Period 12 (March)	Sum of Actuals Period 1 (April)	Sum of Actuals Period 2 (May)	Sum of CURRENT MONTH VARIANCE
RN/RM Substantive	Ward	603.9	609.8	610.2	611.7	612.7	609.4	69.0
	CV19 Costs	10.3	2.0	(0.1)	1.4	1.3	1.1	(1.1)
Total: RN Substantive		**614.2**	**611.8**	**610.2**	**613.1**	**614**	**610.5**	**67.9**

Table 4. Ward/Inpatient Vacancies WTE.

While the number is small, the total RN total establishment (wards and non-wards) has reduced marginally this month as demonstrated in chart 4a below.

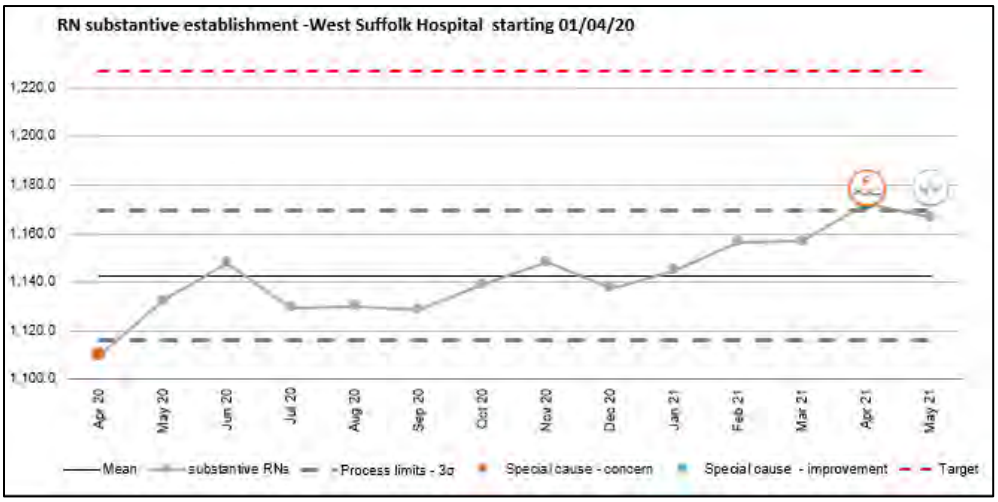


Chart 4a: SPC data adapted from finance ledger

Vacancies NAs (midwifery and Nursing combined):

The national ambition for individual Trusts to reduce NA vacancies to 0% by end of 20/21 financial year was achieved by our organisation. This was driven by increased recruitment, additional HR support focusing on NA recruitment/onboarding and the introduction of a pastoral care role for two senior NA. However, due to the increase in establishment in ED, which has also affected NAs, the total NA vacancy rate observed in April increased to 6.9%

- This month total NA vacancies has reduced to 4.9%
- Inpatient NA vacancies is more favourable and has reduced to 2.64%

	Ward Nursing	Sum of Budget Period 9 (Dec)	Sum of Budget Period 10 (Jan)	Sum of Budget Period 11 (Feb)	Sum of Budget Period 12 (Mar)	Sum of Budget Period 1 (April)	Sum of Budget Period 1 (May)	Sum of CURRENT MONTH VARIANCE
Nursing Unregistered Substantive	Ward	375.1	380.6	386.2	393.8	391.3	393.4	10.7
	CV19 Costs	9.0	0.0	16.9	19.5	10.8	4.3	(4.3)
Total: NA Substantive		**384.0**	**380.6**	**403.0**	**413.2**	**402.1**	**397.6**	**6.4**

Table 5: Ward/Inpatient NA vacancies WTE.

A review of inpatient vacancies, ward by ward, can be found in Appendix 2. Some smaller teams will demonstrate a concerning vacancy rate with only small reduction of WTE. However, an area of significant concern would be;

- F6: vacancy rate of 10.9WTE, however successful recruitment will mean that the ward will be fully established in September 2021. While waiting for new staff to join they have been supported by WSP to source long lines of temporary staff to mitigate the risk. In addition, they will also be supported on a daily basis by F4 staff that are currently redeployed due to reduced elective activity

7. New Starters and Turnover

Overseas Nurse (OSN) recruitment:

Five international nurses arrived in May as planned. The education team are currently scoping options to increase this cohort in light of the recent establishment uplifts, however there are constraints regarding educational facilities, social distancing and accommodation. An options appraisal is under review.

New starters

	January	February	March	April	May
Registered Nurses	16	17	30	18	13
Non-Registered	11	17	28	17	11

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

- In May 2021 13 RNs completed induction; of these; two are community nurses, and five are for the acute trust, four in midwifery, two for bank services
- In May, eleven NAs completed induction; of these two NAs are in the community and eight for the acute Trust and one for bank services

Turnover

On a retrospective review of the last rolling year, turnover for RNs has slightly increased from 5.64 WTE to 5.83% but remains well below the trust ambition of <10%. NA turnover has increased from 9.02% to 10.96% on previous rolling 12 months.

Turn Over 01/06/2020 - 31/05/2021								
Staff Group	Average Headcount	Avg FTE	Starters Headcount	Starters FTE	Leavers Headcount	Leavers FTE	**LTR Headcount %**	**LTR FTE %**
Nursing and Midwifery Registered	1,273.00	1,094.5208	95	76.2600	81	63.8254	**6.36%**	**5.83%**
Additional Clinical Services	566.00	478.6685	152	139.8867	60	52.5067	**10.60%**	**10.96%**

Table 7.

Turnover for staff leaving within 6 months of joining the trust is 5.17% for RNs (n=3) and NAs 8.99% (n=8). This is an improving picture for NAs, but the true impact on the appointment of additional support for new NAs to the trust is still to be seen.

8. Quality Indicators

Falls

Total incidences of falls have reduced marginally on last month but positively, using the falls per 1000 bed day measure, there is further improvement due to increased bed occupancy. Falls per 1000 bed days is 3.5 this is well below the national average (set in 2015) of 6.63. A full list of falls and locations can be found in appendix 3.

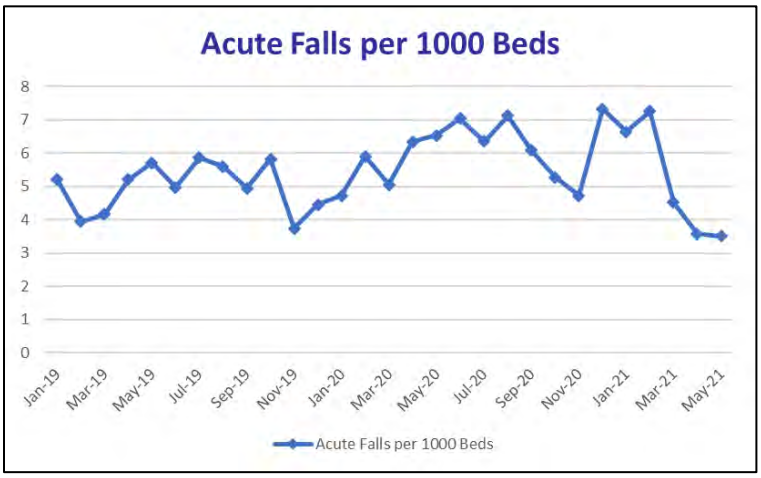


Chart 8

Pressure Ulcers

May saw the fourth consecutive improvement in HAPU in the acute trust which is also mirrored in occupied bed days. There is no current improvement trend in the incidences within the community and indicative of the continued challenge to address compliance and incidence within this patient group.

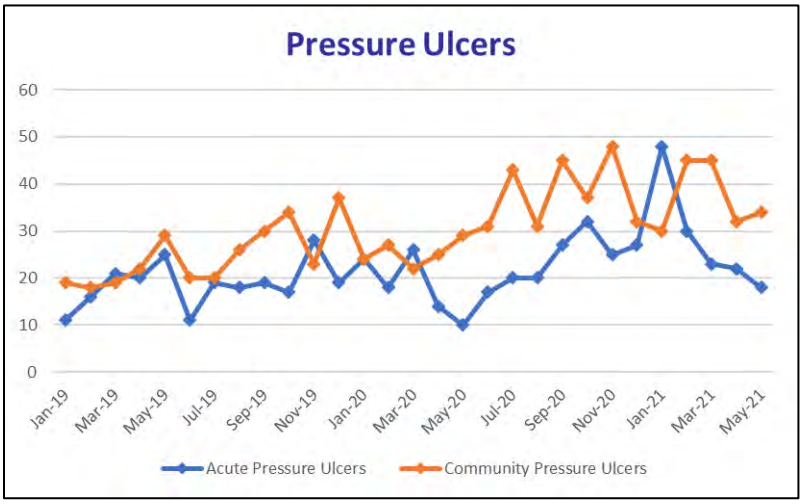


Chart 9a

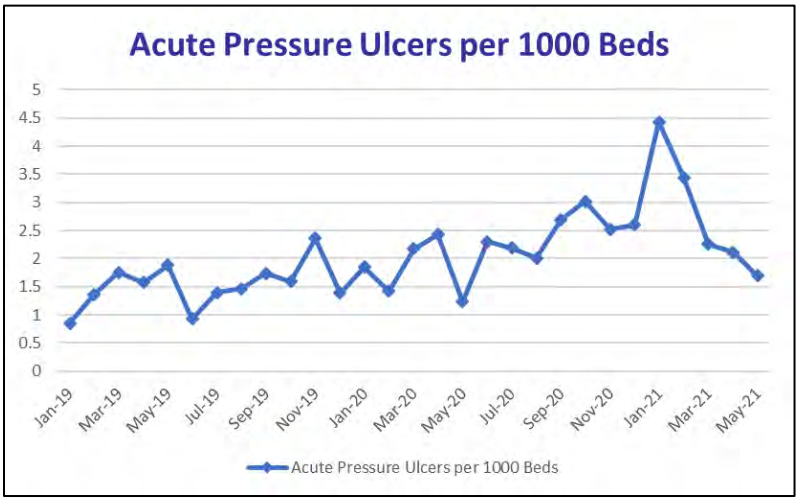


Chart 9b

9. Compliments and Complaints

Table 10. demonstrates the incidence of complaints and compliments for this period. Complaints received are lower than expectation and there is no emerging trend this month. The patient experience team will review trends quarterly to better understand themes and any wider learning.

The clinical helpline has been maintained and an average of 91 calls a day to assist relatives who are unable to attend the wards to receive updates of the care of our patients. This is consistent with last month and likely to be indicative of visiting restrictions being relaxed.

	Compliments	Complaints
December 2020	44	22
January 2021	11	7
February 2021	17	11
March 2021	13	22
April 2021	26	15
May 2021	25	13

Table 10

10. Adverse Staffing Incidences

As per the nursing resource improvement plan, staffing incidences are now being captured on Datix with recognising any red flag events that have occurred as per National Quality Board (NQB) definition (Appendix 4). Nursing staff are encouraged to complete this as required so any resulting patient harm can be identified.

- In May there were 12 Datixs recorded for nurse staffing that resulted in a Red Flag event (see table 11.). No harm is recorded for these incidences.

Red Flag	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21
Registered nursing shortfall of more than 8 hours or >25% of planned nursing hours	11	11	0	3	2	3
>30-minute delay in providing pain relief	2	3	1	0	0	1
Delay or omission of intention rounding	17	17	4	9	2	1
<2 RNs on a shift	2	6	1	1	3	5
Vital signs not recorded as indicated on care plan	10	3	0	1	1	2
Unplanned omissions in providing patient medication	4	4	0	1	0	0
Total	46	44	6	15	8	12

Table 11.

11. Maternity Services

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

Red Flag events

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

There was one red flag event in May

- Delayed induction of labours due to staffing shortages and high activity on labour suite. No patient harm was caused as a result

Midwife to Birth ratio

NB. Data temporarily unavailable due to implementation of eCare.

Supernumerary status of the labour suite co-ordinator

This is a CNST 10 steps to safety requirement and was highlighted as a 'should' from the CQC report in January 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 May 96% compliance was achieved

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. May 2021 (adapted from unify submission)

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each day	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	910.25	908	1398	1601.75	1035	1012	1127	1113	100%	115%	98%	99%	519	3.7	5.2	8.9
Glastonbury Court	718.5	726	1024.5	979	713	712	539.5	538.5	101%	96%	100%	100%	536	2.7	2.8	5.5
AAU	2144.75	2338.5833	2495.5	2207.75	1782.5	1932	1425.016667	1376.5	109%	88%	108%	97%	761	5.6	4.7	10.3
Cardiac Centre	2671.5	2712.5	1197	1289.75	1667.5	1687.5	668.5	650.5	102%	108%	101%	97%	632	7.0	3.1	10.0
F10	0	0	0	0	0	0	0	0	ward closed							
G9	1426	1422.0833	1426	1431	1426	1373	1069.5	1271.5	100%	100%	96%	119%	752	3.7	3.6	7.3
F12	552	673.5	356.5	370.25	713	690	356.5	314.5	122%	104%	97%	88%	240	5.7	2.9	8.5
F7	1782.5	1659.8333	1765.75	1602.5	1426	1409.583333	1754.5	1692	93%	91%	99%	96%	683	4.5	4.8	9.3
F9	1780	1742.75	1777	1743	1069.5	1035.25	1417.5	1686	98%	98%	97%	119%	744	3.7	4.6	8.3
G1	1724.06667	1403.85	446	474	713	713	356.5	372	81%	106%	100%	104%	392	5.4	2.2	7.6
G3	1776	1479.25	1775.5	1867.5	1069.5	1070.25	1069.5	1629	83%	105%	100%	152%	864	3.0	4.0	7.0
G4	1782.5	1710.5	1710	1801.25	1066.5	1056	1410.5	1532.33333	96%	105%	99%	109%	896	3.1	3.7	6.8
G5	0	0	0	0	0	0	0	0	ward closed							
G8	2494.75	2228.0833	1854.5	1682.25	1748	1628.25	1069.5	1161.16667	89%	91%	93%	109%	615	6.3	4.6	10.9
F8	1426	1439	2139	1852.25	1069.5	1023.5	1426	1437.5	101%	87%	96%	101%	723	3.4	4.6	8.0
Critical Care	2733.5	2538.75	335.5	753.5	2782.5	2515.5	0	155	93%	225%	90%	N/A	388	13.0	2.3	15.4
F3	1702	1610.75	2125.5	1889.5	1069.5	1035	1420.5	1508	95%	89%	97%	106%	732	3.6	4.6	8.3
F4	856.25	769.75	777	635.5	667	633.5	540.5	529	90%	82%	95%	98%	633	2.2	1.8	4.1
F5	1778	1464	1422	1210.25	1069.5	1081	1069.5	989.5	82%	85%	101%	93%	698	3.6	3.2	6.8
F6	1966.5	1837.75	1626	1378	1413.83333	1197	713	920	93%	85%	85%	129%	942	3.2	2.4	5.7
Neonatal Unit	1116	1104	372	175	1116	972	372	192	99%	47%	87%	52%	116	17.9	3.2	21.1
F1	1219	1480.75	713	721.75	1064.25	1321.5	0	126.5	121%	101%	124%	100%	115	24.4	7.4	31.7
F14	780	776.5	288	306.5	744	732.5	0	70.5	100%	106%	98%	100%	106	14.2	3.6	17.8
Total	33,340.07	32,026.18	27,024.25	25,972.25	25,425.58	24,830.33	17,805.52	19,265.00	**96%**	**96%**	**98%**	**108%**	**12087**	**4.7**	**3.7**	**8.4**

Appendix 2. Ward by ward vacancies (May 2021): Data adapted from finance report

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

Ward/Department	Registered Nursing (RN)				Ward/Department	Non Registered Nursing (HCSW)			
	Budgetted establishment	Actual establishmet	Vacancy rate (WTE)	Vacancy percentage		Budgeted Establishment	Actual Establishment	Vacancy rate (WTE)	Percentage Vacancy rate
AAU	30.1	33.9	(3.8)	-12.6%	AAU	28.3	26.9	1.5	5%
Accident & Emergency	77.3	65.7	11.6	15.0%	Accident & Emergency	34.5	27.9	6.5	19%
Cardiac Centre	40.7	39.8	0.9	2.2%	Cardiac Centre	15.7	15.9	(0.2)	-1%
Community - Glastonbury Court	11.7	11.0	0.7	5.7%	Community - Glastonbu	12.6	10.3	2.3	18%
Critical Care Services	43.0	43.3	(0.3)	-0.7%	Critical Care Services	1.9	6.8	(4.9)	-262%
Day Surgery Wards	11.0	10.8	0.2	2.1%	Day Surgery Wards	3.9	3.9	0.0	0%
Gynae Ward (On F14)	13.1	10.2	2.9	22.0%	Gynae Ward (On F14)	2.0	1.0	1.0	50%
Neonatal Unit	20.7	17.4	3.3	15.8%	Neonatal Unit	4.3	4.4	(0.1)	-3%
Newmarket Hosp-Rosemary ward	16.6	14.7	1.8	11.0%	Newmarket Hosp-Rose	25.8	19.5	6.2	24%
Recovery Unit	21.9	20.2	1.7	7.6%	Recovery Unit	0.9	0.9	0.0	1%
Ward F1 Paediatrics	22.3	21.8	0.6	2.5%	Ward F1 Paediatrics	7.2	7.0	0.2	3%
Ward F12	11.9	9.5	2.4	20.1%	Ward F12	5.9	3.9	1.9	33%
Ward F3	22.2	20.3	1.9	8.5%	Ward F3	25.8	26.5	(0.7)	-3%
Ward F4	13.6	13.7	(0.0)	-0.3%	Ward F4	14.6	12.1	2.5	17%
Ward F5	22.2	20.1	2.0	9.1%	Ward F5	18.1	16.1	2.0	11%
Ward F6	26.6	15.6	10.9	41.1%	Ward F6	17.4	19.4	(2.1)	-12%
Ward F7 Short Stay	24.9	22.1	2.8	11.3%	Ward F7 Short Stay	25.8	22.6	3.2	12%
Ward F9	21.8	17.1	4.7	21.4%	Ward F9	23.2	29.6	(6.5)	-28%
Ward G1 Hardwick Unit	28.6	24.1	4.5	15.7%	Ward G1 Hardwick Uni	10.5	10.8	(0.3)	-2%
Ward G3	22.1	18.4	3.7	16.6%	Ward G3	23.0	27.3	(4.3)	-19%
Ward G4	22.1	20.4	1.7	7.9%	Ward G4	22.8	21.1	1.7	7%
Ward G8	32.7	29.7	2.9	9.0%	Ward G8	20.6	22.7	(2.1)	-10%
Renal Ward - F8	19.5	19.6	(0.1)	-0.7%	Renal Ward - F8	25.8	22.8	3.0	11%
Ward F10*	0.0	0.0	0.0	NA	Ward F10*	0.0	1.0	(1.0)	0%
Respiratory Ward - G9	23.7	21.9	1.8	7.4%	Respiratory Ward - G9	18.0	18.4	(0.4)	-2%
Total	**600.1**	**541.5**	**58.6**	**9.8%**	**Total**	**388.4**	**378.8**	**9.6**	**2.5%**
Hospital Midwifery	60.0	53.4	6.6	10.9%	Hospital Midwifery	15.6	14.6	1.0	6%
Continuity of Carer Midwifery	18.3	16.9	1.4	7.5%	Continuity of Carer Mid	0	0	0.0	0%
Community Midwifery	19.1	17.3	1.9	9.8%	Community Midwifery	3.8	3.8	(0.0)	0%
Total	**97.4**	**87.6**	**9.8**	**10.1%**	**Total**	**19.4**	**18.4**	**1.0**	**5%**

*F10 closed due to building work, staff have been temporarily redeployed to other areas which now represent an overfill.

Appendix 3:

Ward by Ward breakdown of Falls and Pressure ulcers May 2020

HAPU

May	Cat 2	Cat 3	Unstageable	Total
Total	**15**	**1**	**4**	**20**
F3 -	1	0	1	2
F5 -	2	0	0	2
G1 -	2	0	0	2
G3 -	0	1	1	2
G4 -	1	0	1	2
G8 -	2	0	0	2
Gastroenterology Ward	2	0	0	2
Respiratory Ward	1	0	1	2
F4 -	1	0	0	1
F6 -	1	0	0	1
Renal Ward	1	0	0	1
F7	1	0	0	1

Falls

May	None	Negligible	Minor	Moderate	Major	Total
Total	**39**	**4**	**14**	**1**	**1**	**59**
G8 -	6	1	2	0	0	9
G3 -	3	0	3	0	0	6
F5 -	5	0	0	0	0	5
F7	2	0	2	1	0	5
G4 -	2	1	0	0	1	4
Respiratory Ward	4	0	0	0	0	4
F3 -	2	0	1	0	0	3
F6 -	2	1	0	0	0	3
Cardiac Centre -	2	0	0	0	0	2
G1 -	1	0	1	0	0	2
Renal Ward	1	0	1	0	0	2
Rosemary Ward	2	0	0	0	0	2
Acute Assessment unit (AAU)	1	0	1	0	0	2
Physiotherapy Department	2	0	0	0	0	2
Ambulatory Emergency Care (AEC)	1	0	0	0	0	1
DSU - Ward / Adjacent Area	1	0	0	0	0	1
F11 - Antenatal / Postnatal Ward	1	0	0	0	0	1
Gastroenterology Ward	0	0	1	0	0	1
Glastonbury Court	0	0	1	0	0	1
Lymphoedema Service	0	1	0	0	0	1
Radiology Department	0	0	1	0	0	1
X-Ray Department	1	0	0	0	0	1

Appendix 4: Red Flag Events

Maternity Services

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

Acute Inpatient Services

Unplanned omission in providing patient medications.
Delay of more than 30 minutes in providing pain relief
Patient vital signs not assessed or recorded as outlined in the care plan.
Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as: • pain: asking patients to describe their level of pain level using the local pain assessment tool • personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration • placement: making sure that the items a patient needs are within easy reach • positioning: making sure that the patient is comfortable and the risk of pressure ulcers is assessed and minimised.
A shortfall of more than eight hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift
Fewer than two registered nurses present on a ward during any shift.

11:25 BUILD A JOINED-UP FUTURE

16. Digital Board Report

To receive report

For Report

Presented by Craig Black

Trust Board Meeting – 25 June 2021

Agenda item:	16			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Sarah Jane Relf, Head of Digital Transformation			
Date prepared:	20 June 2021			
Subject:	To receive update from Digital Board			
Purpose:	x	For information		For approval

Executive summary:
This paper confirms key points of interest raised and discussed at the Digital Board on 6 May 2021. The main focus of the meeting was to receive feedback from the future system digital fortnight programme where the clinical leadership teams had been considering the digital opportunities for the new build.

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

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

Previously considered by:	*Separate pillar group meetings and Digital Board.*
Risk and assurance:	*Full risks are reviewed at each meeting with any high-level risks reported through to board assurance framework as appropriate.*
Legislation, regulatory, equality, diversity and dignity implications	*GDPR consideration is applied to all projects.*

Recommendation:
The Board is asked to note the update.

1. Background

1.1 In May 2016, the Trust embarked on a major change programme to introduce a new electronic patient record (EPR). The EPR was built around the Cerner Millennium product and was locally branded e-Care. Over time we have significantly enhanced the original e-Care offer with the introduction of new Cerner modules, implementation of other complimentary digital solutions and the extension of e-Care to other departments.

1.2 The Trust continues to implement additional systems and solutions to work towards improved workflows for staff and patients. These are governed under four pillar groups as shown below:

- Pillar 1: Hospital based clinical systems
- Pillar 2: Population health and single care record
- Pillar 3: Community systems
- Pillar 4: Infrastructure

The Digital Board continues to oversee the entire digital programme. The remainder of this paper describes the items that were discussed at the Digital Board meeting on 6 May 2021.

2. General update on digital programme

2.1 The Digital Board noted the successful go lives for maternity, neonates and some significant medicines changes. It was also noted that the major project to move community staff onto our own digital infrastructure had been completed successfully. It was noted that these were all major projects that had taken significant resource within the department. The team confirmed that they were finalising projects and priorities for 2021/22.

3. Capital budget restrictions

3.1 The Director of Resources gave an update to the digital board on the capital investment plan, explaining that currently, capital is severely constrained. He further advised the allocation from the Department of Health has not been finalised yet so there is uncertainty regarding what the final capital programme will look like, however it is likely to be significantly less than we had received in previous years.

4. Future system digital update

4.1 It was noted that the Chief Information Officer and the Head of Digital Transformation were leading on the digital element of the wider future system work (focussing on the new build for the health and care campus). As part of this work the team had organised a dedicated development programme where the digital clinical leaders had been brought together with the clinical leads for the future system programme.

4.2 The objective of the programme was to ensure that the future system clinical visions had maximised the full potential that existing and new technologies offered. The digital clinical team invested time to learn about new and emerging technologies and then partnered with the future system leads to present ideas and opportunities that could enhance the existing clinical visions.

4.3 A key principle to emerge from the programme was the concept of “digital first but not digital only”. This would mean that the Trust would maximise digital opportunities but ensure that we had alternative non-digital offers for those patients and carers that were either unable to

or did not want to engage with technology. This concept will be explored in detail with staff and patients to understand what the barriers and opportunities would be to this way of working.

4.4 A further key principle from the programme was the need to deliver this work as part of the wider health and social care system, exploiting the partnership opportunities that the alliance and integrated care system would offer.

4.5 Overall the development programme was hailed as a success and the model was suggested as one that should support other future system related workstreams. It was also noted that NHS Digital were very interested in the approach that had been taken.

5. Digital strategy development session

5.1 The formal meeting closed and the digital board members focussed on a development discussion around the refresh of the 5-year digital strategy.

6. Recommendation

6.1 The Trust board is asked to note the report.

Sarah Jane Relf
Head of Digital Transformation

17. Future system board report

To APPROVE report

For Approval

Presented by Craig Black

Public Board Meeting – 25th June 2021

Agenda item:	17			
Presented by:	Craig Black – Executive Director for Resources & Deputy CEO			
Prepared by:	Gary Norgate, Programme Director			
Date prepared:	14/06/2021			
Subject:	Update on the Future System Programme			
Purpose:	X	For information		For approval

Since last month's meeting we have made progress on several fronts and have received confirmation of when we can expect our project to be scheduled as part of the wider National Hospitals Programme (NHP).

Executive Summary

As a general indication of health, the status of those tasks within the control of Future System Programme remain unchanged as 'Green' and significant strides having been made in several key areas:

1. Works continues on the detailed environmental impact assessment (EIA) at Hardwick Manor. Soil samples have been taken, trees have been surveyed and discussions have commenced with the department of archaeology.
2. Discussions with Atos have identified the means through which the technological options emerging from our "Digital Fortnight" will be assessed in terms of costs and benefits.
3. A presentation was delivered to the West Suffolk Hospital Council and to West Suffolk Councillors.
4. Planning for the communications and engagement plan relating to our planning application is in full swing.
5. The co-production of the clinical model for the new hospital remains on track to inform our application for planning permission.
6. Work has begun on understanding the strategy for car parking and the options for ensuring we provide the optimal blend of sufficient on-site and off-site spaces.
7. The clinical co-production team are engaged with the project aimed at reducing Covid backlogs through optimised provider collaboration (Accelerator).
8. The national hospitals programme (NHP) have written to the project team explaining that a schedule for the 40 hospital projects has been finalised and that our Project can expect a construction start date in the latter half of the decade.
9. The next month should provide clarity on the process for funding of our ongoing preparatory works. We should also be nearing the completion of our clinical visions and the associated schedule of accommodation (SOA).

Strategic Outline Case (SOC) – Communication from the New Hospital Programme (NHP) confirms that our project is scheduled to commence in the second half of this decade, following the planned public spending review. This was not unexpected and provides sufficient time and scope to ensure we optimise the clinical design that underpins the physical size and layout of any new hospital.

We need to remain focussed on completing those milestones that ensure we are absolutely and unquestionably "oven ready" by 2025 – these include securing outline and full planning permission which in turn require the development of the clinical model and schedule of accommodation and digital roadmap – so no real change!

This means that the immediate milestones on the critical path remain:

- Phase 2 co-production of an optimised clinical model (including exploration of opportunities for vertical and horizontal integration) – underway - output due 28th July
- Production of outline schedule of accommodation (SOA) based upon the clinical design – underway, runs in parallel with the clinical design – output due 28th July
- Turning the SOA into 1:200 architectural drawings – output due 3rd November
- Completion of Environment Impact Assessment (EIA) – scope has been produced and the assessment has to run across three seasons to ensure the lifecycle of flora and forna are understood – output due 12th December
- Prepare planning submission – submission will be finalised using the outcome of the EIA and architectural drawings – 12th December to 22nd December.
- Formal submission of planning application – 22nd December.
- Outcome of planning application – 4th May 2022

Estates – Work continues on the development and execution of plans to mitigate the risks to a successful planning application. The environmental impact assessment relating to Hardwick Manor continues at pace with tree surveys and soil sampling making significant progress. Discussions have also commenced positively with those responsible for the region's archaeology. The project team have had initial discussion to understand the area of land that would require archaeological assessment as well as how and when these surveys would be carried out. At this stage there is no reason to believe that complying with guidelines on surveys will delay our programme.

The team have started to consider the various options for balancing the need to park on site with the need to minimise environmental impact and the desire to minimise site traffic whilst aiding the health and well-being of staff and visitors. The team will return to the Board with a detailed paper once it has worked up the various options for addressing this shortfall.

Car parking strategy has a significant impact on our staff, our patients, their families and our community. It also not something that cannot be considered in isolation of the wider environmental, public health and wellbeing debate – hence it will be subject to extensive modelling and co-production.

Clinical / Digital Workstream – Following on from last month's discussion of the outputs from our "digital fortnight", the team have met with our partner ATOS to discuss their role in the national programme and how we might analyse the costs and benefits of those technologies that have been identified as important to the realisation of our clinical vision. The key points of our discussion were:

1) The 8 front running trusts have had their respective digital maturity assessed by consultants, Mott McDonald.
2) The digital maturity model has 5 elements:
    a. Digital strategy and vision
    b. Patient and Staff experience (i.e. understanding of how digital would impact each)
    c. Digital estate (the extent to which a Trust's blueprints extend into making the building itself "smart" – so called building information management (BIM))
    d. Digital Technology – to what extent has a Trust defined technology in terms of the impact that it has upon fabric, footprint and flow of and around the building)
    e. Culture, capability and partners assessment (the extent to which the Trust and its partners are ready and willing to accept, implement and realise the changes and benefits that stem from digitization).
3) Of the 8 front running trusts, none were scored "Green" overall.
4) ATOS said that their work with us had impressed them in terms of our engagement, experience and enthusiasm. They would score us highly in terms of the first two criteria but would say we had more to do in terms of Building Information Modelling (BIM). Overall, they would say that we would currently score AMBER / AMBER GREEN.
5) ATOS have been retained by NHP and NHS Digital to work on the further development of a) the standards and blueprints etc and b) a model for assessing the cost, risk and benefit of available technologies.

6) ATOS showed us a prototype of the cost / benefits model and it is highly impressive in terms of its ability to calculate gains in terms of cash and non-cash benefits (e.g. impact on car parking spaces and bed numbers etc).
7) Sitting behind the model are algorithms and equations developed in conjunction with Archus (the healthcare and infrastructure consultancy).
8) The timing of our own research would seem to lend itself nicely to the prompt application of this model.

So, in terms of actions, we agreed:

1) ATOS will position our project with NHP as one that would benefit from formal or informal assessment against the 5 elements described in point 3 above.
2) ATOS to release of the cost / benefit tool to us for application.
3) Technical team to consider how we integrate BIM into our digital blueprints.

The clinical co-production has made significant progress and is on track to inform the schedule of accommodation required for the planning process by the planned date of 28th July. The programme allows for several rounds of iteration and innovation without impacting the planning milestones. Consequently, the teams have time and space to:

a) Reflect on opportunities for supplier collaboration,
b) Revisit the capacity and demand modelling,
c) Understand and apply the efficiencies that stem from our digital blueprint
d) Reflect the central design decisions emanating from the front running trusts.
e) Ensure the entire health and care system come together to address the growth and changes in demand.

Communications and Engagement – We continue to engage our public through presentations at fora such as West Suffolk Councillors, West Suffolk Hospital Council and Mildenhall WI, however, we are also on the cusp of launching an engagement process specifically in support of our planning application. Two periods of intensive engagement have been planned for June and Autumn. The first will focus on engaging the wider public on early plans for the new hospital, how and why the preferred site has been selected and will provide a platform through which people can share comments and feedback. The second of the two periods will add more detail on potential designs and positioning for the new building. Feedback gathered during these engagement phases will help formulate the planning application due to be submitted at the end of the year.

All in all, a month in which the significant progress has been made in the development of our clinical design and the understanding of how this can be enhanced through the application of the latest digital innovations. The work to ensure the hospital remains safe while we develop its replacement continues at pace and we continue to live our goal to make this the most co-produced hospital in the HIP programme. Next month will hopefully produce some clarity of the extent to which our immediate plans will be funded by the NHP.

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:	Future System Programme Board.						
Risk and assurance:							
Legislation, regulatory, equality, diversity and dignity implications	None						
Recommendation: For update to be noted							

11:35 GOVERNANCE

18. Governance report

To APPROVE the report, including subcommittee activities

For Approval

Presented by Ann Alderton

Board of Directors – 25 June 2021

Agenda item:	18			
Presented by:	Ann Alderton, Interim Trust Secretary			
Prepared by:	Karen McHugh, EA to CEO Ruth Williamson, Trust Office Manager			
Date prepared:	17 June 2021			
Subject:	Governance report			
Purpose:	X	For information	X	For approval

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

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

2. **Trust Executive Group report** (for information)
   Workshop undertaken on 2nd June in respect of Trust Strategy. Consultation with staff and representatives to follow.

3. **Council of Governors** (for approval)
   A Council of Governors meeting was held on 17 June 2021 via Microsoft Teams. A report is presented to the board of directors for information to provide insight into these activities (see 18.1).

4. **General condition 6 and Continuity of Services condition 7 certificate** (for approval)
   NHS Improvement has two self-certification requirements for approval by the Board as part of the annual reporting arrangements. The Board is required to approve these statements as part of an annual submission relating to the licence (see 18.2)

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: The board is asked to note the contents of the reports	

Annex A: Scheduled draft agenda items for next meeting – 30 July 2021

Description	Open	Closed	Type	Source	Director
Declaration of interests	✓	✓	Verbal	Matrix	All
Deliver for today					
Patient/staff story	✓	✓	Verbal	Matrix	Exec.
Chief Executive's report	✓		Written	Matrix	SD
Operational report	✓		Written	Action	HB
Report from 3i Committees: Insight, Improvement & Involvement	✓		Written	Matrix	RD / AR /
Finance & workforce performance report	✓		Written	Matrix	CB
Risk and governance report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
Integration report – Q1	✓		Written	Matrix	KV
Invest in quality, staff and clinical leadership					
Quality, safety and improvement report - Infection prevention and control assurance framework - Maternity services quality and performance report (inc. Ockenden) - Nurse staffing report - Nurse staffing strategy review	✓		Written	Matrix	SW / PM
People and OD highlight report - Appraisal and mandatory training report - Staff recommender scores	✓		Written	Matrix	JMO
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	SW
Build a joined-up future					
Digital Board report	✓		Written	Matrix	CB
Future system board report	✓	✓	Written	Matrix	CB
Strategic update, including Alliance, System Executive Group and Integrated Care System (ICS		✓	Written	Matrix	KV / SD
Governance					
Governance report, including - Agenda items for next meeting - Use of Trust's seal - TEG report - Remuneration committee report - Risk appetite statement - Scope for well led developmental review - Annual complaint report - Audit committee report - Annual review of reporting schedule - NED responsibilities	✓		Written	Matrix	AA

Scrutiny Committee report		✓	Written	Matrix	LP
Board assurance framework			Written	Matrix	SW
Confidential staffing matters		✓	Written	Matrix – by exception	JMO
Reflections on the meetings (open and closed meetings)		✓	Verbal	Matrix	SC

18.1. Council of Governors report with Foundation Trust Membership Strategy

For Approval

Presented by Sheila Childerhouse

Board of Directors – 25 June 2021

Agenda item:	18.1			
Presented by:	Sheila Childerhouse			
Prepared by:	Georgina Holmes, Foundation Trust Office Manager			
Date prepared:	18 June 2021			
Subject:	Report from Council of Governors, 17 June 2021			
Purpose:		For information	X	For approval

This report provides a summary of the business considered at the Council of Governors meeting held on 17 June 2021 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 but able to observe via YouTube.
- The Chair welcomed everyone to the meeting and introduced Christopher Lawrence and Ann Alderton.
- Actions from the previous meetings were noted and reviewed. Updates were provided on items in the ongoing issues log, including the People Plan and Future System Programme.
- 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 challenges facing the Trust and highlighted the key strategic issues, including an update on the Trust's strategy review.
- Governors' questions raised during the last quarter were noted. The need for these to be assurance based, rather than operational was stressed.
- A report on engagement activities for the Future System was received and the governors' role in this noted.
- A report was received from the Engagement committee and the amendments to the Membership Strategy approved, subject to a minor correction. These amendments reflected the extended membership area and restrictions on engagement due to social distancing requirements.

  The recruitment targets have been updated to take into account restrictions due to Covid 19. The updated Membership strategy would be submitted to the board for approval on 25 June.
- The quality and performance and finance reports were reviewed and questions asked on areas of challenge, including the recovery/accelerator programme and balancing this with staff wellbeing.
- An update was provided on Freedom to Speak Up and plans for the future.
- Reports were received from the NED chairs of each of the 3i committees.
- A report was received from the Nominations committee and amendments to the terms of reference approved.
- Reports from the lead governor and staff governors were received and noted.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**		**Invest in quality, staff and clinical leadership**		**Build a joined-up future**		
	X		X		X		
Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X	X	X	X	X	X	X
Previously considered by:	Report received by the Board of Directors for information to provide insight into the activities and discussions taking place at the governor meetings.						
Risk and assurance:	Failure of directors and governors to work together effectively. Attendance by non-executive directors at Council of Governor meetings and vice versa. Joint workshop and development sessions.						
Legislation, regulatory, equality, diversity and dignity implications	Health & Social Care Act 2012. Monitor's Code of Governance.						

Recommendation:

The Board is asked to:

- Note the summary report from the Council of Governors.
- Approve the Membership Strategy for 1 April 2021-31 March 2023 (Appendix A)

Appendix A

Membership Engagement Strategy

April 2021 to March 2023

Engagement Strategy

Contents Page **Page**

1. Introduction

West Suffolk NHS Foundation Trust is committed to being a successful membership organisation and strengthening its links with the local community.
We recognise that we need to commit significant resources both in time and effort to developing our membership and engaging with the public and this strategy sets out the actions that we will take in support of this.

1.1 Purpose of strategy

This strategy outlines our vision and the methods we intend to use to maintain and build a representative and engaged public and staff membership. It also outlines our future plans in terms of recruitment and engagement and how we will measure the success of our membership and future engagement.

Delivery of the future plans set out in this strategy will be achieved through an agreed development plan with defined responsibilities and timescales for delivery.

This is an evolving strategy and will be subject to change as lessons are learnt.

1.2 Engagement objectives

Our vision for engagement within the Trust must underpin the organisational vision, priorities and ambitions. We should support the organisation in achieving the Trust's strategy with our aspirations for engagement.

Deliver for today
• Increase understanding amongst the public and members of the Trust's strategy and the range of services offered by it, including current changes in health services and the challenges the Trust and local health and care services are facing • Maintain our existing membership base and ensure that it reflects the diversity of our local communities
Invest in quality, staff and clinical leadership
• Actively engage with the public and members to understand their views and aspirations for the Trust, including how it can develop and improve • Through our representative membership learn from, respond to and work more closely with our patients, public, staff and volunteers to develop and improve our services
Build a joined up future
• Deliver a range of engagement events and activities to focus on engagement and communicating the strategic plans for the Trust • Strengthen engagement with users of community services and staff delivering these services • Through the range of events and contacts promote wellbeing

Through these objectives the Trust will develop a thriving and influential Council of Governors which is embedded in the local community, is responsive to the aspirations and concerns of the public and members, and works effectively with the Board of Directors.

2.0 The membership

Our Membership allows us to develop a closer relationship with the community we serve. It provides us with an opportunity to communicate with our members on issues of importance about our services.

We recognise that for the membership to be effective and successful, we must provide benefits and reasons for people to join us.

Our members will:

- be kept up to date with what is happening at the Trust by receiving the members' newsletter;
- be able to stand for election as a governor;
- have the opportunity to vote in the elections to the Council of Governors;
- be able to learn more about our services by attending member events, including Council of Governor meetings;
- have the opportunity to be included in consultation events on hospital and service developments – both internally for staff and externally for our patients and public;
- have the opportunity to pass on their views and suggestions to governors;
- be invited to attend the Annual Members' Meeting.

Membership is free and there is no obligation for members to get involved apart from receiving the newsletter.

2.1 Becoming a member

Our potential members can be drawn from the following:

- public, including patients who live within our membership area (**public members**)
- staff who are employed by the Trust, or individuals that meet the criteria under 2.2.2 (**staff members**)

An individual who satisfies the criteria for membership of the staff constituency may not become or continue as a member of the public constituency. Members can join more than one foundation Trust.

All members must be 16 years of age or over.

A person can become a member by:

- completing a membership application form, which is available on our website, by request from the membership office or from the hospital's main reception;
- joining 'online' via the Trust's website at www.wsh.nhs.uk;
- e-mailing membership. foundationtrust@wsh.nhs.uk;

2.2 Defining our membership

2.2.1 Public

The Trust has two public constituencies; a) Suffolk and bordering areas; b) Rest of Norfolk, Cambridgeshire and Essex. The minimum number of members in each public constituency will be 100. Patients and members of the public who reside in these areas are eligible to join our public constituencies.

Appendix 1 provides a detailed breakdown of eligible wards for our public constituencies. Public members are recruited on an opt-in basis.

As we continue to develop and provide more services in community settings the Trust recognises that this may mean that services grow beyond the current boundaries of the organisation. Therefore, the Trust expanded its membership area in May 2021 and will continue to review this on an annual basis to ensure it is representative of the area served by the Trust.

2.2.2 Staff

To be eligible to be a staff member, people must either:

- be employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or have been continuously employed by the Trust under a contract of employment for at least 12 months; or

- exercise functions for the purposes of the Trust, without a contract of employment, continuously for a period of at least 12 months. For clarity this does not include individuals who exercise functions for the purposes of the Trust on a voluntary basis.

All staff automatically become members unless they choose to opt-out of the scheme.

3.0 Recruitment of members

We wish to encourage and develop a strong sense of community involvement with the membership. Therefore, we will continue to actively recruit new members.

Our aim is to have a membership that is informed and engaged in our activities and members who feel part of our organisation.

3.1 Methods of recruitment

Our initial membership recruitment drive began as an integral part of our consultation process.

While we undertook some direct mail recruitment campaigns in the early days, more recently we have found that the most effective method of recruitment is face to face. This can be done internally within hospital or out in the community.

While social distancing is being applied as part of the COVID-19 response it will not be possible to undertake our usual face-to-face engagement activities. Changes in working practices as a result of COVID-19 will also impact on the nature of engagement activities e.g. greater use of telephone consultations will mean that more patients receive their care and treatment without the need to come onto the hospital site. Recognising this there will be a need to review how changes to patient pathways may impact on our approaches to engagement, with the expectation of a greater focus on digital engagement in the future.

Methods of recruitment used in the past include:

- attending public meetings and events including festivals, stands in sports & healthy living events and recruitment fairs;
- targeted recruitment of staff members' friends and family;
- using local newspapers;
- on-line recruitment through the Trust's website;
- through a mail-shot to all households in the membership area;
- in-house e.g. Courtyard Café, Friends shop and outpatients

3.2 Who is responsible for recruiting members?

The Board of Directors has overall responsibility for the membership strategy.

The Engagement Committee of the Council of Governors advises on where the Trust should focus its effort on recruitment to ensure we have a balanced membership, and it is the responsibility of all governors and the FT Office Manager to actively recruit members.

Staff and volunteers are also encouraged to recruit members; for example family members, friends or patients and members of the public visiting the Trust.

3.3 Recruitment plan

We aim to recruit new members year on year to maintain our public membership at the current numbers of engaged members. As part of the recruitment plan experience has shown that engaging with the public is a very effective way of recruiting new members and gaining their views on West Suffolk Hospital and the service we provide in the community (covering both the west and east of the county).

3.3.1 Public members

Direct recruitment plan
(subject to social distancing restrictions)

- active engagement and recruitment within the hospital and other healthcare environments e.g. courtyard café, out-patient clinics and healthy living centres
- providing literature to staff working in community settings to share with service users and their families
- public education events e.g. “medicine for members”
- voluntary organisations – ensuring inclusion from ethnic and marginalised groups of people
- education facilities e.g. school talks and college events
- local non-NHS patient groups e.g. support groups
- sports organisations e.g. leisure centres, rugby and football clubs
- PALS office
- Work with partner organisations to establish best practice in membership recruitment e.g. NHS Providers and other NHS FTs.
- Encourage former staff members to become public members on leaving the Trust

Indirect recruitment plan

- development of digital communication; particularly to assist in increasing engagement with younger people and ethnic groups.
- website
- consider inclusion with other patient information e.g. bedside lockers for inpatient areas
- posters and leaflets in clinic and outpatient areas
- posters in GP surgeries, dentists, opticians and pharmacists

Media coverage

- membership newsletter
- local newspaper coverage e.g. the Bury Free Press and East Anglian Daily Times (EADT)
- local radio e.g. Radio Suffolk, Radio West Suffolk
- community newsletter coverage, including Parish Council and local Council information/resource guides

3.3.2 Staff

Staff are automatically members unless they choose to opt-out. New members to the Trust will receive information from HR in their induction pack explaining the benefits of membership. An individual who satisfies the criteria for membership of the staff constituency may not become or continue as a member of the public constituency.

We will seek to ensure that no more than 1% of staff opt-out of membership.

4.0 Engaging with public and members

Engagement with our members is as important as recruitment, to ensure that we have an effective and active membership. We will work with the patient experience team to ensure that Governors contribute to and support the range of engagement activities undertaken by the Trust (as set out in the new Experience of Care Strategy).

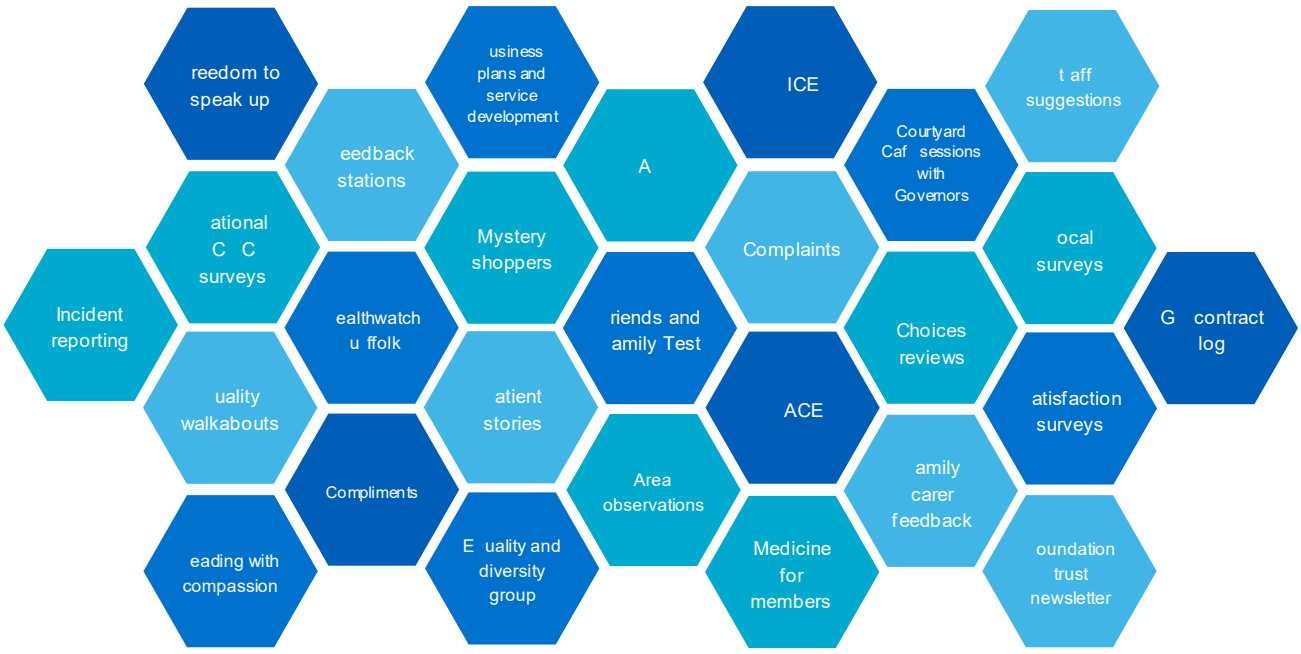


Figure 1: Feedback collection methods from Experience of Care Strategy

4.1 Members' newsletter

The membership newsletter is distributed to all members.

Staff are able to access the newsletter via a link which is included in weekly staff bulletin (Green Sheet) when it is published on the website.

Hard copies are also available in key staff areas including Time Out.

The newsletter provides an opportunity to communicate key issues and developments, including news and "dates for the diary".

4.2 Public and Member events

When COVID-19 social distancing requirements allow it is expected to continue to hold regular events for the public and members. Suggestions for topics will be based on the most popular areas of interest of the members and by the views of governors. Subjects may also be chosen from topical issues, such as quality accounts.

These events will be advertised in the members' newsletter and on the website. They will also be advertised in the weekly staff bulletin ("Green heet") and by posters displayed within the Trust.

Members who have expressed an interest in a particular service or area of interest will be invited to relevant activities.

4.3 Staff involvement

Staff members will be encouraged to take part in public and member events, as it is an opportunity for departments to raise awareness of the services they provide, to highlight benefits of being treated at the Trust and to answer questions from members. It will also be a chance for us to receive valuable feedback from the public and our members.

4.4 Engagement plan

Positive engagement with our members is extremely important. The Engagement Committee of the Council of Governors have considered how we can most effectively engagement with our membership.

As described member recruitment and engagement are often most effective when undertaken together. Therefore the direct recruitment plans set out in section 3.3.1 will also in effect provide effective engagement activities. Future engagement plans with our members will also include:

- the members' newsletter to be distributed to all members
- development of digital communication
- review how changes to patient pathways as a result of COVID-19 may impact on our approaches to engagement
- regular member events with suggestions from governors of recommendations from their members for future member events e.g. "medicine for members"
- staff governors holding staff member engagement sessions
- staff governors to communicate to staff via the "Green heet"
- greater use of electronic communication with members
- the annual members' meeting – this is an opportunity for members to hear more about the Trust's achievements plus the opportunity to ask uestions
- working with partner organisations to establish best practice in membership engagement e.g. NHS Providers and other NHS FTs
- through active engagement gathering information on patients and the public's expectations and/or experiences of the service we provide in the hospital and community e.g. Courtyard café, quality walkabouts and area observations. The results of which are fed back to the Patient & Carers Experience Group.

The Trust is responsible for the delivery of community services in the west of Suffolk and the engagement delivery plan continues to be developed to ensure a focus on the care we provide in the community and in partnership with the West Suffolk Alliance.

The Trust also has a role to play in promoting prevention and a healthy lifestyle. This will be done by working with our partners to engage with the public in promoting prevention and a healthy lifestyle.

5.0 The membership register

We maintain a register of staff and public members and this is available to the public. All members are made aware of the existence of the public register and have the right to refuse to have their details disclosed (General Data Protection Regulation.).

The public register is maintained on our behalf by Civica and contains details of the member's name and the constituency to which they belong. Eligible members of the public constituency who complete a membership application form will be added to the register of members.

The staff register is maintained by the Trust's R department. Eligible staff will automatically be added to the register, unless they 'opt out'.

The public register is validated prior to any mailing to ensure that it remains accurate. Details of members who have moved away or died are removed from the register.

6.0 Monitoring success

The membership strategy will be monitored on behalf of the Board of Directors by the Engagement Committee of the Council of Governors.

The FT Office Manager and the Engagement Committee will also undertake a key role in leading and managing the implementation of this strategy and its future development.

An annual review of the strategy will take place by the Engagement Committee.

6.1 How will the success be measured?

The success of the strategy will be measured by the following criteria:

Criteria	As at 31 March 2021	Target (Mar 2023)
1. Achievement of the recruitment target: a. Total number of Public members b. Staff opting out of membership	 **6251** **<1%**	 6,000 <1%
2. Achieve a representative membership for our membership area, Priorities for action: a. Age – recruitment of under 50s b. Engagement and recruitment events in all market towns of Membership area (Thetford, Newmarket, Stowmarket, Haverhill and Sudbury)	 **1240** **20%**[1]	 1,250 40%
3. An engaged membership measured by: a. number of member events b. member attendance – total all events c. annual members' meeting attendance (each year)	 **2** **362**[2] **295 (2019)**	 3[3] 400[2 and 3] 200

[1]Figure as at March 2020 (paused due to Covid-19)
[2] Includes people attending annual members' meeting – figure as at March 2020 (paused due to Covid-19)
[3] Figures have been adjusted due to Covid-19

A review of the membership recruitment targets will take place each year as part of the annual plan submission to NHS Improvement.

Appendix 1

PUBLIC CONSTITUENCIES OF THE TRUST

The Trust has two public constituencies made up of the wards below. The minimum number of members in each public constituency will be 100. Patients and members of the public who reside in the following areas are eligible to join our public constituencies:

A. Suffolk and bordering areas

Babergh:	All wards.
Braintree:	Bumpstead, Hedingham and Maplestead, Stour Valley North, Stour Valley South, Upper Colne, Yeldham
Breckland:	Conifer, East Guiltcross, Harling and Heathlands, Mid Forest, Thetford-Abbey, Thetford-Castle, Thetford-Guildhall, Thetford-Saxon, Watton, Wayland, Weeting, West Guiltcross
East Cambridgeshire:	Bottisham, Burwell, Cheveley, Dullingham Villages, Fordham Villages, Isleham, Soham North, Soham South, The Swaffhams
East Suffolk:	All wards
Ipswich	All wards.
King's Lynn and: West Norfolk	Denton
Mid Suffolk:	All wards.
South Norfolk:	Bressingham and Burston, Diss and Roydon
West Suffolk:	All wards.

B. Rest of Norfolk, Cambridgeshire and Essex

All wards of Norfolk, Cambridgeshire and Essex, excluding wards mentioned in public constituency A (Suffolk and bordering areas) above.

18.2. Certificate for NHS Improvement licencing

For Approval

Presented by Ann Alderton

Board of Directors – 25 June 2021

Agenda item:	18.2			
Presented by:	Ann Alderton, Interim Trust Secretary			
Prepared by:	Ann Alderton, Interim Trust Secretary			
Date prepared:	18 June 2021			
Subject:	Certificate for NHS Improvement licencing			
Purpose:		For information	X	For approval

Executive summary:

NHS Improvement has two self-certification requirements for approval by the Board as part of the annual reporting arrangements. These follow a similar structure and content to previous years and sit alongside the general condition 6 certificate.

The Board is required to approve the following annual statements and certifications as part of our licencing submissions to NHS Improvement. These are set out below and in greater detail within **Annex A**:

1. **Corporate Governance statement - *Confirmed***
   A range of statements are detailed coving compliance with corporate governance best practice; effective systems and processes; and having the correct personnel in place.

   It is proposed to indicate that the requirement has been met. This is supported by a range of assurances including annual governance assessment; internal and external audit opinions; review by external agencies, including performance and management information reported to the Board and its subcommittees.

2. **Training of governors - *Confirmed***
   The Board is asked to confirm that it is satisfied that during 2020/21 it provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure governors are equipped with the skills and knowledge they require.

   It is proposed to indicate that the requirement has been met. This is supported by the working and information received at the Council of Governors, its subcommittees and workshops; training provided during the year; and governor attendance at external events. This compliance position is supported by details in the Annual Report:

   - Governor training day with external trainer – governance, assurance and the role of governors; quality, accountability and relationship with the Board; effective questioning and challenge; governor feedback and action planning.
   - Joint governor and non-executive director training session with external trainer.
   - Sessions on finance with the Executive Director of Resources, quality and performance with the Chief Operating Officer and Executive Chief Nurse.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**		**Invest in quality, staff and clinical leadership**		**Build a joined-up future**		
	X		X		X		
Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X	X	X				X
Previously considered by:	General condition 6 and Continuity of Services condition 7 certificate approval as part of Annual Report & Accounts. Governor commentary, including training, approved for inclusion in Annual Quality Report.						
Risk and assurance:	Governance and risk management framework underpinned by policy and procedures. Internal and external audit review of control environment. Annual governance review. Internal and External Audit opinions as part of Annual Report and Accounts.						
Legislation, regulatory, equality, diversity and dignity implications	Set out in NHS Improvement Licence						

Recommendation:

1. The Board approve the six corporate governance statements and certification for training of governors (**Annex A**)
2. The Board receive in public session the general condition 6 and continuity of services condition 7 certificates (**Annex B**).

Annex A

Corporate Governance Statement

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

1	Corporate Governance Statement	Response	Risks and mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	

5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	**Confirmed**
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Confirmed**

Signed on behalf of the board of directors, and having regard to the views of the governors

Signature	**Signature**
Name Sheila Childerhouse	**Name** Dr Stephen Dunn

Certification on governance and training of governors

The Board are required to respond "Confirmed" or "Not confirmed" to the following statement. Explanatory information should be provided where required.

2 Training of Governors

The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

Confirmed

Signed on behalf of the Board of directors, and having regard to the views of the governors

Signature		Signature	
Name	Sheila Childerhouse	**Name**	Dr Stephen Dunn
Capacity	Chairman	**Capacity**	Chief Executive
Date	26 June 2020	**Date**	26 June 2020

Annex B General condition 6 and Continuity of Services condition 7 certificate

A. For Condition G6 – Systems for compliance with licence conditions and related obligations

Question 1

Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	**Confirmed**

Requirements to comply - Guidance on Condition G6 (extract from Monitor Licence)

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:
   (a) the Conditions of this Licence,
   (b) any requirements imposed on it under the NHS Acts, and
   (c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:
   (a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and
   (b) regular review of whether those processes and systems have been implemented and of their effectiveness.

B. For continuity of service – availability of resources

Question 2

After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	**Confirmed**

OR

After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	

OR

In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.	

In making the above declarations, the main factors which have been taken into account by the Board of Directors are as follows:

- Following a comprehensive inspection in 2019 the Trust's overall rating was downgraded to 'requires improvement' as a consequence of a reduction in the ratings in four core services (medical care, surgery, maternity and outpatients) with another core area (urgent and emergency) maintaining the same rating as awarded in 2016. The community services (adults, children and young people and inpatient services) were all rated as 'good'.

- After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern.

- In addition, the Trust has a borrowing arrangement in place with the Department of Health and Social Care (DHSC) to support its liquidity position. If the Trust no longer existed, health services funded by the DHSC would still be provided and ultimately all liabilities are underwritten by DHSC.

- The Trust achieved an adjusted surplus of £162k for 2020/21. The Trust is expecting to achieve a break even position for 2021/22.

- As across the NHS, our services this way have been dramatically affected by the Covid-19 pandemic this year. Despite this, we maintained urgent cancer treatment and other surgery throughout the pandemic

- We rapidly deployed new tools to support online health care, including virtual and telephone consultations, and support sessions including online exercise classes from our community cardiac rehabilitation team

- We introduced tools to support home working for staff, and launched regular virtual all-staff briefings to keep staff up to date and to encourage regular contact between the executive and staff

- We continued on our path of service and culture improvement, including education sessions on the Civility Saves Lives project and Merseycare Just Culture project

- We opened a new 10-bed major assessment area within our emergency department, designed to support treatment of infectious disease, including Covid-19

- The Sentinel Stroke National Audit Programme rated the West Suffolk Hospital stroke at its top A grade ranking for the ninth year in a row

- Radiology has been re-accredited with the Quality Standard in Imaging by the UK Accreditation Service for the tenth successive year

- Data sharing from our orthopaedic services was recognised as a National Joint Registry Quality Data Provider

- Community cardiac rehabilitation team accreditation by the British Association for Cardiovascular Prevention and Rehabilitation.

- Endoscopy services were accredited by the Royal College of Physicians Joint Advisory Group on endoscopy
- Our in-house catering team won the Health Business Awards Hospital Catering Award and was highlighted for its good practice in the national review of NHS catering services
- The Trust was part of a partnership awarded a five-year contract to develop the early supported discharge service for stroke patients across Suffolk, providing up to six weeks of intensive stroke rehabilitation in patients' own homes
- Pathology services have returned to in-house management, with renewed investment in equipment and facilities through a clear development and improvement plan
- Our GP practice based at Glemsford Surgery has begun a transformative project to improve patient care with planned improvements to both staffing and physical facilities
- Detailed planning and assessment work at our West Suffolk Hospital has enabled the creation of a significant programme of remedial work to support safe use of the building until delivery of replacement facilities through the national new hospital building programme
- We have begun a major co-production project to understand clinical and community asks for the new healthcare facility, and identified and purchased the neighbouring Hardwick Manor site as our preferred site.

11:45 ITEMS FOR INFORMATION

19. 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

20. Date of next meeting

To NOTE that the next meeting will be held on 30 July in West Suffolk Hospital

For Reference

Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

21. 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