NHS
West Suffolk
NHS Foundation Trust

Board of Directors (In Public)

Schedule	Friday 3 September 2021, 9:15 AM — 11:45 AM BST
Venue	Via video conferencing
Description	A meeting of the Board of Directors will take place on Friday, 3 September 2021 at 9:15am. The meeting will be held virtually via video conferencing
Organiser	Karen McHugh

Agenda

AGENDA
Presented by Sheila Childerhouse

Agenda Open Board 2021 09 03 Sept.docx

9:15 GENERAL BUSINESS
Presented by Sheila Childerhouse

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

2. Apologies for absence: Louisa Pepper, Paul Molyneux, Christopher Lawrence, Kate Vaughton
   To NOTE any apologies for the meeting and request that mobile phones are set to silent
   For Reference - Presented by Sheila Childerhouse

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

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

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

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

6. Minutes of the previous meeting
   To APPROVE the minutes of the meeting held on 30 July 2021
   For Approval - Presented by Sheila Childerhouse

   Item 6 - Open Board Minutes 2021 07 30 July Draft.docx

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

   Item 7 - Board Actions - Active.pdf

   Item 7 - Board Actions - Complete.pdf

8. Patient 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 Craig Black

   Item 9 - CEO Board report August 2021.docx

10:00 DELIVER FOR TODAY

10. Insight Committee Report
    To APPROVE the report
    For Approval - Presented by Richard Davies, Craig Black and Helen Beck

    Item 10 - Insight Committee report - front sheet and CKI.doc

10.1. Finance and workforce report
To APPROVE the report
For Approval - Presented by Nick Macdonald

- Item 10.1 - Finance and workforce report Cover sheet - M04.docx
- Item 10.1 - Finance and Workforce Report- July 2021 Final.pdf

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

- Item 10.2 - Operational Board update August 2021.doc
- Item 10.2 Annex A - SOAG Elective Summary - Sept 2021.pptx

10.3. IQPR
To NOTE the report
For Report - Presented by Helen Beck and Susan Wilkinson

- Item 10.3 - IQPR - Data June 2021.pdf

Comfort Break - 10 minutes

10:45 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

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11. Putting You First Award - August 2021
For INFORMATION
For Approval - Presented by Jeremy Over

- Item 11 - PYF Award - August 2021.doc

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12. Improvement Committee Report
To APPROVE the report
For Approval - Presented by Susan Wilkinson

- Item 12 - Improvement Committee Report and Chair's Key issues.docx

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12.1. Maternity services quality & performance report
To APPROVE the report
For Approval - Presented by Susan Wilkinson and Karen Newbury

Item 12.1 - Maternity Quality and performance report August 2021 03.09.21 Board.docx

Item 12.1 Annex A - MBRRACE-UK Rapid report 2021 Learning from SARS and associated deaths in the UK.docx

Item 12.1 Annex C - CNST submission of evidence, assurances and actions required.docx

Item 12.1 Annex D - Ockenden Submission of evidence, assurances and actions required.docx

Item 12.1 Annex E - Report on Covid 19 effects on Transitional Care and Neonatal Term Admissions.docx

Item 12.1 Annex F - Audit Report for Multidisciplinary Training July 2021.docx

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12.2. Infection prevention and control assurance framework
To APPROVE the report
For Approval - Presented by Susan Wilkinson

Item 12.2 - COVID IPC assurance framework - Sept 2021.docx

12.3. Nursing staffing report
To APPROVE the report
For Approval - Presented by Susan Wilkinson

Item 12.3 - Nurse Staffing report - 3 Sept 2021.docx

11:25 BUILD A JOINED-UP FUTURE

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

Item 13 - Future System Public Board overview - Aug 2021.doc

11:35 GOVERNANCE

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14. Governance report
To APPROVE the report
For Approval - Presented by Ann Alderton

Item 14 - Governance report - September 2021.doc

Item 14 Annex B - Audit Committee Annual Report 2021.doc

Item 14 Annex C - NEDs responsibilities 2021 Feb DRAFT.doc

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15. Organisational Framework for Governance
    To APPROVE the framework
    For Approval - Presented by Ann Alderton

    Item 15 - Organisational Framework for Governance - cover sheet.doc

    Item 15 - Organisational Framework for Governance - final for board.pptx

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16. Board Committee Terms of Reference
    To APPROVE the terms of reference for the following committees:
    • Audit Committee
    • Insight Committee
    • Improvement Committee
    • Senior Leadership Team
    • Involvement Committee
    • Remuneration Committee
    For Approval - Presented by Ann Alderton

    Item 16 - Board Committee Terms of Reference.doc

    Item 16 Annex A - Audit Committee.docx

    Item 16 Annex B - Insight Committee - draft terms of reference.docx

    Item 16 Annex C - Improvement Committee - draft terms of reference.docx

    Item 16 Annex D - Senior Leadership Team Terms of Reference.docx

    Item 16 Annex E - Involvement Committee - draft terms of reference v2 jmo.docx

    Item 16 Annex F - Rem Co ToR annual update 2021.docx

11:45 ITEMS FOR INFORMATION

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

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18. Date of next meeting

To NOTE that the next meeting will be held on 15 October in West Suffolk Hospital
For Reference - Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

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

9:15 GENERAL BUSINESS

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DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 30 JULY 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	•	
Christopher Lawrence	Non Executive Director	•	
Paul Molyneux	Interim Executive Medical Director	•	
Jeremy Over	Executive Director of Workforce and Communications	•	
Louisa Pepper	Non Executive Director		•
Alan Rose	Non Executive Director	•	
Sue Wilkinson	Executive Chief Nurse	•	
In attendance			
Ann Alderton	Interim Trust Secretary		
Helen Davies	Head of Communications		
Georgina Holmes	Trust Office Manager *(minutes)*		
Clement Mawoyo	Director of Integrated Services		
Daniel Spooner	Deputy Chief Nurse		
Governors in attendance (observation only): Florence Bevan, Allen Drain, Sarah Judge, Joe Pajak, Margaret Rutter, Jane Skinner, Liz Steele, Clive Wilson			

Action

GENERAL BUSINESS

21/122 RESOLUTION

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

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

21/123 APOLOGIES FOR ABSENCE

Apologies for absence were noted as above.

- The Chair welcomed Clement Mawoyo who had recently been appointed as joint Director of Adult Health and Social Care which was a very significant role and a key development in the integration of adult community health services and social care services.

  Clement Mawoyo introduced himself and gave a brief summary of his background and experience.

- The Chair referred to the recent announcement that Stephen Dunn would be stepping down as Chief Executive of the Trust. She said that working with him had been very special and she highlighted a number of the changes that he had initiated during his time at WSFT including a potential site for a new hospital, integration with community services and the achievement of many accolades. He had brought a sense of ambition, desire for excellence and compassion for both patients and staff. However, the last two years had been challenging and not everything had been done well and there were a lot of lessons that everyone needed to learn.

  She paid tribute to the way the organisation had managed through Covid under his leadership and to his energy, enthusiasm and total commitment to the Trust. She thanked him for all his work in the Trust and the ICS which would miss his input. His experience both past and recent meant that had a lot to contribute to the wider NHS and she wished him well for the future.

21/124 DECLARATION OF INTERESTS FOR ITEMS ON THE AGENDA

No declarations of interest were received.

21/125 QUESTIONS FROM THE PUBLIC RELATING TO MATTERS ON THE AGENDA

- On behalf of the governors Liz Steele thanked Stephen Dunn and explained that in his role of Chief Executive he had also worked with the cathedral and in other areas that everyone was not always aware of. As well as everything he had achieved whilst at the Trust he also had a personal touch and had worked hard to understand the way that all the different staff groups worked. On behalf of the governors she was very grateful to him for everything that he had done and wished him well for the future.

  The Chief Executive thanked the governors for their support.

Q As we continue to realise the effects of the Covid pandemic, can we be assured that we will be assessing and recognising the inexperience of the new cohort of junior doctors arriving in August? The reasons for this are totally understood, but have we prepared additional support to help them and our patients?

A This would be addressed under agenda item 14.

Q Re long Covid; were there any plans for the Trust's response to long Covid and the focus on this; it was board's responsibility to recognise the importance of this and the effect it could have on staff?

A An update would be provided under agenda item 12.1. Richard Davies was the wellbeing champion and had been personally involved in a meeting that took place in June to consider how to support staff with long Covid and this would continue to be a focus.

21/126 REVIEW OF AGENDA

The agenda was reviewed, agenda item 13.3 would be moved forward in the agenda together with any other items as necessary to accommodate the work commitments of clinicians.

21/127 MINUTES OF MEETING HELD ON 25 JUNE 2021

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

21/128 MATTERS ARISING ACTION SHEET

The ongoing actions were reviewed and the following noted:

Ref 1929; When clearer on national reset expectations (standards/targets) develop local metrics for IQPR to support local innovation and drive improvement. This had been a challenge due to lack of staff capacity; interviews were taking place today for a substantive appointment, or interim if necessary, and this would be the initial focus of the role. A revised target date would be advised following the appointment of an appropriate individual to focus on this.

Ref 1933; Consider how neonatal staffing is reviewed in the context of wider maternity services. A deputy head of midwifery had been appointed and would be working with Dan Spooner and other members of staff on this. An update would be provided at the next meeting.

It was suggested that the appropriate committee should be asked to monitor this and report back to the board.

Ref 1943; Set timeline for development of SPC charts at Trust, division and specialty level. The insight committee would be monitoring this and it would also be picked up by the person who was appointed to initially focus on action 1929. It was agreed to combine this action with 1929.

The completed actions were reviewed and there were no issues.

21/129 STAFF STORY

- Natalie Bailey, head of nursing-mental health, introduced herself and explained the background to her role and the need to bridge the gap between mental health and healthcare services including general hospitals.
- As a result, a number of improvements had been recommended this at both system and Trust level and staff were being supported to do implement these.
- Improvements made in the emergency department included updating policies to determine when mental health patients could attend the emergency department without a physical need.
- The psychiatric team in the Trust had received a steady increase in the number of referrals.
- Progress made by the team to date included setting up a mental health transformation group which met every eight weeks and was attended by a cross-section of representatives.
- Progress was also being made in education and training of staff, ie in the acute assessment unity (AAU) and paediatrics.
- A service level agreement between WSFT and NSFT was nearing completion. NSFT would provide mental health act administration support, oversight and scrutiny to the Trust.
- The Trust's mental health policy would be reviewed and a mental health strategy was being co-produced to align with the Trust's new strategy.
- There was closer working between WSFT and the psychiatric liaison service who would be on site 24/7 in the near future.
- There would be a focus on learning from incidents, including a review of previous incidents over the last three years, as well as learning from best practice, particularly around people with an eating disorder.
- A lot of quality improvement work was also being undertaken.
- Wards would have mental health chaperones.

Q Parity between mental health and public health issues had been an ongoing issue and required culture change. How receptive did people appear to be to this idea of parity?

A People had been extremely receptive. The mental health transformation group had been very pro-active and board members were invited to attend one of these meetings

Q When individuals who were very challenging, ie section 136, presented at the hospital was there a place of safety within the emergency department and who undertook an assessment of them?

A A lot of work had been undertaken with NSFT to make sure that places of safety (136 suites) were available for section 136 patients. However, they had been using the emergency department as a place of safety if really necessary; this would be included in the 136 policy.

Q What about people with learning disabilities and also mental health support for staff?

A A learning disabilities nurse had recently been appointed who worked closely with Natalie Bailey.

Natalie Bailey also worked closely with Emily Baker and the psychological staff wellbeing support team who focussed on the mental health of staff. She would work with directly with staff but where possible directed them to Emily Baker and her team.

Q Was Natalie Bailey linking with the work that was currently being done to bring the community mental health model in line so that there was a one team approach with primary care? How could voluntary sector partners add to continuity in terms of building relationships which could help with this?

A Natalie Bailey was linking with community staff but there was more that could be done locally in the future.

- It was noted that this work should become business as usual for the Trust so that appropriate mental health issues were included in the various reports that went to the board, rather than being considered separately.
- Mental health issues in the acute setting tended to be heard about when things went wrong. However, with the significant increase in mental health attendances it was noticeable that there was a big difference in the management of these patients as this became business as usual within the emergency department team and the Trust.
- The board thanked Natalie Bailey for her work and all the progress that was being made. She had also been an immense support to staff who cared for these patients which could be very challenging.

21/130 CHIEF EXECUTIVE'S REPORT

- The Chief Executive commended Natalie Bailey for her presentation which highlighted the transformation journey in integration across the local health system that the Trust had been on during the last few years
- He said that it had been a privilege to lead an amazing organisation and amazing team of staff and volunteers, including taking part in back to the floor alongside many of them.

- He also had personal experience of the excellent care provided by staff as a number of family members had been patients.
- The last 18 months had been difficult due to the challenges of the CQC report and internal investigation. He had taken full responsibility for the impact on staff as a result of this and was sorry for the affect it had and was having on some staff.
- The Trust was still awaiting the outcome of the external review but it had learned lessons as a result of this and continued to move forward. It had also been through the very challenging pandemic and he felt that now was the time for him to step down.
- He thanked his executive team and highlighted their achievements throughout the last few years.
- The Trust was in the process of producing a new strategy and a new hospital was being planned.
- He thanked Sheila Childerhouse and Roger Quince for everything they had done in supporting him in his role. He was looking forward to taking a break before starting new challenges.
- He wished the Trust well in the future and thanked everyone he had worked with during his time in the role.

DELIVER FOR TODAY

21/131 INSIGHT COMMITTEE REPORT

- The insight committee sought to gain assurance over four aspects; patient access, patient quality and safety, clinical effectiveness and finance and workforce.
- Separate groups covered each of these four areas which in turn provided assurance to the insight committee.
- The last meeting had focussed on patient access, mainly because of concerns around waiting times and in particular long cancer waits. Therefore, the committee wished to gain assurance over the way this was monitored and managed within the organisation.
- Diagnostic waits were a concern that had been highlighted to the committee. Therefore a deep dive had been undertaken work was now being done to address this
- The clinical effectiveness group had not yet met but this would be chaired by Ravi Ayyamuthu who was working closely with Dan Spooner.
- The finance and workforce group was working with HR on the metrics that would be provided to the insight committee so that it could gain assurance on the process around this.
- The patient quality and safety group was still being developed. The VRE outbreak had been escalated and this was being looked at within this group.
- The committee discussed the issues around outstanding data and the pressures on the data team and how they were addressing the issues.
- It was very important that the sub-committees worked well and effectively and it was important to understand how the to use these committees to be curious, eg deep dive into diagnostics.

131.1 Finance and workforce report

- The Trust continued to breakeven and the forecast was to breakeven for the year.
- There was still a significant degree of uncertainty around the financial position for the second half of the year and there was now starting to be uncertainty around elective recovery fund.
- In the first quarter of this year the NHS had outperformed the department of health's (DH) expectations around the volume of elective work that would be achieved. Therefore, the DH had sought to revisit some of the financial incentives that it had put into the system through fear of overspending. As a result the financial system continued to be uncertain.
- Despite this WSFT continued to try to maintain stability in its finances whilst enabling staff to focus on dealing with the operational challenges the Trust was currently facing.
- As a result the focus on the cost improvement programme (CIP) was not as significant this year as in the past. The CIP for each division was less challenging than in previous years and, on the whole, this was being achieved. Due to the operational uncertainty around the second half of the year the aim was to deliver a significant proportion of the CIP in the early part of the year
- Overall, the principal concern was around capital. The cash balance was currently very good but the DH was being much stricter in terms of organisations' flexibility to determine their own capital budgets and trusts had been the set a capital budget.
- It was likely that WSFT would overspend its capital budget, therefore discussions were taking place with colleagues in the ICS and region about this.

Q Did Craig Black have any concerns about next year and statutory ICSs, and more pressure on organisations to work more collaboratively, including financially, with others in the system.

A The way in which finances would be managed was moving in parallel with some of the areas that had been discussed previously, ie equality of access to services across the ICS.

WSFT had a good relationship with colleagues in organisations across the ICS and the recent decision around ICS boundaries had been helpful. This would enable the Trust to continue to build on these relationships and the finance team would need to have similar conversations to those that the clinical and operations teams were having with their counterparts.

Q With regard to joining up with community and primary care and a co-produced, collaborative approach to care across the system, this would have profound implications as to where the money was spent or invested. Could the board be assured that it was recognised that the Trust needed to be very engaged with the ICS as this developed?

A The principle that had always been worked to across the organisation was that the first priority was clinical need and to then make the finances work around this. This had been particularly true in the way the Trust worked with community services and was now becoming true with primary care as well. The ability to move money around the system to reflect where care should be delivered rather than where it had been delivered in the past was something that was being focussed on

Q The government was looking to value engineer the new hospital programme and build cheaper hospitals. Would this have an impact on the work that the future system team had already done?

A Eight pathfinder organisations had been asked to produce options that might be slightly cheaper that their preferred option and the team were working through this. This meant reconsidering what was the preferred option, eg partial rebuilding.

However, this was not possible for WSFT as the main hospital building needed to be replaced, therefore the partial rebuild option would not work. This had been discussed with and accepted by the regional office. The team continued to work on this and look at minimising costs, however they had worked to this principal throughout the production of the business case.

131.2 Operational report

- The majority of this report referred to figures in June. Activity and admissions levels had continued throughout July resulting in pressures on the organisation.
- When this paper was produced a week ago there were five Covid positive cases in the Trust, but this had risen to ten after the weekend. The number had stabilised and not increased this week, however, a few more Covid admissions would put the organisation under extreme pressure which was very concerning.
- There was currently one Covid patient in critical care and of the other cases there were one or two in every age category. There was also a mix of patients who had had one or both vaccines or had not been vaccinated at all, therefore no conclusion could be made from this.
- The patient flow, emergency department and operational teams were commended for all their work in keeping the organisation running smoothly during a very challenging time.
- There was a plan in place with divisional teams to increase capacity for Covid cases if necessary, however empty beds would be required to do this and this week there had been no empty beds. In addition, there had been patients in the emergency department who were waiting beds for up to twelve hours every day which was a very concerning position for the Trust.
- This increase in activity was being managed alongside the RAAC programme. However, pressure on activity was being experienced by every organisation regionally and nationally.
- The new area of the emergency department with a specific place to offload ambulances meant that ambulances were being diverted to WSFT so that they could be offloaded quickly.
- All ambulance trusts across the country were at the highest level of escalation which highlighted the pressure on all organisations and was a real concern. A lot of discussions were taking place to look at what could be done about this, particularly as winter approached.
- This month had felt as bad as any winter the Trust had been through and radical options/solutions were being looked for as the pressure remained very high.

Q As the number of Covid patients reduced had GP streaming been reinstated in the emergency department, particularly to manage minor injuries/attendances?

A GP streaming had not stopped but the number of hours it operated had been reduced in line with the pattern of suitable patient attendances

The other issue was that these shifts were difficult to fill. Suffolk GP Federation had managed to fill the shifts that had been agreed at WSFT. However, the east was struggling with this as at the moment as there was a lot of additional demand on GPs. It was stressed that this was a supply and demand issue, not a financial issue. This pressure on activity was mirrored across every part of the system, with primary care at 120% of routine activity.

Q Was the Trust doing everything possible to try to manage this in conjunction with all its partners across the system in in preparation for the winter?

A Everything possible was being done and the chief operating officer network would be focussing on this at its next meeting. The ICS was also holding a workshop with all its partners next week to look at this. The regional team was also asked people to think differently and radically about solutions to this but it was not known how this would be funded.

Q There was a concern that part of the demand was being driven by people thinking that the pandemic was over and everything was going back to normal. Was the Trust continuing to be effective in communicating with people and making sure that they were not using services inappropriately when the system was under such pressure?

A The Trust continued to rebroadcast national messages and work with the ICS on this. However, this tended to work in reverse and result in an increase in the use of emergency department services. 111 was also seeing a 120-130% increase in calls to the service. There was some additional funding at a national level being put into the 111 service to increase capacity in the short term.

- The alliance was planning to formulate a winter/resilience plan that could be stepped up or stepped down accordingly, this would focus on community prevention and discharge. It was hoped that an update could be provided to the next board meeting.

ACTION: provide update to board on alliance winter resilience plan. **C Mawoyo**

- As a result of the RAAC programme a very good piece of joint working had been undertaken between WSFT and the hospice, who shared the site. The teams had come together to move medical day treatment into space that was not being used by the hospice. The team had made what could have been a very difficult situation work very well which was extremely helpful.
- Re the accelerator and elective programme, the Trust was aiming to get to the higher levels of activity by the end of July.
- All organisations were now seeing the activity requirements increase and seeing pressure around the transformation programmes being accelerated.
- The appendices to this report showed activity levels by organisation across the region. WSFT was doing very well in specialties that did not require a surgical admission or an endoscopy diagnostic procedure.

Q Re waiting lists, how did the Trust set priorities in terms of the impact on people who were waiting, eg orthopaedic patients might have to wait longer?

A All patients on waiting lists had been allocated a priority (P) code following a clinical assessment of their priority, with P1 being the most urgent. P1 and P2 were given first priority, after that the focus would be on the longest waiting patients. It was the system's ambition to have no one waiting longer than 78 weeks by the end of the financial year.

Locally this would be a struggle until WSFT had its additional theatre capacity, therefore it was looking at where else it could source additional capacity. The Trust was now working very collaboratively with ESNEFT and the access leads on both sites were aware of the each other's longest waiting patients and giving patients the opportunity to have their surgery in another location.

This had been difficult to set up due to the work required around pathways, clinical governance and SOPs. These were now in place in ophthalmology and T&O and the two organisations were now looking at ENT and general surgery.

This was a good way of getting patients used to the fact that they may not always be able to have their care/treatment close to home and may need to travel a bit further for.

Q Some of the NEDs had attended a meeting yesterday where several people had talked about merging PTLs within the ICS or across various trusts which was happening in some geographic areas. Could West Suffolk work with this?

A There had been a lot of discussion around this but it did not appear to be happening where acute trusts were separate entities. WSFT was working more along the collaboration route and try to make sure that waiting times were similar. To date there had not been a lot of national guidance on this; how organisations should be managing this was currently not very clear but WSFT was looking at working collaboratively where possible.

131.3 IQPR

- The board received and noted the content of this report which had been included for information. Further information was provided to the insight committee.

21/132 INTEGRATION REPORT

- A significant piece of work had been undertaken following on the from the previous work on equality and diversity and supporting the vaccination programme in difficult to reach communities.
- Funding had now been secured and a post had been recruited to to provide dedicated capacity to look at working with different communities, with a focus on health equity and access to care.
- Targeted pieces of work were being looked at to understand equity of changes that were being put in place to the broader population. This had provided human links into each of the different areas of the population and would help with communication and engagement at a more personal level.
- Work was being undertaken with West Suffolk College to understand if the focus was in the right areas that were going to make a difference to young people in terms of realising their full potential. This work also looked at understanding their levels of anxiety over the last year, how much it had impacted on their outlook and getting them to produce work that encapsulated what made them happy.
- The Suffolk volunteering strategy was currently being reviewed as it also needed to link to the hospital's volunteers. During the vaccination programme communities and volunteering had become a real part of people's lives. Details of the vision, values and objectives of this strategy were provided in the report.
- Another key piece of work was being undertaken with the voluntary sector was to look at how to change the relationship and ways of working with them in terms of commissioning and capacity as part of the operational model and business as usual and ensure continuity of funding.

- A copy of the VCSE Charter for Action was appended to this report and details of its five commitments were provided in the report. This was a very good example of organisations who could support people and follow them through their journey and ensure they realised their full potential, eg the green light trust.
- Outcome measures were also being looked at through the quality improvement team and the data required to evaluate services and impact these were having on people's lives. This also linked with the voluntary sector and how it could be pro-active and preventative rather than reactive.
- Outcome measures were very important in understanding the impact of the support provided to individuals. One of the key things that was being looked at was establishing boundaries across health and social care in order to help cement integration work that was looking at being progressed. It was important to have a good understanding of the baseline and the information that could be provided to the board that would reflect the progress that was being made.
- Another area of work that was being looked at for implementation sooner rather than later was the opportunity for occupational therapists and aligning them to maximise capacity, recognising what a valuable resource they were and the current gaps.
- Work was continuing on making every contact count and delivering the right care in the right place at the right time for the local population whilst reducing duplication across the various teams.

Q When were the quality outcome measures likely to be available?

A This was further forward with therapies than nursing. A workshop had taken place to pull together all the ideas but this needed further work and discussion as to what should be measured and how this would be captured, and if any of this was already being done. This was work in progress and it was expected to take approximately three months to determine what the metrics would be. An update would be provided to the board.

ACTION: update board on proposed outcome measures for adult community services. — **C Mawoyo**

- It was proposed that there should be a future joint board/governor workshop on how social care worked in west Suffolk, particularly around the boundary issues.

ACTION: arrange joint board/governor workshop on social care. — **A Alderton / S Childerhouse**

Q This was a major transformational and culture change across the system and for staff, as well as patient expectation. Were there any barriers in the use of patient data or in other areas and how could the team be best supported in this journey and transformation?

A There were already established information sharing arrangements across the alliance which were being used and would be very useful in this work, therefore this barrier had already been overcome.

Quite a lot of work had already been done as the system and the ICS had not been using data in the way it should to manage risk. The teams now needed to be brought together to look at this in a holistic way and consider how to use this further and provide visibility as the system moved into winter.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

21/133 INVOLVEMENT COMMITTEE REPORT

- Rather than this committee being based on analytics or reports it would be focussing on assurance and deep dives to look at how things were embedded in the organisation, ie in practice rather than by looking at data.
- At its recent meeting the committee had looked at equality, diversity and inclusion (EDI) and the Trust's networks. It also talked about values and the way these were developing.
- Feedback had been received from governors that they did not feel that they were involved in an appropriate way.

ACTION: consider how governors could be more involved in appropriate areas of the Trust. — **A Alderton/ S Childerhouse**

- The committee had provided very helpful challenge to the HR team around the leadership work that was being undertaken with the EDI agenda and the content of annual reporting both internally and the reports required nationally by the NHS.
- The next step was to consider in more detail areas where the greatest opportunity and challenge for the board were and move forward with this work. There was also a need to look at the capacity of the network chairs to do their role.

133.1 People and OD highlight report

- This report provided an example of where the involvement committee could do some further work in relation to the emerging integrating care academy that the university of Suffolk was leading on. WSFT was keen to be actively involved in the development of this academy as it was fundamental to the future development of the health and social care workforce.
- Re the governor question about the Trust's response to long Covid and support for staff. An update was provided in this report on the work that was being undertaken. A number of experts in the organisation had been brought together to consider how to support staff who were suffering from long Covid. Each individual was being supported separately according to their situation and needs.
- Quarterly updates on appraisals and mandatory training were included in this report. Overall the targets for mandatory training were being achieved; further detail was available in appendix 2 including areas that needed to be focussed on.
- Appraisals were approximately 9% below target. This was continuing to be addressed, however the divisions were struggling with operational pressures and the impact of the decant programme. There would be particular focus on the corporate areas which had the lowest compliance.
- The quarterly report from the guardian of safe working hours was attached as appendix 3.
- The board noted the appointment of Dr Tom Bull, consultant haematologist.
- Putting You First Awards had been received by the following staff members in July; Fran Sunderland, pathway 1 therapy lead and Jackie Brown, ward manager F11. The board congratulated Fran and Jackie who were another example of staff going the extra mile to meet the needs of individual patients.
- Re the governor question about additional support for the new cohort of junior doctors arriving in August. There had been a number of discussions with the

appropriate people about this as it was recognised that their training and experience would have been impacted by the pandemic. Trust was very mindful of this and in addition to the usual programme of induction there would be other areas of support available. There was already a WhatsApp group for junior doctors where they could post any concerns they had.

It was recognised that this would be particularly challenging and that junior doctors would have had less 'hand-on' training than usual.

Q It was concerning to note that staff continued to mark the Trust down in the staff survey on action taken on health and wellbeing, considering all the initiatives that had been put in place. What else was being done to explore this?

A One of the areas that the involvement committee would be looking at was the work of the staff health and wellbeing steering group which would be focussing on this. The staff survey produced a great deal of data and there were many factors as to why percentages would change.

The HR team were also very concerned about this. However there had been very positive feedback about the investment in the staff psychological support service and a survey was currently being undertaken to help evaluate the impact of this. The results of this would be shared with the board in the future.

The steering group continued to involve staff representatives in planning ways of addressing this issue.

The procurement of a new occupational health provider (from 1 October 2021) would provide a significant opportunity to review and improve the support that occupational health provided to staff.

The communications team had also focussed on this area with regular communication about support that was available to staff, ie the green sheet each week, regular staff briefings, twice yearly 'love yourself' weeks etc.

21/134 IMPROVEMENT COMMITTEE REPORT

- Discussions had taken place about how the sub-committee structure for all three committees would work.
- The committee would be looking at what was working well, as well as what was not working well.
- Issues being addressed by the sub-committees would be fed simultaneously into the 3i committees as required, eg the VRE issue was being looked at by both the insight and improvement committees.
- This work and remit of this committee continued to be work in progress and would continue to evolve.

134.1 Maternity services quality and performance report

Karen Newbury introduced Justyna Skonieczny who had recently joined the Trust as deputy head of midwifery.

- It was noted that there were a number of attachments to this report that the board needed to be made aware of.
- Clinical stats were now available through e-care which was positive, although there was still a slight delay.

- Through the safety champion walkabouts and feedback from the staff survey the Trust was working hard to engage with and listen to staff and trying to find a solution to any issues they had, or how they were feeling.
- The team was working closely with everyone, including Paul Molyneux as safety champion, to try to make things better and encourage maternity staff to engage more. Support was also being provided by the wellbeing service, occupational health and HR.
- Despite staffing levels currently being very low, women were still receiving one to one care in labour; however, this was sometimes to the detriment of ward staffing and lot of staff were having to work in additional areas.
- Maternity staffing was a national issue and plans were being drawn up to address this. As a result of staffing issues a number of maternity units had had to close which meant that there was a shortage of places for trusts to transfer patients to.
- Staffing issues had had a knock-on effect on a number of areas including appraisal numbers which had decreased in June and were not likely to improve in July. There was also a knock-on effect with equipment checks and foetal monitoring training not being done due to everyone having to focus entirely on clinical work and caring for patients.
- Mandatory training days had continued and were above 90% compliance for all staff groups.
- The SPC charts showed an increase in postpartum haemorrhaging but this was to be expected with the increase in induced labours and caesarean sections. This resulted in an increase in acuity and length of stay which also impacted on staffing.

Q To what extent were the staffing shortages due to the NHS app notifying people that they were required to isolate?

A The reasons for this varied, two weeks ago there were 12 staff who were self-isolating, but only two had been notified by the app. The majority were due to family members being tested positive for Covid.

- At the recent CCG board meeting Lisa Nobes had been very complimentary about the volume of work that had been undertaken and the progress being made by the team at WSFT, despite the challenges they were facing.
- The board recognised the additional pressures on the maternity team due to the CNST submission requirements and meeting the national requirements for data submission.
- At the recent ICS continuity of care meeting it was confirmed that they were currently on target to deliver the continuity of carer plan by spring next year which was a very positive achievement by the maternity team.
- One of the really important roles of the safety champion was to look after the wellbeing of midwives. It was proposed to use a similar method to that used with the doctors and undertake a survey with midwives as to what impacted their wellbeing at work and how the Trust could improve this. This would help to identify areas where issues could be addressed and improved.

134.2 Infection prevention quality and performance report

- In order to provide assurance, an audit had been undertaken on Covid routine swabbing data. Compliance was good for admissions and day 5-7 swabs, however day 3 required further work and this was being followed up.

- The results of this audit had been presented to the nursing and midwifery clinical council and this would continue to be monitored going forward.

134.3 Nurse staffing report

Dan Spooner, deputy chief nurse, joined the meeting to present this report.

- Fill rates remained reasonably static with 90% being maintained across all shift profiles. Areas of exception were highlighted in the appendix to the report.
- Sickness and self-isolation remained static last month. However, this had been challenging over the last few weeks due to the number of staff being required to self-isolate as a result of being contacted via the NHS app.
- Following four months of sustained improvement in substantive staff numbers there had been a slight decrease over the last two months. As a result the recruitment and retention meetings with HR had been reinstated to review this.
- In order to try to address this capacity was being reviewed with the education team to increase the cohort of overseas nurses arriving at the Trust from five per month to eight per month, as from 1 September.
- Nursing indicators remain good with five continuous months of sustained improvement in hospital acquired pressure ulcers. This was very positive and was a reflection on the work undertaken by the wards and tissue viability teams.
- The board acknowledged and thanked the nursing staff for all their hard work, recognising that that they were having to support and cover for team members who were being required to self-isolate at very short notice. This was very challenging as they had been moved around the organisation to work in different teams.

Q Did the number of substantive nurses normally increase over the winter or were there any plans to do this?

A The number of substantive nurses was not increased but the overall nursing establishment was increased when additional capacity was opened. Plans were being put in place for this winter.

134.4 Nurse staffing strategy

- A very good session had taken place with the NMCC (nursing midwifery and clinical council) meeting last month where they looked at a co-produced piece of work on how the new strategy would be produced.
- This session had been undertaken virtually and had worked very well. There had had been 100% engagement from everybody with a lot of people feeling they were able to comment or contribute.
- The themes that came out of this would now be taken away to start to build around the visions and ambitions of the strategy. This would be constantly checked with the nursing teams to ensure that they agreed with the wording and content so that this would be totally co-produced strategy.
- It was hoped to bring the strategy to the board in the near future.

Q For the future were there any any potential innovations that could be applied across the nursing and social care teams?

A It was important to work towards building bridges between community health and social care teams and work to develop a programme to help to maximise capacity across health and social care.

21/135 SUPPORTING JUNIOR DOCTORS OUT OF HOURS IN THE SURGICAL DIVISION

Andrew Dunn, orthopaedic consultant and clinical director for surgery, attended the meeting for this item.

- The background and reason for this report was explained, together with the action that had been taken to date and future plans to support the junior doctor workforce.
- Feedback and information gathering had come from multiple sources in order to understand the issues and how junior doctors could be supported.
- The report included details of actions that were currently being taken and future actions required, together with financial implications of these actions.
- The board noted and supported the recommendations in the report.

Q Recognising that the junior doctors would not be as well prepared as usual when they joined the Trust in August and that it would not be possible to make the proposed changes in time, was there going to be extra senior supervision for junior surgeons in August?

A Individual conversations had taken place with the general surgical consultants and registrars and previous issues and concerns raised about communication and supporting junior doctors. There would be an increased presence in the surgical unit and it was hoped to do the same in the emergency department as the acuity of patients attending was quite high.

A lot of senior clinicians in the organisation were aware of the culture changes and journey in making sure that everyone acted in a kind and compassionate way and supported and listened to junior doctors when they raised concerns.

It was frustrating that it had not been possible to put all the plans in place by August but progress was now being made.

- Additional measures were also being put in place including production of a set of internal professional standards around the number of consultant ward rounds during the week and at weekends, in order to provide support for junior doctors.
- A task and finish group had also been set up to look at deteriorating patients and handover day and night so that junior doctors and nurses felt comfortable escalating issues and to provide a further level of support.

Q Was there a forum for junior doctors, on an ongoing basis, to learn about issues etc?

A There was a vast amount of work going on to support junior doctors, including inviting a representative to join the task and finish group. A number of surveys had been undertaken with different groups of junior doctors about how they felt about various things and there was also the WhatsApp group which enabled them to raise issues as they arose.

BUILD A JOINED-UP FUTURE

21/136 FUTURE SYSTEM BOARD REPORT

- This report gave details of the work that had been undertaken over the last month, in particular communication around the planning application and engagement sessions that were taking place.

GOVERNANCE

21/137 GOVERNANCE REPORT

- The board received the report and noted the following for which the correct processes had been followed:
    - The use of the Trust seal
    - Emergency powers had been exercised in between board meetings
- Work required on the quality accounts had been completed and these were now in the public domain and could be viewed on the Trust's website.

21/138 BOARD ASSURANCE FRAMEWORK (BAF)

- This was last reviewed by the board in February and in future discussions on the BAF would take place in the public board meetings.
- The BAF had been updated and risks were now in the process of being linked to the assurance committees of the board so that they could keep a watch on the detail in terms of how these risks were being managed.
- The target risk for the management of pathology had been reached, therefore it was recommended to the board that this should be referred to the improvement committee for a decision as to whether it should be de-escalated from the BAF.
- The risk relating to the partnership with the alliance had reduced and changed, therefore it was recommended that this was referred to the involvement committee for a decision on de-escalation.
- It was noted that the BAF was an essential tool for helping to manage the board agenda as well as the agendas for the assurance committees.

Q Was there an appropriate place in the BAF to recognise the transition and challenges that the board itself was going through which could be a risk to the organisation and its reputation?

A Elements of the board's transitional risk had been risk assessed and discussed with the executive team. It was not considered that this was not sufficiently high to merit inclusion in the BAF. However, this could be discussed further with the executive team as there had been further changes since this document was reviewed and updated. A recommendation would then be made to the board.

ACTION: review with the executive team whether the risks around the board's transitional change should be included in the BAF. **A Alderton**

ITEMS FOR INFORMATION

21/139 ANY OTHER BUSINESS

- There was no further business.

21/140 DATE OF NEXT MEETING

Friday 3 September 2021, 9.15am

RESOLUTION TO MOVE TO CLOSED SESSION

21/141 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 meeting - action points

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
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. Set timeline for develop SPC charts at Trust, division and specialty level (previously action 1943)	IQPR pack being developed but the revision (taking out) and update (adding in) will take more time. This is also impacted by 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. **Revised target to be provided following appointment of appropirate individual to focus on this.**	HB	~~30/04/2021~~ tba	Amber	
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. Update to be provided to September meeting. **Appropriate 3i committee to be asked to monitor this and report back to the board. New Deputy HOM commenced in August, 2021 and will lead on this review.**	SW	~~25/06/2021~~ 03/09/21	Amber	
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	15/10/21	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	15/10/21	Green	

1974	Open	28/05/21	Item 14.3	Provide further information to the board on the ward accreditation programme	Using a codesign methodology, the Ward accreditation steering group has been meeting weekly since May to scope the needs of the project, identify stakeholders and relevant workstreams. The steering group has now moved to monthly meetings and a smaller project group will take the actions identified forward in creating tools, process and pilot schedule. The project plan will be presented to the board in September. **Project continues, update at October board.**	SW	~~30/07/2021~~ ~~03/09/2021~~ 15/10/2021	Amber	
1979	Open	25/6/21	Item 8	Provide feedback to board on outcome of CCG review of Trust's provision/support for patients with learning disabilities.	**Verbal update to be provided by Sue Wilkinson at today's meeting.**	SW	03/09/21	Green	
1984	Open	30/7/21	Item 10.1	Provide update to board on alliance winter resilience plan.		HB/CM	15/10/21	Green	
1985	Open	30/7/21	Item 11	Provide update on metrics being developed to identify appropriate outcome measures for adult community services	**Update to be provided following completion of workshops (approx 3 months)**	HB	17/12/21	Green	
1986	Open	30/7/21	Item 11/ 12	Arrange joint board/CoG workshop on how social care works in west Suffolk , particulary relating to boundary issues. Consider how governors could be more involved in appropriate areas of the Trust.	**Work programme for Council of Governors being developed.**	AA/SC	15/10/21	Green	

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

Board meeting - action points

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
1987	Open	30/7/21	Item 17	Follow up discussion required re board transitional risk and whether this should be included in the BAF.	Risk assessment completed and did not meet threshold for inclusion.	AA	03/09/21	Complete	03/09/2021

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

8. Patient 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 Craig Black

Board of Directors – 3 September 2021

Agenda item:	9			
Presented by:	Craig Black, Interim Chief Executive Officer			
Prepared by:	James Goffin, Communications Manager Helen Davies, Head of Communications			
Date prepared:	31 August 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

As this is my first CEO report, I would like to take the time to say a huge thank you to Steve Dunn who has been a brilliant CEO for our Trust for the last seven years and has recently stood down.

Steve oversaw so many changes in his time here, including merging the hospital with the community to make the Trust what it is today – a place that supports those that come through our doors in the hospital, but also patients throughout our west Suffolk community.

Steve is much-loved throughout the Trust and would always take the time to stop and talk to staff when he was in and out of the hospital. The dozens of messages on our staff Facebook group shows how many of you were fond of him and will miss him.

I am very thankful that I had the opportunity to work alongside Steve and it goes without saying that I, and countless others that he worked with, learned so much from him as he led us through the most difficult 18 months the NHS has ever witnessed. Thank you for your dedication and passion Steve.

You may have seen the media attention surrounding the condition of our hospital recently. **In August we invited BBC Look East into our West Suffolk Hospital** as part of their reports into the condition of a number of 'Best Buy' hospitals throughout the country, which we are one of.

The invite was extended to the BBC to show them how we have been dealing with the challenges of running an ageing hospital and how our estates teams have been leading the way nationally in their management of these complex issues. I hope it also helped as a way of reassuring both patients and staff that we're acting responsibly and following expert advice at all times to keep the hospital as safe as possible.

This is an ongoing challenge for all of us at the Trust and I want to recognise the expertise and professionalism of the estates team and the forbearance of all staff for coping with the disruption that's happening which includes relocation of some of our services. I know this is not easy for any of our staff and we hugely appreciate the patience and understanding. We are doing all we can to make these works as quick and painless as possible. We built our fantastic G10 de-cant ward in a matter of weeks. This opened at the end of July and should help to ease our capacity issues as we move through the programme of essential estates works.

Whilst we must remain cautious and do what's right to keep each other safe, many aspects in our life are going back to pre-pandemic times. I'm **delighted that more and more of our incredible volunteers** are getting back into our hospital. Our dedicated volunteer services manager Val Dutton wrote recently in a blog about how much of an impact the pandemic had on being able to have volunteers on site, and how in March 2020 we had to stand down all of our volunteers.

Our volunteers really are a special group of people. They are people in our local community who give their time, dedication and passion to help both patients and colleagues. For some, volunteering is a way of meeting new people and finding company and for some it's wanting to give back to the NHS where they, or a loved one, may have previously received treatment.

So, it's fantastic that more and more volunteers are back in their roles, playing a vital part in the daily running of our Trust, in roles that vary from being a wheelchair volunteer and helping those with mobility issues get from A to B through to being that friendly face in our Friends Shop. I'm delighted that the red lanyard brigade is back!

Another thing many people missed throughout the pandemic is the ability to get to the gym or go for a swim like they used to. So, it's great news that **over 2,000 Trust staff have now signed up for the Abbeycroft Leisure wellbeing scheme**. The scheme, launched back in April, was born out of a partnership between ourselves and local leisure provider, Abbeycroft Leisure, who have leisure facilities in many towns throughout the west of Suffolk.

The scheme has given all staff the opportunity to access activities such as swimming, gym membership, group exercise classes and racquet sports at no cost to them. We continue to hear from staff on our Facebook page how happy they are with this opportunity to take some time away from work and home life and do something they enjoy that's hugely beneficial to their physical and mental health.

It goes without saying that this has been one of the most difficult periods the NHS has ever faced, so it's important more than ever to be able to take the time to look after ourselves and the wellbeing scheme is a great way to do that! While the scheme has been operating for nearly 6 months, sign-ups continue to grow with July being a bumper month for new starters at leisure centres in locations such as Bury, Haverhill, Newmarket and more. I'm delighted we have been able to make this investment in our staff's wellbeing.

For the first time as a Trust, we have appointed our first ever locality liaison coordinator. Madelaine Sibley has recently joined the team in the discharge hub and she will be supporting both wards and community teams with advanced planning for patients being admitted and discharged.

Maddie's role is hugely beneficial for our Trust as it aims to bridge the gap between what's going on in the community and the hospital. It gives the opportunity for colleagues to get information about their patient safely and quickly as Maddie has access to a wide array of notes including GP, district nurse, therapy and community matron notes. I have no doubt that Maddie will be a great resource and colleague in our Trust.

You may have seen in the local press the incredible story of one of our critical care nurses saving the life of a man when she was off-duty. Debbie Lavender was out for dinner with her partner when another patron of the Maybush pub in Waldringfield, suffered a cardiac arrest.

With the help of bystanders, Debbie performed CPR and used a defibrillator to successfully regain the person's pulse before the ambulance arrived on scene. Thanks to Debbie's quick actions, the patron – who had no previous health concerns – is now on the road to recovery and is back playing football again.

Debbie's actions were recently recognised by the Royal Humane Society after being nominated by the air ambulance's aftercare team. We are so proud of Debbie and her quick-thinking and bravery!

One of our chaplains, Rufin Emmanuel, is celebrating his 25th anniversary of his ordination as a priest. Rufin, who joined us last year, was ordained in 1996 in Lahore, Pakistan before coming to England 20 years ago.

He joined as the trust was beginning to deal with the impact of the pandemic, significantly changing the lives of staff and patients.

Congratulations to Rufin for reaching a magnificent 25 years as a priest and thank you for all the support you and your team give our colleagues and patients every single day.

I also want to congratulate the FY1 and 2 doctors who were recognised for their outstanding achievements over the year at an event last month.

As a Trust, our medical training team supports over 70 doctors throughout their foundation training and award recipients were nominated by educational supervisors for being outstanding trainees, going above and beyond what might be expected.

Thank you to every single one of our FY1 and 2 doctors for all the hard work you put in every single day to make the lives of our community better and safer.

10:00 DELIVER FOR TODAY

10. Insight Committee Report

To APPROVE the report

For Approval

Presented by Richard Davies, Craig Black and Helen Beck

Board of Directors – 3 September 2021

Agenda item:	xx			
Presented by:	Richard Davies			
Prepared by:	Richard Davies/Ann Alderton			
Date prepared:	23 August 2021			
Subject:	Insight Committee Report and Chair's Key Issues			
Purpose:	X	For information	X	For approval

Executive summary:

The Insight Committee had its second meeting on 2 August 2021.

The Committee was able to consider its Terms of Reference, and building on the enormous amount of work that Ann Alderton has put into the design of the new governance structure, to clarify and refine its role as a true Board assurance committee. A key element of this assurance is the work being done by the four governance subcommittees (Patient Access, Patient Quality and Safety, Clinical Effectiveness and Finance and Workforce Efficiency). The Patient Access subcommittee is the most mature, but we received assurance regarding the progress of the other subcommittees and expect much more detailed reports at the next Insight Committee meeting in September. Attached is the Chair's Key Issues document which will constitute the standard template for Insight Committee reports to Board.

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:	N/A
Risk and assurance:	The development of and transition to a new structure for organisational governance may result in a failure to escalate significant risks to management, the executive team and the board of directors, caused by a disruption to the previous information and communication flows whilst new arrangements are being established.
Legislation, regulatory, equality, diversity and dignity implications	Well-Led Framework NHSI FT Code of Governance

Recommendation:
To approve the report

Putting you first

Chair's Key Issues

Part A

Originating Committee	Insight Committee	Date of Meeting	2 August 2021
Chaired by	Richard Davies	Lead Executive Director	Craig Black/Helen Beck

Agenda Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref	Paper attached? ✓
4	**Terms of Reference and Work Programme** The committee considered the draft Terms of Reference and work programme and made suggested amendments which will be incorporated into the document for Board approval.	**Approval**	**N/A**	**Separate agenda item**
5	**Governance Group reports** **Patient Access** The Patient Access governance group reported the following governance priorities to the meeting: • Further work needed to develop community performance metrics and urgent and emergency standards; • Endoscopy and dermatology access standards are not being met but the reasons why are understood and solutions are being pursued. Both areas will continue to be reported on to the committee and will be subject to additional scrutiny until the required level of assurance is received; • Responding to a negative report by internal audit on the use of P codes, a specialty P code compliance report would be brought to the 4 October meeting of the committee. Positive assurance was provided on the improvement of the breast two-week wait which stood at 17% in April but by July was at 92.86%.	**Assurance**	**N/A**	
Date Completed and Forwarded to Trust Secretary		**16 August 2021**		

Putting you first

Part B

Receiving Committee	Board of Directors	Date of Meeting	3 September 2021
Chaired by	Sheila Childerhouse	Lead Executive Director	Craig Black

Agenda Item	Record of Consideration Given (Approved/ Response/ Action)

Date Completed and Forwarded to Chair of Originating Committee	

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10.1. Finance and workforce report

To APPROVE the report

For Approval

Presented by Nick Macdonald

Board of Directors – 3 September 2021

Agenda item:	10.1			
Presented by:	Nick Macdonald, Executive Director of Resources (Interim)			
Prepared by:	Nick Macdonald, Executive Director of Resources (Interim)			
Date prepared:	30th August 2021			
Subject:	Finance and Workforce Board Report – July 2021			
Purpose:		For information	x	For approval

Executive summary:
The reported I&E for July 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. 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 for H1.

Whilst there is still uncertainty over our income for the second half of the year there is likely to be a reduction in our income of between 3% and 3.5% in order to drive Cost Improvements. As a result, we believe a forecast deficit of £5.0m for 2021-22 is now realistic.

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
July 2021 (Month 4)

Executive Sponsor : Nick Macdonald, Director of Resources (Interim)
Author : Nick Macdonald, Deputy Director of Finance

Financial Summary

I&E Position YTD	£0m	break-even
Variance against Plan YTD	£0m	on-plan
Movement in month against plan	£0m	on-plan
EBITDA position YTD	£5.6m	on-plan
EBITDA margin YTD	5%	on-plan
Cash at bank	£10.3m	

Executive Summary

- The reported I&E for July is break-even (YTD break-even).
- Forecast deficit of £5.0m for 2021-22

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 for 2021-22
- Delivery of CIP programme

SUMMARY INCOME AND EXPENDITURE ACCOUNT - July 2021	July 2021 Budget £m	July 2021 Actual £m	July 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	23.1	23.5	0.4	95.0	94.1	(0.9)
Other Income	3.0	2.8	(0.2)	12.9	11.9	(1.0)
Total Income	**26.1**	**26.3**	**0.2**	**107.9**	**106.0**	**(1.9)**
Pay Costs	17.1	17.0	0.0	67.6	68.7	(1.1)
Non-pay Costs	7.8	7.8	0.0	35.3	31.6	3.7
Operating Expenditure	**24.9**	**24.8**	**0.0**	**102.9**	**100.4**	**2.6**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA excl STF	**1.2**	**1.5**	**0.2**	**4.9**	**5.6**	**0.7**
Depreciation	0.8	0.7	0.0	3.0	3.0	0.1
Finance costs	0.5	0.7	(0.3)	1.9	2.7	(0.8)
SURPLUS/(DEFICIT)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**(0.0)**

FINANCE AND WORKFORCE REPORT – July 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	X

FINANCE AND WORKFORCE REPORT – July 2021

Income and Expenditure Summary as at July 2021

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

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 for H1.

Whilst there is still uncertainty over our income for the second half of the year there is likely to be a reduction in our income of between 3% and 3.5% in order to drive Cost Improvements. As a result, we believe a forecast deficit of £5.0m for 2021-22 is now realistic.

Given the uncertainty over our funding we will continue to review this position and will provide an update to the next Board which will include funding and expenditure associated with the Elective Recovery Fund.

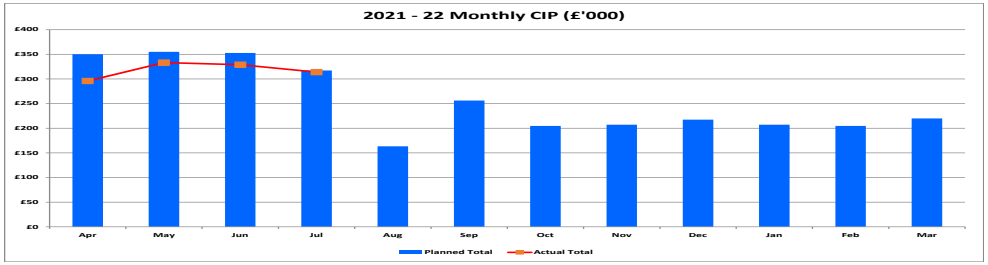
Summary of I&E indicators

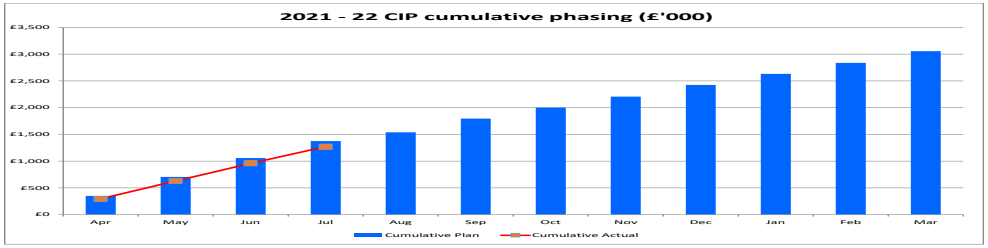
Income and Expenditure	Plan/ Target £000'	Actual/ Forecast £000'	Variance to plan (adv)/ fav £000'	Direction of travel (variance)	RAG (report on red)
In month surplus/ (deficit)	0	0	0	⇔	Green
YTD surplus/ (deficit)	0	0	0	⇔	Green
EBITDA (excl top-up) YTD	6	6	0	⇔	Green
EBITDA %	0.0%	0.0%	0.0%	⇔	Green
Clinical Income YTD	(74,352)	(73,215)	(1,137)	↓	Amber
Non-Clinical Income YTD	(33,500)	(32,766)	(734)	↑	Amber
Pay YTD	67,605	68,739	(1,133)	↓	Amber
Non-Pay YTD	40,250	37,250	3,000	↓	Green
CIP Target YTD	1,375	1,272	(103)	↑	Green

Cost Improvement Programme (CIP) 2021-22

The CIP programme for 2021-22 is £3.1m (100%). In the year to July we achieved £1,272k (41.6%) against a plan of £1.375k (45%), which is a shortfall of £103k.

Recurring/Non Recurring	2021-22 Annual Plan	Plan YTD	Actual YTD
	£'000	£'000	£'000
Recurring			
Outpatients	-	-	-
Procurement	242	48	48
Activity growth	-	-	-
Additional sessions	101	80	80
Community Equipment Service	271	90	88
Drugs	51	13	12
Estates and Facilities	63	25	5
Other	280	101	86
Other Income	147	27	44
Pay controls	28	9	5
Service Review	-	-	-
Staffing Review	36	12	12
Theatre Efficiency	20	4	-
Contract Review	319	106	43
Workforce	-	-	-
Consultant staffing	-	-	-
Agency	-	-	-
Car Park income	75	25	-
Unidentified CIP	504	0	-
Recurring Total	**2,137**	**541**	**422**
Non-Recurring			
Pay controls	99	74	118
Theatre Efficiency	280	221	191
Staffing Review	-	-	-
Other	540	540	540
Estates and Facilities	-	-	-
Non-Recurring Total	**919**	**835**	**850**
Total CIP	**3,056**	**1,375**	**1,272**





FINANCE AND WORKFORCE REPORT – July 2021

Trends and Analysis

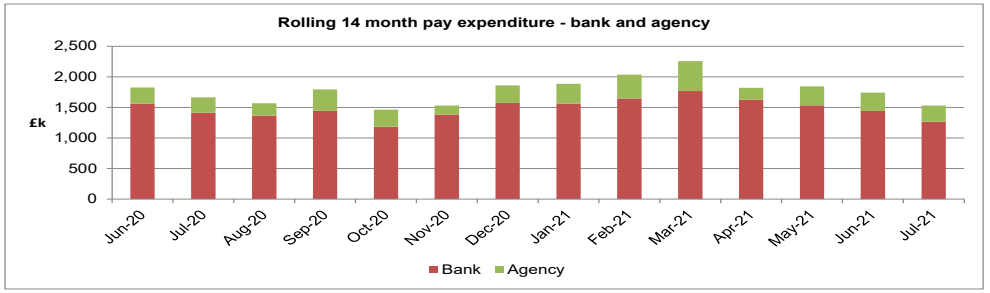
Workforce

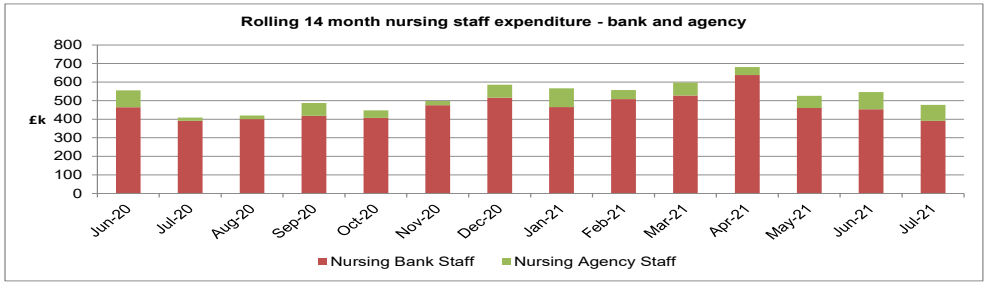
During July the Trust spent in line with the pay budget (£1.1m overspent YTD).

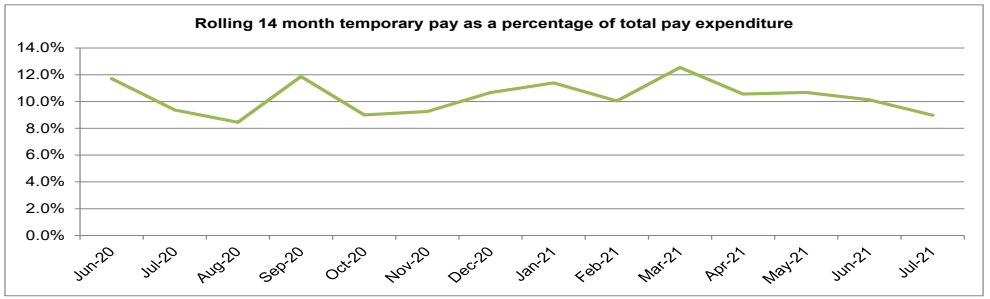
Monthly Expenditure (£)				
As at July 2021	Jul-21	Jun-21	Jul-20	YTD
	£000's	£000's	£000's	£000's
Budgeted Costs in-month	17,051	16,860	17,051	67,605
Substantive Staff	15,517	15,449	16,102	61,806
Medical Agency Staff	83	128	194	448
Medical Locum Staff	255	203	346	1,086
Additional Medical Sessions	162	378	272	998
Nursing Agency Staff	85	93	18	287
Nursing Bank Staff	392	453	391	1,943
Other Agency Staff	96	77	42	331
Other Bank Staff	189	189	219	916
Overtime	102	98	96	444
On Call	166	121	86	478
Total Temporary Expenditure	1,530	1,739	1,665	6,932
Total Expenditure on Pay	17,047	17,188	17,768	68,739
Variance (F/(A))	4	(329)	(717)	(1,133)
Temp. Staff Costs as % of Total Pay	9.0%	10.1%	9.4%	10.1%
memo: Total Agency Spend in-month	265	298	253	1,067

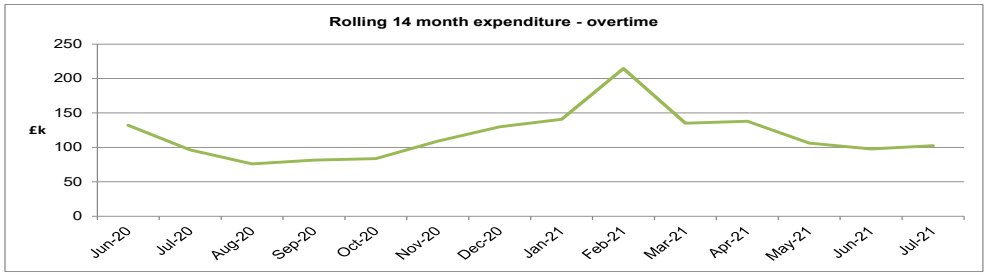
Monthly WTE				
As at July 2021	Jul-21	Jun-21	Jul-20	YTD
	£000's	£000's	£000's	£000's
Budgeted WTE in-month	4,403.9	4,371.2	4,403.9	18,807.0
Substantive Staff	4,038.7	4,063.0	3,791.9	16,191.8
Medical Agency Staff	8.5	9.4	18.1	25.1
Medical Locum Staff	23.7	22.8	33.2	104.4
Additional Medical Sessions	4.1	8.0	8.8	21.5
Nursing Agency Staff	11.0	9.5	21.3	40.5
Nursing Bank Staff	117.1	129.4	127.4	534.1
Other Agency Staff	20.9	25.9	5.1	63.7
Other Bank Staff	75.1	78.1	83.6	360.6
Overtime	23.4	22.5	28.2	106.4
On Call	6.9	8.2	7.6	29.6
Total Temporary WTE	290.6	313.8	333.3	1,285.6
Total WTE	4,329.3	4,376.7	4,125.2	17,477.5
Variance (F/(A))	74.6	(5.5)	278.8	1,329.6
Temp. Staff WTE as % of Total WTE	6.7%	7.2%	8.1%	7.4%
memo: Total Agency WTE in-month	40.4	44.7	44.6	129.2

Pay Costs









FINANCE AND WORKFORCE REPORT – July 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	(7,541)	(8,069)	527	(29,511)	(28,879)	(632)
Other Income	(291)	(264)	(26)	(1,162)	(1,034)	(128)
Total Income	**(7,832)**	**(8,333)**	**501**	**(30,673)**	**(29,913)**	**(760)**
Pay Costs	4,447	4,552	(105)	17,585	18,763	(1,178)
Non-pay Costs	1,573	1,709	(136)	6,558	6,885	(327)
Operating Expenditure	**6,019**	**6,261**	**(242)**	**24,143**	**25,649**	**(1,505)**
SURPLUS / (DEFICIT)	**1,813**	**2,072**	**260**	**6,530**	**4,265**	**(2,265)**
SURGERY						
NHS Contract Income	(5,375)	(4,406)	(970)	(20,907)	(19,543)	(1,363)
Other Income	(199)	(185)	(14)	(796)	(720)	(76)
Total Income	**(5,574)**	**(4,590)**	**(984)**	**(21,703)**	**(20,264)**	**(1,439)**
Pay Costs	3,554	3,430	125	13,991	14,067	(76)
Non-pay Costs	1,184	1,269	(85)	4,666	4,596	70
Operating Expenditure	**4,738**	**4,699**	**39**	**18,657**	**18,663**	**(6)**
SURPLUS / (DEFICIT)	**836**	**(109)**	**(945)**	**3,046**	**1,600**	**(1,445)**
WOMENS AND CHILDRENS						
NHS Contract Income	(2,045)	(1,810)	(234)	(7,891)	(7,470)	(420)
Other Income	(67)	(72)	5	(268)	(277)	9
Total Income	**(2,112)**	**(1,883)**	**(229)**	**(8,159)**	**(7,747)**	**(411)**
Pay Costs	1,484	1,470	14	5,949	5,898	51
Non-pay Costs	167	194	(27)	683	900	(217)
Operating Expenditure	**1,650**	**1,664**	**(13)**	**6,632**	**6,798**	**(166)**
SURPLUS / (DEFICIT)	**461**	**219**	**(242)**	**1,527**	**950**	**(577)**
CLINICAL SUPPORT						
NHS Contract Income	(638)	(511)	(127)	(2,429)	(2,142)	(287)
Other Income	(157)	(154)	(3)	(628)	(620)	(8)
Total Income	**(795)**	**(665)**	**(131)**	**(3,058)**	**(2,762)**	**(296)**
Pay Costs	2,033	2,071	(38)	8,199	8,262	(63)
Non-pay Costs	1,010	1,232	(223)	4,037	4,232	(195)
Operating Expenditure	**3,043**	**3,304**	**(260)**	**12,237**	**12,495**	**(258)**
SURPLUS / (DEFICIT)	**(2,248)**	**(2,639)**	**(391)**	**(9,179)**	**(9,733)**	**(554)**
COMMUNITY SERVICES						
NHS Contract Income	(2,677)	(2,636)	(42)	(10,709)	(10,549)	(161)
Other Income	(1,121)	(1,112)	(9)	(4,484)	(4,434)	(50)
Total Income	**(3,798)**	**(3,748)**	**(51)**	**(15,194)**	**(14,983)**	**(211)**
Pay Costs	2,709	2,809	(100)	10,802	11,083	(281)
Non-pay Costs	1,246	1,344	(98)	4,735	4,878	(144)
Operating Expenditure	**3,955**	**4,153**	**(198)**	**15,537**	**15,961**	**(425)**
SURPLUS / (DEFICIT)	**(156)**	**(406)**	**(249)**	**(343)**	**(978)**	**(635)**
ESTATES AND FACILITIES						
NHS Contract Income	0	0	0	0	0	0
Other Income	(446)	(260)	(187)	(1,786)	(1,012)	(774)
Total Income	**(446)**	**(260)**	**(187)**	**(1,786)**	**(1,012)**	**(774)**
Pay Costs	946	1,007	(61)	3,789	4,094	(305)
Non-pay Costs	655	614	40	2,619	2,428	191
Operating Expenditure	**1,600**	**1,621**	**(21)**	**6,408**	**6,522**	**(114)**
SURPLUS / (DEFICIT)	**(1,154)**	**(1,361)**	**(207)**	**(4,622)**	**(5,510)**	**(888)**
CORPORATE						
NHS Contract Income	(4,805)	(6,000)	1,194	(17,355)	(19,206)	1,850
Other Income	(722)	(797)	75	(9,893)	(10,032)	140
Total Income	**(5,527)**	**(6,797)**	**1,269**	**(27,248)**	**(29,238)**	**1,990**
Pay Costs	1,878	1,708	170	7,290	6,570	719
Non-pay Costs	1,859	1,225	633	11,541	7,506	4,035
Capital Charges and Financing Costs	1,342	1,639	(297)	5,375	5,753	(378)
Operating Expenditure	**5,079**	**2,933**	**2,146**	**24,205**	**14,077**	**10,129**
SURPLUS / (DEFICIT)	**448**	**3,863**	**3,415**	**3,043**	**15,162**	**12,119**
TOTAL						
NHS Contract Income	(23,082)	(23,431)	348	(88,802)	(87,789)	(1,013)
Other Income	(3,003)	(2,844)	(159)	(19,017)	(18,130)	(887)
Total Income	**(26,085)**	**(26,275)**	**190**	**(107,819)**	**(105,919)**	**(1,900)**
Pay Costs	17,051	17,047	4	67,605	68,739	(1,133)
Non-pay Costs	7,692	7,587	105	34,839	31,426	3,413
Capital Charges and Financing Costs	1,342	1,639	(297)	5,375	5,753	(378)
Operating Expenditure	**26,085**	**26,274**	**(188)**	**107,819**	**105,918**	**1,901**
SURPLUS / (DEFICIT)	**(0)**	**1**	**1**	**0**	**2**	**1**

Page 5

Medicine (Sarah Watson)

The division is ahead of plan in month by £260k (YTD behind plan by £2.27m).

Clinical income is ahead of plan by £527k in month but behind plan by £632k YTD. A & E has seen significant and sustained increases in attendances since April. In month this has led to non-elective activity significantly outperforming planned activity by 12%, the 2yr average by 22% and average 19/20 activity by 13%.

It should be noted that as well as being below plan in month, both Elective and Outpatient activity are now below the national expectations for activity recovery (set against average 19/20 activity) which may impact on the Trusts ability to achieve ERF and Accelerator funding.

Activity Type	Vs Plan	Vs 24 Mth Avg	Vs 19/20 Avg
Non-Elective	12%	22%	13%
Outpatients	-10%	-1%	-7%
Elective	-16%	10%	-12%

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 Medicine is behind July plan by £268k (£1.63m YTD).

Pay costs account for £105k (in month) and £1.18m (YTD) of the overall overspend. Significant variances include:

- Junior Drs (£68k). 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 (£87k) – the reduction in the use of temporary staffing to cover substantive vacancies is a continued area of focus for the division.

Non-pay costs are £136k over budget in month due largely to excluded drugs which will be reclaimed in subsequent periods.

Surgery (Simon Taylor)

The division is behind plan in month by £945 (YTD £1,445k)

Clinical income is behind plan by £970k in month (£1.363m YTD). Day case activity continues to exceed plan, by 9.5% in July as the division continues to operate weekend additional sessions. Elective inpatient activity remains behind plan as it continues to be restricted by the elective theatre closures due to ongoing works. Ward movements within the month have increased bed capacity which has enabled more flexibility to deliver additional activity during the weekend. Conversations continue with independent providers and other NHS

organisations to utilise available resources. Overall, outpatient activity remains below plan and 19/20 levels in July. Outpatient attendance activity continues to increase month on month (increase of 14% from June to July). Due to current system issues, the Outpatient procedures activity reported are significantly lower than previous months (45% down from June) and will be adjusted once reporting issues are resolved. Non-elective activity remains high, exceeding plan in month by 25%, which is impacting upon the elective programme delivery. Specialities experiencing high demand are General Surgery and Orthopaedics.

Excluding clinical income, the division is ahead of plan in month by £25k and behind plan by £82k YTD.

Pay expenditure reported an underspend of £125k in month (£76k overspent YTD). Underspends in month are due largely to vacancies within the division and the reduction in additional session spend because of capacity constraints.

Non-pay expenditure was overspent by £85k in month (£70k underspent YTD).

Women and Children's (Michelle O'Donnell)
In June, the Division reported an adverse variance of £242k (£577k YTD)

Income was £229k behind plan in-month (£411k YTD). In month, elective and non-elective activity was behind plan. Year to date, the neonatal unit has been busy and ante & post natal care registrations have exceeded plan. Whilst outpatient activity is broadly on plan, the lower number of paediatric and obstetric non-elective admissions from the start of the financial year has outweighed this. It is likely that paediatric non-elective admissions will increase as the department is planning to receive a large number of RSV cases over the next few months.

Pay reported a £14k underspend in-month (£51k YTD). In-month, the paediatric consultants did not perform any additional sessions which when combined with the vacancies in midwifery created an underspend. YTD unfilled midwife posts have offset cost pressures from COVID and backlog recovery. Maternity services will recruit to more positions the Continuity of Carer initiative is expanded.

Non-pay reported a £27k overspend in-month (£217k YTD). YTD cost pressures from processing historic invoices in Maternity and consistent overspends on the paediatric drugs budget have generated this overspend.

Clinical Support (Michelle O'Donnell)
In July, the Division reported an adverse variance of £391k (£544k YTD).

Income was £131k behind plan in-month (£296k YTD). In-month, the Radiology Service was behind plan for inpatient, outpatient, breast screening and direct access activity. YTD direct access radiology has increased to accommodate the increase in GP referrals. However, breast screening and outpatient radiology activity has been lower than plan. It is likely that breast screening and outpatient radiology activity will increase as the backlogs in these areas are addressed.

Pay reported a £38k overspend in-month (£63k YTD). In-month and year to date, diagnostics has overspent on medical and non-medical pay as the team work additional hours to address the current backlog demand for imaging, and pathology has overspent from providing the COVID SAMBA testing service. The vacancies in outpatient nursing and pharmacy have offset part of this pressure.

Non-pay reported a £223k overspend in-month (£195k YTD). In-month, payments for mobile radiology and additional endoscopy capacity have generated the overspend. YTD, underspends in pathology non-pay have not been able to fully offset recovery related pressures in radiology and outpatients.

Community Services (Lesley Standring)
In July, the Division reported an adverse variance of £249k (YTD £635k).

Income reported £51k below plan in July (YTD £160k), where elements of the division's income plan continue to be impacted by COVID. It is expected that the recovery work underway will recover this shortfall during the next few months.

Pay reported an adverse variance of £100k in month (YTD £281k). Agency staff were used to cover some vacant Therapy roles in Adult Physiotherapy, Occupational Therapy, Dietetics and the Early Intervention Team. A small team of registered nursing agency staff is providing additional capacity to the Community Health Teams, working peripatetically. This fixed term team is above the budgeted establishment.

Non-pay reported an adverse variance of £98k in July (YTD £144k). This was due to additional community equipment costs to enable timely hospital discharges, with a spike in costs incurred this month. There has also 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 resulting in non-pay expenditure increasing on dressings and consumables. Expenditure will increase further in line with the restoration and recovery of services, as well as the additional demand placed on Community teams due to the RAAC works.

FINANCE AND WORKFORCE REPORT – July 2021

Statement of Financial Position at 31 July 2021

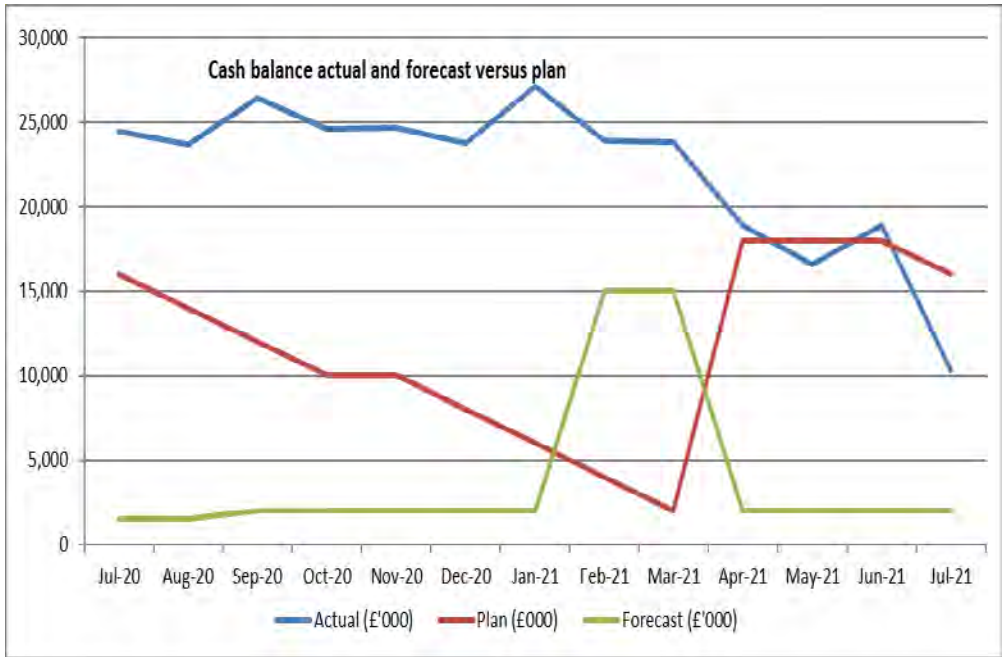
STATEMENT OF FINANCIAL POSITION

	As at 1 April 2021	Plan 31 March 2022	Plan YTD 31 July 2021	Actual at 31 July 2021	Variance YTD 31 July 2021
	£000	£000	£000	£000	£000
Intangible assets	52,198	54,398	52,798	61,465	8,667
Property, plant and equipment	137,103	168,603	146,103	142,177	(3,926)
Trade and other receivables	6,341	6,341	6,341	6,341	0
Total non-current assets	**195,642**	**229,342**	**205,242**	**209,983**	**4,741**
Inventories	3,481	3,481	3,481	3,575	94
Trade and other receivables	19,362	19,362	19,362	19,366	4
Cash and cash equivalents	23,788	2,006	16,006	10,284	(5,722)
Total current assets	**46,631**	**24,849**	**38,849**	**33,225**	**(5,624)**
Trade and other payables	(52,522)	(37,779)	(45,779)	(44,819)	960
Borrowing repayable within 1 year	(6,439)	(5,500)	(5,500)	(6,059)	(559)
Current Provisions	(46)	(46)	(46)	(46)	0
Other liabilities	(1,357)	(3,357)	(3,357)	(2,644)	713
Total current liabilities	**(60,364)**	**(46,682)**	**(54,682)**	**(53,568)**	**1,114**
Total assets less current liabilities	**181,909**	**207,509**	**189,409**	**189,640**	**231**
Borrowings	(47,719)	(43,319)	(47,719)	(48,450)	(731)
Provisions	(852)	(852)	(852)	(852)	0
Total non-current liabilities	**(48,571)**	**(44,171)**	**(48,571)**	**(49,302)**	**(731)**
Total assets employed	**133,338**	**163,338**	**140,838**	**140,338**	**(500)**
Financed by					
Public dividend capital	158,650	188,650	166,150	165,650	(500)
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**	**140,838**	**140,338**	**(500)**

There has been little movement in the balance sheet against plan and the year-end position and the balances continue to be 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 movement in cash is noted below.

Cash Balance Forecast for the year

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



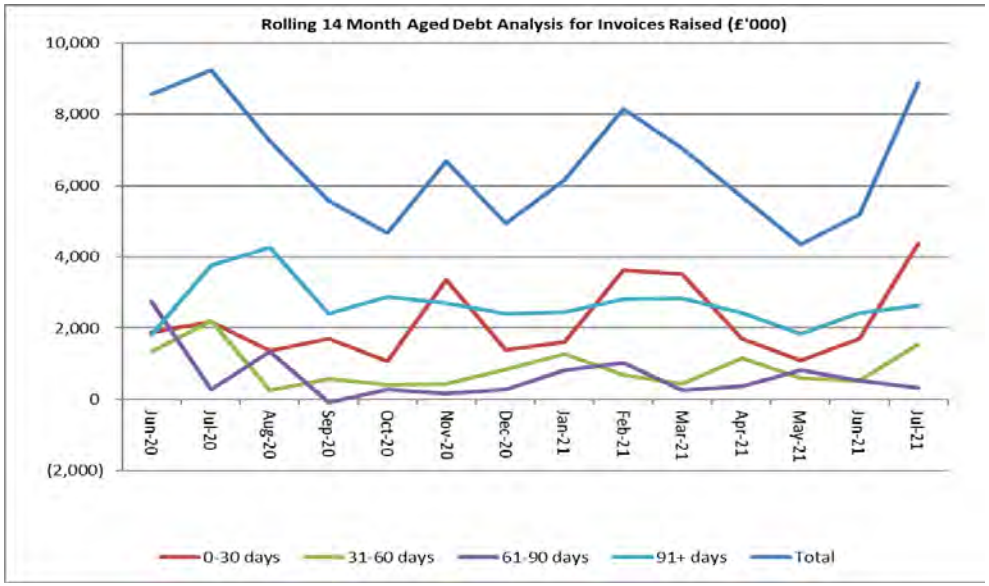
The Trust's cash position is currently being rigorously monitored during 2021/22 as the Trust will no longer be receiving any income in advance as it was in 2020/21. We also need to ensure that the timing of the capital payments is line with capital cash funding due to be received. The cash position has fallen since the prior month mainly due to the large number of capital payments made for which PDC income has not yet been received in the bank.

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 – July 2021

Debt Management

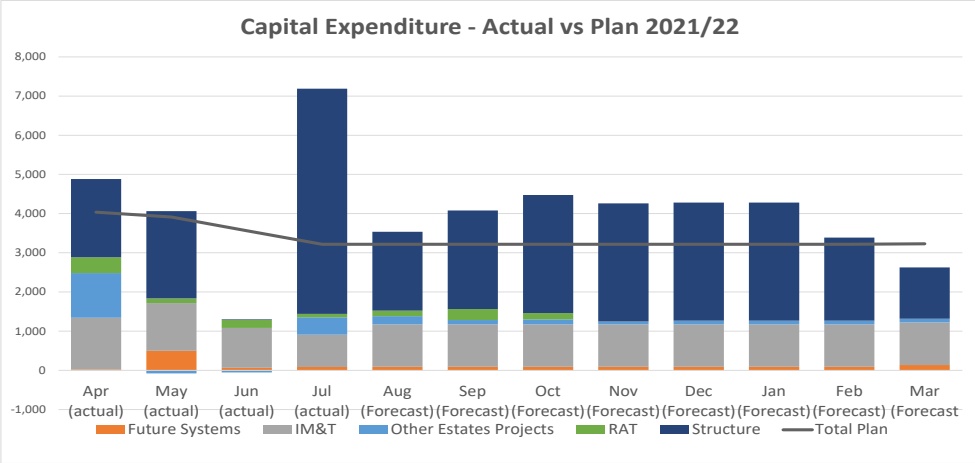
The graph below shows the level of invoiced debt based on age of debt.



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 continues to remain stable. The large majority of the debts outstanding are historic debts, although these are reducing. Over 82% of these outstanding debts relate to NHS Organisations, with 24% 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 Actual £'000	Jul Actual £'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	66	85	90	90	90	90	90	90	90	137	1,440
IM&T	1,316	1,219	1,016	825	1,084	1,084	1,084	1,084	1,084	1,084	1,084	1,084	13,048
Other Estates Projects	1,142	-79	-55	442	210	110	126	72	95	95	95	94	2,347
RAT	403	120	203	90	137	280	160	0	0	0	0	0	1,393
Structure	1,999	2,226	16	5,747	2,014	2,514	3,014	3,014	3,014	3,014	2,118	1,310	30,000
Total / Forecast	4,884	3,984	1,246	7,189	3,535	4,078	4,474	4,260	4,283	4,283	3,387	2,625	48,228
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 year to date figures agree to the separate return submitted to NHSI. The other main focus of the programme is the continuation of the Ecare programme. The original plan submitted did not reflect the full plan for Ecare and at the moment this forecast to overspend the existing budget. This issue has been discussed with NHSI with the view to additional funding to support the ongoing expenditure to develop the system.

10.2. Operational report

To APPROVE a report

For Approval

Presented by Helen Beck

Trust Board – 3 September 2021

Agenda item:	10.2			
Presented by:	Helen Beck, Executive Chief Operating Officer			
Prepared by:	Alex Baldwin, deputy chief operating officer			
Date prepared:	27 August 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.

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

The trust is currently facing some of the most sustained operational pressures of recent times, if not ever. Demand continues to be high with 7852 ED attendances in July 2021 (compared with 7752 in June - an increase of 17% on the pre-pandemic norms.) Two of the three highest attendance days have occurred in the last calendar month. The majority of the increase continues to be seen in walk in minor non-admitted cases and we have not, to date, seen a significant increase in admissions.

We have seen a significant increase in the number of delayed admissions. In the last week we have had **eight** 12-hour DTA breaches, length of wait for admission exceeding 20 hours on occasion and a significant delay in admitting all categories of patient. The number of patients waiting in ED over 12 hrs has increased again to 86 in July (4 April, 23 May, 30 June). This continues to reflect our internal bed pressures and the pressures on mental health services.
In addition, the bed capacity issues resulted in cancellation of cancer surgery which is unheard of at WSFT.

There are several contributory factors for this situation, including the overall reduction in general and acute beds (as required for the RAAC programme) and reduced social care capacity in the community – at the time of writing we are caring for **37** inpatients who have exceeded their right to reside and are awaiting ongoing care in the community. The impact on the trust can be seen in an increase in stranded patient numbers (**170** +7 days, **77** +14 days, **45** +21 days).

Compounding these capacity constraints are staffing issues and combined they create a severely stressed and strained organisation.

This picture is reflected across the ICS and indeed nationwide. System support has been sought and there are ongoing discussion relating to opportunities for improvement but at present the focus is on medium to long term solutions which provide little immediate relief.

In more positive news Covid levels remain static (a peak of inpatients in the low 10's which is manageable with our current capacity constraints). The current modelling, which as previously reported is limited and uncertain, suggests we can expect to see this low-level demand continue through the late summer and autumn months with hospital admissions expected to rise in early January following Christmas festivities.

Winter planning

The trust is approximately four weeks in to the annual winter planning round, which should perhaps be re-termed seasonal planning. Current focus in on creating additional inpatient capacity but this is a challenging ask given the space constraints. Consideration is being given to the use of capacity in our community hospitals and the joint project team are working this through.
A multidisciplinary team meets weekly to track progress and provide assurance, an initial report from which will be presented for detailed discussion at Scrutiny Committee in September.

RAAC bearing extension and operational impact

The RAAC programme continues to progress well although a series of unforeseen delays mean the proposed end date of October 21 is at risk.

Wave 3 has been completed and wave 4 will commence as planned at the beginning of September. We have successfully completed the bearing extension programme on F6 and the surgical team have now returned to their base. Likewise, the work on F14 has been completed. In an amendment to the planned programme the orthopaedic service has moved to F14 temporarily. This allows NNU to move to F2 whilst full failsafe work in that area is completed. This is a priority for the programme but means that the Gynae team will remain on F10 longer than planned which is not ideal. The discharge waiting area has returned to the old MTU space which creates additional capacity to take stretcher patients and increases the availability of overnight surge capacity, albeit small.

The remainder of the wave 4 programme will see the F3 team move back to F3 from F4 and F7 move to F9. The F4 bearing extension work is scheduled to be completed by the end of October and F7 by early December. In addition, the failsafe programme in theatres continues with theatres 1-4 closed through the duration of September and October.

A combination of increased operational pressures and estates challenges has heightened the pressure on the programme. This is under constant review and is being managed ably by the CRT but it is worth noting that it is becoming increasingly difficult to manage the component parts successfully and to meet all agreed deadlines.

Accelerator Programme and Elective Recovery

The accompanying slide deck (Annex A), which was presented at the most recent SNEE elective recovery and accelerator operational meeting, gives the latest position in terms of achievement against the target level of 100% of 19/20 baseline activity and the associated impact on our RTT position.

The system successfully achieved its first milestone as anticipated and is well on track to do the same for August. The impact of the theatre closure programme at WSFT has been felt in terms of activity and waiting times as evident in the data although there is recognition that we our outperforming our initial estimates in terms of the volume of elective activity delivered. Collaborative working across the 2 sites is making progress although patient choice and clinical governance issues continue to be a barrier to full access. The Vanguard Unit has been installed at Ipswich and has been operational for the last 2 weeks. The barriers to full access are being worked through at length and increased utilisation is expected.

Independent sector capacity is being utilised although there is a general lack of providers in West Suffolk. We have access to lists at BMI Bury St Edmunds which are being utilised well in addition to capacity at Newmedica in Ipswich who a supporting with ophthalmology pathways. Additional capacity has been made available at the Ramsey Oakes Hospital (Colchester) and the Nuffield Health (Ipswich). This reflects a growing focus on taking a system approach to reducing waiting times. Recognising that there are large disparities in waiting time across the region we are working with colleagues at ESNEFT to ensure equity of access to additional capacity. This includes sharing of waiting lists between the two organisations and transfer of patients where appropriate. It must be said, however, that patient choice continues to be a key factor with many choosing to wait longer for surgery on the main site than accepting a date elsewhere.

At the request of NHSE/I colleagues we have submitted bids for capital investment in support of elective recovery. This includes funding for an orthopaedic suite, extended vanguard use, and conversion of non-clinical space on the WSFT site. At present it is unclear when/if funding will be made available. In addition, activity expectations and the financial position for H2 remains uncertain.

Recommendation

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

Appendix1: SNEE weekly activity and accelerator report

Total		Week ending	Wait time (92%ile)	Wait list	>18 wks	>52 wks	>78 wks	>98 wks	>104 wks	%<18wks
15 August 2021	44	15 August 2021	57 weeks	23809	7966	2233	1112	131	52	66.5%
22 August 2021	44	22 August 2021	57 weeks	23896	8141	2251	1122	149	65	65.9%
WSFT		Change	0	87	175	18	10	18	13	-0.6%
All										
		44430WSFTTotal	44423WSFTTotal	44416WSF	44409WSF	All				
		Clock stops	<=18w	>18w	Total	Crude clearance time*				
		This week	721	224	945	26 weeks				

Total		Week ending	Wait time (92%ile)	Wait list	>18 wks	>52 wks	>78 wks	>98 wks	
15 August 2021	44	15 August 2021	40 weeks	59700	17825	1717	418	35	
22 August 2021	44	22 August 2021	40 weeks	60129	18089	1691	438	37	
ESNEFT		Change	0	429	264	-26	20	2	
All									
		44430ESNEFTTotal	44423ESNEFTTotal	44416ESN	44409ESN	All			
		Clock stops	<=18w	>18w	Total	Crude clearance time*			
		This week	1794	667	2461	25 weeks			
		Last 4 weeks	1873	704	2577	24 weeks		10307	
		*If no more work came in how long would it take to clear the waiting list							

Weekly activity review

Latest update summary attached with 3 week moving average updates for capacity used in the period up to week ending 22 August 2021. Please note there is often a lag in the outpatient coding and this improves on validation. n.b. the waiting list elements only change monthly).

Figures for JUNE are based on 31 May - 4 July and JULY are 5 July - 1 August average. N.b. June figures may be understated as the bank holiday fell differently in the 2019/20 baseline year.

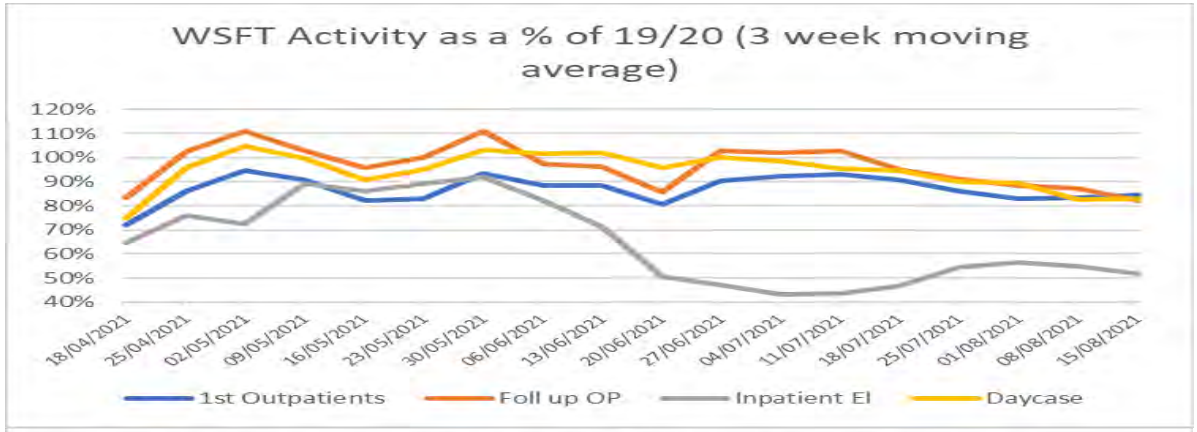
Key headlines:								
First outpatients:		JUNE	88.5%	JULY	88.1%			
Overall	85%	was	85%	Target:	85%	(from July)		
WSFT	81%	was	82%					
ESNEFT	86%	was	86%					
Follow up outpatients:		JUNE	95.0%	JULY	94.9%			
Overall	86%	was	89%	Target:	85%	(from July)		
WSFT	82%	was	85%					
ESNEFT	88%	was	90%					
Inpatient electives:		JUNE	81.5%	JULY	87.5%			
Overall	84%	was	85%	Target:	85%	(from July)		
WSFT	48%	was	52%					
ESNEFT	95%	was	95%					
Daycases:		JUNE	98.2%	JULY	97.2%			
Overall	92%	was	92%	Target:	85%	(from July)		
WSFT	83%	was	83%					
ESNEFT	94%	was	95%					
MRI:		JUNE	95.4%	JULY	94.9%			
Overall	98%	was	95%	Target:	85%	(from July)		
WSFT	85%	was	79%					
ESNEFT	103%	was	101%					
CT:		JUNE	106.4%	JULY	106.1%			
Overall	109%	was	105%	Target:	85%	(from July)		
WSFT	113%	was	113%					
ESNEFT	107%	was	103%					
Endoscopy:		JUNE	101.6%	JULY	106.7%			
Overall	99%	was	98%	Target:	85%	(from July)		
WSFT	102%	was	98%					
ESNEFT	97%	was	98%					
n.b. data from Weeks 18-20 as there is a lag in the reporting								

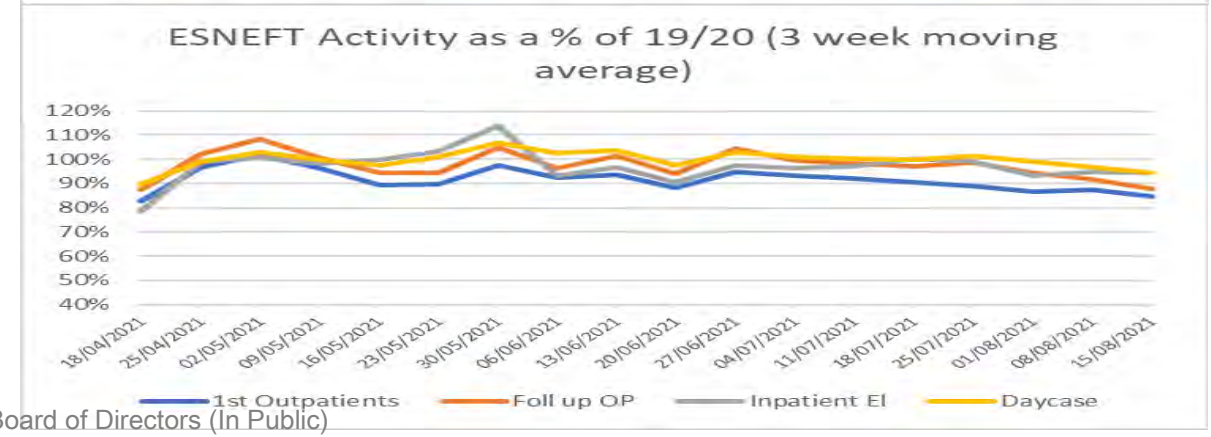
Suffolk and North East Essex ICS: Elective Recovery

September 2021

Current Performance Against Thresholds

- The national expectation of delivering a rise from 70% to 85% of 2019/20 activity has been consistently met with the exception of WSFT inpatient electives due to remedial work on RAAC planks in 5 theatres. This work will be complete in November.
- The accelerator programme expectation was that the system would deliver 100% of 19/20 values by the end of July 2021. The table below does not include our independent sector capacity and is not adjusted for case mix acuity which is higher than in 2019/20. We anticipate the final costed outcome to be at or around 100%.
- There has been a slight dip in August which is thought to be due to more staff taking leave than in previous years.

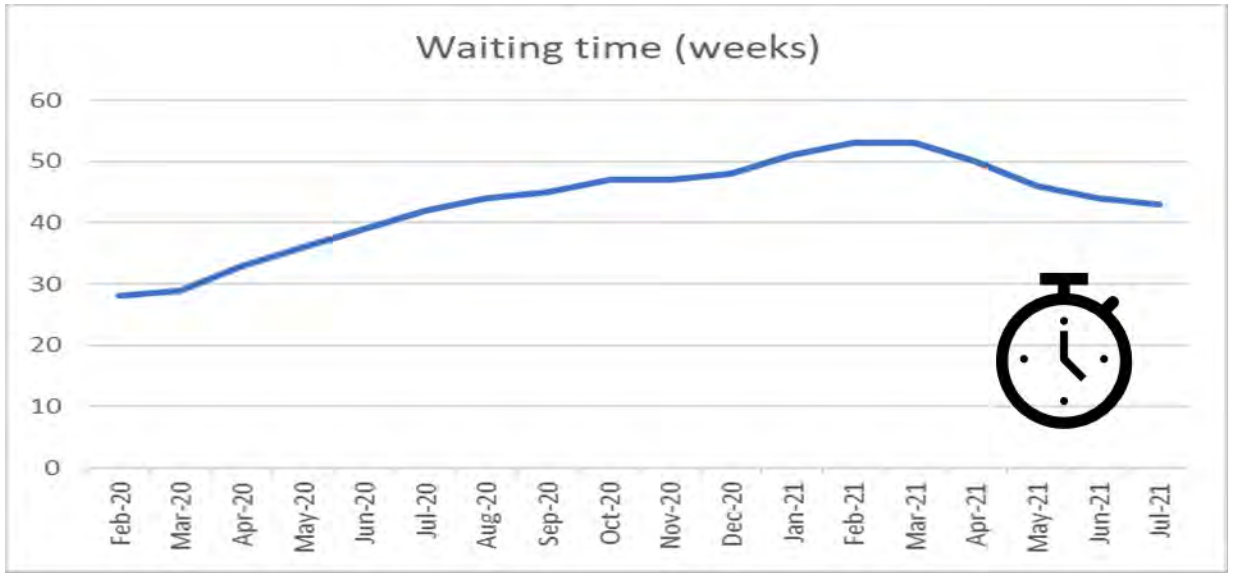


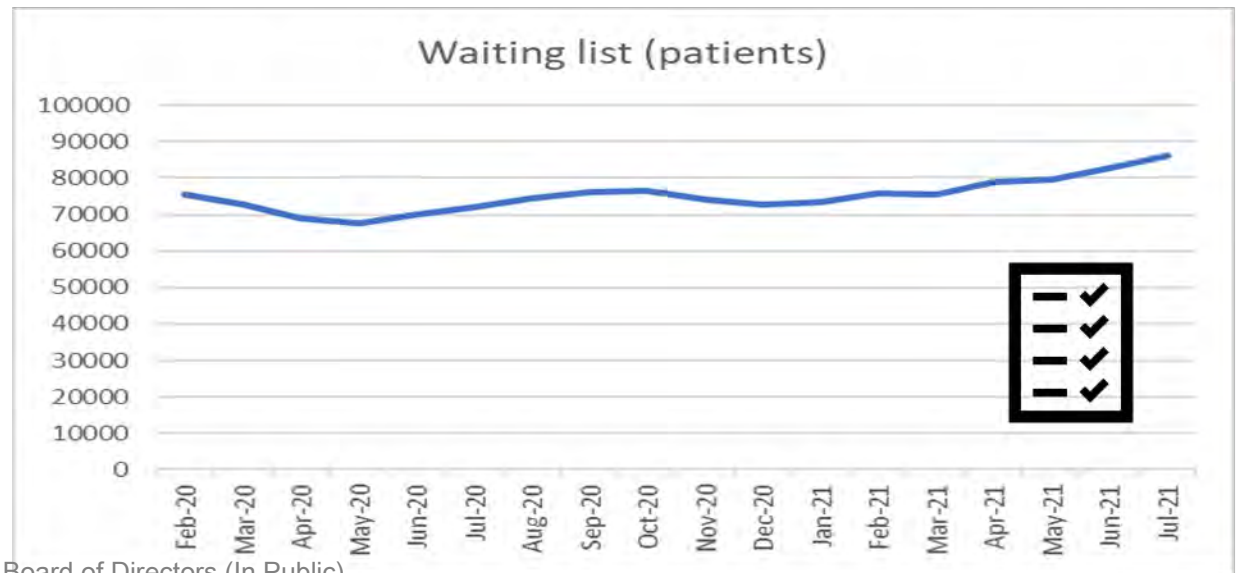


July 2021 (based on weekly returns (excludes IS and case mix adjustment)

	WSFT	ESNEFT	SNEE
First Outpatients	85%	89%	88%
Follow-up Outpatients	90%	96%	94%
Inpatient Electives	54%	97%	88%
Daycases	90%	99%	97%

Impact on waiting list





Waiting times are beginning to fall and the latest validated position shows 43 weeks

1 year waits are falling rapidly and the latest validated position shows just over 4,000 waiting

The waiting list continues to grow, this is partly because capacity is focussed on long waiters at the moment

Long waiters and current position

- Between April and August both Trusts (to differing degrees) have seen:
  - Waiting times fall
  - Waiting lists grow
  - Fewer patients waiting longer than 1 year
- ESNEFT have seen small reductions in their very long waiters (20 of the 22 104 week waiters are oral max facs surgery for which a solution is being sought)
- Many of WSFTs long waiters are orthopaedics (31 of 52 104 week waiters) and will be challenging to treat while the theatre works are ongoing
- There is a large waiting time differential between trusts for some specialties. Joint working is being explored starting in ophthalmology and orthopaedics.

ESNEFT

Week ending	Wait time (92%ile)	Wait list	>18 wks	>52 wks	>78 wks	>98 wks	>104 wks	%<18wks
04 April 2021	47 weeks	55661	22075	3850	374	32	24	60.3%
15 August 2021	40 weeks	59700	17825	1717	418	35	22	70.1%
Change	-7	4039	-4250	-2133	44	3	-2	9.8%

WSFT

Week ending	Wait time (92%ile)	Wait list	>18 wks	>52 wks	>78 wks	>98 wks	>104 wks	%<18wks
04 April 2021	65 weeks	21402	8923	3318	550	21	9	58.3%
15 August 2021	57 weeks	23809	7966	2233	1112	131	52	66.5%
Change	-8	2407	-957	-1085	562	110	43	8.2%

15 August 2021	Wait time (92%ile) weeks				
	ESNEFT	WSFT	Difference	SNEE	InHealth
General Surgery	50	55	5	52	
Urology	36	68	32	45	
Trauma & Orthopaedics	49	81	32	58	
Ear, Nose & Throat (ENT)	36	61	25	41	
Ophthalmology	27	80	53	34	
Oral Surgery	35			35	
Plastic Surgery	35	56	21	49	
General Medicine	20	18	2	20	
Gastroenterology	39	37	2	38	
Cardiology	17	20	3	17	
Dermatology	31	17	14	29	
Thoracic Medicine	37	24	13	36	
Neurology	21	16	5	21	
Rheumatology	35	14	21	35	
Geriatric Medicine	11	12	1	12	
Gynaecology	43	75	32	49	
Other	39	39	0	39	
Endoscopy					21
Total	40	57	17	43	

Performance against gateways

Gateway	Updates	Rating
Clinical Validation, Waiting List and Long Waits	**ESNEFT:** The current position stands at 96%. Plans are in place to reduce the clinical burden this requires. codes are captured administratively. **WSFT:** As at 25th July 86%. Approach for further improvement agreed with the Clinical Directors and aiming for improved position. **Long waits:** both Trusts reducing the overall wait times – challenges remain with ESNEFT sourcing Oral Max Facs Surgery capacity (national issue) and WSFT with completing some inpatient elective pathways due to RAAC plank issues in theatres and bed base.	On track but scrutiny of long waits is rising
Addressing Health Inequalities	A review by ESNEFT showed that there was no difference in wait times between patients of different ethnic origin but that patients from areas with a lower deprivation index were waiting shorter times. It is thought this is due to later presentation and further work needs to be completed on this. Virtual appointments are being used extensively by both Trusts – further work needs to be undertaken to understand if there are any barriers to accessing these.	On track but further work from WSFT and on virtual appointments needed
Transforming Outpatients	Roll out and monitoring of advice and guidance and patient initiated follow up (PIFU) continues with both Trusts expanding their offers. WSFT working on automating data capture for PIFU. Virtual appointments continue although there has been a slight drop at ESNEFT – this is clinically led and is being reviewed.	On track – further work ongoing
System-led Recovery	Good working relationships are being built between the access leads and progress is beginning to be made with mutual aid discussions around orthopaedics and ophthalmology. The system is working well with the independent sector – further opportunities are being explored to try to increase usage further. These developments need to be clinically led and this may take a bit more time to ensure it is sustainable.	On track – further work ongoing
People Recovery Plans	Significant work undertaken to monitor and promote staff wellbeing. Further measures and capacity may be needed in the medium term as fatigue is becoming an issue with staff working weekends and extended hours.	On track – highlighted as key risk

High level modelling: WSFT

WSFT	Feb '20 wait list	Jul '21 wait list	Growth during Covid	Current monthly trend (based on last quarter)	Additional % to return to Feb '20 in 1 year	Additional % to return to Feb '20 in 2 years	Additional % to return to Feb '20 in 3 years	Current 92%ile wait (aim is 18 weeks)
General Surgery	3261	3758	15%	-127	Sufficient if demand and capacity stable			55 weeks
Urology	1149	1547	35%	-9	7%	2%	1%	68 weeks
T&O	2787	4070	46%	+86	42%	30%	26%	81 weeks
ENT	1842	2471	34%	+33	14%	10%	8%	61 weeks
Ophthalmology	2093	1533	-27%	+10	Already below Feb 2020			80 weeks
Dermatology	1425	1491	5%	+130	25%	24%	24%	17 weeks
Gynaecology	2109	2520	19%	+12	9%	5%	4%	75 Weeks
Total	**19593**	**23217**	**18%**	**+390**	**12%**	**9%**	**8%**	**57 weeks**

Method:
This is a crude analysis of the waiting list size and run rates to ascertain how many additional clock stop events are needed by specialty to return the wait list size to February 2020.
The method does not account for:

- Waiting times
- Case mix, sub-specialties or differentiate between non-admitted, admitted and validation
- Changes in trends brought on by capacity changes e.g. Winter, Covid
- Changes in demand (currently at 88% of 19/20

Conclusions:

- There are some specialties where incremental efficiencies alone will not recover the waiting list (T&O being the most significant)
- Step changes in capacity (or demand) will be required to bring these waits down
- There are some specialties where the waits are long yet the waiting list has reduced (ophthalmology)
- There are opportunities to work together with WSFT to either provide or receive mutual aid and to co-commission additional capacity

High level modelling: ESNEFT

ESNEFT	Feb '20 wait list	Jul '21 wait list	Growth during Covid	Current monthly trend (based on last quarter)	Additional % to return to Feb '20 in 1 year	Additional % to return to Feb '20 in 2 years	Additional % to return to Feb '20 in 3 years	Current 92%ile wait (aim is 18 weeks)
General Surgery	6056	10004	65%	+163	24%	16%	13%	50 weeks
Urology	4006	3162	-21%	+12	Already below Feb 2020			36 weeks
T&O	7105	8340	17%	+58	11%	7%	6%	49 weeks
ENT	3710	5775	56%	+67	17%	11%	9%	36 weeks
Ophthalmology	5759	6856	19%	+464	36%	33%	32%	27 weeks
Dermatology	5869	4981	-15%	+372	Already below Feb 2020			31 wekks
Gynaecology	4325	5558	29%	+169	23%	18%	17%	43 weeks
Total	**55822**	**62852**	**13%**	**+1978**	**15%**	**14%**	**13%**	**40 weeks**

Method:
This is a crude analysis of the waiting list size and run rates to ascertain how many additional clock stop events are needed by specialty to return the wait list size to February 2020.
The method does not account for:

- Waiting times
- Case mix, sub-specialties or differentiate between non-admitted, admitted and validation
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Conclusions:

- There are some specialties where incremental efficiencies alone will not recover the waiting list
- Step changes in capacity (or demand) will be required to bring these waits down
- There are some specialties where the waits are long yet the waiting list has reduced
- There are opportunities to work together with WSFT to either provide or receive mutual aid and to co-commission additional capacity

Pathway reviews and productivity impact – next steps: WSFT (1 of 2)

Overview:

A review of 24 GIRFT High Volume, Low Complexity (HVLC) pathways, was undertaken in June/July 2021, across the following specialities:

- Trauma and Orthopaedics (excluding spinal)
- Ophthalmology
- Urology
- ENT
- Gynaecology
- General Surgery

The following approach was taken to provide a qualitative and quantitative view of opportunities:

- Baseline of current performance data and Model Hospital metrics
- Gap analysis between current pathways and best practice GIRFT pathways
- Collaboration with clinical and operational leads to review current standard practices against the GIRFT HVLC procedures.
- Joint identification of opportunities for improvement per speciality

The review demonstrated that, whilst there is a degree of compliance, there are opportunities which can be explored.

Pathway reviews and productivity impact – next steps: WSFT (2 of 2)

Opportunities:

The summary opportunities for all specialities are detailed below. These actions together with speciality specific opportunities are being built into existing clinical GIRFT action plans, programmes of work such as the Outpatient Transformation Programme and system or place based, transformational programmes (Eye Care and MSK).

Common actions across all specialities
Initial opportunities • Progress virtual clinical prioritisation with ESNEFT to maximise clinical treatment capacity • Virtual consultations/consent - specialities to roll out virtual consultations at referral stage and at points in the pathways such as consent, PAU and post discharge follow up (where clinically possible) • Review and refine referral processes, with focus on conservative treatment and criterion • Variation in theatre planning and usage suggest scope to further review this part of the pathway, specifically theatre utilisation and efficiency in line with increasing Model Hospital reports for checks and balance • Work up plans to increase day surgery for specific pathways • Enhance allied health input on pathways where specified in GIRFT or to prepare patients for surgery, and to support post operative recovery (acute and community) Further opportunities: • Refine advice and guidance to maximise benefit to patient and effective use of Consultant time • Patient information to be improved for some specialities; explore website hosting and developing content to a) support stabilisation of stabilization long waiters b) health optimisation in preparation for operation c) specific procedure support preparation • Revisit short notice pools at earliest practicable point (post Covid)

Pathway reviews and productivity impact – next steps: ESNEFT (1 of 2)

Overview:

ESNEFT's Elective Transformation Project Plan includes the following Workstreams:

- Review of pre-operative assessment
- Theatre efficiency
- Advice and guidance, patient initiated follow up and virtual clinics
- Review of patients on non-admitted pathways
- Reduction of follow up appointments
- Getting it right first time (GIRFT)
- New pathways of care
- Reduction of follow up appointment backlog
- Reduction of first appointment backlog
- Accelerator programme – 29 pathways (GIRFT)
- Mobile ophthalmology unit
- Increased clinical activity

Pathway reviews and productivity impact – next steps: ESNEFT (2 of 2)

ENT:
- Supporting WSFT endo sinus and nasal surgery backlog
- Increased myringoplasty capacity

Ophthalmology (cataracts):
- Additional pre-op in Vanguard
- Bumper weekends
- Reducing variation
- Cataract only lists
- Additional case on other lists

Gynaecology:
- Increase use of ambulatory care unit
- Reduce dropped slots
- Undertake U/S pre referral

Orthopaedics:
- Additional sessions
- Hips and knees:
  - Reduce variation
  - Reduce follow ups
  - Reduce dropped slots

Spinal:
- Improve pre referral use of physio
- Additional lists
- Reduce follow ups
- Reduce variation
- Reduce dropped slots
- Review use of senior registrars

Urology:
- Additional capacity
- One stop bumper weekends
- Nurse led clinics
- One stop nurse led clinics
- Reduce dropped slots

General Surgery:
- Hernia:
  - Weekend lists
  - Additional lists
  - Reducing dropped slots
- Laparoscopic cholecystectomy
  - Dedicated lists
  - Reducing dropped slots

Possible capital investments: indicative costs and activity impact summary*

Scheme	Trust	Site	Overview of impact	Estimated capital
Orthopaedic Suite	WSFT	Newmarket	c. 1,000 orthopaedic additional slots	£25.4m
Orthopaedic Suite Expansion**	ESNEFT	Colchester	Additional 5,500 patients (over and above existing proposed EOC activity) to be treated each year.	£13.4m
3 new permanent laparoscopic theatres over new UTC**	ESNEFT	Ipswich	An extra 3600 patients a year to be treated.	£8.4m
Expanded Endoscopy Unit	ESNEFT	Ipswich	An additional 2,400 endoscopy procedures to be performed each year.	£4.3m
Extend Vanguard use	SNEE	Ipswich	c. 2.5k daycase patients a year or a mix of daycase and inpatient	c. £2.7m
New Urology Unit	ESNEFT	Ipswich	An additional 2,400 endoscopy procedures to be performed each year.	£1.8m
New Day Surgery Unit	ESNEFT	Colchester	Theatre capacity for day surgery for 5,500 adults and 1,000 children to be treated each year. The new day surgery unit at Colchester will also free up the existing day surgery unit to do 2,400 additional endoscopies.	£1.75m
Expanded ICU	ESNEFT	Colchester	Either 11 Level 2 beds or a mix of up to 4 level 3 beds and 3 Level 2 beds	£0.8m
Conversion of old clinical photo room	WSFT	Bury	80 additional daycase patients per week across the services. Consultant room could provide additional clinic space capacity for up to 24 new urology outpatients per week.	£0.3m
BMI Bury	WSFT	BMI Bury	TBC – currently operates 5 days a week in hours only and does not utilise all theatre sessions.	TBC
New Endoscopy Unit	ESNEFT	Colchester	An additional 2,400 endoscopy procedures to be performed each year.	TBC

*n.b. Revenue implications to be discussed and agreed

**n.b. we have not yet prioritised these schemes as SNEE, however, ESNEFT wished to flag these schemes as their priorities

Private sector utilisation

Provider	Brief Update	Additional Potential?
Ramsay Oaks - Colchester	ESNEFT continue to work very closely with the Oaks and significant volumes of activity are being carried out under sub contract	WSFT exploring potential for using Oaks – beginning with T&O
Newmedica Ipswich	Significant (c. 250 a month) patients are choosing to go to Newmedica for cataract procedures. WSFT are working with Newmedica to send up to 200 patients a month from the waiting list.	WSFT have yet to achieve the full 200 a month and have been working hard on the messaging to persuade more patients to go.
BMI Bury	WSFT have limited usage of the BMI in Bury and continue to utilise this. BMI are also undertaking choice work that is directly referred.	The BMI site is underutilised – WSFT are exploring with BMI what they could do to improve this.
Nuffield Ipswich	The Nuffield have provided some diagnostic capacity but have focussed the rest of their capacity on clearing their private backlogs.	Trusts are talking to Nuffield about any other capacity that might be available. Nuffield are not currently open to NHS choice.
InHealth Ipswich	IESCCG has a substantial block contract with InHealth for endoscopy – InHealth have been clearing their backlogs.	InHealth have additional capacity but up until now this has been only available at a premium or with guarantees on income. WSFT are exploring if they can use this.

Examples of joint working

Access leads continue to work together to look at waiting times to identify any further opportunities that may arise for Mutual Aid. Conversations have taken place with the T&O Colchester Clinical Lead and his counterpart at West Suffolk to see if there can be mutual aid offered in relation to the T&O waiting lists. However, these discussions have only just started to take place.

Ophthalmology: Discussions took place between the operational teams and clinical leads and it was agreed that we would transfer 10 cataract patients per week from West Suffolk to ESNEFT at the Ipswich site. The clinical criteria was agreed and patients have now been transferred and operated on.

Urology: It was identified that TURP patients could be transferred from West Suffolk to ESNEFT at the Ipswich site. Conversations are currently taking place to identify the clinical criteria for these patients and we are looking at primarily long waiting patients sitting over 52 weeks on the PTL at West Suffolk. Discussions are also taking place as to whether it would be suitable for new patients to transfer their whole pathway to Ipswich.

ENT: Discussions took place between the operational teams and the clinical teams and it was agreed that 4 ENT patients per week could be transferred from West Suffolk to ESNEFT at the Ipswich site. However, further capacity has been identified and this number has increased to 12 per week.

Rheumatology: It was identified that the waiting times at West Suffolk were significantly lower than at the ESNEFT Ipswich site. Therefore, agreement has been reached that 5 patients per week can be transferred from Ipswich to West Suffolk. These, however, are patients that have not had their first OPA. The patients will be identified in the first instance as those that live in the surrounding areas between Ipswich and Bury. This is very much in the early planning stages.

10.3. IQPR

To NOTE the report

For Report

Presented by Helen Beck and Susan Wilkinson

Trust Public Board Meeting - 3 September 2021

Agenda Item:	10.3			
Presented By:	Helen Beck & Sue Wilkinson			
Prepared By:	Information Team			
Date Prepared:	Jun-21			
Subject:	IQPR			
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.

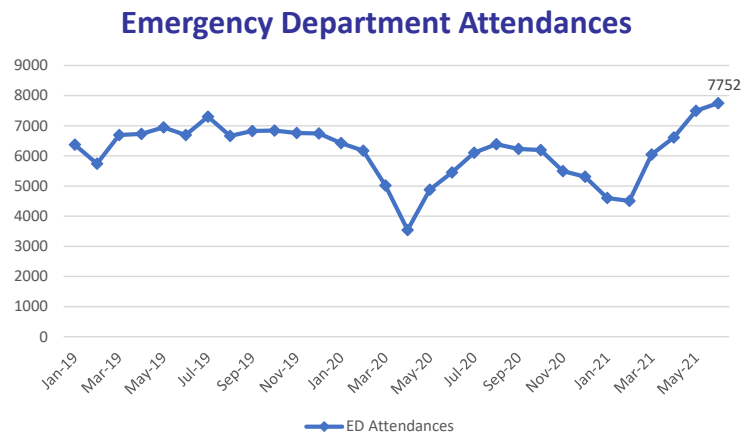
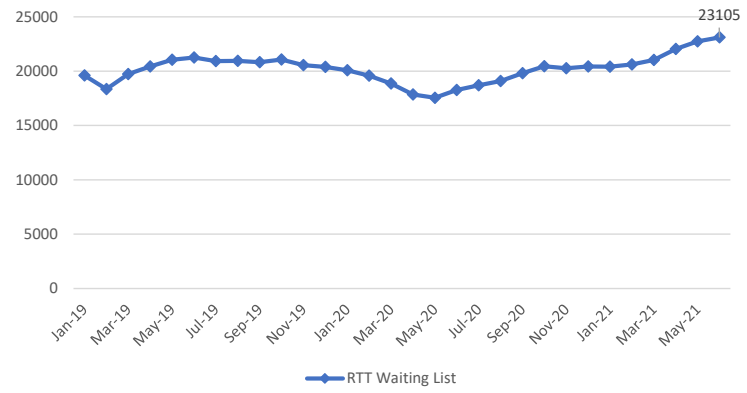
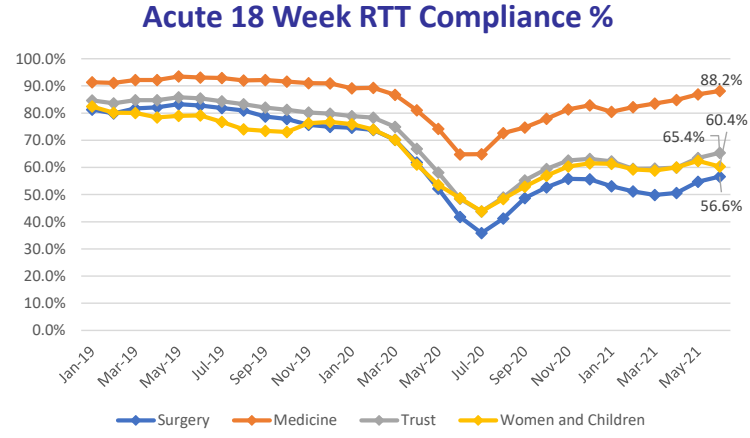
Trust Priorities [Please indicate Trust priorities relevant to the subject of the report]	**Delivery for Today**	**Invest in Quality, Staff and Clinical Leadership**	**Build a Joined-up Future**
	X		

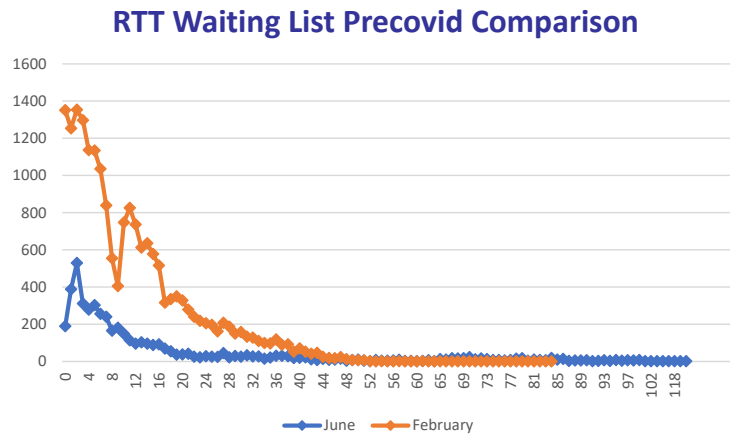
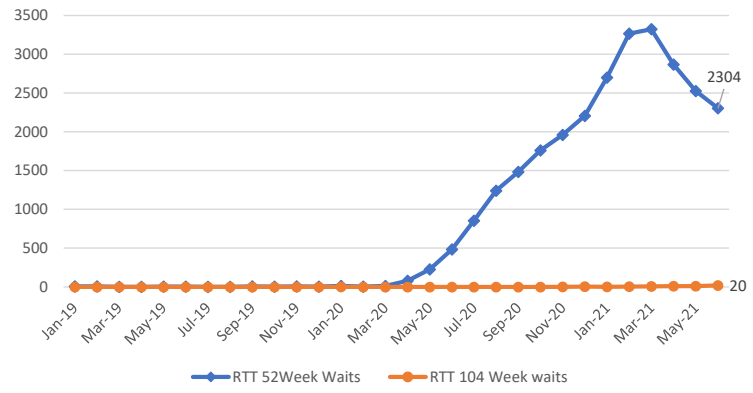
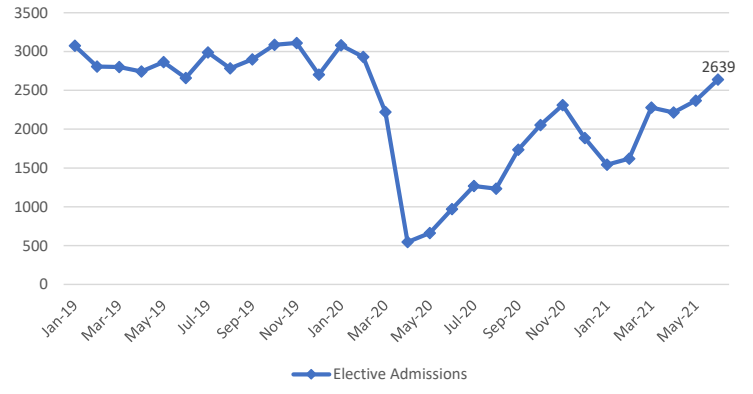
Trust Ambitions [Please indicate ambitions relevant to the subject of the report]	Deliver personal care	Deliver safe care	Deliver joined-up care	Support a healthy start	Support a healthy life	Support ageing well	Support all our staff
		X	**X**				**X**

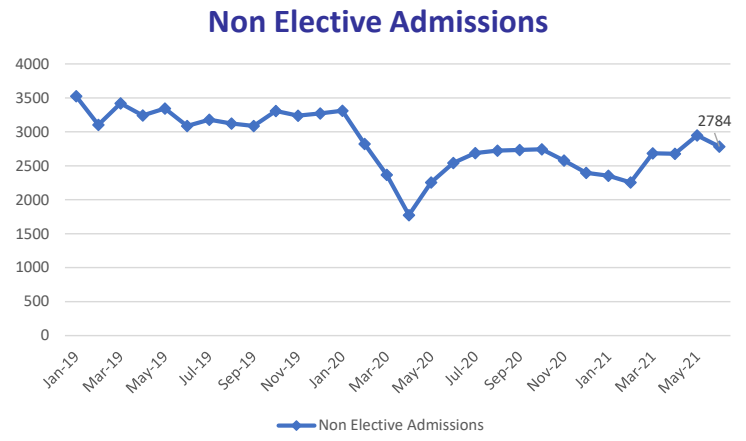
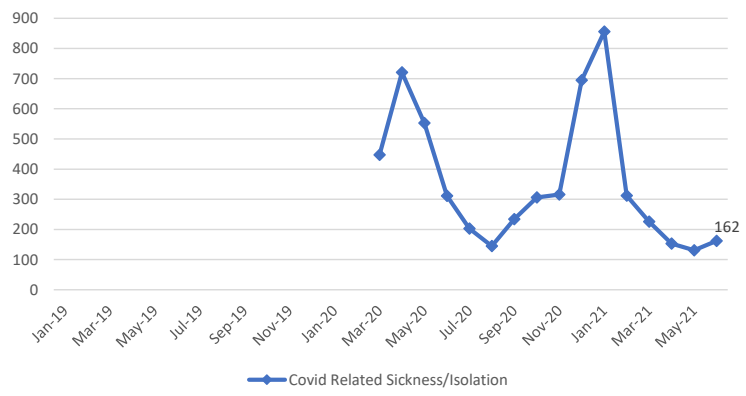
Previously Considered by:	Insight committee
Risk and Assurance:	
Legislation, Regulatory, Equality, Diversity and Dignity Implications	

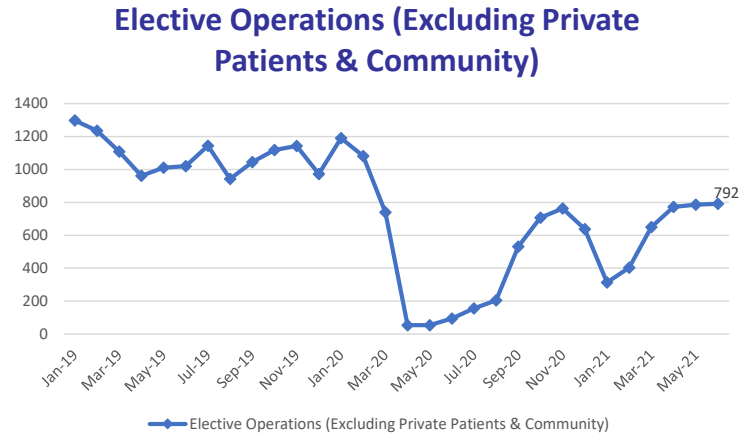
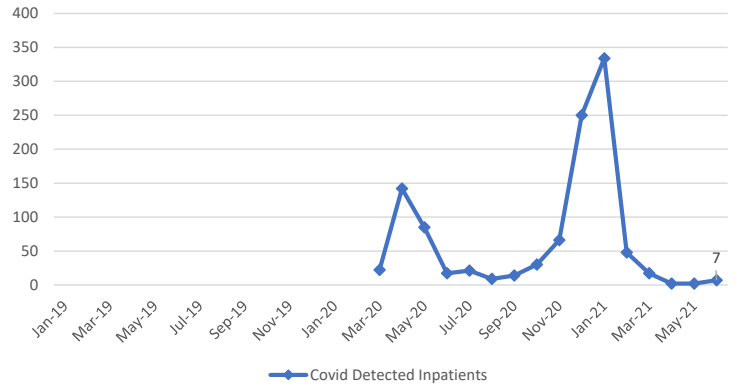
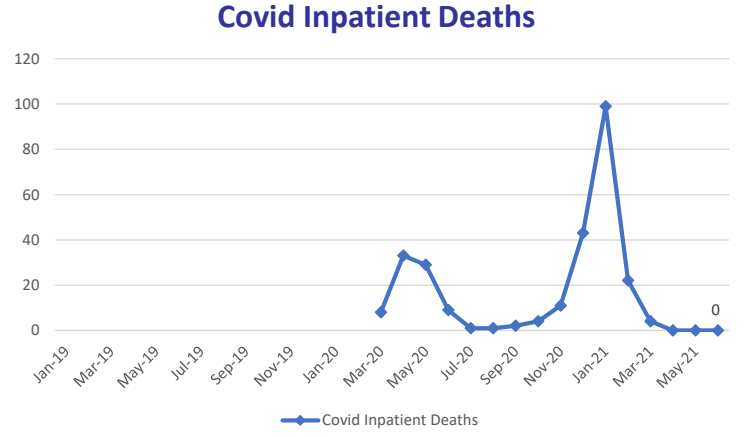
Recommendation:

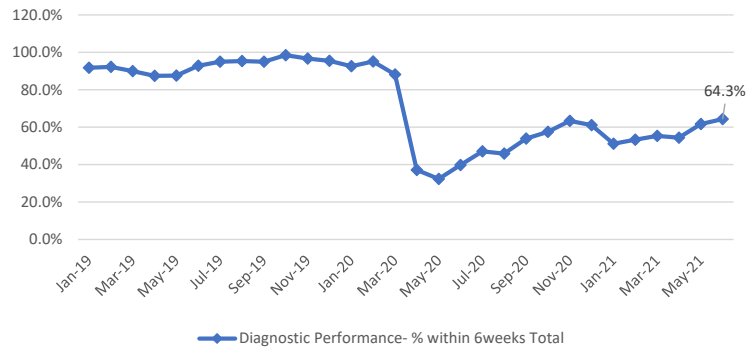
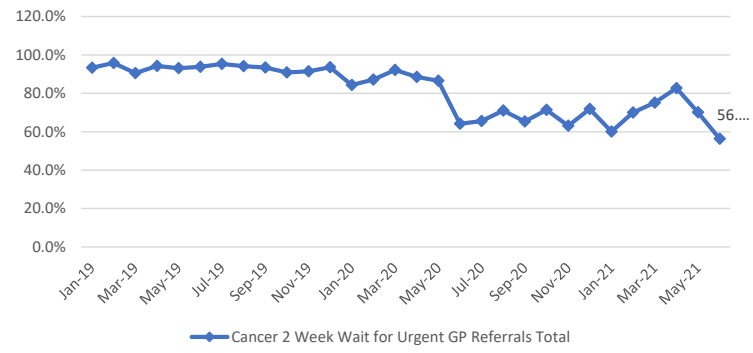
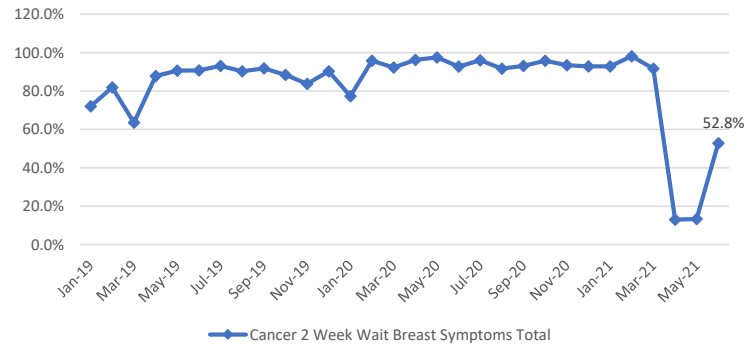
That Board note the report.

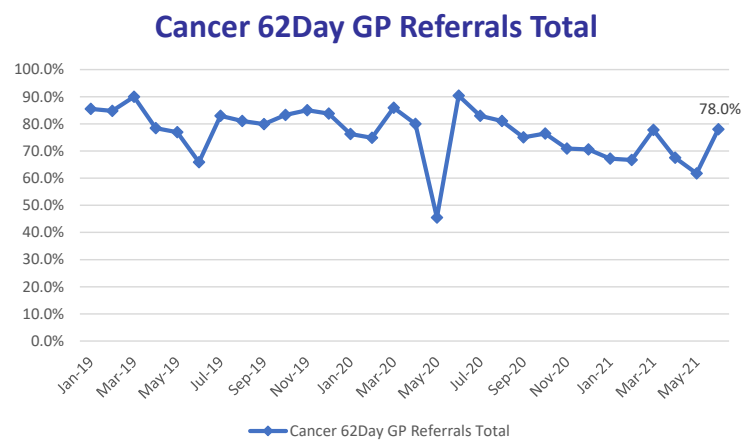
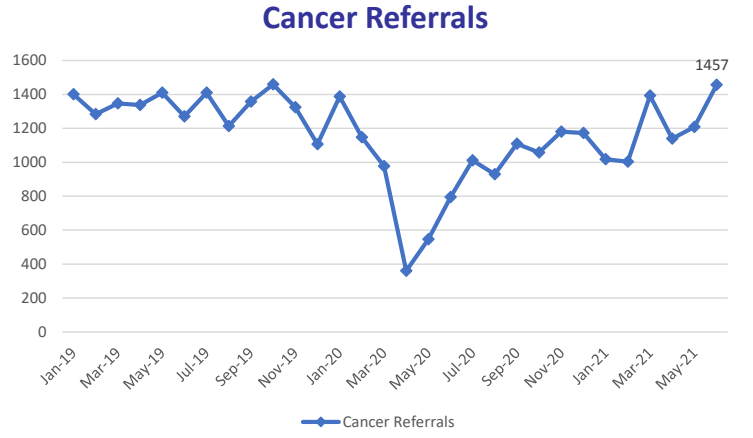
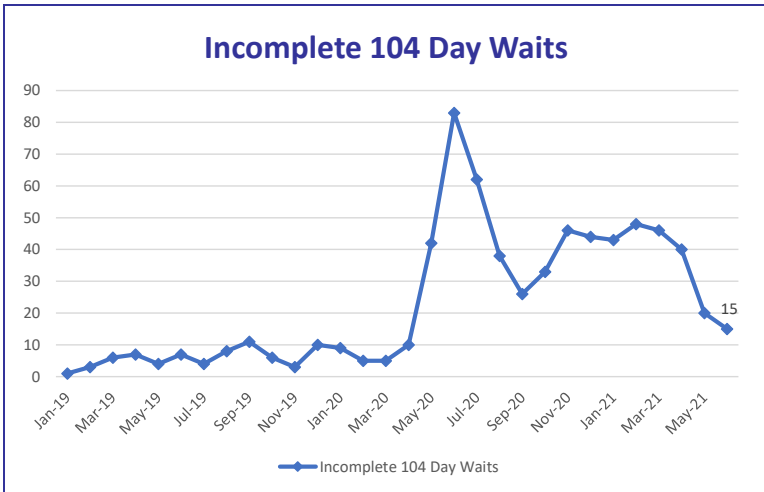
Board Report KPIs	Narratives
	There were 7496 attendances to ED in May 2021, and 7752 in June 2021 representing an increase of 256 attendances. Comparing June 2021 numbers to June 2019 when there were 6692 attendances; this represents an increase of 16% on attendances. Comparing June 2020 numbers (5449) to June 2021; there is an increase of 42%. Comparing the non- admitted patients of May 21 and June 21 it can be seen that whilst overall numbers of non-admitted patients have remained the same, the proportion of Minor patients has increased going from 2590 to 2901 representing an increase of 12%. Psychiatry attendances remain high. We continue to analyse the data and also to look at the possibility of extending the GP hours in ED.
A count of the arrivals at the Emergency Department. This metric has no national target but is key to understanding demand for non elective services.	
	The overall waiting list size continues to grow in line with referrals returning to pre-pandemic levels in most areas and a reduction in completed pathways.
A count of the patients on the waiting list for treatment.	
	Continued improvement in RTT performance for the trust and specifically within Medicine who are as a whole at 88%. Surgery has again managed to improve their position despite the constraints in theatres and women's and children's performance has dropped, with Gynaecology at 60% and Paediatrics at 84% compliance. Gynaecology has significant capacity constraints within Urogynaecology.
% of patients on incomplete RTT pathways	

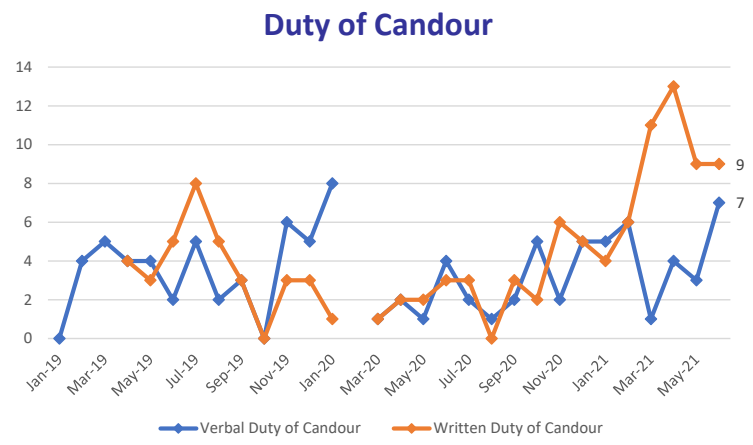
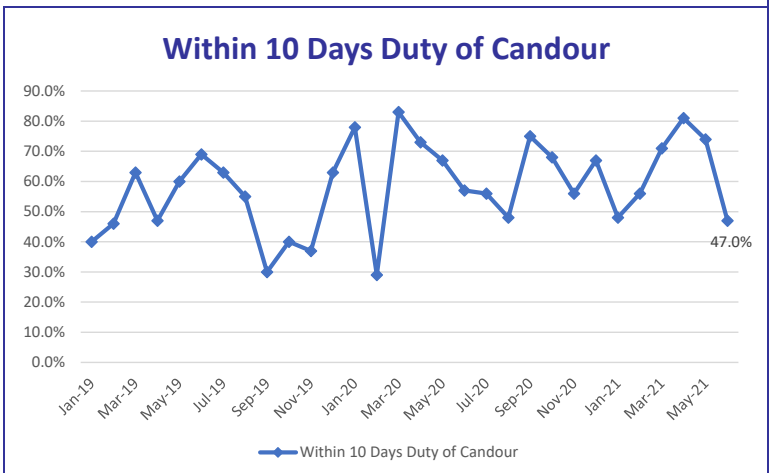
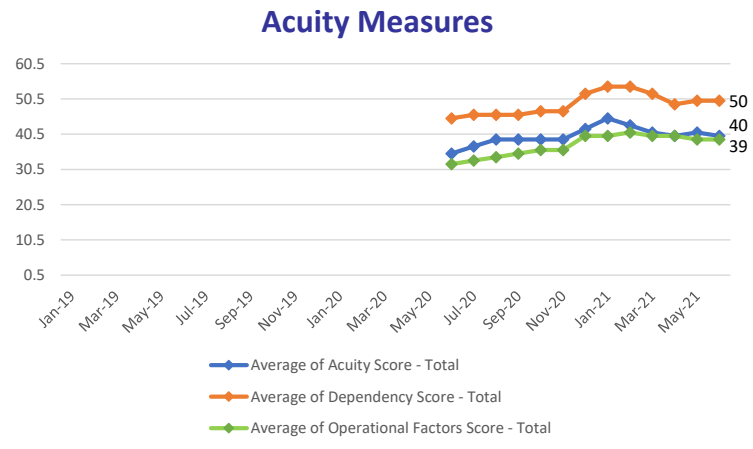
Board Report KPIs	Narratives
	As in previous months the tail is continuing to grow with the reduction in capacity but the overall shape is very similar to that of pre-Covid.
A year on year comparison of the number of patients waiting for treatment.	
	Continued reduction in 52 week waits as patients as we continue to treat day case long waits. Until October when we can start to treat higher numbers of 52WW we will not be able to forecast the recovery of this position. The position of 104 week waits is at 20 for June 2021 compared to 11 in May 2021
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.	
	Increase in total elective admissions, in large part due to increases in endoscopy and day case activity. The day case activity level represents a significant improvement in utilisation and productivity in the day case unit as the benchmark data included day case activity undertaken in main theatres which is currently not possible.
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.	

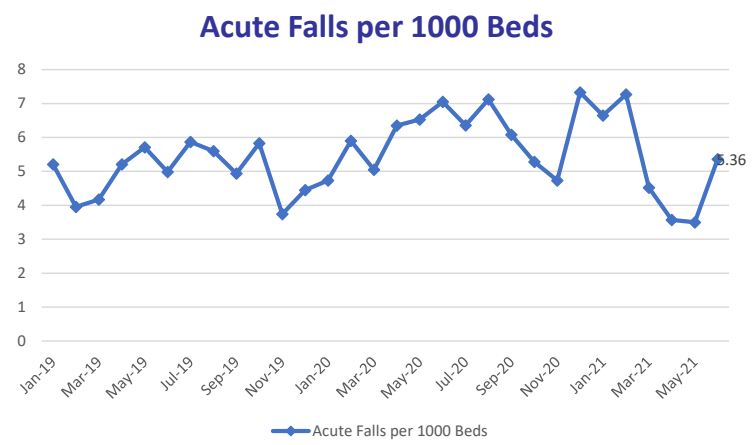
Board Report KPIs	Narratives
	There were 2947 Non-elective admissions in May 21 compared with 2784 in June21, which represents a 5.5% decrease. This is most likely owing to the increased number of minor attendances but also increased use of teams such as EIT, preventing admissions. This month, surgery and T &O admissions remained stable, medicine showed a decrease, whilst paediatrics increased and Obs and Gynae admissions increased significantly: - April 35, May 57 and June 92 admissions which will require some analysis.
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 June 2021 was 3.8%, a slight increase on May 2021 figures of 3.7%. To note this is the first month on month increase in absence since March 2021.
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 June 2021 there were 162 episodes recorded which is an increase on May 2021 which recorded 131 episodes of COVID-19 related sickness. To note this is the first increase in numbers since January 2021.
A count of our staff who have been off sick with a Covid related symptoms or to isolate. This is a local metric to monitor the impact of Covid on our workforce.	

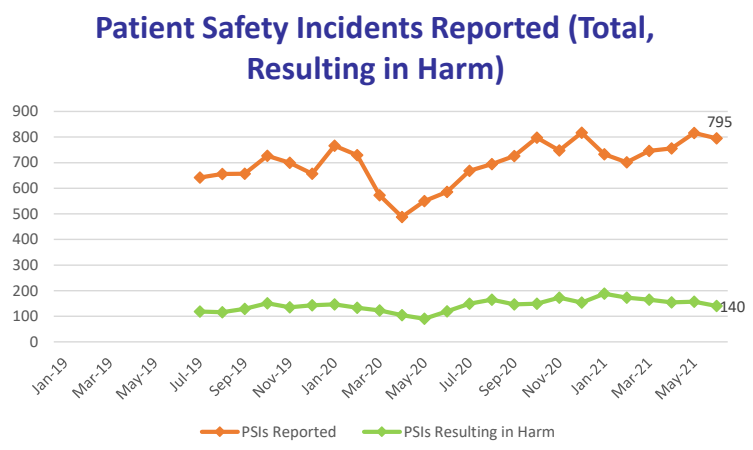
Board Report KPIs	Narratives
	Elective surgery numbers around the same for June 21 as May 21, with day case activity at over 90% of that of pre Covid but inpatient activity down at 43% due to the RAAC works.
This is a count of the number of operations that were carried out. This is a local measure to monitor our productivity and recovery from Covid.	
	There were 7 individual patients admitted during June, who had their first diagnosis of Covid-19. In June the highest number of Covid positive inpatients residing in the trust on any one day was 2.
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 June. 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.	

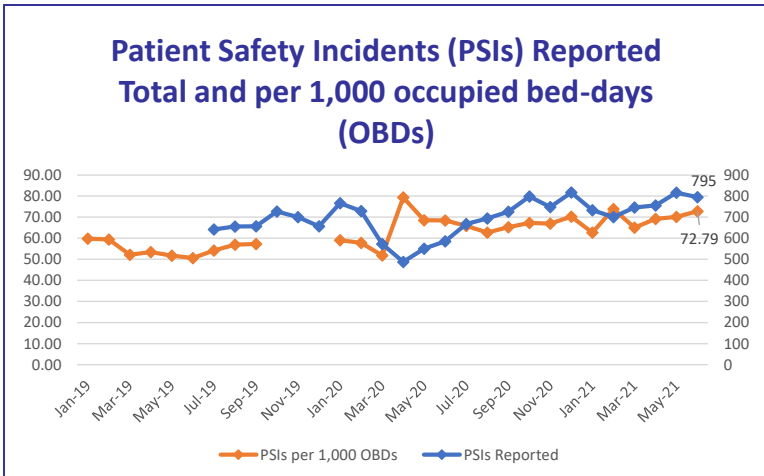
Board Report KPIs	Narratives
Diagnostic Performance- % within 6weeks Total 	Diagnostic performance remains to be a significant challenge in certain areas. June performance has slightly increased by 2%. Audiology has made improvements from 34% in May to 65% in June. Colonoscopy, Flexible sigmoidoscopy, Gastroscopy and cystoscopy have all also made improvements from Mays position: Colonoscopy at 36.08% Flexible sigmoidoscopy at 34.37% Cystoscopy at 48% Gastroscopy at 46.08%
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 	Increase in June performance of 2WW with recovery commencing in Breast, Upper GI and Head and Neck but a significant drop in performance in Skin down to 21% from 90% in April. June saw a huge increase in 2WW referrals for Skin which will remain a challenge. With Lower GI and Skin at such low levels of compliance and being the highest volume specialities this will hinder the ability to recover bottom line performance.
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 	Significant improvement in the performance, with further improvement expected in July and full recovery from September 2021.
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.	

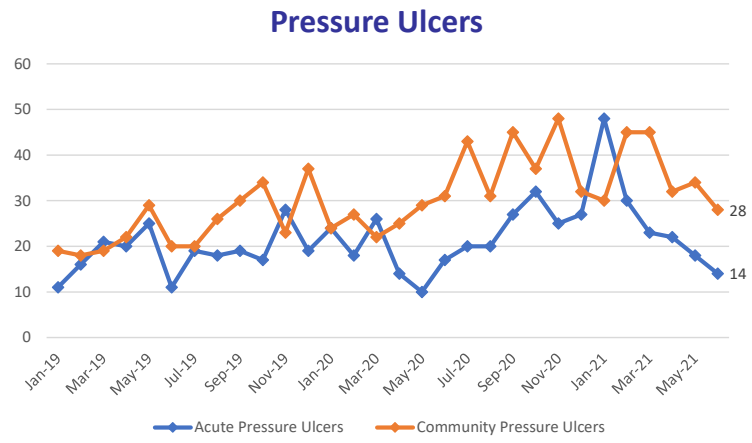
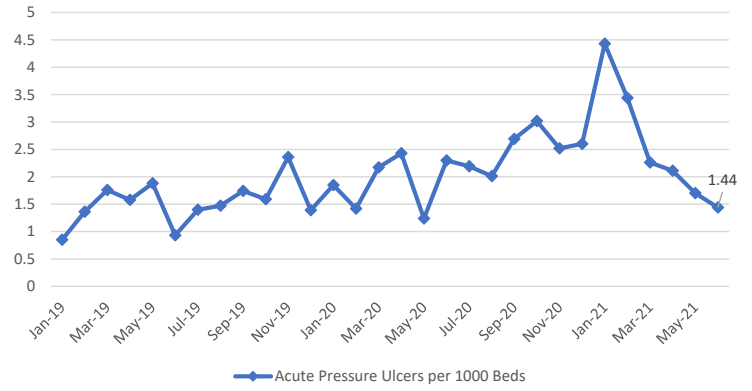
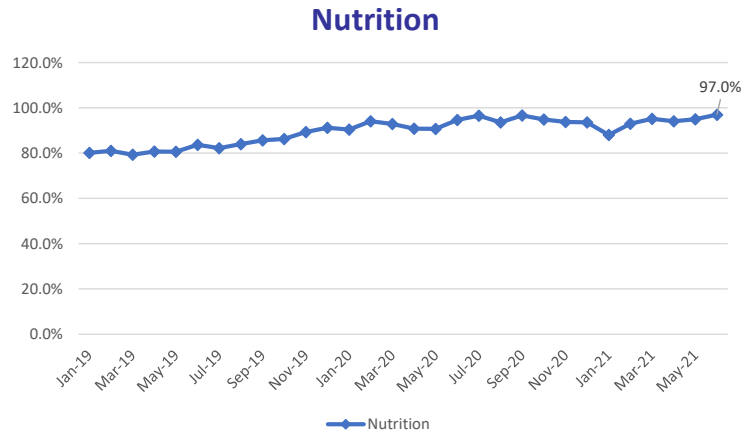
Board Report KPIs	Narratives
	Provisional performance for June has improved and back in line with recovery trajectory. July and August will be a challenge with reductions in theatre capacity to treat patients within 62 days.
To measure compliance with the national standards for access to cancer treatment. 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.	
	Substantial increase in cancer referrals, predominantly within Skin, Lower GI and Breast.
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).	
	Continued improvement of the 104 day position with weekly review of all patients waiting over 104 day for escalation and clinical review.
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.	

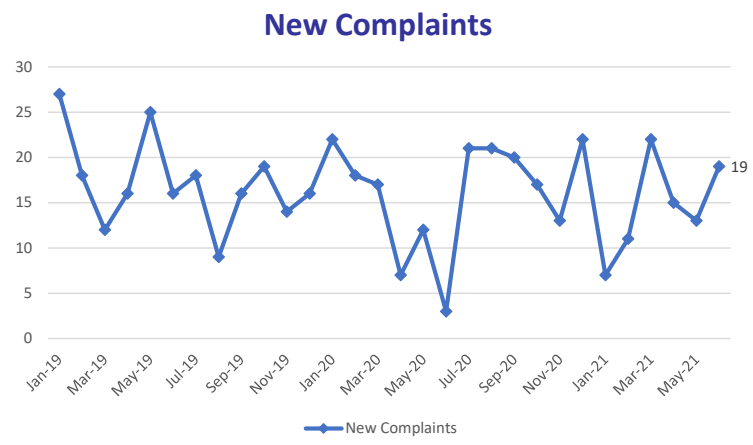
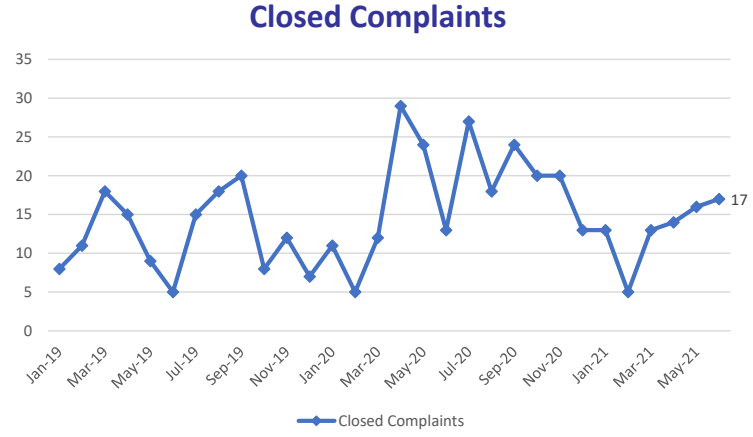
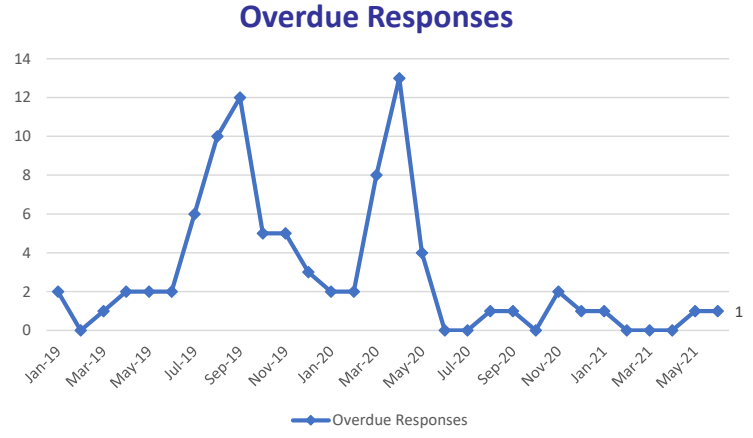
Board Report KPIs	Narratives
	Duty of Candour was discussed at the (3i) Improvement committee in July which agreed that a formal task & finish group, chaired by a senior medical leader should be set up to progress all aspects of Duty of Candour. Margaret Moody (CD for Specialist Medicine) has agreed to be the chair with a first meeting scheduled for August to agree scope and wider membership
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 June, 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. 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.	

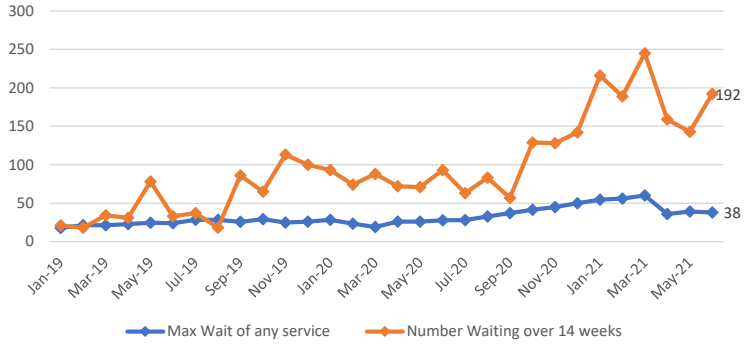
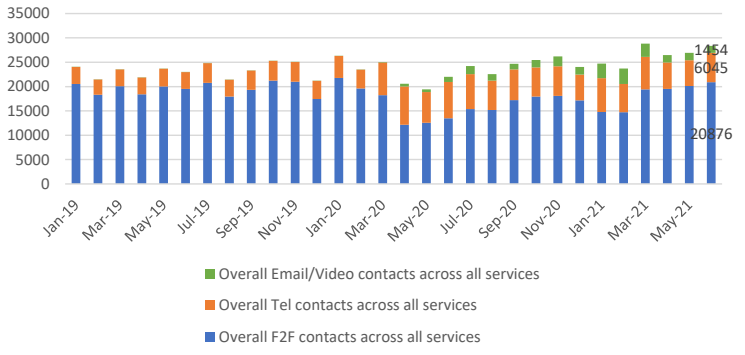
Board Report KPIs	Narratives
	This is now reported in Staffing paper.
A measure of the number of falls in the acute hospital measured per 1000 bed days. Community falls are excluded from this metric.	

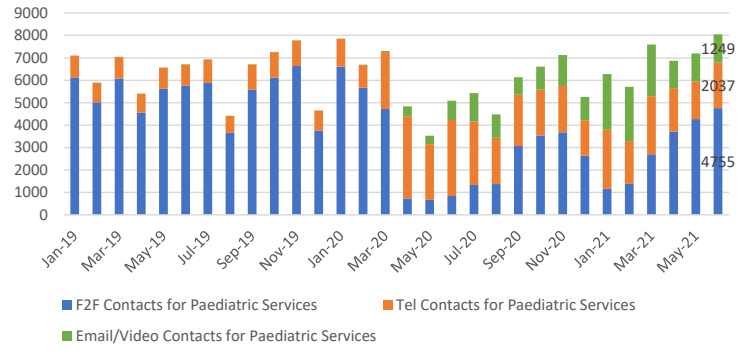
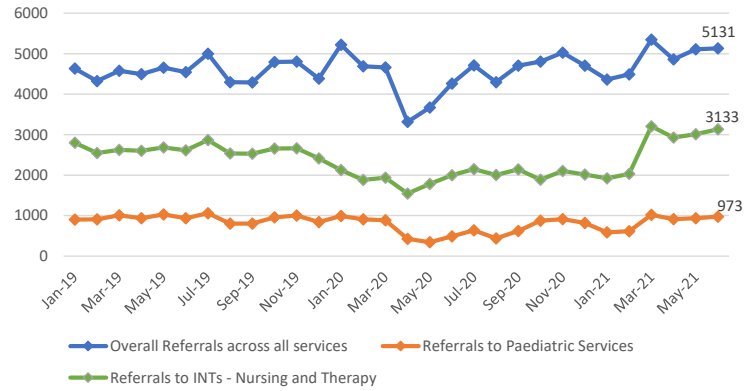
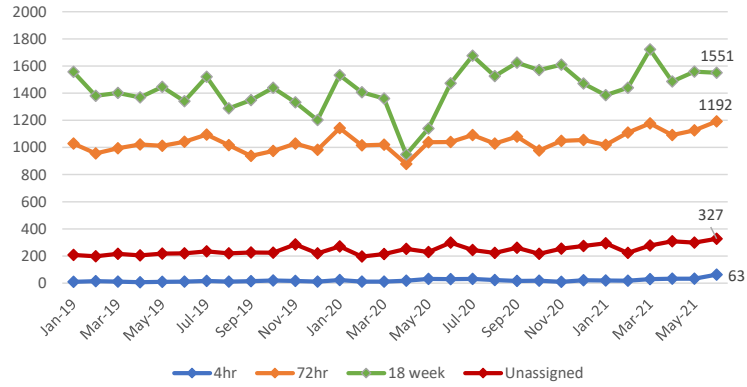
	The number of patient safety incidents reported in June fell slightly compared to May possibly as a consequence of reduced bed occupancy. The number of incidents resulting in harm fell compared to recent months.
A count of the number of patient safety incidents reported in total and those resulting in harm	

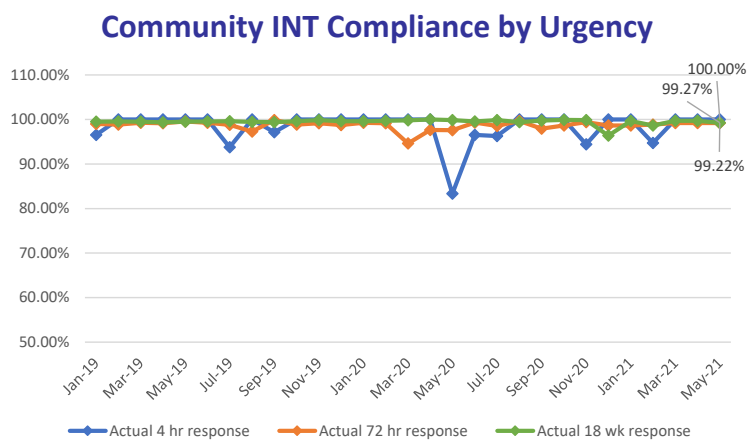
	The incidents reported per 1,000 bed days rose in June but remains within the normal limits of the recent 12 months.
The number of patient safety incidents reported as a percentage of occupied bed days to measure reporting rates	

Board Report KPIs	Narratives
 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.
 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.	
 % 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
	19 formal complaints received in June which is on trend for an average month pre-Covid however is the highest month received since March 2021. A continued trend we have been seeing lately is in regards to communication across all divisions however throughout June the categories varied between patient care and communication. An increased volume received in relation to the emergency department which most relate to staff behaviour/professionalism. We will be working with the matron to review how we can minimise these within the department.
New formal complaints received and accepted, this counts both West Suffolk Hospital and Community	
	17 complaints closed during April as we received a high number of green/amber complaints in May, which allowed us to respond in a timely manner due to shorter investigations. We will be working to increase this number to reduce the total complaints open and allow us to manage complaints even more effectively. High amount of complaints received towards the back end of June so will put pressure in July/August.
Formal complaints signed off by the CEO, this counts both West Suffolk Hospital and Community	
	A slight delay with a letter being signed at the trust office however all complainants were kept updated with a timeframe or were guaranteed a timeframe, which was honoured and adhered to.
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 stayed at 2 in June. At the end of June these services were: Paed SLT and Wheelchairs. The maximum wait for each of these services are: Paed SLT - 33 weeks (increased from 29) Wheelchairs - 38 week (decreased from 39 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 June was 93.14% with the lowest individual service being Wheelchairs at 85.12%.
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, May and June have been exceptionally above the levels of either March, April, May and June in the last 2 years of 2020 and 2019.

Board Report KPIs	Narratives
Contacts for Community Paediatric Services  Activity is counted as a face to face/telephone/email/video contact with a patient/carer/parent which is clinically relevant. This means activity that a clinician carries out which is writing reports, liaising with other healthcare professionals is NOT counted as activity. This is in line with acute systems where there is an assumption that clinicians will carry out related activities that result from contact with a patient.	The Paediatric services have moved a high proportion of their activity to telephone and email/video contacts but they are still unable to carry out any group work due to social distancing requirements. There are also shortages in clinic availability in certain locations. The wearing of masks and social distancing means Speech and Language therapy is particularly hard to do. The services are reviewing all possible options. Activity as a whole has increased for the last 3 months
Community Referrals  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 majority of the community services has exceeded the levels of the same months in April, May, June 2019 and 2020
Community INT Referrals by Urgency  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)	Referrals to the INT services have returned to pre-COVID numbers or exceeded them.

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)	

Comfort Break - 10 minutes

10:45 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

11. Putting You First Award - August 2021

For INFORMATION

For Approval

Presented by Jeremy Over

Board of Directors – Friday 03 September 2021

Agenda item:	11			
Presented by:	Jeremy Over, Executive Director of Workforce and Communications			
Prepared by:	Members of the Workforce & Communications directorate			
Date prepared:	27 August 2021			
Subject:	Putting You First Award – August 2021			
Purpose:	✓	For information		For approval

Putting You First Awards – celebrating and appreciating the contribution of our staff

August 2021 winner: Ward G8 staff team
Nominated by Tracy McCullagh

I would like to nominate the staff on ward G8 for a Putting You First award.

It was a patient's daughter's wedding. As the patient could not attend the wedding the staff arranged with yourselves to have the video link-which was amazing as this meant that the patient could still be included in this special day!

Maria, G8's ward manager, brought in bunting, fairy lights, balloons to the decorate the room where the video link was occurring. Other staff on the ward made cupcakes, and came into work on their day off, to do the patients hair, make-up, and help her dress for the occasion. The patient was overjoyed!

I am so proud of Maria and the G8 staff: they go over and beyond, to make occasions like this so memorable for the patient. The care and compassion they show melts my heart - they truly deserve this award.

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

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

Previously considered by:	N/A

Putting you first

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	N/A
Recommendation:	For information.

12. Improvement Committee Report

To APPROVE the report

For Approval

Presented by Susan Wilkinson

Board of Directors – 3 September 2021

Agenda item:	12			
Presented by:	Sheila Childerhouse			
Prepared by:	Ann Alderton			
Date prepared:	23 August 2021			
Subject:	Improvement Committee Report and Chair's Key Issues			
Purpose:	X	For information	X	For approval

Executive summary:

The Improvement Committee met on 9 August 2021. The transition to the committee operating as a board assurance committee is still in progress, further steps towards which included the approval of its terms of reference and the decommissioning of the Improvement Programme Board.

Attached is the Chair's Key Issues document which will constitute the standard template for Improvement Committee reports to Board.

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*	*Deliver*	*Deliver joined-up*	*Support a healthy*	*Support a healthy*	*Support ageing*	*Support all our*
	X	X	X	X	X	X	X

Previously considered by:	N/A
Risk and assurance:	The development of and transition to a new structure for organisational governance may result in a failure to escalate significant risks to management, the executive team and the board of directors, caused by a disruption to the previous information and communication flows whilst new arrangements are being established.
Legislation, regulatory, equality, diversity and dignity implications	Well-Led Framework NHSI FT Code of Governance

Recommendation:

To approve the report

Chair's Key Issues

Part A

Originating Committee	Improvement Committee	Date of Meeting	9 August 2021
Chaired by	Sheila Childerhouse	Lead Executive Director	Sue Wilkinson

Agenda Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref	Paper attached? ✓
4.1.1	**Blood Transfusion** A letter had been received from the Medicines and Healthcare Products Regulatory agency (MHRA) confirming that the Trust would no longer be under surveillance and would revert back to annual submissions and 3-yearly inspections	**Assurance**		
4.2.2	**Pathology** Following the transfer of the management of the pathology services from NEEPS to WSFT on 1 November 2020, the remedial actions required to achieve expected standards had been or were being implemented, resulting in risks being downgraded. The BAF risk had also been downgraded as a result of the increased control in place to manage identified risks, with the only outstanding actions relating to assurances through GIRFT and an internal audit. The committee approved the removal of this risk from the BAF	**Assurance**	**BAF Risk removed**	
5	**Improvement Programme Board Decommissioning** The Programme Management Office continued to monitor the implementation of actions relating to the CQC report and outstanding actions have been allocated to the relevant 3i committees for follow up. It was noted that internal audit had noted that evidence had been successfully monitored, correctly captured and was transparent.	**Assurance**		
6	**Terms of Reference** The Terms of Reference for the committee were reviewed and approved, with further consideration needed on attendance from external partners at board committees.	**Approval (Separate Board Item)**		✓

Date Completed and Forwarded to Trust Secretary	23 August 2021

Part B

Receiving Committee	Board of Directors	Date of Meeting	3 September 2021
Chaired by	Sheila Childerhouse	Lead Executive Director	Craig Black

Agenda Item	Record of Consideration Given (Approved/ Response/ Action)
Date Completed and Forwarded to Chair of Originating Committee	

12.1. Maternity services quality & performance report

To APPROVE the report

For Approval

Presented by Susan Wilkinson and Karen Newbury

Trust Open Board – 3 September 2021

Agenda item:	12.1			
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:	August 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
- Maternity improvement plan
- Safety champion feedback from walkabout
- National Staff Satisfaction Survey Results
- Service user feedback
- National best practice publications, MBRRACE-UK – Learning from SARS-CO-2 (Annex A)
- Local HSIB reports
- Reporting and learning from incidents
- Maternity Clinical and Quality dashboard (Annex B)
- CNST Maternity Improvement Scheme Submission of evidence, assurances and actions required (Annex C)
- Ockenden Submission of evidence, assurances and actions required (Annex D)
- Continuity of Carer Trajectory
- Covid 19 effects on transitional Care and Neonatal Term Admissions (Annex E)
- Multidisciplinary Training in Maternity Report July 2021 (Annex F)

eCare

Data collection is an improving picture and issues due to workflow and user input are slowly being resolved. The eCare and Information team continue to work closely with maternity team to address this.

In the meantime, there is approximately a 2-month delay in providing the same level of reporting until all of these issues have been resolved. The Digital Midwife 1-year fixed contract post has now been appointed and we are awaiting confirmation of a start date.

Maternity improvement plan

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, SBLCBv2, UKOSS). In addition, this month, the plan has captured the actions needing completion from the Ockenden and Maternity Incentive Scheme evidence submissions.

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 09/07/21, 14/08/21 & 21/08/21. Issues raised; Continuity of Carer midwives being called in more due to unit escalation which is impacting on work/life balance, increased regulatory burden and ongoing staffing shortages and high workload. The following suggestions were made by staff; due to the increase of women with gestational diabetes there is an interest for bespoke training around this subject, in relation to the staffing crisis to consider enhanced rates of pay and weekly payment for bank. On a very positive note staff reported they felt more comfortable with eCare. With the support from HR, the Board Safety Champion has planned a very short survey to ask staff how we can support them during the national staffing shortage, enhancement rates have been introduced and take up is currently high which will reduce the need for escalation midwives being called in. The Diabetic specialist midwife has been asked to look at bespoke training in regards to gestational diabetes.

Concerns raised from previous walkabouts are captured on the Safety Champion action plan until actions complete and moving forward issues raised and actions taken will be summarised in the monthly maternity staff paper 'Risky Business'.

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, however survey returns were low in number. The division is keen to develop further action points by listening to staff in more detail and have led focus groups run by a manager from a different department. Staff engagement from maternity has been minimal. The division alongside their HR Business partner and Board Safety Champion continues to develop different methods to engage with staff to ensure support and that there is every opportunity for staff to be listened to in a productive way.

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 July, the maternity service received 116 FFT returns. The average score across all areas was 97.5% and 100% if woman reported that they were treated with respect and dignity by staff.

National best practice publications

MBRRACE-UK provides a national reporting framework for the surveillance and investigating the causes of maternal deaths, stillbirths and infant deaths. Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK has been published in July, a gap analysis has been completed and required adaptations and improvements to meet the recommendation in this report are either complete or on target to achieve. (Annex A)

Local HSIB 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 13 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.

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. The panel has now had the first three cases for review and the eight-week timeframe originally given is near to closing
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 July.

Maternity dashboard (see Annex B)
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 delayed and therefore the data included is to June 2021. From this month onwards, red rated data will be represented in line with the national NHSI model of SPC charts.

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. Annex B highlights the red rated domains for July 2021 and improvement from previous red rated domains.

Indicators	Narrative
Appraisal completion	reflects staffing issues at present, however high on line-managers agenda to complete
Mandatory training	improving trajectory with anaesthetic team
Fetal monitoring training	working with PDM and finance team for solution
Equipment checks	reflects staffing issues at present, however ongoing monitoring and compliance checks.
Supernumerary status of the labour suite co-ordinator and Midwife to birth ratio	Number of births in July 214 with increased acuity, in addition to Covid absences and staffing shortages.
1 to 1 care in labour for May & June	Delay in data availability and therefore this is the first opportunity to report this. In both months this equates to 1 woman, who was not known to be in labour until first examination who quickly progressed to birth.

CNST Maternity incentive scheme
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. The CNST (MIS) declaration form has been submitted within the requested timeframe. Maternity Incentive Scheme Submission of evidence, assurances and actions required (Annex C) presents an overview of the Trust's assessment against the 10 safety actions. When the submission dates were changed on 3 occasions, some of the dates whereby reports needed to be seen by the Trust Board were removed. However, when the submission information and summary sheets were issued, these dates had been retained. Some of the dates that reports needed Board review and guidance needed to be in place by had passed by up to 18 months and therefore the Trust was non-compliant on this basis rather than the fact that reports had not been written.

Ockenden Submission of evidence, assurances and actions required (Annex D)
This report provides evidence to the Trust Board of submissions of evidence and WSH Trust assessment against the Immediate and Essential Actions in response to the Ockenden Report published December 2020.

The Trust is awaiting confirmation from the NHS Collaborative Ockenden evidence platform about the next steps with regard to the Trust submissions.

The Maternity Services within the Trust are working on ensuring that the actions are completed within a timely manner.

Progress reports will be submitted at the end of each quarter throughout the year.

Update audit plan to include regular audits on key aspects of care.

Continuity of Carer Trajectory roll out plan

The plan has been provided to give NHSE oversight of our continuity of carer roll out plan to include recruitment, meeting model recommendations, communication plans, priority of disadvantaged groups, Training Needs Analysis, Equipment and Estates and the monitoring of outcomes and data. All dates set and timeframes will have to be flexible due to current national midwifery shortages and increased absence due to Covid-19.

Covid 19 effects on transitional Care and Neonatal Term Admissions (Annex E)

The report was to review the effect of Covid 19 on Transitional Care and Neonatal Term Admissions. There did not appear to be a significant impact on the numbers of term babies admitted to the Neonatal unit or a change in the reasons for admission during the first lockdown at the start of the pandemic. The impact of Covid 19 on admissions to TC during the review period was difficult to interpret because of the unreliable data available, particularly around babies readmitted from home and babies undergoing step-down in their care. The service has made significant improvements in data collection for this group of babies and data is now collated, reviewed and interpreted monthly further quality improvements are ongoing.

Multidisciplinary Training in Maternity Report July 2021 (Annex F)

The content of the programmes meets the needs of the service and the recommended topics to be included. The Training Needs Analysis (TNA) has been updated to reflect changing needs for staff training and education.

Progress against the requirements of the TNA will be monitored through quarterly training reports to Maternity and Gynaecology Quality and Safety Group, Divisional Board and through the monthly Quality report to the Trust Board through the Head of Midwifery. In future, a training report will also be submitted to the LMNS Board, and the Perinatal Quality Oversight Group for the Region so that there is oversight of the issues facing the Trust, LMNS and region which will add to the National safety agenda.

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			

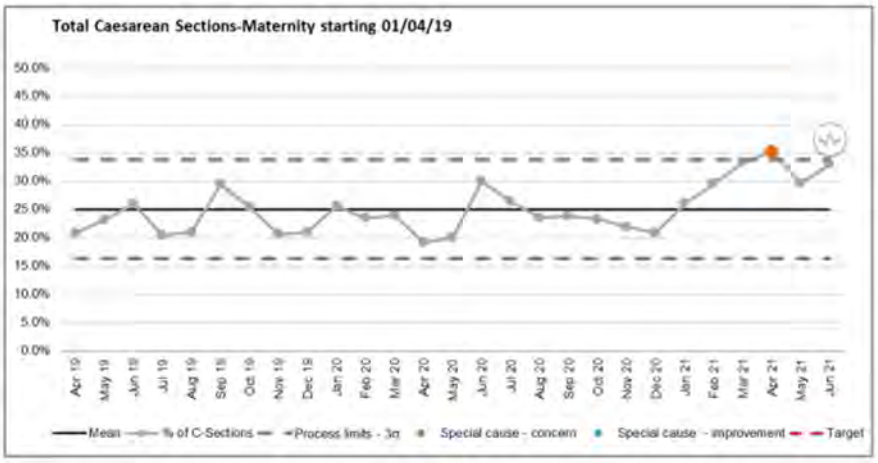
Previously considered by:	Women's Health Governance
Risk and assurance:	None

Legislation, regulatory, equality, diversity and dignity implications	None
Recommendation: The Board to discuss content	

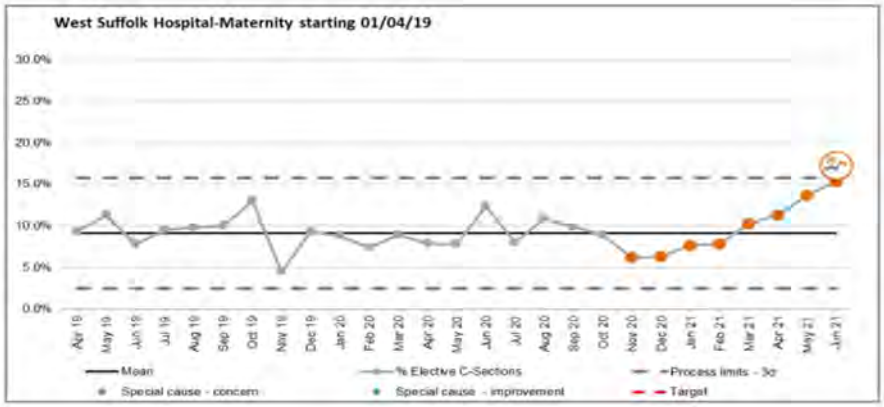
Annex A - MBRRACE-UK Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK

Annex B - Clinical SPC charts from June 2021 Data and Red domains on Maternity Quality Dashboard July 2021.

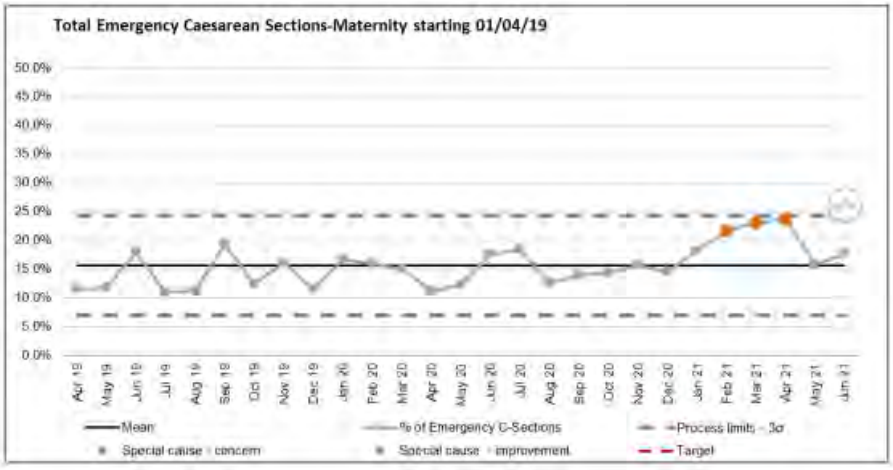
All LSCS



Elective LSCS



Emergency LSCS



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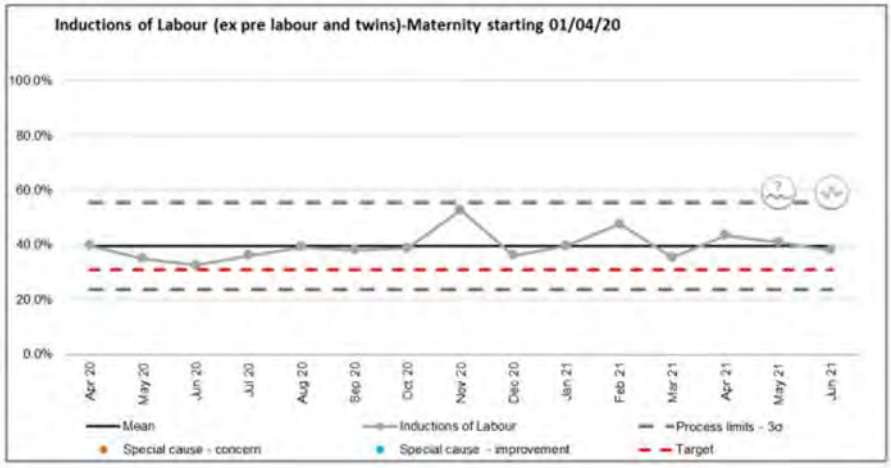

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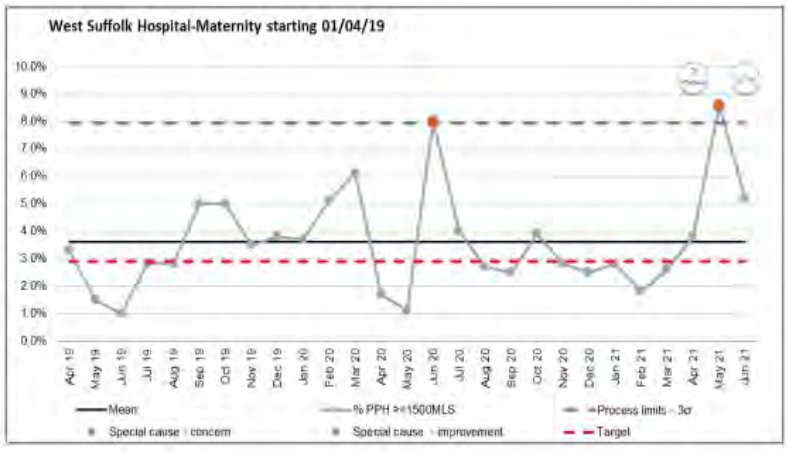

West Suffolk NHSFT		IDWIFERY SERVICE: QUALITY DASHBOAR					
QUALITY TOPIC							
STAFF SUPPORT & DEVELOPMENT							
Appraisal completion	**Standard**	**Feb**	**March**	**April**	**May**	**June**	**July**
Midwives Hospital % in date	**90%**	87%	80%	96%	91%	81%	68%
Midwives Community & ANC % in date	**90%**	98%	98%	99%	97%	98%	97.7%
Support Staff Hospital % in date	**90%**	83%	81%	90%	88%	84%	86%
Support Staff Community & ANC % in date	**90%**	87%	100%	89%	94%	93%	100%
Medical Staff (Consultant) % in date	**90%**			82%	89%	94%	66%
Mandatory Training Overview	**Standard**	**Feb**	**March**	**April**	**May**	**June**	**July**
Midwives: % compliance for **all** training	**90%**	92.1%	95.5%	97.7%	98.7%	98.7%	98.5%
Midwives: % compliance with **PROMPT** training	**90%**	87.3%	96.0%	100.0%	100.0%	99.3%	97.7%
Midwives: % compliance with **GAP** training	**90%**	89.0%	87.0%	86.0%	78.0%	77.8%	81.7%
Midwives: % compliance with **Safeguarding** Children training	**90%**	96.0%	98.0%	99.0%	100.0%	100.0%	98.0%
Midwives: % compliance with **All Fetal Monitoring** training	**90%**	75.9%	78.1%	86.3%	56.3%	68.6%	89.6%
ANC Midwives: % compliance with **All Fetal Monitoring** training	**90%**	71.4%	100.0%	100.0%	85.7%	83.3%	50.0%
Anaesthetic compliance with **PROMPT** training	**90%**	64.3%	73.3%	57.9%	70.0%	75.0%	85.7%
Theatre staff compliance with **PROMPT** training	**90%**	50.0%	74.4%	87.5%	88.4%	93.3%	95.4%
EQUIPMENT SAFETY							
Checking of Emergency Equipment	**Standard**	**Feb**	**March**	**April**	**May**	**June**	**July**
Labour Suite: Adult Trolley	**100%**	100%	97%	93%	100%	97%	94%
Labour Suite: Resuscitaires		98%	99%	97%	96%	95%	81%
Ward F11: Adult Trolley		100%	97%	97%	94%	100%	94%
Ward F11: Resuscitaire		100%	97%	97%	100%	97%	97%
MLBU: Resuscitaires	**100%**	93%	97%	100%	90%	99%	87%
Community: Emergency Bags		100%	94%	94%	97%	94%	94%
MONTHLY QUALITY & SAFETY AUDITS:							
	Standard	**Feb**	**March**	**April**	**May**	**June**	**July**
Supernumerary Status of LS Coordinator	**100%**	92%	94%	93%	96%	96%	81%
1-1 Care in Labour	**100%**	100%			99.50%	98.90%	No Data
MW: Birth Ratio	**1:28**	1:27		**1:24**	**1:28**	**1:26**	**1.33**
No. Red Flags reported		6	1		1	4	17
Fresh Eyes							
Labour Suite	**100%**	67%	100%	63%	50%	77%	100%
Fresh Ears							
MLBU	**100%**	100%	66%	100%	100%	66%	100%
Epidural response <30 min	**90%**	Data per 1/4	88%	Data per 1/4	Data per 1/4	96%	Data per 1/4
LSCS decision to delivery time met							
Grade 1 LSCS	**95%**	67.0%	100.0%	100.0%	100.0%	100.0%	100%
Grade 2 LSCS	**80%**	81%	64.0%	74.0%	64.0%	64.0%	85.70%
Governance							
Ouutstanding Datix (last day of the month)		4	2	2	2	7	13
Out of date guidelines		2	2	2	2	4	6
Number of serious incidents		2	1	1	0	1	1

Annex C – CNST Maternity Improvement Scheme Submission of evidence, assurances and actions required

Annex D – Ockenden Submission of evidence, assurances and actions required

Annex E – Covid 19 effects on transitional Care and Neonatal Term Admissions

Annex F- Multidisciplinary Training in Maternity Report July 2021

NHS
West Suffolk
NHS Foundation Trust

Saving Lives, Improving Mothers' Care. Rapid Report 2021

Report Title	Saving Lives, Improving Mothers' Care. Rapid Report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK. June 2020-March 2021 Published 08 July 2021
Report for	Women's and Children's Division Quality & Safety Meeting
Report from	Maternity Services
Lead for Safety Action	Kate Croissant
Report Author	Karen Green - Clinical Quality and Governance Matron

1. **Report Title –** Response to Saving Lives, Improving Mothers' Care. Rapid Report 2021

2. **Purpose of the Report**

   To demonstrate compliance with the recommendations contained in the report and to share information on Maternity services throughout the organisation.

3. **Background**

In August 2020 following the first wave of SARS-CoV-2 pandemic MBRRACE-UK published a report detailing key learning from SARS-Cov-2 related and associated deaths. Recommendations for changes to care for services for pregnant and postpartum women in the context of any future waves of the pandemic were outlined. In response a paper with associated action plan was presented to the Barnet Hospital Clinical Performance and Patient Safety Committee on 27 October 2020. All elements of that action plan have now been completed.

The second wave of SARS-CoV-2 brought further challenges to services and a higher burden of infection, together with new variants of concern. A further rapid review was undertaken to ensure new messages for care and services were identified in a timely manner. This report published by MBRRACE-UK in July 2021 includes lessons learned from the care of all women who died following a positive test for SARS-CoV-2, or where infection was diagnosed at autopsy and from the deaths of women whose care or engagement with care was influenced by changes as a consequence of the pandemic. The report does not include women who died from mental health causes or who were murdered because of delays to coronial and / or inquest processes. These will be included in the main 2021 and 2022 MBRRACE-UK maternal reports.

The care of seventeen women was reviewed. Three women did not have SARS-CoV-2 infection but their care or engagement with care was influenced by service changes as a consequence of the pandemic. Fourteen women died with SARS-CoV-2 between 01/06/2020 and 31/03/2021. Of these 14 women, 11 died during or up to six weeks after pregnancy and three died between six weeks and one year after the end of pregnancy. Ten of the women, including two who died in the late postpartum period died from causes directly related to COVID-19, nine from cardio-respiratory complications and one from thrombotic complications. Four women had confirmed SARS-CoV-2 at the time of their death but died from unrelated causes, however the coincidental diagnosis of SARS-CoV-2 in two of these women impacted substantially on their care.

Characteristics of note are that 8 (60%) of the women who died from complications of COVID-19 were overweight or obese (BMI ≥ 30kg/m²) and 2 were overweight (BMI 25-29kg/m²). Six women were from black and minority ethnic groups, all five Asian women were of Pakistani ethnicity. Five (50%) of the ten women who died from COVID-19 were in the third trimester of pregnancy at the time of onset. Five had pre-existing mental health conditions, one of the seven women who died from other causes had known mental health problems. Pre-existing diabetes, hypertension or cardiac disease were not identified in any of the women.

Overall, three quarters of the women who died were multiparous; the 17 women who died had 30 existing children, thus a total of 38 motherless children remain

There are a number of areas that require adaptations and improvements to meet the recommendations in this report. These are including, but not exclusively;

- Update of the Covid Guideline to include the role of the weekly MDT in the care planning and support for outpatient pregnant service users who are Covid positive. This is embedded in practice but not reflected in guidance
- Formalise the informal relationships between obstetric non-obstetric consultants within the hospital. This will strengthen the care of women who cross disciplines
- Hasten the ongoing development of the maternal medicine and referral to tertiary unit guidelines. This will support the referral of women with Covid 19 who require care that can not be provided at this hospital.
- Review of the remaining remote appointments that were established at the onset of the pandemic. If remote appointments are to remain guidance should be developed to ensure that care is personalised and clinicians have autonomy to provide face to face appointments to those identified to have vulnerabilities or physical impairments
- Review the telephone triage tool.

NHS West Suffolk NHS Foundation Trust

Recommendations Action Plan

MBRRACE-UK Maternal, Newborn and Infant Clinical Outcome Review Programme
Report: Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK June 2020 - March 2021. Published 08 Jul 2021

RAG Key:

	No action required. Trust process that meets current recommendations in place and evidenced.
	Process in place. Minor action only required; in progress and on target to achieve.
	Action required and on target.
	Action required and overdue.

Recommendations	Audience	Trust Practice	GAP (if applicable)	Action	Lead	Date for Achievement	RAG
1. Ensure protocols for assessment and monitoring of pregnant women with COVID-19 in the community take account of known risk factors for severe disease in pregnancy	General Practices, NHS 111, Community-based Antenatal Services	Covid 19 SOP outlines those with Covid 19 Guideline includes robust Outpatient contact requirements (inc documentation of known risk factors). Daily contact for positive outpatients.	Weekly MDT for Covid positive outpatients has been embedded for some time but Covid guideline does not make this explicit	Add Weekly MDT requirement to Covid 19 in pregnancy guideline.	KG	31.08.21	

Recommendations	Audience	Trust Practice	GAP (if applicable)	Action	Lead	Date for Achievement	RAG
		Women with Covid and who have risk factors are referred to weekly MDT review group for discussion and oversight VTE guideline updated to outline the additional requirements for Covid positive service users (LWMH)					
2. Ensure early senior involvement of the maternal medicine team for any pregnant or postpartum woman admitted with COVID-19, whatever her gestation and wherever in the hospital she receives care	Hospitals/ Trusts/Health Boards, All Health Professionals	Clear guidance in MAT 0108 Management of pregnant and peripartum attending ED or admitted under a non-obstetric speciality – not Covid specific but robust guidance Pop up alert on electronic patient records system – requiring ED or the admitting ward to alert on call obstetrics team of	No formal maternal medicine team at WSH, informal agreements for links with other specialities need to be formalised.	Formalise links with other specialities within WSH	VB	31.01,22	

Recommendations	Audience	Trust Practice	GAP (if applicable)	Action	Lead	Date for Achievement	RAG
		2 weekly maternal medicine meeting s within the region used primarily for care planning in pregnancy and for labour Maternal medicine team – in infancy at WSH. admission/attendance of a pregnant service user and to use MEOWS not NEWS2 Informal arrangements with specialities within WSH to support obstetricians in the care of complex inpatient service users.					
3. Ensure care for pregnant and postpartum women with COVID-19 follows RCOG/RCM guidance	Hospitals/Trusts/Health Boards, All Health Professionals	RCOG guidance referenced in Covid 19 infection in pregnancy guideline.	None	None			

Recommendations	Audience	Trust Practice	GAP (if applicable)	Action	Lead	Date for Achievement	RAG
		Guideline does not cover visiting or screening with the use of newly developed tests.					
4. Ensure protocols for assessment of pregnant women with respiratory symptoms include the consideration of SARS-CoV-2 and the different pattern of symptoms in pregnant compared to non-pregnant women. Be aware that the degree of respiratory symptoms may mask the severity of underlying lung pathology and that progression to respiratory failure in COVID-19 can occur rapidly.	Royal College of Obstetricians and Gynaecologists / Royal College of Midwives/Obstetric Anaesthetists Association/Royal Colleges of Physicians/ Royal College of General Practitioners COVID-19 Guideline Development Groups, Hospitals/Trusts/	Need to review local guidelines to refer that symptoms may not be cough, fever, SOB and / or change to taste and smell. Also, other elements mentioned here.	Covid guideline written early in the pandemic and was a tool to standardise the care of women with confirmed/suspected Covid. There are gaps in the guidance regarding symptoms	Add symptoms to Covid 19 guideline	KG	31.09.21	

Recommendations	Audience	Trust Practice	GAP (if applicable)	Action	Lead	Date for Achievement	RAG
	Health Boards, All Health Professionals						
5. Referrals to the NHS ECMO service should be made for pregnant women or women post-pregnancy using the same criteria as for other adult patients i.e. if worsening severe respiratory failure despite appropriate conventional ventilatory support, or for women in whom lung protective ventilation cannot be achieved because of the severity of hypoxaemia or hypercapnia, or significant air-leak (e.g, barotrauma or bronchopleural fistula)	Hospitals/Trusts/Health Boards, All Health Professional	Women referred to tertiary unit at CUH, WSH unable to provide that level of care	No Maternal medicine guidance or tertiary referral process guidance specific to this trust	Develop SOP/Guidance outlining criteria and process of referral to tertiary centre	VB	31.09.21	
1. Treat pregnant and postpartum women the same as non-pregnant women unless there is a clear reason not to (Multiple MBRRACE-UK Reports)	Hospitals/Trusts/Health Boards, All Health Professionals	Clear guidance in MAT 0108 Management of pregnant and peripartum attending ED or admitted under a non-obstetric speciality – outlining that pregnancy should not be a predictor of place of care. Women should be admitted under the speciality most	None	None			

Recommendations	Audience	Trust Practice	GAP (if applicable)	Action	Lead	Date for Achievement	RAG
		specialised to her clinical picture. The importance of MDT face to face reviews of pregnant service users outside the maternity department is embedded and supported by guidance. Factors such as breastfeeding and bonding must come secondary to ensuring service users are cared for within the correct discipline.					
2. The limitations of remote consultation methods should be recognised, including being aware that some women will not have sufficient internet access on their mobile devices or other computer hardware, there are challenges for women from socially vulnerable groups, women for whom English is not their first language or women who are hearing impaired, and that women may have unvoiced concerns regarding their care if they	Hospitals/Trusts/Health Boards, All Health Professionals	Remote consultations remain in some areas of community care and consultations in pregnancy between service user and obstetrician These are minimal now as the recovery following the changes	Booking appointment remains remote as do VBAC telephone appointments and first day PN call. No guidance regarding remote appointments outlining their limitations and cautions	Decision to be made regarding the permanency of the changes made during Covid. If the remote services are to continue guidance should be developed	KB/CA/KC	31.09.21	

Recommendations	Audience	Trust Practice	GAP (if applicable)	Action	Lead	Date for Achievement	RAG
have less contact in person (RCOG/RCM Coronavirus guidance version 13)		introduced during the early Covid period.					
3. Face to face treatment may be preferable when the patient has complex clinical needs, you need to examine the patient or [it is] hard to ensure, by remote means, that patients have all the information they want and need about treatment options (GMC guidance on remote consultations)	Hospitals/Trusts/Health Boards, All Health Professionals	Face to face routine if treatments are required. As above, no guidance regarding this.	Need to implement guideline/SOP	As above	KC	31.09.21	
4. Women should be advised to continue their routine antenatal care, although it may be modified, unless they meet self-isolation criteria for individuals or households (including social bubbles) with suspected or confirmed COVID-19 (RCOG/RCM Coronavirus guidance version 13)	Hospitals/Trusts/Health Boards, All Health Professionals	No changes to routine antenatal care with the exception of a telephone rather than face to face booking appointment. All services that had been moved to locations out of the hospital have now returned. This is not specifically outlined in the Covid guideline.	Not explicit in Covid guideline	Covid-19 guideline update	KG	31.09.21	
5. Maternity units should develop triage tools to assess the severity of illness for women who telephone with suspected or confirmed COVID-19. This	Hospitals/ Trusts/Health Boards, All	Decision made not to add this to call triage call information. Initially	Triage call sheet does not reflect this recommendation	Develop a triage tool and liaise with Ecare team to make available on Ecare	RL/GW/CP		

Recommendations	Audience	Trust Practice	GAP (if applicable)	Action	Lead	Date for Achievement	RAG
should include an assessment of symptoms, clinical and social risk factors and escalation pathways. This should include 'safety netting advice' about the risks of deterioration and when to seek urgent medical attention (RCOG/RCM Coronavirus guidance version 13)	Health Professionals, Regional maternity strategy organisations	awareness was raised amongst the team					
6. While pyrexia may suggest COVID-19, clinicians should not assume that all pyrexia is due to COVID-19. The possibility of bacterial infection should be considered and a full sepsis screen performed in line with the UK Sepsis Trust Sepsis Screening and Action Tool and intravenous (IV) antibiotics administered when appropriate (RCOG/RCM Coronavirus guidance version 13)	Hospitals/Trusts/Health Boards, All Health Professionals	Sepsis pathway and guidance not specific for Covid Sepsis pathway is activated by MEOWS tool regardless of Covid status	Not clear in currant guidance	Update Covid guideline Update Sepsis guideline	KG	31.09.21	
7. Clinicians should be aware that young, fit women can compensate for deterioration in respiratory function and are able to maintain normal oxygen saturations until sudden decompensation (RCOG/RCM Coronavirus guidance version 13)	All Health Professionals	Included in coronavirus guideline	Needs to be reflected in local guidance	Update Covid guideline	KG	31.09.21	
8. An urgent multidisciplinary team meeting should be arranged for any	Hospitals/	Included in coronavirus guideline	None	none			

Recommendations	Audience	Trust Practice	GAP (if applicable)	Action	Lead	Date for Achievement	RAG
unwell [pregnant or postpartum] woman with suspected or confirmed COVID-19 (RCOG/RCM Coronavirus guidance version 13)	Trusts/Health Boards, All Health Professionals	Role of the MDT lso in MAT 0108 Management of pregnant and peripartum attending ED or admitted under a non-obstetric speciality					
9. Women should have a venous thromboembolism (VTE) risk assessment performed during their pregnancy in line with RCOG Green-top Guideline No. 37a. Infection with SARS-CoV-2 should be considered a transient risk factor and trigger reassessment (RCOG/RCM Coronavirus guidance version 13)	General Practices/ Hospitals/Trusts/Health Boards, All Health Professionals	Included in coronavirus guideline	None	None			
10. Social workers should explain [to ensure face to face contact] why it is essential that they have access to the home, or that they see and speak to the children, to ensure they are safe and well. Visits should be face-to-face where possible and should be sufficient to meet the intended purpose of the visit whether that is safeguarding or promotion of the child's welfare	All Social Care Professionals	N/A	None	None			

Recommendations	Audience	Trust Practice	GAP (if applicable)	Action	Lead	Date for Achievement	RAG
(Coronavirus (COVID-19): guidance for children's social care services)							
11. Arrange urgent assessment [of pregnant women with UTI in secondary care if there are any features of serious systemic illness such as sepsis or pyelonephritis (NICE Clinical Knowledge Summary Urinary tract infection (lower) - women)	All Health Professionals	No guidance locally for this		Include in the sepsis guideline	GB	31.09.21	
12. Employers should ensure pregnant women are able to adhere to any active national guidance on social distancing and/or advice for pregnant women considered to be clinically extremely vulnerable. Employers should consider both how to redeploy staff who are 28 weeks pregnant and beyond or with underlying health conditions that place them at a greater risk of severe illness from coronavirus and how to maximise the potential for homeworking, wherever possible. Where adjustments to the work environment and role are not possible and alternative work cannot be found, [pregnant women] should be suspended on paid leave. (Department of Health and Social Care	All Employers	Refer to HR services	? trust guidance	Ensure this is within Trust HR policies	SW	31.09.21	

Recommendations	Audience	Trust Practice	GAP (if applicable)	Action	Lead	Date for Achievement	RAG
guidance Coronavirus: Advice for Pregnant Employees)							

Women's and Children's Divisional Board – NHSR Maternity Incentive Scheme (CNST) Submissions and Compliance

Agenda item:	12.1 Annex C – Trust Public Board			
Presented by:	Karen Newbury, Head of Midwifery			
Prepared by:	Karen Newbury – Head of Midwifery / Beverley Gordon – Project Midwife			
Date prepared:	August 2021			
Subject:	Maternity Incentive Scheme Submission of evidence, assurances and actions required			
Purpose:	X	For information		For approval

Executive summary:

This report presents an overview of the Trust's assessment against the NHSR (CNST) Maternity Incentive Scheme 10 Safety Actions. The scheme is in the third year and the evidence required for this year, builds on the previous years. Submission of evidence to the scheme should have occurred in July 2020 but the date was delayed 3 times due to the pandemic and the final date was 22/7/21. During this time, some of the safety actions were reviewed and some evidence was no longer required and standards to be achieved were changed but all 10 safety actions remained in place.

The 10 safety actions cover the following areas:

1. Perinatal Mortality Review
2. Submission of Data meeting the criteria for the Maternity Services Data Set
3. Transitional Care and Term Admissions to the Neonatal Unit
4. Clinical (non-midwifery) Workforce
5. Midwifery Workforce
6. Saving Babies Lives v2 – 5 elements
7. Maternity Services User feedback
8. Multidisciplinary Emergency Obstetric Training
9. Maternity Safety Champions

10 Reporting to NHS Resolution and HSIB

Evidence gathering

Evidence was gathered over a long period of time right up until the point that reports were being confirmed and approved.

The sources of evidence came from guidelines, standard operating procedures, audits and data collection.

All the information was collated into one report for each safety action. Sub-reports were submitted through the Governance processes for approval.

When the submission dates were changed in 3 occasions, some of the dates whereby reports needed to be seen by the Trust Board were removed. However, when the submission information and summary sheets were issued, these dates had been retained. Some of the dates that reports needed Board review and guidance needed to be in place by had passed by up to 18 months and

therefore the Trust was non-compliant on this basis rather than the fact that reports had not been written.

Evidence Submitted for Review by the Trust Board against the requirements of the Safety Actions

The Maternity Service was able to demonstrate that they were fully compliant with 4 out of the 10 safety actions (40%). The standards will be maintained by having processes embedded which will allow for regular monitoring and reporting.

The following table demonstrates where the Trust was non-compliant and the areas that are required to be improved. These areas are included in Appendix 2. All elements that are currently compliant will be monitored on a regular and ongoing basis – these are summarised in Appendix 1.

Safety Action number and title	Trust Compliance	Areas to Improve
1. Perinatal Mortality Review – is the Trust using the Perinatal Mortality Review Tool to review and Report?	8 elements – 100% compliance in all	Maintain standards – monitor through PMRT reports.
2. Are you submitting data to the Maternity Services Data Set?	12 criteria – 100%	Ensure data is entered correctly.
3. Can you demonstrate that you have transitional care to support the avoiding term admissions into neonatal units?	6 elements. – 3 compliant and 3 non-compliant as follows. Review of NNU term admissions and TC during Covid 19 period March -August 2020. Whilst the review took place, the report was not reviewed by the Trust by 26/2/21. ATAIN action plans maintained and updated with submission to key personnel monthly – this has not been submitted and reviewed by the Board Safety Champion monthly. Progress against Covid19 related requirements have not been submitted and reviewed by the Board level Safety Champion on a monthly basis from January 2021.	Ensure TC is recorded on badgernet so that information that is extracted is accurate and reliable for use in reports. Ensure that reviews and reports are undertaken and presented for approval within the required timeframes. Process for review of reports and actions to be embedded to ensure that all key personnel have access to accurate information and actions in place every month. Quarterly reports for TC as well as ATAIN. Monthly reports to all Safety Champions.
4. Can you demonstrate an effective system of clinical workforce planning to the required standard?	Anaesthetists: report not seen by the Board prior to MIS submission. Neonatal Medical Workforce – completed Neonatal Nursing Workforce – completed Obstetric workforce – guideline in place.	Ensure that reviews and reports are undertaken and presented for approval within the required timeframes.
5. Can you demonstrate an effective system of	10 elements: Not compliant with 100%	Staffing issues increased during the latest period of the

midwifery workforce planning to the required standard?	supernumerary labour ward coordinator. Not compliant with 100% 1 to 1 care in labour.	pandemic. Raised as a local, Regional and National concern.
6. Can you demonstrate compliance with all 5 elements of Saving Babies Lives?	**Element 1** – Smoking status at 36 weeks **Element 2** – UAD not embedded in practice **Element 3** – Fetal Movements – only 75% women received information by 28 weeks **Element 4** – commitment to face to face training when able to do so FM training – compliance>90% all staff groups **Element 5** – Steroids – poor compliance – small numbers and birth occurring before 2nd steroids	Ensure practices are embedded and 'business as usual'. Provide exception reports for pre-term labour standards where clinical care takes precedence. Improve training compliance, ensure staff are allocated time to complete mandatory training.
7. Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on?	5 elements – all compliant	
8. Can you evidence that the maternity unit staff groups have attended as a minimum a half-day 'in house' multi-professional maternity emergencies training session, which can be provided digitally or remotely, since the launch of the MIS year 3 in December 2019?	16 elements – non-compliant with 4. Non-compliance with 90% in each of the relevant staff groups attending emergency training. Non-compliance with all relevant staff attendance at neonatal resuscitation training in the scheme period. Neonatal resuscitation training is not currently MDT. Different training for maternity staff to the NNU staff. Non-compliance with 90% in each of the relevant staff groups attending neonatal resuscitation.	Discrepancy between the safety action requirements for MDT neonatal resuscitation training and the local arrangements and programmes in place. Central database required for all staff training which is administered centrally and is accurate so that there is oversight by all line managers to manage non-compliance.
9. Can you demonstrate that the Trust Safety Champions (Obstetrics, midwifery and neonatal) are meeting bi-monthly with the Board level safety Champions to escalate locally identified issues?	17 elements – 6 non-compliant Non-compliant with the written pathway for MSC being in place by 28/2/20. Now in place and in 2nd version. Monthly feedback sessions for staff were not in place in	Ensure that reviews and reports are undertaken and presented for approval within the required timeframes. Process for review of reports and actions to be embedded to ensure that all key personnel have access to accurate

	January and February 2020. Unable to evidence a safety dashboard which reflects concerns raised by staff and service users which is available and visible to all. Lack of evidence of progress against actions taken as a result of concerns raised during Board SC walkarounds which is visible to all from February 2021. Lack of evidence of review of the Continuity of Care plans and progress by the Board level Safety Champions. Review and reports from UKOSS, MBRRACE and letters to patients regarding Covid 19 not reviewed by the Board by 30/11/20.	information and actions in place every month or as required so any issues can be raised to the Trust Board, Regional safety forums and the LMNS Board.
10 Have you reported 100% of qualifying incidents under the NHS Resolution Early Notification Scheme?	4 elements including referral to HSIB – all compliant.	

Recommendations

The Division and the Trust Board are asked to receive this report and support the Maternity Services in progress the actions required to maintain quality and safety within the Trust for service users and staff.

When actions are required which require processes to be updated, progress should be monitored at the Maternity Improvement Board and through the overarching plan to improve and maintain quality and safety.

Next Steps

Year 4 of the Maternity Incentive Scheme Safety Actions has been launched on 9th August 2021. Whilst the Safety Action headlines are the same, they build on the process of embedding safe practices making the elements 'Business as Usual'. Work will begin within the next month on ensuring that the Trust is progressing towards full compliance up to the submission date in June 2022.

Trust priorities	Deliver for today		Invest in quality, staff and clinical leadership		Build a joined-up future		
	X		X		X		
Trust ambitions	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
		X	X	X			
Previously considered by:							
Risk and assurance:							
Legislation, regulatory, equality, diversity and dignity implications							
Recommendation: The Board to discuss content							

Appendix 1 Embedding of ongoing processes

Safety Action	Topic	Action needed	Lead Responsible	Evidence of embedding processes by spot checks or audits
1	PMRT	Ensure process for reporting to MBRRACE and PMRT completion is embedded in practice	Quality and safety Team	Database updated and monitored for compliance through PMRT reports. Quarterly PMRT reports. Stop and check at the end of Quarter 4 (end March 2022) and thereafter annually.
2	MSDS	Data inputted correctly to digital records. Information submitted to MSDS within timeframes.	Digital Team	Submissions confirmed by NHS digital when required.
3	TC and ATAIN	Monthly reports and action for TC and ATAIN. Shared with MSC and staff. Quarterly progress reports on meeting standards. Exception reports submitted to Board meetings in a timely manner.	Quality and safety Team with MSC and NNU staff.	Analysis and review reports on a monthly basis and summary quarterly reports on progress.
4	Clinical workforce	Annual reports on a 6-month period of staffing rotas to ensure safe standards maintained.	Clinical Leaders	Exception reporting when required with actions being overseen by the Divisional Board and Trust Board. Annual report submitted to the Trust Board to confirm compliance with safe staffing standards.
5	Midwifery Workforce	Monthly reporting of key indicators – 1-1 care in labour and supernumerary status of the LW coordinator.	HoM and lead midwives	Exception reports to Trust Board. Annual report on midwifery workforce.
6	Saving Babies Lives	Maintain quarterly surveys and exception reporting of issues complying with the 5 elements.	SBL leads and Quality and safety team	Submission of quarterly surveys to MSC, Trust Board and national leads. Annual audit report on compliance with all 5 elements.

7	Maternity Users Feedback	Responses to surveys and user feedback with actions taken to address issues raised.		Annual report from MVP. Minutes of meetings where coproduction takes place. 'You said we did'
8	MDT training	Central database and recording of training. Programmes meet requirements.	Trainers and administrative support	
9	Maternity Safety Champions	Exception reports submitted to MSC and Board meetings in a timely manner. MSC Board level champions receiving monthly reports and exception reports. MSC Board champions to ensure that concerns raised by service users and staff are actioned and progress reported on a dashboard which is visible		Minutes of Board meetings where reports are presented and approved. Minutes of MSC meetings and progress reports from concerns raised at walkarounds.
10	NHSR Early Notification and HSIB	Reporting of qualifying cases to HSIB and ENS	Quality and safety Team	Database of SIs, internal and external reviews, monitored for compliance through quarterly governance reports as above.

Appendix 2 Action Plans submitted for outstanding issues

Safety Action	Action needed	Lead Responsible	Date to be completed	Evidence of completion
3	Ensure TC is recorded on badgernet so that information that is extracted is accurate and reliable for use in reports. Ensure that reviews and reports are undertaken and presented for approval within the required timeframes. Process for review of reports and actions to be embedded to ensure that all key personnel have access to accurate information and actions in place every month. Quarterly reports for TC as well as ATAIN. Monthly reports to all Safety Champions.	Quality and Safety Team NNU leads MSC	Process in place from 1/10/21	Reports presented and minutes of meetings
5	Staffing issues increased during the latest period of the pandemic. Raised as a local, Regional and National concern.	HoM and leads	Monthly quality dashboard reports as ongoing process	Quality Dashboard Incident reporting
6	Ensure practices are embedded and 'business as usual'. Provide exception reports for pre-term labour standards where clinical care takes precedence. Improve training compliance, ensure staff are allocated time to complete mandatory training.	Trainers and leads; LW leads	Monthly quality dashboard reports as ongoing process. Quarterly surveys.	Quarterly SBL surveys As a minimum annual audit reports submitted to Q&S, MSC, LMNS and Board. Minutes of meetings.
8	Discrepancy between the safety action requirements for MDT neonatal resuscitation training and the local arrangements and programmes in place.	Trainers and clinical leads;	Programmes updated by 31/12/21 Database embedded from 1/1/22.	Monthly quality dashboard. Quarterly reports on training compliance to Q&S, Divisional Board, LMNS.

	Central database required for all staff training which is administered centrally and is accurate so that there is oversight by all line managers to manage non-compliance.			Training programmes in place. Development of a MDT database.
9	Ensure that reviews and reports are undertaken and presented for approval within the required timeframes. Process for review of reports and actions to be embedded to ensure that all key personnel have access to accurate information and actions in place every month or as required so any issues can be raised to the Trust Board, Regional safety forums and the LMNS Board.	MSC and clinical leads	Ongoing process	

Women's and Children's Divisional Board – Ockenden Submissions and Compliance

Agenda item:	Item 12.1 Annex D – Trust Public Board			
Presented by:	Karen Newbury, Head of Midwifery			
Prepared by:	Karen Newbury – Head of Midwifery / Beverley Gordon – Project Midwife / Rebecca Gibson Head of Compliance & Effectiveness			
Date prepared:	August 2021			
Subject:	Ockenden Submission of evidence, assurances and actions required			
Purpose:	X	For information		For approval

Executive summary:

This report provides evidence to the Division, Maternity Safety Champions and the Trust Board of submissions and WSH Trust assessment against the Immediate and Essential Actions in response to the Ockenden Report published December 2020.

The report was published following reviews of the care of 250 mothers and babies who had received maternity and neonatal care from Shrewsbury and Telford Hospitals Trust. Local learning and actions were put in place in the following aspects of maternity and neonatal care:

- **Maternity Care**
- **Maternal Deaths**
- **Obstetric anaesthesia**
- **Neonatal Services**

The lessons learned and actions taken were translated into a national 'survey' of all maternity units to answer the main question which was whether we can be assured as a Trust that our governance and safety processes are sufficiently embedded to reduce the likelihood of similar maternity patient safety issues occurring at WSH and avoidance of harm to mothers, babies and staff.

The Ockenden report had recommendations against **7** Immediate and Essential Actions in section 1 of the report. The headings for these 7 recommendations were:

1. Enhanced Safety
2. Listening to Women and Families
3. Staff Training and Working Together
4. Managing Complex Pregnancies
5. Risk Assessment Throughout Pregnancy
6. Monitoring Fetal Wellbeing
7. Informed Consent

In addition, in section 2 there were a further **3** categories for consideration of evidence making **10** in total. These categories were:

- Maternity Workforce
- Midwifery Workforce
- NICE guidance and other guidance documents

The **10** areas of the Maternity Services were broken down into **49** questions. Only **47** of these questions needed to have a submission of evidence at this point in time.

Information and evidence were gathered and uploaded to the national reporting portal by the required date. It was not for the Trust to say that the evidence submitted met the required standard as this will be assessed by an independent team so the following assessment is undertaken on the basis of whether we could provide sufficient evidence against the criteria required in order to demonstrate the processes we have and will have in place in the future.

WSH response

Some of the evidence was submitted against more than one question and/or immediate and essential action but in total the Trust submitted **223** evidential documents against the 47 questions.

Out of the **47** questions, the Trust was able to provide evidence which appeared to meet the criteria for **25** questions and therefore we assessed these as 'green'. Most of these have processes that are in place and embedded but monitoring of these needs to be sustained and spot checks undertaken to ensure that the standards are maintained throughout the services as 'business as usual'. These actions can be found in the monitoring plan in Appendix 1.

In **6** questions, the Trust have got processes in place but additional work is required to ensure that evidence is available to demonstrate assurances e.g. attendance at Board meetings and that SI reports have been disseminated to Trust Board members and LMNS. These were assessed as 'yellow' and have been added to the action plan in Appendix 2.

In **16** questions, The Trust needs to ensure that processes are embedded, monitored and maintained at the correct standards. These actions can be found in the action plan in Appendix 3.

As mentioned above some of the questions are repeated in different IEA and questions so the number of actions does not reflect the above numbers necessarily.

Standard operating procedures were developed to confirm and describe the processes for care and governance pathways that were already in place but not clearly defined and processes were developed where pathways needed to be enhanced to a higher level of safety and quality. A table of new and updated pathways can be found in appendix 4.

Audits were undertaken to provide assurances that care pathways were embedded and each audit had a report outlining the standards expected, whether the standards were met and any actions required to address shortfalls. A summary of these audits and the results can be found in Appendix 5.

Recommendations

The Board is asked to receive the report for information and approval.

The Maternity Service team are asked to progress the work required to provide assurance of quality and safe care.

Next steps

The Trust is awaiting confirmation from the NHS Collaborative Ockenden evidence platform about the next steps with regard to the Trust submissions.

The Maternity Services within the Trust are working on ensuring that the actions are completed within a timely manner.

Progress reports will be submitted at the end of each quarter throughout the year.

Update audit plan to include regular audits on key aspects of care.

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
Previously considered by:			Maternity and Gynaecology Quality and Safety Group				
Risk and assurance:			Any risks associated with non-compliance or non-submission will be managed as a clinical risk and impact on patient safety and quality				
Legislation, regulatory, equality, diversity and dignity implications			This report provides evidence of our responses to regulatory requirements				
Recommendation: The Board to receive the report for information and oversight							

Appendix 1 Embedding and Monitoring of ongoing processes – 'Business as Usual' – 'green'

IEA number	Question Number	Action needed	Lead Responsible	Evidence of embedding processes by spot checks or audits
1	1	Presentation of Dashboards internally and externally including LMNS	HOM	Minutes of meetings where dashboard presented and discussed. Stop and check at the end of Quarter 2 (end September 2021) and Quarter 4 (end March 2022).
1	2	Database with external involvement in SIs	Quality and Safety Team	Database of SIs and external reviews Stop and check at the end of Quarter 3 (end December 2021) and Quarter 1 (end June 2022).
1 & 2	4 & 12	Ensure process for reporting to MBRRACE and PMRT completion is embedded in practice	Quality and safety Team	Database updated and monitored for compliance through PMRT reports. Quarterly PMRT reports. Stop and check at the end of Quarter 4 (end March 2022) and thereafter annually.
1	5	Information submitted to MSDS	Digital Team	Submissions confirmed by NHS digital when required.
1	6	Reporting of qualifying cases to HSIB and ENS	Quality and safety Team	Database of SIs, internal and external reviews, monitored for compliance through quarterly governance reports as above.
1	7	Implementation of the Perinatal Clinical Surveillance Model	Quality and safety Team	On-going process involving all of the above processes.
2 & 7	13, 15 & 43	User feedback and coproduction	MVP and maternity matrons	Progression of MVP action plan and minutes of meetings outlining progress against the actions required. Presented at Quality and Safety quarterly.

3	18 & 22	Twice daily MDT ward rounds led by the consultant obstetrician	Labour Ward leads	Quarterly audits to demonstrate maintenance of standards.
3	19	Ringfenced CNST monies for maternity training	Operational Managers and Finance partners	Ensure there is an audit trail for any money received for training.
3 and section 2	20 & 45	Effective workforce – non-midwifery	Leads for obstetricians / paediatricians / anaesthetists / NNU nursing staffing	Rota checks to ensure staffing levels maintained safely. Annual reviews of rotas.
4	24, 25, 26, 28 & 29	Management of complex maternal medicine, development of maternal medicine centres and care planning	Maternal medicine leads	Local referral process in place and annual audits for compliance. Regional maternal medicine centres in place.
7	41 & 42	Women involved in decision making, informed choices	Lead midwives in each clinical area	Annual audits of compliance with standards
Section 2	46, 47 & 48	Midwifery workforce, HOM responsibilities, midwifery leadership	HOM and Chief Nurse with LMNS and Regional Mw involvement	Annual report for midwifery workforce and leadership roles against national standards.

Appendix 2 Action Plan for processes that need further evidence of embedding in ongoing work - yellow

IEA number	Question Number	Action needed	Lead Responsible	Date to be completed	Evidence of completion
1	3 & 8	Sharing of SI and HSIB reports with the Trust Board and LMNS	Quality and Safety Team and Divisional leaders	To commence when next SI/HSIB investigation is started or completed	Process for reports to be shared and minutes of meetings where reports are shared.
2	11, 14 & 16	Evidence of NED MSC and MD MSC representation and involvement in maternity services discussion at Board level, MVP and LMNS	NED/MSC Board champions	Once confirmed at MSC meeting how this will be evidenced.	Minutes of Board/LMNS/MVP meetings indicate the presence and input from NED and Board level champion in MSC role rather than their substantive roles.
3	17	Validation of education and training reports to LMNS on a quarterly basis	Training leads and administrative support. HOM and Clinical lead to present	From 1st October 2021	Completion of template for training compliance and minutes of LMNS meetings where information discussed, confirmed at Q&S meeting before submission.

Appendix 3 Actions requiring further work and embedding to provide assurances – 'amber'

IEA number	Question Number	Action needed	Lead Responsible	Date to be completed	Evidence of completion
3 & 6	21, 23, 37	90% MDT in-house training and schedule in place to meet trajectory; reports to Board and LMNS. Increase in number of obstetric anaesthetists attending PROMPT. Anaesthetists to have agreed training time for PROMPT attendance. NN resuscitation training to be MDT. Database of training to include all members of the MDT and have ability to flag up when training is du and overdue.	Training leads for midwives / obstetricians / anaesthetists / paeds / NNU. Admin support	Programmes updated and agreed by 31/12/21. Training rostered from 1/1/22. All Obstetric anaesthetists to attend PROMPT by 31/5/21 Database in place 1/10/21.	Database giving up to date information on MDT NN resus training. Training programmes in place.
4	28	Audit plan to include all elements of safe care to be monitored	Quality and Safety Team with Audit lead.	Audit plan to be updated by 31/10/21	Audit plan presented and agreed, audits progressed and presented against plan.
5	30, 31 & 33	Risk assessment at each contact, documentation of place of birth review, PCPs	Lead Midwives providing clinical care	Re-audit compliance September & October 2021 and every quarter until >80%	Re-audit results presented. Audit plan Minutes of meetings where reports discussed.
5, 6	32, 34, 35, 36, 38	SBL compliance with all elements: UAD in practice FM training and leads for case reviews Steroids	Leads for fetal medicine Fetal Monitoring leads	31/10/21 to complete re-audits where <95%	Re-audit results and reports. Implementation of UAD. Fetal monitoring training compliance for the MDT.

		Place of birth Submission of information from survey to Trust Board	Q&S team	ompliance reached. Audit plan by 31/10/21	Ongoing process for presentation of reports and surveys at Division and Board.
7	39, 40 & 44	Information for women, website information updates and completion of actions from surveys etc – MVP action plans completed and information improved.	MVP Communication team Leads for clinical areas	Complete all actions by 31/12/21	Review of all media and information demonstrates improvement. Minutes of MVP meeting where action plan signed off.
Section 2	49	Guideline process and NICE guidance gap analysis	Guideline and audit leads	Ongoing process	Process embedded for GAP analyses to be completed and risk assessments if Trust non-compliant with national guidance.

Appendix 4 Guidelines/SOPs and Policies – new and updated

Title and Document number	New or Updated	Purpose	Approved and uploaded	Review date
Perinatal Mortality Review	New	Outlines the pre-existing processes involved in ensuring that perinatal review takes place and involvement of an external reviewer and the mother and family in this process.	Approved	
Maternal Medicine	New	Outlines the pre-existing referral and management processes involved in ensuring that women who need additional maternal medicine input locally and from tertiary centres are referred, reviewed and management plans are agreed and documented with the woman.	Approved	
Saving Babies Lives	New	Outlines the pre-existing overarching processes involved in ensuring that the Trust is progressing towards being fully compliant with all 5 elements and stillbirth and neonatal death rates are reduced and women and babies have appropriate care offered to minimise risk.	Approved	
Maternal Death Guidelines	Updated	Updated to include HSIB and external reviews.	Approved	
Obstetric staffing operational plan including ward rounds	New	Outlines the pre-existing processes involved in ensuring that women have input from and plans made with the consultant obstetrician.	Approved	
Handover of Care Guidelines	Updated	Updated with handover and new ward round details included.	Approved	
Obstetric Anaesthetists staffing plan and role of 770 bleep holder	New	Outlines the pre-existing processes involved in ensuring that	Approved	

Maternity and Neonatal Training and Education strategy – now a SOP	Updated	Updated to a SOP outlining the requirements for all MDT (maternity and neonatal) training and how this is monitored	Approved?	
Risk Assessment in pregnancy - SOP	New	Outlines the pre-existing processes involved in ensuring that women are risk assessed at each contact in pregnancy.	Approved	
Sharing from Serious Incidents	New	Outlines the pre-existing processes involved in ensuring that full serious incident reports (including HSIB, PMRT, SI and PSIRF) are shared with the local teams, Trust Board and LMNS so that learning is shared across the organisation(s).	Approved?	
Maternity Quality and Safety Framework	Updated	Updated from being the Maternity Risk Management Policy to a framework for all aspects of Maternity Clinical Governance.	Approved	
Maternity Safety Champions	Updated	Updated with updated personnel and role of NED.	Approved	
Maternity Dashboards	New	Outlines the existing processes for preparation, sharing and exception reporting at Divisional/Board and LMNS levels	Approved	

Appendix 5 Audits Undertaken

Title	Compliance with standard	Action Plan in place	Re-audit/Review date	Added to Audit plan
Complex pregnancy: i) risk assessment, ii) criteria in place, iii) named lead, iv) early referral to specialist, v) management plan	i) 100% ii) 100% iii) 100% iv) 100% v) 100%	Share results, SOP embedded, re-audit as part of the annual plan	30/6/21	
Antenatal risk assessment: i) at each visit, ii) place of birth, documentation of plan and changes, iii) personalised care plan in place agreed by woman	i) 31.3% ii) 39% iii) 74.5%	Share results, SOP launched, digital records updated, re-audit	31/12/21	
Involvement in decision making: i)evidence of involvement in decision making including risks and benefits, place of birth, ii) individualised plan for care outside of guidance, documentation	i) 94% ii) 100%	Share results	30/6/21	
i)PMRT, ii) HSIB and iii) EN schemes: Referral, reports and compliance with timeframes and involvement of women in the processes.	i) 100% ii) 100% iii) 100%	Limited by HSIB process and evidence	Quarterly PMRT and HSIB reports	
Consultant led ward rounds: MDT, twice daily	96%	SOP and guideline in place	30/9/21	
Saving Babies Lives: i) Smoking; ii) SGA; iii)Fetal Movements; iv)Fetal Monitoring; v) Pre-term labour – a)	**Smoking:** • Booking 100% • 36 wks 87.5%	Embed 36 week practices	Monthly audits – on dashboard	
	SGA: Booking risk assessment: 97.5% BMI – referral 97.5% BMI – scans 95% UAD: not in practice	Implement UAD training and practice GAP training	Training updates 30/11/21	

	Missed SGA: within and above average GAP training: 77.8% - 91.57%			
	Fetal Movements: Info by 28 wks: 75% EFM: 100%	Embed practice of information sharing	Re-audit 30/11/21	
	Fetal Monitoring: MDT training for all IP fetal monitoring and HF: 88.1% to 96%	FM training compliance improved Leads	Re-audit training compliance 30/9/21	
	Pre-term Labour: a) steroids: 25% b) magnesium sulfate: 100% c) place of birth 60%	Small numbers Exceptions due to clinical need	Re-audit with larger numbers 30/9/21	
Information for women: Leaflets; website; Gaps, surveys; reviews	Varied results – actions taken	Action plan to be completed	31/12/21	

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Maternity Governance – Quality & Safety

Report Title	Report on Covid 19 effects on Transitional Care and Neonatal Term Admissions
Report for	Approval and Information
Report from	Maternity Services
Report Author	Beverley Gordon, Project Midwife Jane Lovedale Midwife Maternity Quality & Safety Team

Report Title

Report on Covid 19 effects on Transitional Care (TC) and Neonatal Term Admissions - a review of term admissions to the neonatal unit and to TC during the Covid-19 period (Sunday 1 March 2020 – Monday 31 August 2020).

Background

The Maternity Incentive Scheme year 3 has been relaunched after a pause during the Covid 19 first wave. The standards and requirements have been updated and now include aspects of care relating to Covid 19 which the Trust needs to consider and share learning for the future.

Purpose of the Report

To provide local information on the effect of Covid-19 on neonatal morbidity
to identify the impact of:

- Closures or reduced capacity of TC
- Changes to parental access
- Staff redeployment
- Changes to postnatal visits leading to an increase in admissions including those for jaundice, weight loss and poor feeding.

During this period the service had an ongoing monthly review process of admissions to the NNU and TC including action plans to address service improvements identified against local guidelines:

- WSH MAT0146 Admission of babies to the NNU May 2019
- WSH MAT 0180 Operational policy for Neonatal Transitional Care V 1 2019
- WSH MAT 0180 Operational policy for Neonatal Transitional Care and V2 June 2020.

Review of Term Admissions to the NNU

During the time period the process for reviewing admissions to the neonatal unit was well established as part of the ATAIN programme. However, the process for reviewing admissions to transitional care was still in the early stages of development.

The audit was able to compare the number of term babies admitted to the NNU in 2020 with the same period for 2019. Admissions were 48 and 44 respectively therefore a marginal

decrease during the pandemic was noted, although it is difficult to ascertain with such small numbers whether this is significant. However, the reason for these admissions were generally the same therefore there was no identified themes in the reasons for term admissions to NNU during the first lockdown at the start of the pandemic.

Review of babies admitted to Transitional Care

The review of admissions to transitional care identified significant issues with data collection. Information was variable; babies admitted to TC from birth, the postnatal ward or 'step down' care from NNU was not always correct, the data being calculated from both BadgetNet neonatal data system) and paper records. Data for babies admitted to TC from home was at this time wholly reliant on paper records (admissions booklet). It was anticipated that with the introduction of eCare in March 2020 this would have been rectified, however due to the pandemic implementation of eCare was delayed until the following year.

A significant amount of work was undertaken during 2020 to improve the data collection for TC. This was particularly around recording and extracting accurate data on BadgerNet, however there is still further improvement required to be able to capture this significant group of babies care and work is ongoing to ensure this is robust.

Local Information –Neonatal – March 1st to 31stAugust 2020

Table 1 Term admissions and babies admitted to transitional care – comparison to previous year

Number of Babies born 1/3/20-31/08/20	Term Admissions % of babies born 1/3/20-31/08/20	Admissions to TC % of babies born 1/3/20 – 31/08/20	Number of Babies born 1/3/19-31/08/19	Term Admissions % of babies born 1/3/19-31/08/19	Admissions to TC % of babies born 1/3/19 – 31/08/19
1096 ↓	44 (4.0%) =	147* (13.4%)	1188	48 (4.0%)	Unable to obtain reliable data for comparison

* *This data has been collected manually from admission registers so may not be accurate*.

The number of stillborn babies born in the Covid period reviewed in 2020 did not alter significantly from the same period in 2019.

Table 2 Serious Incidents, morbidity, stillbirths and neonatal losses

Morbidity & Mortality	Number and % 1/3/20-31/08/20	Number and % 1/3/19-31/08/19	Covid related 2020
Stillbirth	1(0.06%)	4 (0.25%)	Contributory factor but not root cause
Neonatal Death	1(0.06%)	0	Contributory factor but did not affect the outcome for this baby.
HIE and Therapeutic Cooling	1(0.07%)	1 – baby had HIE 3 but was not cooled	Contributory factor but did not affect the outcome for this baby.

The review of term admissions to the Neonatal unit and Transitional Care during the Covid period was undertaken has considered the impact of:

Closures or reduced capacity of the NNU and Transitional Care (TC)

Between March 1st and August 31st 2020 babies continued to receive transitional care on the post-natal ward. Babies readmitted from home received care on the neonatal unit in a side room. If no side room was available babies were cared for on the paediatric ward. Therefore, there were no changes or reduced capacity for babies requiring TC as the service continued as prior to the pandemic.

Changes to parental access

Reduced parental access was considered as potentially having the most impact on parents during this period, although most of this was anecdotal evidence. The significance of the impact on access was dependant on where the baby was receiving care. The postnatal ward had no visiting allowed throughout the first lockdown and partners were expected to leave the hospital following the birth and could not return until the mother and baby were discharged home. Because of this and where possible the Labour Suite aimed to try and keep both parents together as long was possible to allow for parental bonding, although this was dependant on clinical activity.

Midwives felt at the time that parents understood the serious situation the country was in and there was little resistance from partners, and no formal complaints were received around parental access during this time.

Babies readmitted from home under normal circumstances are admitted to a side room, this is usually on the neonatal unit. Occasionally due to capacity issues on the NNU, some babies are admitted to the paediatric inpatient ward instead so do not have the full benefit of the transitional care model.

During this period babies on the NNU including those receiving TC in a side room were allowed one parent visiting each day for up to six hours and this could change on a daily basis to suit the parents. This had an impact in particular on babies currently receiving neonatal care but clinically well enough to transfer to transitional care because once on the postnatal ward parents had to adhere to more restrictive visiting. Although none of the records specifically stated this being an issue, there were occasions where neonatal staff had written women were tired and wanted babies to remain on the NNU. At the time this was highlighted to staff and a reminder of the importance of reducing separation of babies from their mothers.

Staff redeployment

No staff were redeployed to any other area during the period of the review.

Changes to postnatal visits leading to an increase in admissions including those for jaundice, weight loss and poor feeding.

During the period of the first lockdown changes were made to face to face contacts with women by the community teams. The service followed the frequent updates of RCOG/ RCM guidance which in relation to postnatal visiting outlined a minimum of 3 contacts and ensuring face to face contact for vulnerable women, those who have had operative births and preterm/low birth weight babies or medical /neonatal conditions. (SOP 15 Management of Covid 19 within clinics & Home visits in the Community Setting)

In addition, the service highlighted relevant parental information to families via the maternity face book page on various on aspects of Covid 19 and care of babies as well as jaundice in the newborn and routine local postnatal information.


covid19_advice_for_ parents_when_childnt


Coronavirus_-_Pare information_for_


CS49907-NYY-ICON-LEAFLET-NEW (1).pd

Unlike babies admitted to NNU where we were able to compare the data with the same period in 2019, unfortunately because of the variability of TC data in 2019 there could not be a comparison made in the numbers of babies readmitted from home with jaundice, poor feeding or weight loss.
Of the 147 babies admitted to transitional care in the time period 27% were admitted with jaundice, poor feeding or weight loss, but the significance could not be ascertained. Anecdotal evidence from the community matron suggested that there had not been a significant increase that had become apparent to the community teams.

Guidelines and Policy

A number of specific policies, SOPs and guidelines were put in place to manage the Covid risk whilst continuing to manage a safe service. This guidance included managing the service in a different way. The changes to services are outlined in Appendix 1.

The links for the guidelines that were put in place are as follows:

http://staff.wsha.local/Intranet/MaternityGuidelines/docs/MAT-SOP15ManagementofCovid19inclinicorhomesetting.pdf

Conclusions

There did not appear to be a significant impact on the numbers of term babies admitted to the Neonatal unit or a change in the reasons for admission during the first lockdown at the start of the pandemic. The impact of Covid 19 on admissions to TC during the review period was difficult to interpret because of the unreliable data available, particularly around babies readmitted from home and babies undergoing step-down in their care. The service has made significant improvements in data collection for this group of babies and data is now collated, reviewed and interpreted monthly further quality improvements are ongoing.

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Appendix 1 Changes to antenatal and postnatal processes for Covid period

Change due to COVID	Impact on service/ care	Impact on women	Impact on partners	Impact on staff	Amendments made
Bookings in community virtually phone /'Visionable'	New way of working & time to access the cameras & headphones was delayed	Not face to face but no negative feedback received	Maybe more difficult if over the phone	New way of working but was quicker but some difficulties completing records to begin with New IT skills	This has continued as has been successful& no plans to change currently **Working well**
Carbon monoxide monitoring was stopped nationally	This meant we were not meeting the requirements for SBLCB2 but continued to ask all women at booking & 36/40 if they smoked women & refer to OLS & ask all smokers at each appt	Less visible encouragement to stop	Partners who attended are offered a CO reading which could increase the chance of them stopping	Changing their way discussing & monitoring smokers	This has been reinstated nationally this week so I am looking at this with the smoking cessation midwife to reintroduce safely
Commenced self - monitoring of BP for women (see SOP)	Increased processes & training for women & originally purchasing BP machines as the national programme to provide them was delayed	Asking the women to be responsible for their own care & reporting to health professionals	None	Increased task to train & ensure the woman understands the use, process, readings & who & when to contact	This has continued & I am not aware of any issues raised
All parent education classes were stopped immediately	No parent education for women & looking at provision of a new virtual class This has been unsuccessful until	Lack of information for women about labour & postnatal care Women are directed to an independent provider for the LMS – Suffolk Babies	Lack of information	The staff felt uncomfortable about virtual classes & despite several attempt were not proactive in supporting this	More recently videos have been produced for feeding We have met with IT support to move this forward

	recently – video clips on Face Book				With C of C this will be more proactive & is commencing
Guidance for midwives & MSW to reduce contamination when performing postnatal home visits These were a minimum of 3 visits as per RCOG but additional for high risk women (see SOP)	Increased time for appts & visits due to PPE	Staff wearing PPE & requesting to visit is a different way such as partner not in the room etc if he was symptomatic	partner not in the room etc if he was symptomatic	Increased stress & anxiety Longer visits & clinic appts	This has not really changed although staff are more confident now due to PPE & use to this way of working

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Audit Report for Multidisciplinary Training

June 2021 – updated July 2021

Author: Beverley Gordon, Project Midwife

In collaboration with the Maternity Training faculty and administrative support

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1. Introduction

The importance of working and training together as a multidisciplinary team (MDT) has never been more important.

2. Standards to be met

Ockenden

Q 17. Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMNS, 3 times a year.

Evidence required:

Training together

Confirmation of MDT training AND this is validated through the LMNS x 3 per year

Minimum evidence required

• Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.
• Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session.
• LMNS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data.
• Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.
• A clear trajectory in place to meet and maintain compliance as articulated in the TNA.

Q21 and Q37 Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?
As above and in addition - Attendance records - summarised

NHSR Maternity Incentive Scheme (MIS)

Safety action 8 – as Q21 and 37 above

Can you evidence that the maternity unit staff groups have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

a) Covid-19 specific e-learning training has been made available to the multi-professional team members?
b) team required to be involved in immediate resuscitation of the newborn and management of the deteriorating new born infant have attended your in-house neonatal resuscitation training or Newborn Life Support (NLS) course since the launch of MIS year three in December 2019?
c) there is a commitment by the trust board to facilitate multi-professional training sessions, including fetal monitoring training once when this is permitted.

The Covid-19 specific e-learning training content can be delivered **remotely or digitally**, including local Covid-19/PPE emergency care and maternity critical care (see section on MIS and Covid-19 maternity specific e-learning training below).
 All content should be based on current evidence, national guidelines and local systems and risk issues.
 The content can be locally produced or using the national available resources including video simulations, on-line presentations, national resources and/or interactive video-conferencing.
 Participation should be recorded, ideally through the standard Trust Managed Learning Environment (MLE) or equivalent database for recording training with simple evidence of reflection.

MIS and Covid-19 specific e-learning training
Based on the MBRRACE-UK findings and recommendations, maternity units should provide training for the following elements that relate to care of pregnant and postpartum women during the current Covid-19 pandemic.
There should be unit level multi-professional training for all staff caring for pregnant & postpartum women with suspected or confirmed Covid-19, including a general overview of care principles, and individual susceptibility e.g. ethnicity, hypertension and diabetes.
In addition, there should be specific training concerning women requiring maternal critical care and also the triage of pregnant & postpartum women with mental health concerns.

Maternal Critical Care training:
The maternity multi-professional team (as well as representatives from acute medical & critical care) specialists where appropriate should have training in maternal critical care, including: the use of maternal critical care observation charts, structured review proformas, deterioration & escalation thresholds, timing of birth and postnatal care.
These training sessions should also cover an understanding of Covid-19 specific therapies in pregnancy, and the importance of twice-daily multidisciplinary structured reviews to ensure comprehensive, multi-disciplinary and coordinated care across different care settings.

Women with mental health & safeguarding concerns:
There should be training for all maternity carers to recognise, triage and care for women with mental health & safeguarding concerns in pregnancy.
This should include information on local pathways and procedures to ensure face-to-face assessments and fast-track access to specialist perinatal mental health and safeguarding support services.
Training should also include recognition of concerning ‘red flags’, particularly repeated referrals that should prompt urgent review.

Who should attend?

- Obstetric consultants
- All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota
- Obstetric anaesthetic consultants
- All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota

- Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)
- Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit)
- Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum)

Anaesthetic staff and maternity critical staff are not required to attend fetal monitoring and the below staff groups are **not** required to attend neonatal resuscitation training.
This includes:

- Obstetric anaesthetic consultants
- All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota and
- Maternity critical care staff (Including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit)

Critical care includes: operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit.
For small units with no dedicated maternity critical care staff, it will be sufficient to provide evidence that training has been made available to the obstetric, midwifery, MSW/MCAs and anaesthetic staff, alongside any additional full time maternity ODPs, anaesthetic nurses and other staff groups mentioned above as relevant.

Maternity theatre staff are a vital part of the multidisciplinary team and are encouraged to attend the Covid-19 related training, however they will **not** be part of MIS year three compliance assessment.
There will be further work shared with Trusts by the NHS England Competencies Group in the future regarding the core competencies required for this staff group.
Maternity theatre staff group includes:
 Scrub nurses
 Circulators
 Surgical care practitioners

Neonatal Resuscitation
Staff in attendance at deliveries should be included for immediate newborn resuscitation training as listed below
 Neonatal Consultants or Paediatric consultants covering neonatal units
 Neonatal junior doctors (who attend any deliveries)
 Neonatal nurses (Band 5 and above)
 Advanced Neonatal Nurse Practitioner (ANNP)
 Midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and Maternity theatre midwives who also work outside of theatres.

What is the minimum training that we should include for in house neonatal resuscitation?
Identification of a baby requiring resuscitation after birth and support immediate neonatal resuscitation until specialist neonatal help is available
 Assessed ability to delivery inflation breaths

 Knowledge and understanding of the NLS algorithm
 How to call for help within the organisation
 Situation, Background, Assessment Recommendation (SBAR) or equivalent communication tool handover on arrival of help

The training should also include recognition of the deteriorating newborn infant with actions to be taken.
Management of the newborn airway will ideally be delivered by **face to face training**.
If social distancing guidelines preclude face to face training then remote or digital training will be acceptable.

Which members of the team can teach in house neonatal resuscitation training?
The gold standard would be for this training to be delivered by a trained NLS instructor.
The minimum standard would be for training to be provided by staff who hold an in-date NLS provider certificate and also have a teaching role such as a clinical skills facilitator.

Attendance on separate NLS training for maternity staff should be locally decided but this would be the gold standard.

Covid restrictions and modifications
With regards to the requirement for your local training to include simulated emergencies and/or hands on workshops, we acknowledge that this may be difficult given the social distancing and staff safety requirements. Hands on simulation of emergencies will not be required during social distancing.
Participation in remotely delivered training will be sufficient from October 2020 to July 2021.

Staff on long term sickness during the MIS reporting period should not be counted towards compliance.
Self-isolating or shielding staff should access the remote training resources.
In light of the changes in the scheme timescale, all new starters should be included in the training compliance.
Only new starters joining the Unit from 1 July 2021 should not be counted towards compliance numbers.

3. Findings

3a Emergency Obstetric Training

Sessions held

11 PROMPT sessions were held from December 2019 until May 2021. The service plan to have a minimum of 8 sessions per year dependent on room availability. Two sessions were cancelled in 2020 due to COVID. In 2021, 8 sessions are planned but an additional session will be arranged if needed to meet the trajectory of 90% in all staff groups.
Some of the training became virtual training sessions and staff joined on TEAMS. Whilst this is not ideal, it was important to ensure that staff were able to meet safely and also to include staff who were shielding and/or working from home for other reasons.

Content for PROMPT and Neonatal Resuscitation – programme for sessions

The content of the PROMPT training is shown below. Whilst it does not specifically mention Covid training, all aspects of management of obstetric emergency training for maternal

08.15- 08.30	Introduction and welcome		
08.30- 10.00 (30 mins)	PET		
	Human Factors		
	CORD PROLAPSE *(preterm, to include mag sulphate)*		
10.00- 10.30	Break		
10.30- 12.45 (45 mins)	(10.30-11.15) SHOULDER DYSTOCIA/PPH		
	(11.15-12.00) SEPSIS AND MATERNAL COLLAPSE		
	(12.00-12.45) NEONATAL RESUSCITATION		
12.45	Evaluation and thank you		

collapse, hypertension and sepsis will include care of the critically ill woman and escalation of concerns.

Attendance

Attendees were asked to record their attendance on a signing in sheet or this was confirmed by indicating a tick on the attendance sheets to avoid sharing of pens or when virtual sessions were held. Attendance was recorded on a master database for midwifery, nursing and support staff; from July 2020, obstetric staff are also recorded on the database, anaesthetic staff and theatre staff from October 2020. Compliance for PROMPT training is recorded as a monthly figure on the Quality dashboard.

The paediatrician training is recorded on a separate training database which is maintained within the operational management team within the Child Health Service.
The names of the faculty staff were also recorded on the attendance sheets.
The attendance sheets have been retained for information.

Compliance with each professional group attending to 90% for December 2019 to June 2021 – data taken from May 2021

	% Attendance in period of audit	Comments
All Midwives	**96.99%**	
Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum	**90%**	Commenced participation in PROMPT June 2020
Obstetric Consultants Other obstetric staff	**92.59%**	Commenced data in July 2020
Obstetric Anaesthetic Consultants	**70%**	Commenced data in Oct 2020
Other obstetric anaesthetic staff	**NA**	Combined with Consultant staff
Maternity Theatre staff	**88.37%**	Commenced data in Oct 2020

Were all the sessions multidisciplinary?

All the sessions had more than one professional group in attendance, however, for some sessions this was limited to midwifery, support staff and obstetric staff. Of the 11 sessions held, 1 had minimal attendance by any other staff groups other than midwives so was not truly multidisciplinary (**90% compliance)** The number of sessions that had staff from most professional groups has increased over the last 6 months and the inclusion of theatre staff and paramedics (whose attendance is not mandated) is commendable.

3b Neonatal Resuscitation Training

Neonatal Resuscitation is in included in the emergency training days (PROMPT). However the paediatric staff and neonatal nurses do not routinely attend these sessions unless they are facilitating the training and part of the faculty.

All the paediatric middle grades and consultants have NLS Providers (or Instructors) training. Neonatal junior doctors (who attend any deliveries) attend the Resuscitation Council (UK) NLS at, or soon after induction, plus weekly NLS simulated refresher sessions.

Neonatal nurses (Band 5 and above) attend 4 yearly Resuscitation Council (UK) NLS course. All neonatal staff, both registered and non-registered, attend annual NLS refresher training (in-house), and have access to the weekly NLS sim refresher training. In-house NLS refreshers are run by qualified NLS instructors. NLS sim refresher training is run by a paediatric consultant NNU PDN.

Professional Group	% In date for NLS (4 years) or attended local NLS since December 2019	Comments
All Midwives	**96.99%**	
Neonatal Consultants or Paediatric consultants covering neonatal units	13/14 in date (93%) 1/14 not complaint (7%)	NLS 4 yearly 2/12 due to attend update within the next year. 1 consultant who is currently outside the timeframe will attend the next available course
Neonatal junior doctors (who attend any deliveries)	6/7 in date (86%) 1/7 not compliant (14%)	Registrar level – NLS 4 yearly 2 due to renew in next year 1 not compliant - to attend August 2021 – has attended American equivalent
	11/11 in date (100%)	Tier 1 level – includes advanced nurse practitioners as well as all other junior doctors. Attendance at local NLS training at induction as a minimum.
Neonatal nurses (Band 5 and above)	100%	100% of registered staff are NLS compliant

3c Perinatal Mental Health and Safeguarding

All maternity staff have level 3 safeguarding children training – minimum 12 hours over 3 years – combined with Perinatal Mental Health training. This is delivered either face to face in a room or virtually and some training is on-line Trust training.

In **May 2021**, the compliance for the obstetric staff was **92%** and for midwives and support staff – **100%.**

92% of neonatal nursing staff are compliant with Safeguarding adults and level 3 Safeguarding children training. One member of staff is on long term sick leave and therefore not currently compliant.

There are 30 paediatricians on the list of staff expected to complete of adult safeguarding training and children's safeguarding training. 23/30 (**77%**) have a record of completion of adult safeguarding in the last 18 months. 29/30 (**97%**) of the doctors have had safeguarding children training within the last 18 months.

3d Fetal Monitoring Training – see separate report

4. Conclusions

Content:

The content of the programmes meets the needs of the service and the recommended topics to be included. Whilst these do not specifically include topics which have a direct Covid-19 aspect, the training for adult resuscitation does include updated national guidance around this use of PPE before resuscitation is commenced and the Resuscitation Council guidance is included in all procedures. The use of PPE, social distancing and the number of staff present for procedures is now part of everyday practice and therefore when undertaking face to face training, this are maintained.

Attendance:

Attendance records are maintained indicating when staff have attended and facilitated training. These are used to inform the compliance on the database.
Compliance with training is at a high level in some staff groups and for some types of MDT training. More work is required to move towards increased evidence of compliance in the anaesthetic staff group at PROMPT and the obstetric staff completing fetal monitoring training sessions. Due to the flexible retirement of the current postholder, a replacement fetal monitoring lead consultant is being appointed to ensure this continues to have senior oversight and facilitation.
The Adult Safeguarding training compliance for paediatricians needs to be addressed to ensure that staff in these key roles are up to date with this mandatory training.
In future, the training reports will need to breakdown the professional groups into trainees and consultants in order to identify where progress needs to be made and maintained.
Virtual training has provided opportunities for staff to attend safely but when it is possible to complete this face to face the Trust has taken steps to make this available safely.
Once the future pathway of the pandemic is known, compliance will be addressed and a realistic trajectory set.

Multidisciplinary Training:

The attendance at all the training sessions is predominantly multidisciplinary except the neonatal resuscitation where the midwives have training as part of the PROMPT training and the paediatricians and neonatal nursing staff receive this as part of the local Neonatal Life Support refresher sessions and weekly sim sessions. It is proposed that work will be undertaken to facilitate joint training sessions in the future.

Good progress has been made with inclusion of theatre staff into the PROMPT sessions and a commendable aspect of this training is the regular inclusion of paramedics at these sessions.

The attendance of anaesthetic doctors at the PROMPT training has been affected by Covid 19 as staff have been prioritised to working within areas of urgent and essential need. With the reduction in cases required intensive care, allocation of staff to sessions will be improved over the coming months. This has also been inhibited by the training not being allocated as mandatory for this group of staff. This has been escalated to the Trust Medical Director who is the Board level Safety Champion for a proposal to address this issue.

Perinatal Mental health and Safeguarding

Progress has been made to ensure maternity staff have training sessions relating to perinatal mental health and adult and children's safeguarding on a regular basis. A virtual training programme has been developed jointly between the Perinatal Mental Health Midwife and the Lead Midwife for Safeguarding along with sessions for paediatric and nursing staff which are delivered by the Lead Nurse for Safeguarding.

The Training Needs Analysis (TNA) has been updated to reflect changing needs for staff training and education.
Progress against the requirements of the TNA will be monitored through quarterly training reports to Maternity and Gynaecology Quality and Safety Group, Divisional Board and through the monthly Quality report to the Trust Board through the Head of Midwifery. In future, a training report will also be submitted to the LMNS Board, and the Perinatal Quality Oversight Group for the Region so that there is oversight of the issues facing the Trust, LMNS and region which will add to the National safety agenda.

5. Monitoring of compliance

The Maternity Quality Dashboard records the monthly compliance for maternity training. It is proposed that the NNU also has a quality dashboard to monitor the same aspects of training. Non-attendance or non-compliance with the training schedules is escalated to the staff member's line manager to address any issues relating to performance, competence and attendance.
Reports on training compliance will be submitted to the Board via the Head of Midwifery Quality report each month and to the LMNS on at least a quarterly basis.

7. Actions required

ACTION	LEAD	DATE FOR COMPLETION	EVIDENCE OF COMPLETION
Develop MDT programme for Neonatal Resuscitation	Dr I Evans – Safety Champion Dr Tom Houghton – NLS lead Maija Blagg – PDN – NNU Trina Harvey – PDM – Maternity Sharon Baragry – PDM – Maternity	31/12/21	Training programme in place
Improve recording and monitoring of neonatal resuscitation training both inhouse and external NLS training	Dr I Evans – Safety Champion Dr Tom Houghton – NLS lead Maija Blagg – PDN – NNU Trina Harvey – PDM – Maternity Sharon Baragry – PDM – Maternity	30/9/21	Database accessible to all and attendance monitored
Increase Fetal Monitoring Compliance – see separate report	Dr R Ayyamuthu – Clinical Director Kate Croissant – Clinical Lead	31/8/21	See separate report
Report on training compliance each quarter to Division, Trust Board and LMNS	Trina Harvey – PDM – Maternity Sharon Baragry – PDM – Maternity Charlotte Brock, lead midwife FM Lead Consultant Dr R Ayyamuthu – Clinical Director	15/10/21	Compliance report July-September 2021

	Kate Croissant – Clinical Lead Dr Tom Houghton, NLS lead Dr Binu Anand – Clinical Lead Maiija Blagg – PDN - NNU		
Proposal for anaesthetic input into training to be mandatory to increase ability to attend and facilitate training	Dr Paul Molyneux – Medical Director with Clinical Director for theatres and anaesthetics	31/12/21	Increase in training time for anaesthetists
Increase Adult Safeguarding training compliance for paediatricians	Dr Binu Anand – Clinical Lead Dr Ravi Ayyamuthu – Clinical Director	31/10/21	

12.2. Infection prevention and control assurance framework

To APPROVE the report

For Approval

Presented by Susan Wilkinson

Board of Directors – 3rd September 2021

Item no:	12.2			
Presented by:	Sue Wilkinson Exec Chief nurse			
Prepared by:	Rebecca Gibson – Head of Compliance & Effectiveness			
Date prepared:	August 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

The integrated 'learning from Covid' report is being developed by the Public health team and is preliminary scheduled to be included in the next Board report along with the updated BAF.

**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	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)	Jul 21	0	0	0 →
Staff work-related C19 cases reported to RIDDOR	Jul 21	0	0	0
Incidents relating to C19 management	Jul 21	16	19	22
Admissions swabs within 24 hours of DTA	Jul 21	98%	98%	97% ↓
Day 3 and Day 5-7 swabs	See below			
C19 clusters / outbreaks	Jul 21	0	0	0 →
Staff sickness / absence due to C19	Jul 21	226	131	↓↑

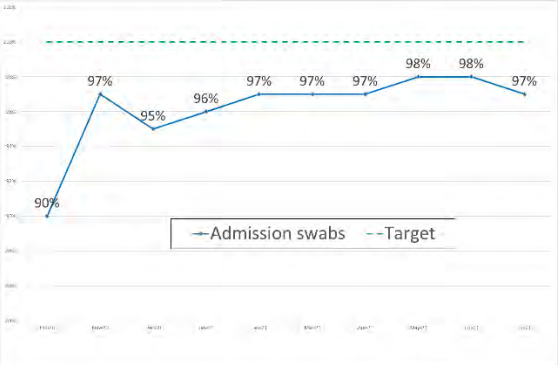
Associated charts / tables / narrative

C-19 admission swabs

The total number of patients swabbed in July remained similar to previous months with compliance of 96% of patients having a swab taken within 24 hours of the DTA in June and 97% in total.

49 patients (3%) did not have a record of having a swab taken in this episode.

NB: The data has been refined to exclude the Gynae assessment unit. This has had the effect of increasing % compliance by a small margin ~1% (and the back data has been updated to reflect this)

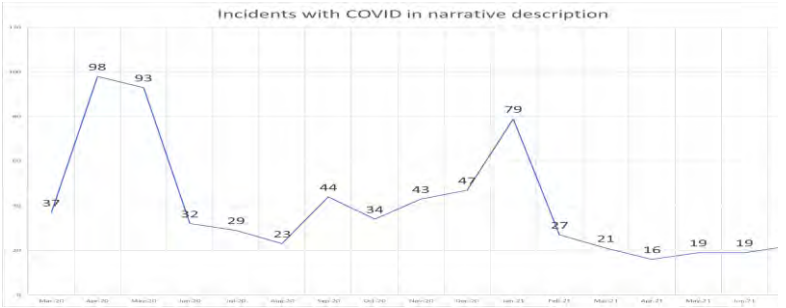


Day 3 and Day 5-7 swabs audit

This has now been set up as a weekly audit undertaken by the central clinical effectiveness team starting in August. The first week showed the same pattern of Day 3 where later evening eCare flag resulted in patients being swabbed the following morning.

The audit now has a widened audit sample of LoS >5 days to enable a greater range of patients for the Day 3 swab check and will be undertaken each week on one medical and one surgical ward for all patients with a LoS of 4-10 days. The surgical ward achieved 100% in the first weekly audit but there is no data to present for medicine whilst some anomalies regarding counting and start times are resolved.

The audit also identified that the SoP on the staff intranet site required an update (which has since been actioned)



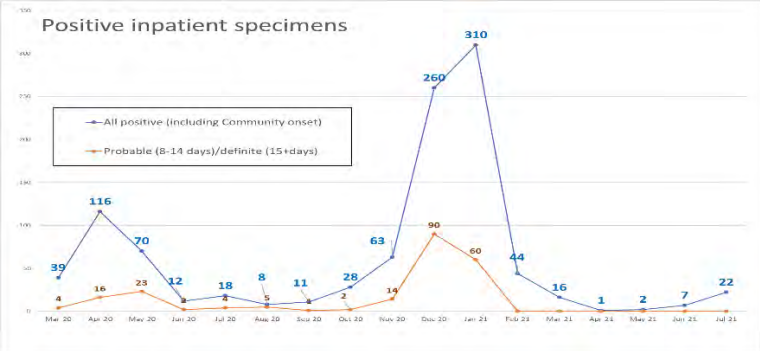
The number of **incidents relating to C-19** recorded in July remained similar to recent months.

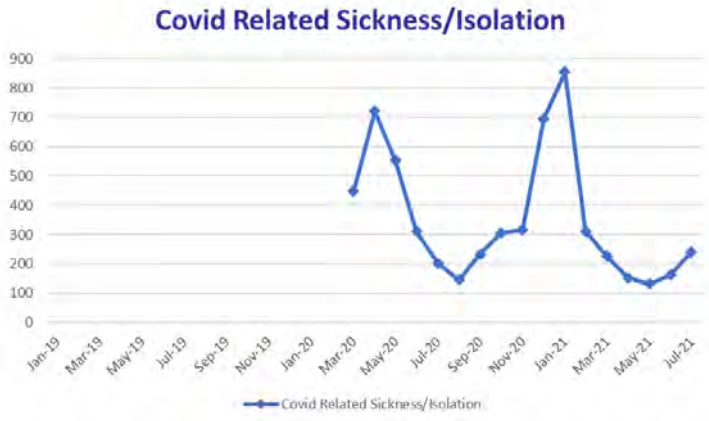
All 22 reported incidents were green.

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 July. The number of community onset continued to rise in July matching the national picture.





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 July 2021 there were 242 episodes recorded, an increase from June (162 episodes) which matches the national picture.

12.3. Nursing staffing report

To APPROVE the report

For Approval

Presented by Susan Wilkinson

Trust Board – 3 September 2021

Agenda item:	12.3			
Presented by:	Susan Wilkinson, Executive Chief Nurse			
Prepared by:	Daniel Spooner Deputy Chief Nurse			
Date prepared:	August 2021			
Subject:	Quality and Workforce Report & Dashboard – Nursing July 2021			
Purpose:	X	For information		For approval

Executive summary:

This paper reports on safe staffing fill rates and mitigations for inpatient areas for July 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%
- Staff isolation rates have increased as predicted
- Vacancy rate have increased marginally this month but substantive staff remains static
- Staff challenges within maternity services increasing this month

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 July'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 July 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 July 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 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%
Average Fill rate for June 21	94%	95%	95%	109%
Average Fill rate for July 21	93%	93%	95%	107%

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
- Overfill of NA attributed to increase need of 1:1 care overnight
- Overfill seen in F12 due to relocation of ward, which increased footprint and nursing need
- Large overfill of Day NA in ITU. Due to OSN joining roster while waiting for NMC Pin
- Low fill rates seen in F9 and G1, mitigated through daily staff redeployment

3. Care Hours per Patient Day (CHPPD)

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

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

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

4. Sickness

Sickness rates for nursing assistants (NAs) has increased this month. RN sickness has seen a marginal improvement.

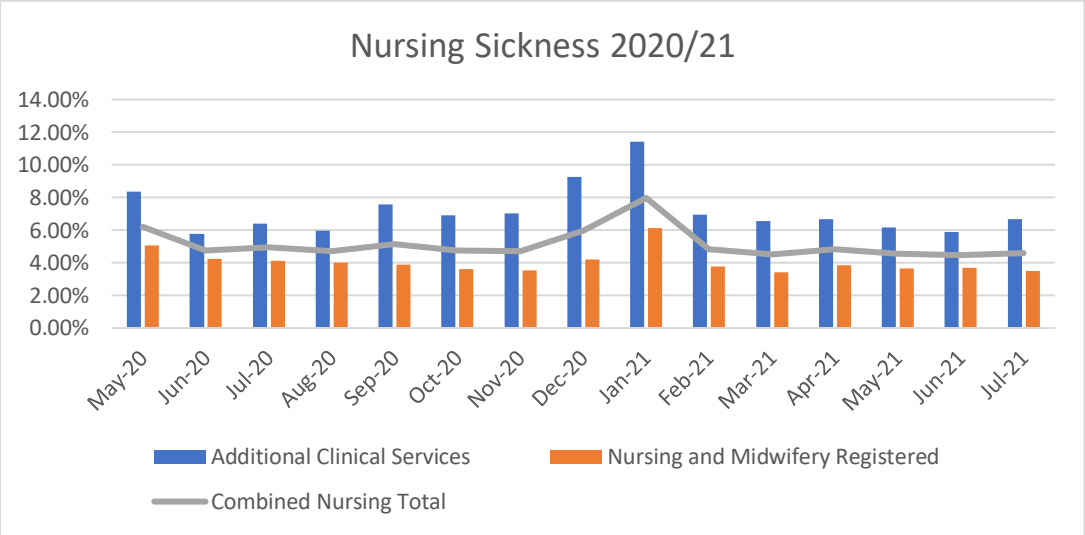


Chart 2.

	Dec	Jan 21	Feb 21	Mar 21	April 21	May 21	Jun-21	July-21
Unregistered staff (support workers)	9.16%	11.31%	6.71%	6.34%	6.61%	6.28%	5.97%	6.66%
Registered Nurse/Midwives	4.16%	6.13%	3.67%	3.34%	3.79%	3.60%	3.70%	3.50%
Combined Registered/Unregistered	**5.92%**	**7.95%**	**4.71%**	**4.39%**	**4.77%**	**4.55%**	**4.50%**	**4.60%**

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). As anticipated, the continuing increase in prevalence in the community this month and the relaxing of social interaction rules has seen a rise in staff that are required to isolated due to potential or confirmed Covid contacts. This is illustrated in chart 3.

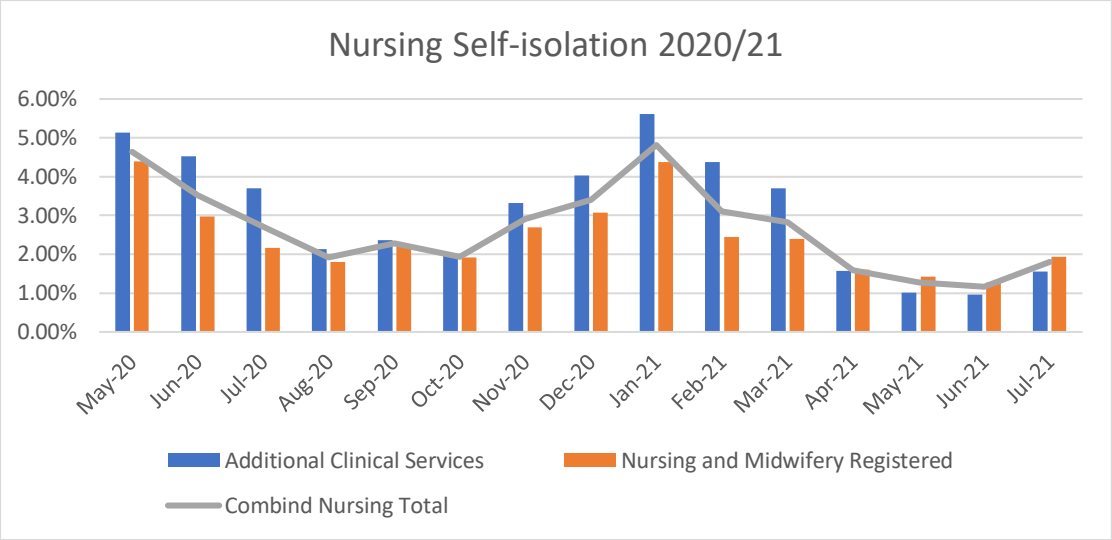


Chart 3

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:

- F3 remains on F4
- F1 move to G10 (larger footprint)
- F6 moved to F3
- F5 moved to F9

6. Recruitment and Retention

Vacancies: Registered nursing (RN/RM):

- WTE vacancies for inpatient areas is 81.5 WTE.
- The vacancy percentage for RN/RM within inpatient areas has increased from 11.1% to 11.9%. Total substantive numbers remain relatively static (Table 4). Increases in budgeted WTE in a number of areas has increased the overall vacancy rate. These areas include;
    - Recovery
    - Ward G1
- Overall vacancy percentage for RNs (inpatient and all other areas) is 9.3%, an increase of 0.7% from previous month.

	Ward RNs	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 Actuals Period 3 (June)	Sum of Actuals Period 4 (July)	WTE VACANCY at period 4
RN/RM Substantive	Ward	610.2	611.7	612.7	609.4	603.1	602.0	81.5
	CV19 Costs	(0.1)	1.4	1.3	1.1	0.0	0.0	0.0
Total: RN Substantive		**610.2**	**613.1**	**614**	**610.5**	**603.1**	**602.0**	**81.5**

Table 4. Ward/Inpatient actual substantive staff with WTE vacancy

The chart below demonstrates the total RN establishment for the organisation (wards and non-wards). While we have seen an increase in vacancy rate this financial year due to the increase establishment in many areas, the total number of substantive RNs is not declining (chart 4a). For example, comparing the same period last year, the inpatient areas have 26.5 WTE more nurses within its total establishment.

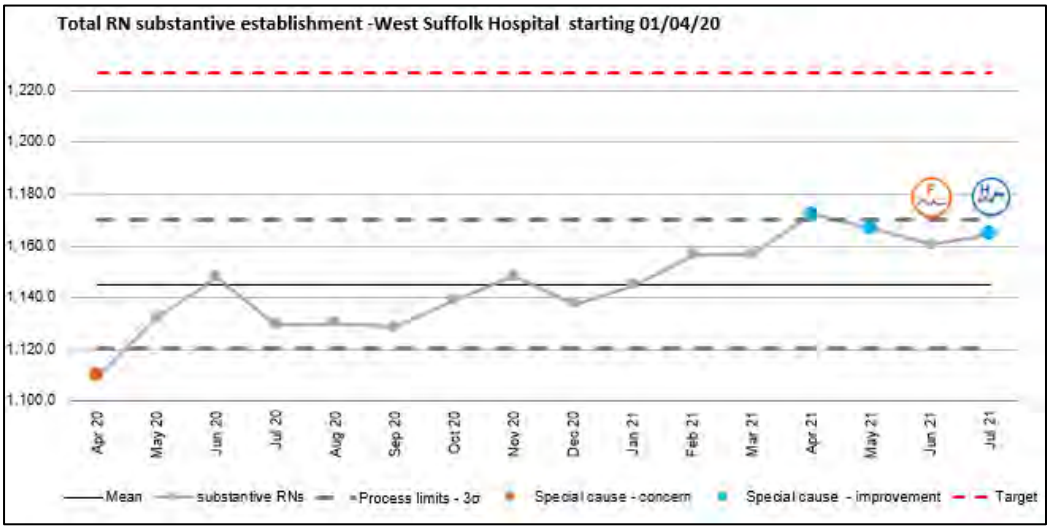


Chart 4a: SPC data adapted from finance ledger

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 increased from last month to 6.5%
- Inpatient NA vacancies while more favourable has increased to 3.8% with a WTE vacancy of 15.3. (table 5)

	Ward Nursing	Sum of Budget Period 11 (Feb)	Sum of Budget Period 12 (Mar)	Sum of Budget Period 1 (April)	Sum of Budget Period 2 (May)	Sum of Budget Period 3 (June)	Sum of Budget Period 4 (July)	WTE VACANCY at period 4
Nursing Unregistered Substantive	Ward	386.2	393.8	391.3	393.4	395.3	389.3	15.3
	CV19 Costs	16.9	19.5	10.8	4.3	0.0	0.0	0.0
Total: NA Substantive		**403.0**	**413.2**	**402.1**	**397.6**	**395.3**	**389.3**	**15.3**

Table 5: Ward/Inpatient NA substantive count and resulting WTE vacancy

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, areas of note include

- F6 remains a concern given their high vacancy rate, however this has improved on month
- G8 also has high vacancy rate following uplift in April the clinical teams are engaging with HR to produce rotational posts in order to attract more staff

- Midwifery services continues to have a high vacancy rate. The HOM is collaborating with regional and national teams to respond to 8-point plan to address this regional and national concern.

7. New Starters and Turnover

International Nurse Recruitment:

Five international nurses arrived in July as planned. The DCN and head of education are working closely with NHSI/E to ensure pipeline of arrivals remains on track. To improve this, the Education team have completed the option appraisal and are now able to facilitate the increase in monthly cohort from five OSNs to 8 OSN. This will commence from September. The recruitment teams are also meeting with an international recruitment agency to source an additional pipeline to supersede our independent pipeline, which is likely to yield a more consistent, reliable resourcing of nurses.

New starters

	February	March	April	May	June	July
Registered Nurses	17	30	18	13	9	12
Non-Registered	17	28	17	11	17	16

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

- In July 2021 twelve RNs completed induction; of these; ten were for acute services, one for pure bank and one Midwife joined this cohort
- In July 2021, sixteen NAs completed induction; of these seven NAs are for the acute Trust, three for bank services and six for community services

At the time of writing, twenty-two student nurses are anticipated to commence in the trust as newly qualified nurses. The education team are keeping close contact so that none are lost through attrition. It is likely they will join the trust in late September/October. We are predicted to retain 90% of Student nurses that have trained within WSH.

Turnover

On a retrospective review of the last rolling 6 months, turnover for RNs has slightly increased from 5.72% to 5.92 but remains well below the trust ambition of <10%. NA turnover has marginally improved from 10.82 to 10.79% on previous rolling 6 months.

Turn Over 01/08/2020 - 31/07/2021								
Staff Group	Average Headcount	Avg FTE	Starters Headcount	Starters FTE	Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
Nursing and Midwifery Registered	1,274.50	1,096.06	97.00	79.10	82.00	64.91	6.43%	5.92%
Additional Clinical Services	578.00	487.11	157	140.05	59	52.55	10.21%	10.79%

Table 7.

8. Quality Indicators

Falls

The number of falls reported in July has increased. Within July the majority of the falls resulted in no harm however there was one fall with major harm (AAU). There was an increase in the number of repeat fallers (n=14), with 9 patients falling twice, 2 falling three times, 2 falling four times and 1 patient falling five times. An emerging theme of the falls review includes patients falling while mobilising to the bathroom. Posters encouraging patients to use the call buzzers will be circulated to the wards to display in toilets and bathrooms as this is where a significant number of falls are occurring.

Falls per 1000 bed days is below the national average (set in 2015) of 6.63. A full list of falls and locations can be found in appendix 3.

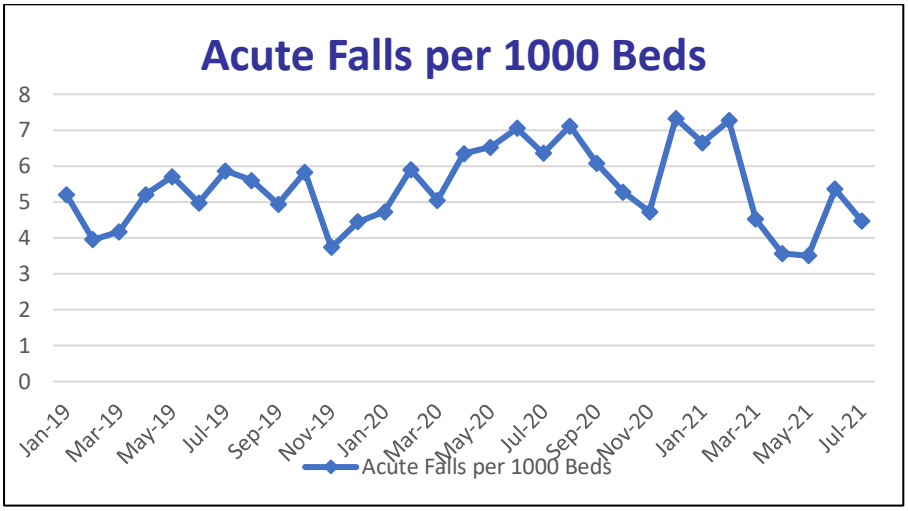


Chart 8

Pressure Ulcers

This month a slight increase on the lower than average numbers that were reported in June. There is no particular pattern across the wards with the exception of our F8 reporting five HAPU in July. The ward team are currently in the later stages of commencing a QI project within F8, baseline data has been collected, ready to go live with the project in August 2021.

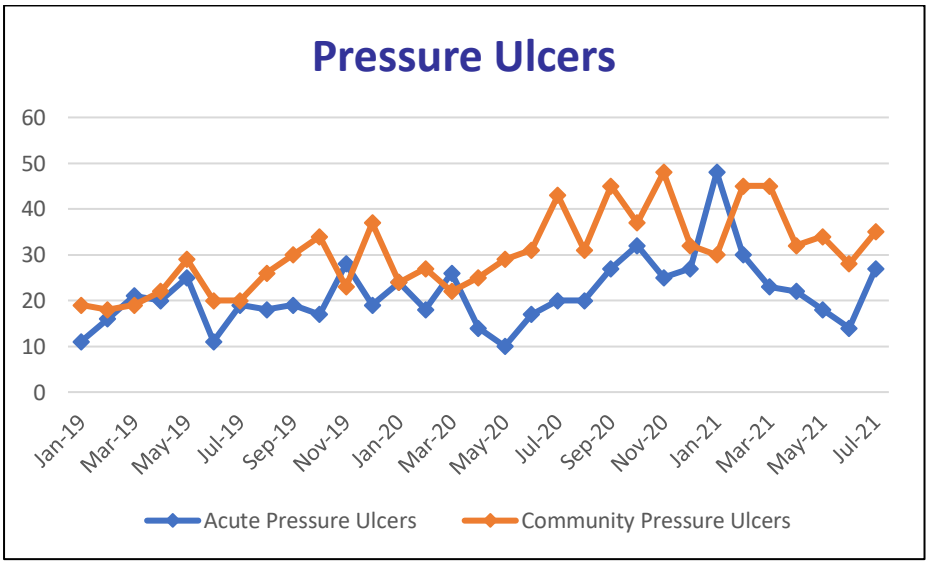


Chart 9a

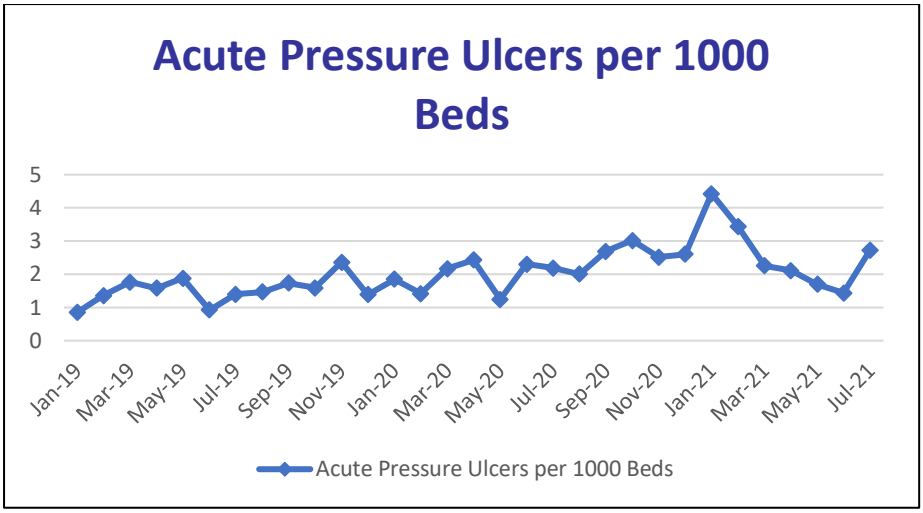


Chart 9b

9. Compliments and Complaints

Table 10. demonstrates the incidence of complaints and compliments for this period.

The clinical helpline has been maintained and an average of 95 calls a day to assist relatives who are unable to attend the wards to receive updates of the care of our patients. This is an increase on last month driven by increased promotion of the service to support the demands on the clinical teams.

	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
June 2021	31	19
July 2021	23	20

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 49 Datixs recorded for nurse staffing that resulted in a Red Flag event (see table 11.). No harm is recorded for these incidences. This is a significant increase on the preceding months and reflective of the decreasing fill rate seen this month and potential impact of an increase in staff isolation.

Red Flag	Jan 21	Feb 21	Mar 21	Apr 21	May 21	June 21	July 21
Registered nursing shortfall of more than 8 hours or >25% of planned nursing hours	11	0	3	2	3	4	23
>30-minute delay in providing pain relief	3	1	0	0	1	0	4
Delay or omission of intention rounding	17	4	9	2	1	5	12
<2 RNs on a shift	6	1	1	3	5	1	1
Vital signs not recorded as indicated on care plan	3	0	1	1	2	1	0

Unplanned omissions in providing patient medication	4	0	1	0	0	0	1
Total	44	6	15	8	12	11	49

Table 11.

11. Maternity Services

A full maternity staffing report will be attached to the maternity paper as per CNST requirements.

The maternity service has experienced increasing challenges this month and this is reflected in the number of red flag events, Midwife to birth ratio and the supernumery status of the labour suit coordinator. This is now recognised as a national staff crisis and the maternity team will be responding to regional and national assurances around staffing mitigation.

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 were seventeen red flag events in July;

Midwife to Birth ratio

- Birth: Midwife ratio in July was 1:33. Birthrate+ recommend a Midwife to Birth ratio of 1:27.7

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 July 81% 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. July 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	854	1035	1846.5	1695	1035	908.5	1242.5	1186.5	121%	92%	88%	95%	452	4.3	6.4	10.7
Glastonbury Court	715.75	739	1067	975.75	713	726.5	541.5	541.5	103%	91%	102%	100%	384	3.8	4.0	7.8
AAU	2125.5	2164.4167	2495	1806.5	1771	1863.5	1426	1325	102%	72%	105%	93%	761	5.3	4.1	9.4
Cardiac Centre	2907	2602	1352.5	1243.5	1782.5	1598.5	713	713	90%	92%	90%	100%	632	6.6	3.1	9.7
G9	1426	1408	1426	1352.5	1426	1391.5	1069.5	1271.5	99%	95%	98%	119%	752	3.7	3.5	7.2
F12	564	660	356.5	350.5	713	692	356.5	356.5	117%	98%	97%	100%	240	5.6	2.9	8.6
F7	1782.5	1560	1741.5	1387.5	1426	1337.25	1776.5	1699.5	88%	80%	94%	96%	683	4.2	4.5	8.8
F9	1782.5	1370	1771	1697.5	1066.75	1036	1426	1613.75	77%	96%	97%	113%	744	3.2	4.5	7.7
G1	1433	1052	352.5	350	713	714	356.5	294.75	73%	99%	100%	83%	392	4.5	1.6	6.1
G3	1771	1438.4167	1775.5	1842	1069.5	1002	1069.5	1541	81%	104%	94%	144%	864	2.8	3.9	6.7
G4	1768.5	1684	1860.5	1735.5	1065	1060	1426	1456.83333	95%	93%	100%	102%	896	3.1	3.6	6.6
G8	2498	2085.5	1835.5	1485	1771	1570.833333	1050.5	1147.25	83%	81%	89%	109%	615	5.9	4.3	10.2
F8	1426	1465	2101.5	1722.7333	1069.5	927	1426	1426	103%	82%	87%	100%	723	3.3	4.4	7.7
Critical Care	2718.5	2612.75	339.5	1023	2688	2513	0	508.5	96%	301%	93%	N/A	388	13.2	3.9	17.2
F3	1679	1575.5	2139.5	2010.25	1069.5	1058	1426	1353	94%	94%	99%	95%	732	3.6	4.6	8.2
F4	655.5	587	322	322	713	586.5	402.5	368	90%	100%	82%	91%	633	1.9	1.1	2.9
F5	1778	1445.5	1410.25	1241.75	1069.5	952.25	1060	971.5	81%	88%	89%	92%	698	3.4	3.2	6.6
F6	1937.45	1591.5	1649.5	1703.75	1426	1150.25	713	770.5	82%	103%	81%	108%	942	2.9	2.6	5.5
Neonatal Unit	984	1000.5	252	244	1032	996	192	168	102%	97%	97%	88%	116	17.2	3.6	20.8
F1	1208.75	1476.25	713	805.25	1069.5	1278.65	0	172.5	122%	113%	120%	100%	115	24.0	8.5	32.5
F14	780	809.93333	324	297.5	744	692.5	0	84	104%	92%	93%	100%	106	14.2	3.6	17.8
Total	32,794.95	30,362.27	27,131.25	25,291.48	25,432.75	24,054.73	17,673.50	18,969.08	**93%**	**93%**	**95%**	**107%**	**11868**	**4.6**	**3.7**	**8.3**

Appendix 2. Ward by ward vacancies (July 2021): Data adapted from finance report

NHS West Suffolk NHS Foundation Trust

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	30.0	0.1	0.4%	AAU	28.3	25.3	3.0	11%
Accident & Emergency	77.3	64.8	12.5	16.2%	Accident & Emergency	34.5	28.2	6.3	18%
Cardiac Centre	40.7	38.8	1.9	4.6%	Cardiac Centre	15.7	16.2	(0.5)	-3%
Community - Glastonbury Court	11.7	11.9	(0.2)	-1.7%	Community - Glastonbu	12.6	10.9	1.7	14%
Critical Care Services	43.0	41.3	1.8	4.1%	Critical Care Services	1.9	7.8	(5.9)	-315%
Day Surgery Wards	11.0	11.7	(0.7)	-6.1%	Day Surgery Wards	3.9	3.9	0.0	0%
Gynae Ward (On F14)	13.1	12.2	0.9	7.0%	Gynae Ward (On F14)	2.0	1.0	1.0	50%
Neonatal Unit	20.7	17.8	3.0	14.3%	Neonatal Unit	4.3	4.1	0.2	4%
Newmarket Hosp-Rosemary ward	16.6	14.7	1.9	11.3%	Newmarket Hosp-Rose	25.8	20.5	5.3	20%
Recovery Unit	25.4	19.6	5.8	22.8%	Recovery Unit	0.9	0.9	0.0	1%
Ward F1 Paediatrics	22.3	22.8	(0.5)	-2.0%	Ward F1 Paediatrics	7.7	5.4	2.3	30%
Ward F12	11.9	9.2	2.7	22.7%	Ward F12	5.9	4.9	0.9	16%
Ward F3	22.2	20.7	1.5	6.7%	Ward F3	25.8	24.3	1.5	6%
Ward F4	13.6	13.7	(0.0)	-0.3%	Ward F4	14.6	11.5	3.1	21%
Ward F5	22.2	19.4	2.8	12.6%	Ward F5	18.1	16.5	1.6	9%
Ward F6	26.6	18.3	8.3	31.2%	Ward F6	17.4	16.8	0.5	3%
Ward F7 Short Stay	24.9	22.8	2.1	8.6%	Ward F7 Short Stay	25.8	22.3	3.5	14%
Ward F9	21.8	16.7	5.1	23.2%	Ward F9	23.2	29.6	(6.5)	-28%
Ward G1 Hardwick Unit	30.6	26.8	3.7	12.2%	Ward G1 Hardwick Uni	10.5	11.1	(0.6)	-5%
Ward G3	22.1	19.6	2.5	11.4%	Ward G3	23.0	28.3	(5.3)	-23%
Ward G4	22.1	19.1	3.0	13.6%	Ward G4	22.8	21.1	1.7	7%
Ward G8	32.7	26.4	6.3	19.2%	Ward G8	20.6	21.1	(0.5)	-2%
Renal Ward - F8	19.5	18.5	1.0	5.0%	Renal Ward - F8	25.8	21.7	4.1	16%
Ward F10*	0.0	0.0	0.0	NA	Ward F10*	0.0	0.1	(0.1)	0%
Respiratory Ward - G9	23.7	22.9	0.8	3.2%	Respiratory Ward - G9	18.0	20.8	(2.8)	-15%
Total	**605.6**	**539.4**	**66.2**	**10.9%**	**Total**	**388.9**	**374.3**	**14.6**	**3.7%**
Hospital Midwifery	59.6	49.0	10.6	17.7%	Hospital Midwifery	15.6	14.6	1.0	6%
Continuity of Carer Midwifery	18.3	11.8	6.5	35.6%	Continuity of Carer Mid	0	0	0.0	0%
Community Midwifery	19.1	19.4	(0.3)	-1.4%	Community Midwifery	3.8	3.8	(0.0)	0%
Total	**97.0**	**80.2**	**16.8**	**17.3%**	**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 July 2020

HAPU

July 2021	Cat 2 (Minor)	Unstageable	Total
Cardiac Centre - Ward	1	0	1
Critical Care Unit	1	0	1
F12 Isolation Ward	1	0	1
F5 - ward	1	0	1
F6 - ward	1	0	1
G1 - ward	1	0	1
G3 - ward	1	0	1
Rosemary Ward	1	0	1
G4 - ward	2	0	2
Respiratory Ward	2	0	2
F7	2	0	2
F3 - ward	3	0	3
G8 - ward	2	2	4
Renal Ward	5	0	5
Total	**24**	**2**	**26**

Falls

July 2021	None	Negligible	Minor	Total
Critical Care Unit	0	0	1	1
Emergency X-ray	0	0	1	1
Eye Treatment Centre - Ward	0	1	0	1
F11 - Antenatal / Postnatal Ward	1	0	0	1
F14 (Gynae - EPAU)	1	0	0	1
F3 - ward	1	0	0	1
Glastonbury Court	1	0	0	1
Macmillan Unit	1	0	0	1
Main Outpatient Department	0	1	0	1
Physiotherapy Department	1	0	0	1
Cardiac Centre - Ward	1	0	1	2
F12 Isolation Ward	2	0	0	2
Renal Ward	1	0	1	2
Respiratory Ward	2	0	0	2
F4 - ward	2	1	0	3
F5 - ward	3	0	0	3
F6 - ward	4	0	0	4
G1 - ward	5	0	0	5
G3 - Endocrine and General Medicine	6	0	0	6
Gastroenterology Ward	4	2	0	6
F7	4	0	2	6
Emergency Department	6	0	1	7
G4 - ward	8	0	0	8
G8 - ward	7	0	1	8
Acute Assessment unit (AAU)	9	1	0	10
Rosemary Ward	11	0	3	14
Total	**81**	**6**	**11**	**98**

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

13. Future system board report

To APPROVE report

For Approval

Presented by Craig Black

Public Board Meeting – 3 September 2021

Agenda item:	13			
Presented by:	Craig Black – Interim CEO			
Prepared by:	Gary Norgate, Programme Director			
Date prepared:	16/08/2021			
Subject:	Future System Programme - Programme Directors Overview			
Purpose:	X	For information		For approval

Since last month's meeting we have made progress on several fronts and have completed the first phase of our face to face engagement activities that support our application for planning permission.

Before commencing with an executive summary of our progress, I would like to offer thanks and best wishes to our departing CEO, Dr. Steve Dunn. Although, we'll undoubtedly miss his energy, insight and experience, his departure does not create a specific risk to our project and we'll all remain focussed on delivering an outcome of which he'd be proud.

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. Work continues on the detailed environmental impact assessment (EIA) with the majority of conclusions drawn to date representing an improvement on those foreseen by the initial desk research.
2. The second phase of our co-production activities has been translated into a schedule of accommodation (SOA) that will inform the physical design for which we will be seeking planning permission.
3. Said SOA reflects new ideas for quality improvement and a demand growth forecast for the next 10 years. Building the resultant hospital would present significant issues in terms of capital and operational affordability and, with this in mind, Phase 3 of the co-production process, in which the total SOA will be peer reviewed and co-refined, has been launched.
4. Alongside internal co-refinement activities, a system wide response to managing demand growth has been launched.
5. In order to ensure operational support for the suggestions emerging from the clinical co-production we have held the inaugural meeting of the WSFT Executive Panel. This panel will prioritise developments and decide which suggestions are progressed through the governance of the Programme Board.
6. Four more members of the Future System team have successfully completed the "Better Business Cases" masterclass training.
7. The first phase of engagement activities supporting our application for planning permission have been completed and we have received over 700 responses to our request for feedback.
8. Parking and Highways are, by far, the most commonly expressed concerns.
9. Assessments of traffic flows are underway as is the production of options for the provision and

management of parking. We hope to share the outcome of this research with the public during the second phase of our planning engagement strategy.

10. The content for these engagements will provide the public with their first view and sense of what a new hospital on Hardwick Manor might look like (height and positioning).
11. We have now received the means through which to apply for funding for the development of our Outline Business Case.
12. We have now completed the re-planning of our project and will communicate a clear path for ensuring we are truly “oven ready” to proceed with construction by 2025 (earliest).
13. Heads of Terms have now been agreed with a neighbouring land owner for the use of his fields as an estate path and storage compound for the duration of our construction phase. These terms are now being translated into legally binding agreements.

Strategic Outline Case (SOC) – Further to last month’s report I can now confirm that:

Our strategic outline case (SOC) remains, along with the SOC’s and Outline Business Cases produced by other HIP projects, on hold until the central National Hospital Programme can gain Treasury sign off for its overarching Programme case. Capital funding remains, understandably, the principle area of debate and the risk of each project having to operate within a “tight” capital budget remains real.

We have now received the mechanism through which to apply for funding to cover the activities (including planning permission and the development of outline designs) that will enable us to progress the development of an outline business case. This removes the risk of the Trust having to cover the expense of the project. Our application is being prepared and will seek funding in the region of £7m.

In addition to Zoe Selmes achieving “Practitioner” status, four more of our team have successfully passed through the formally assessed “Better Business Cases Masterclass”. This adds significant depth to our understanding of the intricacies of the business case process and also provides additional assurance that our SOC has sufficiently met the criteria against which it will eventually be assessed. The course highlights the importance of a system-wide approach to the development of a solution and vindicates the co-production approach that we have adopted.

In terms of the overall project plan, our core team met off-site and dedicated a day to working through the finer points of our plan – as well as taking time to understand our relative strengths and how they could be best applied to our challenge. The resultant plan is best summed up by the following milestones:

Strategic Analysis Of SoA	**2.6 wks**	**Tue 06/07/21**	**Fri 23/07/21**
Issue SoA (inclusive of 2031 growth modelling)	0 days	Tue 06/07/21	Tue 06/07/21
Review / Revisit SoA in Relation to "Core" Services & Type 1, Type 2 and Type 3 Accommodation & Services	2.2 wks	Wed 07/07/21	Wed 21/07/21
Agree "core" Type 1, Type 2 and Type 3 SoA's	2 days	Thu 22/07/21	Fri 23/07/21
Potential "Gap" Identified (at strategic level)	0 days	Fri 23/07/21	Fri 23/07/21
Town & Country Planning	**25 wks**	**Fri 23/07/21**	**Fri 28/01/22**
Agree / Issue 100,000m2 (Max) "Core" SoA to Support Planning Process	0 days	Fri 23/07/21	Fri 23/07/21
Review Building Typologies Against 100,000m2 SoA	1 wk	Mon 26/07/21	Fri 30/07/21
Finalise Building Typology Report	0 days	Fri 30/07/21	Fri 30/07/21
Review Building Typology Report with Stakeholders	2 wks	Mon 02/08/21	Fri 13/08/21
Building Typology Agreed for Planning Purposes	0 days	Fri 13/08/21	Fri 13/08/21
EIA Progression and Planning Design	16 wks	Mon 16/08/21	Fri 03/12/21
Public Consultation (Phase 2)	6 wks	Mon 18/10/21	Fri 26/11/21
Collation of Application & Legal Review	6 wks	Mon 06/12/21	Fri 28/01/22
Submit Application	0 days	Fri 28/01/22	Fri 28/01/22
Rationalisation of SoA	**19.4 wks**	**Mon 26/07/21**	**Tue 07/12/21**
Scene Setting Briefings	1 wk	Mon 26/07/21	Fri 30/07/21
Phase 3 Clinical / Architectural Engagement	14.4 wks	Mon 02/08/21	Tue 09/11/21
Review Results of Rationalisation Process and Prepare Report on SoA & "Gap"	4 wks	Wed 10/11/21	Tue 07/12/21
Real "Gap" Confirmed	0 days	Tue 07/12/21	Tue 07/12/21
Strategic "System" Solution	**47.2 wks**	**Mon 26/07/21**	**Mon 04/07/22**
Arrange / Progress System Wide Briefing Sessions to Clarify / Agree Process	6 wks	Mon 26/07/21	Fri 03/09/21
System Wide Resolution for "Gap" (as Phase 3 Clinical Engagement Emerges)	13.4 wks	Mon 06/09/21	Tue 07/12/21
System Wide Resolution / Finalisation of "Gap" including Economic Modelling (Once Phase 3 Engagement is Complete)	27.8 wks	Wed 08/12/21	Mon 04/07/22
Outline Business Case	**63.6 wks**	**Wed 08/12/21**	**Mon 20/03/23**
Prepare OBC design for "Core" Services to be Delivered on Hardwick Manor	27.8 wks	Wed 08/12/21	Mon 04/07/22
Finalisation of Economic Case (based on SoA's)	8 wks	Tue 10/05/22	Mon 04/07/22
Finalise Capital Costs	4 wks	Tue 05/07/22	Mon 01/08/22
Prepare Financial Case	8 wks	Tue 02/08/22	Mon 26/09/22
Finalise OBC Drafting	1.8 wks	Tue 27/09/22	Fri 07/10/22
OBC Approvals / Governance	8 wks	Mon 10/10/22	Fri 02/12/22
NHSE/I Approval	14 wks	Mon 05/12/22	Mon 20/03/23
Full Business Case (FBC)	**99.8 wks**	**Mon 07/11/22**	**Fri 11/10/24**
Construction & Occupation	**168 wks**	**Mon 14/10/24**	**Mon 03/01/28**

"The first date listed is the start date, second date is the date that the task is scheduled to be complete"

The key points to note are that we have a c.12 months to co-refine the clinical model and provide the basis for the designs that will go into our OBC which we aim to submit in December 2022. In this same period, we will have completed our planning application and the economic, commercial, financial and management cases that are the essential elements of this stage of the project. In essence these cases respectively outline; which option we want to progress, who might build it, how much it will cost / its affordability and whether it can be delivered by the organisation and its partners.

The dark blue tasks entitled "Strategic System Solution" allude to the fact that we cannot simply build a bigger hospital in the vain hope that it will address the growth in demand that we experience in all aspects of our health and care system. This work (discussed in greater detail below) is designed to ensure the hospital that we build is not rapidly overwhelmed by ever increasing demand, or rapidly

"gummed up" by an inability to discharge patients into the care of our over stretched mental health, social care, community and primary care partners. This work will run in parallel to the other activities and will seek to deliver outcomes in time to influence our outline and full business cases. "That said, these solutions are far from easy to agree and implement and in the event that timescales for this activity exceed those for the OBC / FBC, their conclusions and recommendations will be progressed as additional phases of change and development.

Estates

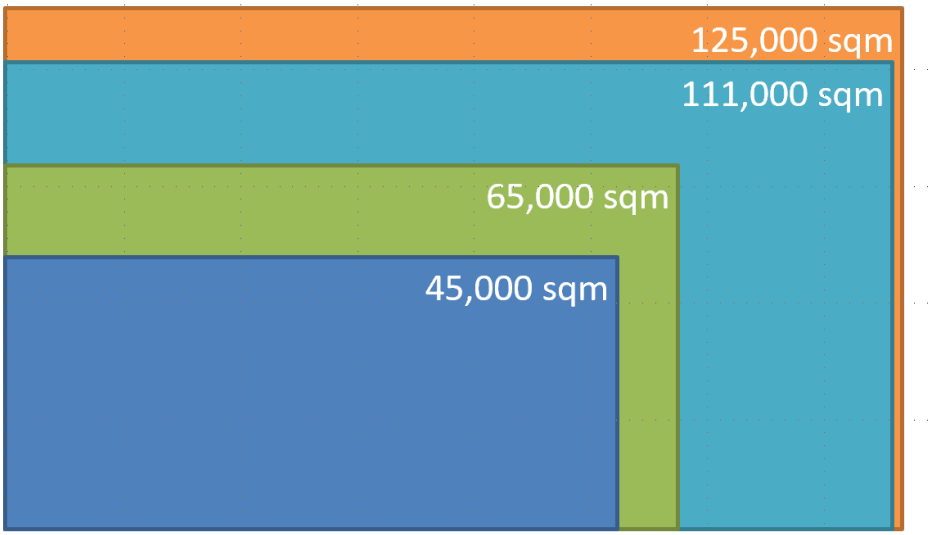
Our environmental impact analysis is making great progress and we have now completed the survey of over 1,100 trees as well as making significant progress on botanical and wildlife surveys. The outputs of work to date have failed to identify any 'show stoppers' and results are considered to be favourable to those that had been predicted as part of our desk-based site appraisal. Next steps include the agreed archaeological survey, detailed traffic analysis and the autumnal fungi survey.

As previously discussed a key part of our construction strategy is the development of a secure "works compound" and estates road. These facilities will allow us to store materials and transport them whilst minimising disruption of local roads. To this end we have been engaged with neighbouring land owners on the temporary use of their land and I am now able to announce the agreement of heads of terms. The next step is to turn these terms into legally binding documents.

Clinical / Digital Workstream

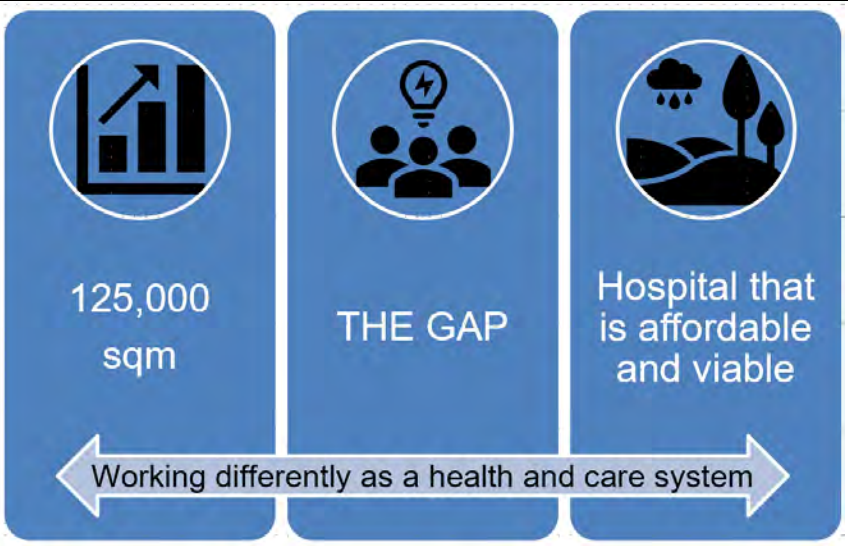
Following the completion of the second phase of co-production, the graphic below shows how our current RAAC infrastructure, occupying some 45k sqm, expands to 65k sqm when it is rebuilt to reflect modern spatial standards. Once we apply a forecast for the growth in demand for each speciality over a 10-year period, the space required expands to 111k sqm. Finally, if we include the quality improvement initiatives identified during co-production, the space required expands to 125k sqm – nearly three times the size of the current hospital.

Such a hospital is simply undeliverable at a capital, operational and resource level.



Numbers are rounded to nearest 1,000

To address this challenge, the Phase 3 co-production activity will peer review the design for each respective speciality and thus co-refine the overall model. This activity, although important is, alone, unlikely to result in an affordable, sustainable design, however, it will allow us to identify the true nature of our gap.



It is clear that simply driving down the size of a new hospital is as futile as simply building a larger one, i.e. the challenge of increasing demand is being experienced by each and every part of our health and care system and as such the only way to address this ever-increasing driver of cost and growth is to tackle it collectively as a system. Consequently, work has commenced to re-invigorate the opportunities presented through collaboration throughout the ICS. As essential as this work is, we cannot lose sight of the fact that The West Suffolk Hospital has significant infrastructure challenges and that we need to maintain focus on delivering an alternative building. With this in mind, the project plan above shows how the building of a new hospital will progress in parallel with identifying the changes to the ways in which we deliver service which will ensure it remains viable. Either project cannot be truly successful without the other but both may progress at a different pace and require independent business cases (the national hospital program is designed to fund the replacement of our hospital rather than the full transformation of our system) so the task of managing overall cohesion becomes critical.

Communications and Engagement

As highlighted in the graphic below we have now completed the first phase of the engagement plan supporting our application for planning consent. We held 6 face-to-face events which were very well received, although we were reminded of the need to run events in Mildenhall and Brandon – which we will happily do for the second phase planned for October. Within the 700 completed feedback forms it soon became clear that the most commonly expressed concerns relate to traffic, parking and how these collectively impact access to the hospital.

Detailed analysis of both issues is underway and our plans for ensuring the situation is improved will be shared during the second phase of engagement.

- Two online briefings with local residents and members of the public
- Six COVID-secure in person events held at Thetford, Haverhill, Bury St Edmunds, Newmarket, Sudbury and Stowmarket
- Over 700 feedback forms have been returned to date

In addition to the incredible amount of effort that has been put in by our clinical staff to the co-production of our schedule of accommodation, we are now in the process of involving our 'army' of public co-production volunteers to test and co-refine our assumptions. I hope to report some of this rich and valuable insight at next month's meeting.

All in all, a month in which the significant progress has been made in the development of our clinical design, our ability to fund the development of our business case, the re-planning of our project, the development of the key elements of our planning application and the engagement of our community. Equally exciting is the work now underway to ensure the whole of our Integrated Care System are engaged in determining how we can work together in order to ensure we don't just build a new hospital that rapidly runs out of space!
Next month, we see the continuation of staff and public engagement through the execution of Phase 3 of our Co-production process and the building of momentum for an ICS solution to our growth conundrum. We will also progress the next steps of our environmental impact assessment as we prepare for the next round of face to face public engagement.

	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:	None						
Risk and assurance:	None						
Legislation, regulatory, equality, diversity and dignity implications	None						

Recommendation: The Board are asked to note the progress being made towards the building of a new, sustainable, hospital.

11:35 GOVERNANCE

14. Governance report

To APPROVE the report

For Approval

Presented by Ann Alderton

Board of Directors – 3 September 2021

Agenda item:	14			
Presented by:	Ann Alderton, Interim Trust Secretary			
Prepared by:	Ann Alderton, Interim Trust Secretary			
Date prepared:	24 August 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. **Appointment of Interim Chief Executive Officer** (for information)
   Following the resignation of Stephen Dunn as Chief Executive Officer of the Trust, the Remuneration Committee met on 2 August 2021 to appoint Craig Black as Interim Chief Executive. In accordance with the Trust's Constitution, this appointment was approved by the Council of Governors on 3 August 2021. Nick Macdonald (Deputy Director of Finance and Resources will be the Interim Director of Resources during this period.

   Another meeting of the Remuneration Committee will take place in the coming week to discuss the appointment of a new Chief Executive for the Trust.

3. **Audit Committee Report** (for information)
   A meeting of the Audit Committee was held on 30 July 2021 after the last board meeting. Members considered it would be preferable for future meetings to take place before a board meeting, for assurance purposes. The key issues discussed included the Board Assurance Framework and Organisational Framework for Governance, which had already been covered at the 30 July board meeting. Other issues discussed included the following:

   Internal Audit Report – the internal auditors reported on the four final reports in the 2020/21 internal audit plan, which included one substantial assurance opinion (CQC Improvement Plan), two reasonable assurance opinions (Surveillance Patients Processes; Community – NEL CSU exit project review) and one partial assurance opinion. The partial assurance opinion related to the audit of Data Quality – Long Waiting Patients and Harm Reviews, where sample testing identified under-reporting on Datix and inconsistent use of P (priority) codes, resulting in potential delays in treatment. Action is being taken to address the audit findings.

   Counter Fraud - the Local Counter Fraud specialist gave an update on recent counter-fraud activity in the Trust and presented the Counter Fraud Annual Report for 2020/21. The level of investigative work was down slightly on the previous year.

   External Audit – the concluding work to complete the annual audit was discussed, with the auditor's report scheduled to be ready for the 3 September board meeting. This would be BDO's final year as the Trust's external auditors as the appointment of former BDO staff into key finance positions at the Trust meant that they would no longer meet the criteria for independence. A process to appoint new auditors will take place imminently, involving both the Audit Committee and Council of Governors.

Financial Reporting - The committee approved £288k of losses and compensations, a high proportion of which related to expired stock and debt write-offs of £149,585.

Annual Report of the Audit Committee 2020/21 – the committee approved the Annual Report of the Audit Committee to the board, which is appended to this paper in Annex B.

Terms of Reference – the committee reviewed its Terms of Reference, which are submitted with other board committee terms of reference for the board's approval in item 16.

NED Responsibilities (for information)
Following the appointment of Jude Chin as Interim non-executive director, the Trust Board has its full complement of non-executive directors once again. Attached in Annex C is the updated schedule of non-executive director responsibilities.

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 content of the report.

Annex A: Scheduled draft agenda items for next meeting – 15 October 2021

Description	Open	Closed	Type	Source	Director
Declaration of interests	✓	✓	Verbal	Matrix	All
General Business					
Patient/staff story	✓	✓	Verbal	Matrix	Exec.
Chief Executive's report	✓		Written	Matrix	CB
Operational report	✓		Written	Action	HB
Report from 3i Committees: Insight, Improvement & Involvement	✓		Written	Matrix	RD / AR /
Finance & workforce performance report	✓		Written	Matrix	NM
Risk and governance report, including risks escalated from subcommittees		✓	Written	Matrix	AA
Deliver for Today/Invest in Quality, Staff and Clinical Leadership					
Insight Committee Report - Finance and workforce report - Operational report - IQPR	✓		Written	Matrix	NM/HB/RD
Involvement Committee Report - People and OD Highlight Report o Appraisal and mandatory training report o Quarterly Staff Survey	✓		Written	Matrix	JMO/AR
Improvement Committee Report - Infection prevention and control assurance framework - Maternity services quality and performance report (inc. Ockenden) - Nurse staffing report	✓		Written	Matrix	SW / PM
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	SW
Build a joined-up future					
Future system board report	✓	✓	Written	Matrix	CB
Strategic update, including Alliance, System Executive Group and Integrated Care System		✓	Written	Matrix	KV / CB
Governance					
Governance report, including - Agenda items for next meeting - Use of Trust's seal - Senior Leadership Team report - Remuneration committee report - Risk appetite statement - Scope for well led developmental review	✓		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

NHS
West Suffolk
NHS Foundation Trust

Audit Committee Annual Report 2020/21

1. Background

1.1 The Audit Committee of West Suffolk NHS Foundation Trust is established under Board delegation with approved Terms of Reference that are in line with those set out in the NHS Audit Committee Handbook.

1.2 This report covers the year from 1 April 2020 to 31 March 2021.

1.3 The Committee consists of a minimum of 3 Non-Executive Directors, one of whom has recent and relevant financial experience. The Committee has met on 5 occasions during the year to discharge its responsibility for scrutinising the risks and controls that affect all aspects of the organisation's business.

1.4 The meetings have also been attended, by invitation, by the Chief Executive, the Executive Director of Resources, the Executive Chief Nurse, the Deputy Chief Nurse, the Medical Director, the Trust Secretary and Head of Governance, the Assistant Director of Finance or Deputy Director of Finance, Internal Audit, External Audit and the Counter Fraud Service. The Chair of the Trust has also attended the Committee meetings.

1.5 The Committee focuses on all aspects of Corporate Governance including assurance on clinical governance and risk management.

1.6 This report deals with the Audit Committee meetings held between 1 April 2020 and 31 March 2021. Therefore, reports that are approved outside this period would be covered in the following year despite the subject matter of the report relating to the year. E.g. the Annual Report and Accounts for 2020/21 will be reported in the year they were approved by the Committee i.e. 2021/22.

2. Meetings during 2020/21

2.1 There were 5 meetings of the Committee during 2020/21: 24 April 2020, 19 June 2020 (for the approval of the 2019/20 accounts only), 31 July 2020, 6 November 2020 and 29 January 2021, with the following member attendance:

	Title	Attendance / No. possible
Angus Eaton (Chair)	Non-Executive Director	4/5
Gary Norgate	Non-Executive Director	1/1
Alan Rose	Non-Executive Director	5/5
Richard Davies	Non-Executive Director	5/5
Louisa Pepper	Non-Executive Director	2/5
David Wilkes	Non-Executive Director	2/2

2.2 There are no sub-committees of the Audit Committee. The Audit Committee was supported by the Quality and Risk Committee during 2020/21, the minutes of which were considered at every Audit Committee meeting.

3. Principal Review Areas

3.1 Annual Governance Statement

3.1.1 The Audit Committee reviewed the 2019/20 Annual Governance Statement for the Trust for the 12 months to 31 March 2020 in April and June 2020 and confirmed that it was consistent with the view of the Committee on the Trust's system of internal control. Note that the Annual Governance Statement for 2020/21 was reviewed in April and June 2021.

3.1.2 The Audit Committee received the Head of Internal Audit opinion 2019/20 in June 2020 which concluded:

The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.

Specific issues highlighted were:

- Business Continuity (Partial Assurance)

  The audit identified that the control framework required improvement. The areas of weakness related to incomplete operational Business Continuity Plans and the Trust not having a defined training framework in place in respect of business continuity planning/preparedness. Related policies also needed to be brought up to date and made available to all staff.

- Procurement (Partial Assurance)

  Control weaknesses were identified in relation to a lack of process around contract monitoring and retention of contract documentation, including a lack of monitoring of the contracts database.

- Freedom to Speak Up (No Assurance)

  During the course of the audit it was identified that the control framework required improvement for both the design of the controls and the adherence of the existing controls in place. Records also lacked the expected requirements in line with the National Guardian's Office.

3.2 Annual Accounts Approval

3.2.1 The Committee reviewed the draft accounting policies proposed and considered the significant accounting estimates and judgements in advance of the production of the accounts.

3.2.2 The Committee reviewed the 2019/20 Annual Accounts, Annual Report and the Letter of Representation for the 12 months to 31 March 2020 and recommended these for approval by the Trust Board.

3.3 Terms of Reference

3.3.1 The Committee is required to review its Terms of Reference (ToR) during the year.

3.3.2 A revised version of the Terms of reference was agreed at the meeting in July 2020.

3.3.3 The key requirements included in the Terms of Reference, and whether they have been met during the year, have been considered in the Appendix to this report.

3.4 Governance Documents

3.4.1 The Committee has a duty to undertake a review of the Trust's Governance Documents every other year, unless there are matters that require review at an earlier date. These comprise the Standing Orders, Standing Financial Instructions and The Scheme of Delegation. These are due to be reviewed in 2022.

3.5 Governance

3.5.1 In respect of Governance the Committee's responsibilities are set out in the terms of reference as:

- The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. The Audit Committee will look to the Quality & Risk Committee for assurance on items of clinical quality and corporate risk, including: health & safety, research and information governance.

3.5.2 The Committee achieved this through a number of actions:-

- Monitor and review the Annual Governance Statement
- Receiving the annual Head of Internal Audit opinion
- Receiving the audit report of the External Auditors on the Annual Accounts
- Reviewing the effectiveness of the Board Assurance Framework (with support from Internal Audit);
- Receiving the minutes of the Quality & Risk Committee.

3.5.3 Board Assurance Framework Deep Dive Reviews – during the 2020/21 financial year the Committee conducted deep dive reviews of key areas within the Trust:

- ***Quality and Performance Reporting during COVID*** – Jo Rayner (Head of Performance) held a discussion around the Trust Board's requirements for monthly reporting information during COVID to ensure that it remained relevant and focused on the areas of most importance during this time.

- ***IT Update*** – Mike Bone (Chief Information Officer) made a presentation on the progress of the Trust's current IT Strategy. This included the migration of Community Staff away from North East London Clinical Support Unit to being an integral part of the Trust's network and the work undertaken to ensure that all staff had the facilities and equipment to be able to work from home during the pandemic.

- ***Data Quality and Business Intelligence*** – The Committee received a presentation from Nickie Yates (Head of Information) and Ian Coe which covered the Trust's Data Quality Strategy. The presentation covered the progress made by the Trust as a result of recommendations raised by Internal Audit and the CQC around data quality and also a demonstration of the current information reports that are readily available to be accessed on demand.

- ***Risk Appetite Session*** – Janine Combrinck (Director from BDO) led a presentation and discussion around risk appetite to enable the Directors to better identify and consider the risks posed by the Trust.

3.6 Charitable Funds Annual Accounts

3.6.1 The Board delegated authority to the Audit Committee to approve the Charitable Fund accounts for the full year to 31 March 2020. The Committee approved the accounts at its January 2021 meeting.

4. Other work undertaken

4.1 Internal Audit

4.1.1 The Committee received the following reports from the Internal Auditors:-

- Progress report against the Audit Plan at every meeting including implementation of recommendations
- 2019/20 Head of Internal Audit Opinion – April 2020
- 2020/21 Internal Audit Plan – April 2020
- 2021/22 Draft Internal Audit Plan – January 2021

4.1.2 Following a thorough procurement process, RSM were re-appointed as the Trust's Internal Auditors from 1 April 2019 for a period of 3 years.

4.2 External Audit

4.2.1 The Committee received the following reports from the External Auditors:-

- 2019/20 Report to Those Charged with Governance (ISA 260) - June 2020
- 2019/20 Report on the Quality Report to the Council of Governors – June 2020
- 2019/20 Annual Audit Letter - July 2020
- 2019/20 Charitable Fund Accounts Report to Those Charged with Governance (ISA 260) - January 2021
- 2020/21 External Audit Plan- January 2021

4.3 Counter Fraud

4.3.1 Following a thorough procurement process, the Committee received the following reports from the Local Counter Fraud Specialist provided by RSM:

- Progress Report- all meetings
- Regular Fraud Notices
- Counter Fraud Annual Report 2019/20 – July 2020

4.3.2 RSM were appointed as the Trust's Local Counter Fraud Specialists from 1 April 2019 for a period of 3 years.

5. Audit Committee Responsibilities – performance

5.1 As part of its responsibilities the Committee should assess its performance against its terms of reference not less than every 2 years. The Committee completed the HFMA self-assessment checklist in March 2020 and therefore this not due to be completed until March 2022.

6. Audit Committee Impact

6.1 It is important that the Audit Committee makes an impact on the Trust, particularly around ensuring the robustness of the Governance Structure.

6.2 In assessing this, it is important to note that the main reports submitted to the Committee by External and Internal Audit supported the robustness of the Governance structure.

6.3 There were a number of specific areas where the Committee undertook action to address issues or where specific items were raised and discussed, including:

- The Committee received a report on losses and special payments. This report is reviewed on an annual basis.
- The Committee received a report on waivers and critically reviewed the drivers behind the number of waivers. This report is reviewed on an annual basis.
- The Committee received reports for the approval of debt write offs.
- The Trust critically reviewed management responses to Internal and External Audit Reports to ensure risks and actions were being managed adequately and in a timely manner.
- The Committee received a report on the Supply Chain risks.

6.4 The above items reflect that the Committee has had a positive impact on the governance arrangements of the Trust

7. Conclusion

7.1 This report highlights the main areas of work undertaken by the Audit Committee during the period. It demonstrates that the Committee operated effectively and had a positive impact on the Trust.

7.2 The Committee is asked to review the report, make any changes and approve a final version for submission to the Trust Board.

Appendix – Key requirement included in Terms of Reference

Para Ref	Requirement of Terms of Reference	Requirement Met?	Date
5.6	Committee to hold a private meeting with both Internal and External Audit.	✓	November 2020
6.1	Meetings will be held at least three times a year.	✓	April 2020, June 2020, July 2020, November 2020, January 2021
8.1.1.2	Monitor and review the effectiveness of systems of internal financial and budgetary control and the integrity of reporting statements.	✓	Completed through Internal and External Audit reviews and opinions
8.1.1.3	Monitor and review the effectiveness of systems for ensuring the optimum collection of income.	✓	Completed through Internal and External Audit reviews and opinions
8.1.1.4	Monitor and review the effectiveness of risk management systems.	✓	Completed through Internal Audit reviews and opinions
8.1.1.5	Monitor and review the effectiveness of the Board Assurance Framework (BAF).	✓	Every meeting
8.1.1.6	Use of a 'deep dive' programme of reviews to test the BAF.	✓	Every meeting – except the June meeting, which is just for the approval of the Annual Report & Accounts
8.1.1.7	Monitor and review the Quality Report assurance and review alongside the Annual Report and Accounts.	**N/A**	There was no requirement for the Trust to produce a Quality Report during 2019/20.
8.1.1.8	Monitor and review the systems for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements.	✓	Completed through relevant reviews throughout the year
8.1.1.9	Monitor and review the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority.	✓	Completed through Counter Fraud reviews
8.1.4	Review the minutes from the Quality & Risk Committee.	✓	Every meeting
8.2 & 8.2.5	Review of the effectiveness and quality of the Internal Audit Function.	✓	Completed and brought to the Committee in November 2020.
8.2.2	Review of the Internal Audit Strategy and Operational Plan.	✓	April 2020 for 2020/21 Audit Plan (final plan)
8.2.3	Consideration of major findings of Internal Audit investigations and the effectiveness of the management response.	✓	Every meeting
8.3	Review of the effectiveness of the Counter Fraud Service.	✓	Completed and brought to the Committee in November 2020.
8.3.2	Consideration of major findings of Counter Fraud investigations and	✓	Every meeting

0

Appendix – Key requirement included in Terms of Reference

Para Ref	Requirement of Terms of Reference	Requirement Met?	Date
	the effectiveness of the management response.		
8.3.4	Receipt and review of the annual review of work undertaken by the Counter Fraud Service.	✓	July 2020 for 2019/20.
8.4	Review of the effectiveness and quality of the External Audit Function, including their independence.	✓	July 2020 (for 2019/20 performance).
8.4.3 & 8.4.4	Review of the External Audit Plan, before the audit commences.	✓	January 2021 for the 2020/21 Audit.
8.4.5	Review reports from External Audit, together with management responses.	✓	June 2020
8.5.1	Review the Annual Report and Financial Statements of the Trust and the Charitable Funds, covering: • The Annual Governance Statement • Changes in, and compliance with, accounting policies • Explanation of estimates and provisions having a material effect • Unadjusted misstatements • Major judgemental areas • Schedule of losses and special payments • Significant adjustments resulting from the audit. These are reviewed prior to endorsement by the Board of Directors (for the Trust accounts).	✓	June 2020 for the Trust's 2019/20 Annual Report and Accounts. January 2021 for the 2019/20 Charitable Fund's Annual Report and Accounts.
8.6.1	Review changes to Standing Orders, Standing Financial Instructions and Scheme of Delegation.	✓	N/A for 2020/21 as the review is complete bi-annually
8.7.1	Review Schedule of Waivers.	✓	July 2020 – reviewed annually
8.7.2	Review schedules of losses and compensations.	✓	July 2020 – reviewed annually
8.7.3	Monitor the process to ensure that Supply Chain Risk is identified and appropriate actions have been taken.	✓	July 2020 – reviewed annually
9.2	Review the Terms of Reference Annually.	✓	July 2020
9.3	Undertake a self-assessment of the Audit Committee performance (bi-annually).	✓	July 2020
9.4	Complete an Annual Report on activities of the Audit Committee.	✓	July 2020 (for review of 2019/20)

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Non-executive directors' responsibilities – August 2021

	Primary responsibilities	Responsibilities as required	Lead assurance roles
Sheila Childerhouse **Chair and Non-executive director** **Term:** 1 Jan 2018 - 31 Dec 2020	• Chair Board – Public, Closed (**Chair**) • Scrutiny Committee • Remuneration Committee • Council of Governors (**Chair**) *Option to attendance any other Board committees* • ICS chairs meeting (Chair) Pending appointment of new NED: • Charitable Funds Committee • 2nd Clinical Safety & Effectiveness Committee (only attend if Richard Davies unavailable)	• Board Workshops • External relationships • Consultant appointments • Quality walkabouts • Governor meetings with NEDs • Investigations and appeals • CCG Board meetings	• Integrated care system • NHS England and Improvement • NED link to CEO • NED link to Director of Integration and Partnerships
Richard Davies **Non-executive director** **Term:** 1 Mar 2017 – 28 Feb 2020 **Reappointed:** 1 Mar 2020 – 28 Feb 2023	• Board meeting – Public, Closed • Audit Committee • Remuneration Committee • Future System Board • Insight Committee (Chair)	• Board Workshops • Consultant appointments • Quality walkabouts • Revalidation Support Group • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• Senior Independent Director, including whistleblowing • NED link to Medical Director • Staff health and wellbeing • Patient safety, including learning from deaths • Safeguarding children

	Primary responsibilities	Responsibilities as required	Lead assurance roles
Christopher Lawrence **Non-executive director** **Term:** 1 Jun 2021-31 May 2024	• Board meeting – Public, Closed • Audit Committee (**Chair)** • Charitable Funds Committee • Ethics Committee • Future System Board	• Board Workshops • Consultant appointments • Attend Q&RC • Quality walkabouts • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• NED link to Director of Finance • Risk management • Procurement - moved from Gary
Louisa Pepper **Non-executive director** **Term:** 1 September 2018 – 31 Aug 2021 **Reappointed** 1 September 2021-31 Aug 2024	• Board meeting – Public, Closed • Audit Committee • Remuneration Committee • Scrutiny Committee (**Chair**) • Ethics Committee (**Chair**)	• Board Workshops • Consultant appointments • Quality walkabouts • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• NED link to Chief operating officer • Access, including RTT • Security • Emergency preparedness, resilience and response (EPRR) – including COVID response • Pathology
Alan Rose **Deputy Chair and Non-executive director** **Term:** 1 April 2017 – 31 March 2020 **Reappointed:** 1 April 2020 – 31 March 2023	• Board meeting – Public, Closed • Audit Committee • Scrutiny Committee • Remuneration Committee (Chair) • Involvement Committee (Chair) • Clinical Excellence & Discretionary Awards Committee	• Board Workshops • Consultant appointments • Quality walkabouts • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• Deputy Chair • NED link to Chief Nurse • Patient experience and public engagement • Safeguarding - adults • End of life (moved from Richard)

	Primary responsibilities	Responsibilities as required	Lead assurance roles
Jude Chin **Non-executive director** **Term:** August 2021 – July 2022	• Board meeting – Public, Closed • Audit Committee • Remuneration Committee • Improvement Committee (**Chair**) • ***Attending wide range of committees during induction***	• Board Workshops • Consultant appointments • Quality walkabouts • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• To be confirmed

15. Organisational Framework for Governance

To APPROVE the framework

For Approval

Presented by Ann Alderton

Board of Directors - 3 September 2021

Agenda item:	15			
Presented by:	Ann Alderton, Interim Trust Secretary			
Prepared by:	Ann Alderton, Interim Trust Secretary			
Date prepared:	23 August 2021			
Subject:	Organisational Framework for Governance			
Purpose:		For information	X	For approval

Executive summary:

Following a review of the Trust's governance structure during 2020/21, a new committee reporting structure to the Board of Directors was introduced in May 2021.

Influenced by the National Patient Safety Strategy (2019), three new board committees were introduced, as follows:

- Insight – improve understanding of quality and safety, drawing on multiple sources of information – what the data says (internal and external). Key enabler – effective quality and safety measures
- Involvement – give people the skills and opportunity to inform and improve services. Key enablers – effective engagement and skill sets to assess service needs and delivery
- Improvement – effective improvement programmes at corporate and service level. Key enablers – structured understanding and support of QI methods

This document explains the principles of corporate governance, the way it works at West Suffolk Hospital NHS Foundation Trust and how the new structure for governance meets the regulatory requirement of the NHSE/I Well Led Framework.

It also explains how the Trust uses available information and intelligence to plan at strategic and operational levels to improve services and manage risks to delivery, how it understands and provides assurance in regard to performance, how it identifies when to take action to effect change and continuous improvement and how the Board of Directors exercises its accountability to those who deliver and use its services.

Once approved, it is intended that this document will be used to inform board committees, management committees, working groups, training events and used as a source of reference when updating governance related documents, such as the scheme of delegation and other general Trust policies and procedures.

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:	Executive Directors' Meeting Board of Directors (briefings during development phase)						
Risk and assurance:	The development of and transition to a new structure for organisational governance may result in a failure to escalate significant risks to management, the executive team and the board of directors, caused by a disruption to the previous information and communication flows whilst new arrangements are being established.						
Legislation, regulatory, equality, diversity and dignity implications	Well-led Framework (NHSEI) FT Code of Governance						
Recommendation: To approve the attached Organisational Framework for Governance							

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Organisational Framework for Governance

September 2021

How to use this document

What is this Guide?

This guide outlines the structure, accountabilities and processes by which governance and onward assurance to the board is achieved

It supports the following Key Lines of Enquiry in the Well-Led Framework:

- Is there the leadership capacity and capability to deliver high quality, sustainable care?
- Is there a clear vision and credible strategy to deliver high quality sustainable care to people, and robust plans to deliver?
- Is there a culture of high quality, sustainable care?
- Are there clear responsibilities, roles and systems of accountability to support good governance and management?
- Are there clear and effective processes for managing risks, issues and performance?
- Is appropriate and accurate information being effectively processed, challenged and acted on?
- Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services
- Are there robust systems and processes for learning, continuous improvement and innovation?

Why use this Guide?

This framework is to support you to have a clear understanding of the governance objectives and delivery mechanisms within the West Suffolk Hospital NHS Foundation Trust.

Based on best practice in corporate and integrated governance and the Trust's own supporting strategies and systems, this document explains how the Trust is able to use the necessary information and intelligence to enable it to plan at strategic and operational levels to improve services and manage risks to delivery; and how it understands and is assured with regard to performance and when it needs to take appropriate action to effect change and make improvements.

How to get the most out of this Guide?

Reading the entire document will provide a comprehensive overview of governance structures and mechanisms in the Trust. However, the following contents page enables ease of navigation through the sections that are most relevant to you. It is structured around the three domains of governance in the Trust – corporate, management committees and integrated governance. The framework is not intended to be a static document, and will be regularly updated and reviewed to ensure it continues to provide staff with the information they require.

Version Control

Updates to this document should be authorised by the Board Secretary

Contents

Executive Summary

Governance is primarily conducted and orchestrated through the leadership and functions of the Board, it is however the business and primary concern of everyone in the organisation. Governance is essentially the art of knowing and conducting the activities of the organisation. For the Board to undertake its duties effectively, it requires the structure, people and process of governance to be integrated into the fabric of the organisation and, that any "Ward to Board" risks and issues are well articulated and escalated via an easily navigated path. A key job of the Board is to seek assurance that risks to its strategic objectives are known and that there are clear plans in place to mitigate, eliminate or manage them. The Board is the key place where all the aspects of governance (clinical, financial, cost, staffing, information, research etc.) come together.

To deliver effective governance requires some core competency skills across the organisation.

Using the building blocks in the Well-Led Framework for the NHS and best practice in corporate and integrated governance, this document explains how the Trust uses available information and intelligence to plan at strategic and operational levels to improve services and manage risks to delivery, how it understands and provides assurance in regard to performance, how it identifies when to take action to effect change and continuous improvement and how the Board of Directors exercises its accountability to those who deliver and use its services.

- **Sophisticated levels of challenge and scrutiny**

This document articulates a clear and coherent escalation of information from ward to board and the front line of our support services through a clear description of leadership and accountability at service and divisional levels. We have ensured consistency in reporting as well as a standardised document for escalation from committee to board.

- **Consistent organisational accountability through our 3i Governance framework**

Our organisational framework for governance aims to clarify board and executive roles, the supporting capacity and capability to deliver corporate objectives and our assurance and accountability flows through information and governance. It explains the individual and collective responsibilities of board directors for different aspects of governance and the means by which the Board of Directors is accountable to the people who use services, the public, staff and external partners engaged and involved in supporting high quality sustainable services.

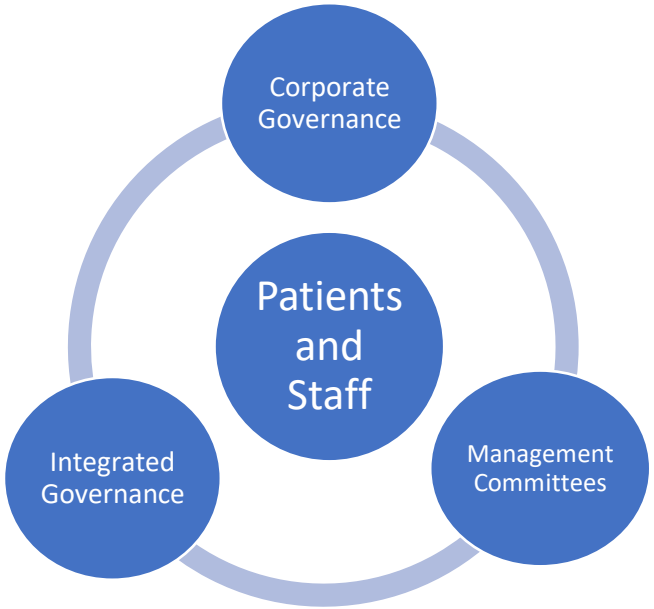
- **Determining appetite for risk and tolerance for delegation to management and committees**

We have reviewed and updated our risk appetite tolerance aligned to re-structured governance committees

Introduction

This document describes the way in which the organisation effectively "governs" its finance, performance and quality objectives for both patients and staff. The governance process is a series of dependent relationships that link the structure, people and processes by which governance is delivered.

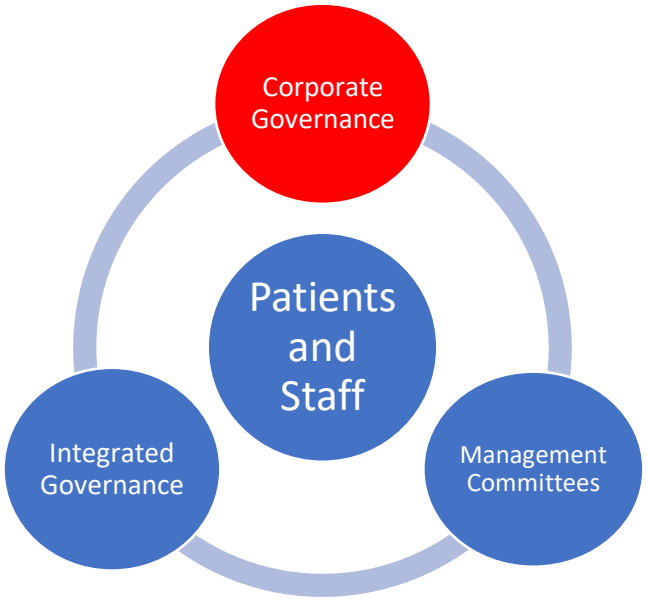
- The board leads the ***Corporate Governance*** oversight within the organisation, providing both internal and external assurance about our work. It achieves that by oversight of its management and operational processes. Section 1 of this document describes the Trust's Corporate Governance processes, the context within which the Trust operates and how it identifies and manages risk.
- ***Management Committees*** and groups (Section 2) drive the ambitions of the Board. They provide oversight of core risks, coordinate actions to improve or mitigate risk. They take direction from the Board whilst also providing assurance on the quality and performance being achieved.
- The next tier of governance is closest to the delivery of services. ***Integrated Governance*** (Section 3) is the framework through which the Trust leads, directors and controls its functions in order to achieve its organisational objectives, safety and quality of services and in which it relates to patients and carers, the wider community and partner organisations. Included within that is ***Divisional Governance.*** Led by our frontline staff, this is critically important in relation to its direct impact on patient care and how services are delivered.



Section 1 Corporate Governance

This section outlines the corporate oversight of the organisation by describing

- The way in which the organisation takes into account external stakeholders and regulatory context
- The overall vision and strategic purpose of the Trust
- Governance Priorities: an overview of the improvement plan to create robust and sustainable corporate and clinical governance systems
- The way in which the board receives and uses information in order to make decisions through the Executive Committee structure
- The approach to risk management and related processes within the organisation



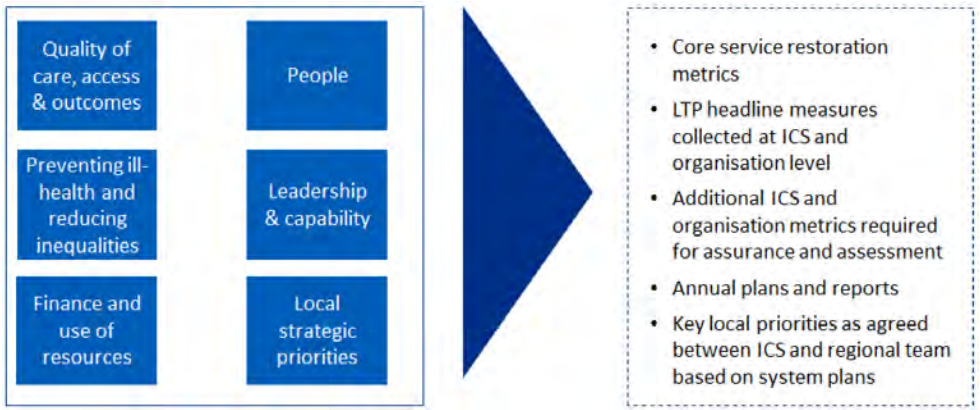
Regulatory Framework

Proportionate, risk-based regulation plays an important role in building public confidence in the NHS. Two main regulators hold NHS providers to account for the quality of care they deliver and how they are run.

- **The Care Quality Commission** is the independent regulator of health and social care services, they register, inspect and monitor providers of health services including NHS Foundation Trusts, and enforce action where necessary
- **NHS England and NHS Improvement** are responsible for overseeing providers of NHS funded care acting as both an economic regulator and supporting providers to meet standards set by the CQC

For 2021/22, the **NHS System Oversight Framework** outlines the approach NHS England and NHS Improvement will take to oversee organisational performance and describes how all NHS providers will be held to account. There are six themes, which align to quality, financial, people, tackling ill-health and health inequalities, strategic and leadership indicators.

Good governance of the organisation ensures that the board is able to give an account to stakeholders of its strategic and operational management of the organisation. Therefore our strategic objectives and performance measures are derived from and aligned to this framework.



Our Vision and Strategic Objectives

One of the hallmarks of a well led organisation is a compelling organisational vision that puts quality of care and the safety of its patients central to all of its activities, agreed in consultation with stakeholders, patients and staff. The Trust's vision and strategic objectives are described below as an explicit statement and the desired outcomes. The vision and objectives are the foundation upon which the board is able to measure organisational success and to effectively scrutinise, hold management to account and make effective decisions to drive overall improvement

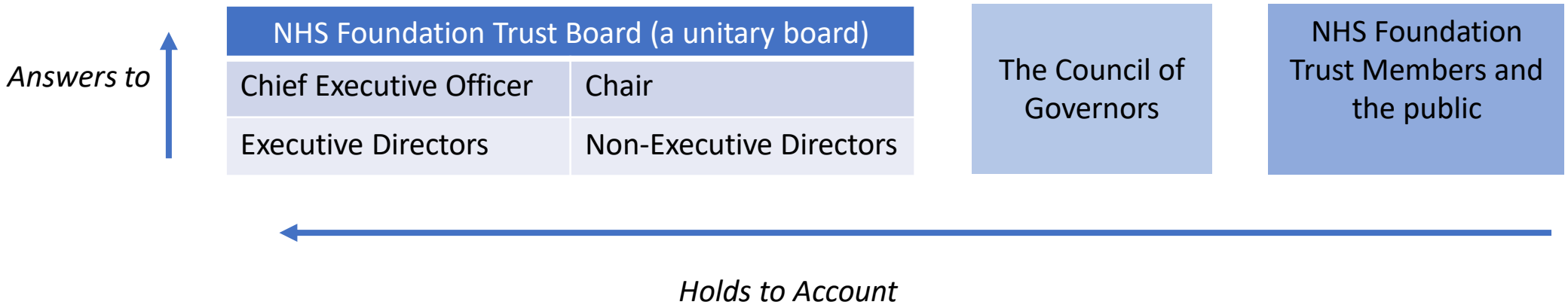
Vision Deliver the best quality and safest care for our local community			
Ambition	First for our Patients	First for our Staff	First for the Future
Strategic Objectives	• Collaborate to provide seamless care at the right time and in the right place • Use feedback, learning, research and innovation to improve care and outcomes	• Build a positive, inclusive culture that fosters open and honest communication • Enhance staff wellbeing • Invest in education, training and workforce development	• Make the biggest possible contribution to prevent ill-health, increase wellbeing and reduce health inequalities • Invest in infrastructure, buildings and technology
Powered by our First Trust Values Fairness, Inclusion, Respect, Safety, Teamwork			

Foundation Trust Governance Structure

Accountability flows outwards to national healthcare regulators as well as to the public who access services locally. The Chair, Sheila Childerhouse, leads both the Council of Governors and the Board of Directors. Local accountability is the means by which Boards demonstrate their duty of care to those that use services and to their staff. The interaction between the council of governors and the board of directors is one of the most important relationships within foundation trusts.

The Council of Governors, collectively, is the body that connects the Trust with its patients, service users, staff and stakeholders in the community that it serves. It comprises governors who are elected by the membership and who represent staff and the public served by the Trust and stakeholder governors who are appointed by organisations who have an important relationship with the Trust.

As part of their statutory duties to hold the non-executives, individually and collectively, to account for the performance of the board of directors and to represent the interests of Trust members and the public, governors need to understand how the Board of Directors uses information and intelligence to understand and be assured that the people who use services, the public, staff and external partners are engaged and involved to support high quality sustainable services. This depends on a good flow of information between the Board of Directors and Council of Governors in order to support effective and informed dialogue and debate.



Corporate Assurance

In addition to setting the strategic direction of the organisation, the Board must identify and manage any likely risk and issue in achieving its strategic objectives.

The Board must ensure that there are robust systems of accountability that enable it to monitor operational performance and the impact on patients and staff as it delivers its strategic and vision.

This is more acutely managed through delegated responsibility to board committees and relevant board members. The types of board committees are based on both the statutory requirements of Foundation Trusts (Audit and Remuneration Committees for example) as well as a new framework for oversight of quality, safety and improvement.

Influenced by the National Patient Safety Strategy (2019), the framework was structured around:

- Insight – improve understanding of quality and safety drawing on multiple sources of information – what the data says (internal and external). Key enabler – effective quality and safety measures
- Involvement – give people the skills and opportunity to inform and improve services. Key enablers – effective engagement and skill sets to assess service needs and delivery
- Improvement – effective improvement programmes from at corporate and service level. Key enablers – structured understanding and support of QI methods

This section sets out the assurance map of the organisation and describes how information is received by each of the four main committees of the Board, and then onward to the Board itself.

There are summaries for each board committee describing the responsibilities and reporting arrangements

Of note is a refreshed committee structure and timetable:

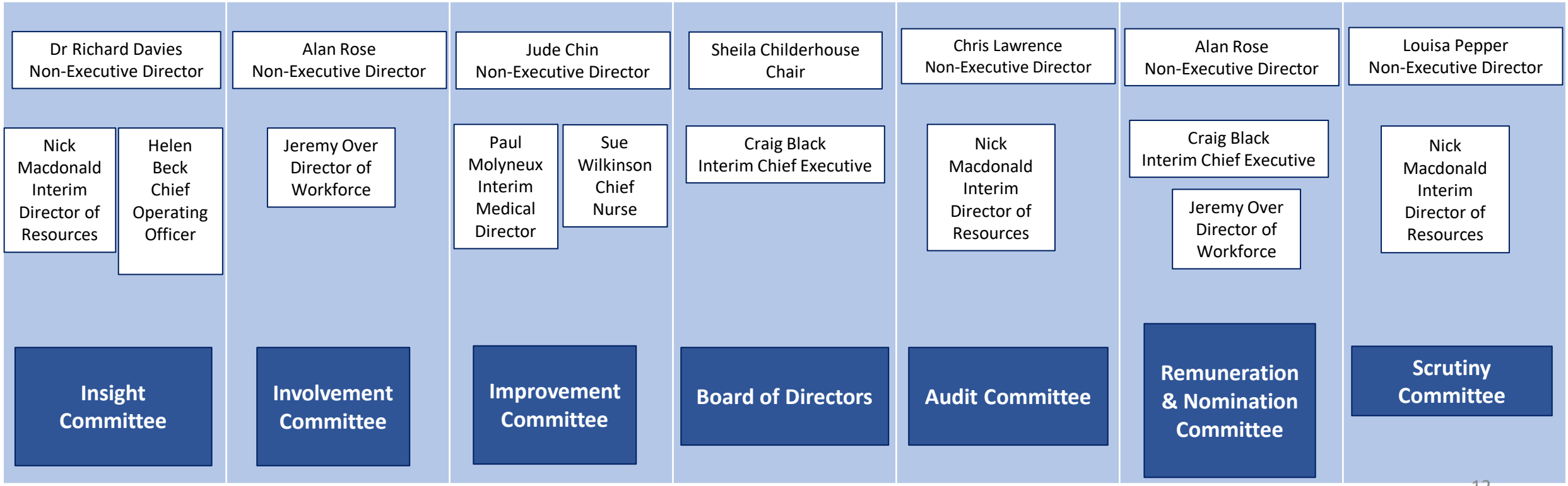
- Senior Leadership Team meets every other week, allowing sufficient time for the executive leadership to analyse and summarise the information received from the management committees, and escalate key matters of attention to the Board Committees
- A refreshed cycle of the board assurance committees ensures that there is a flow of assurance and escalation to the Board of Directors.

Governance Priorities

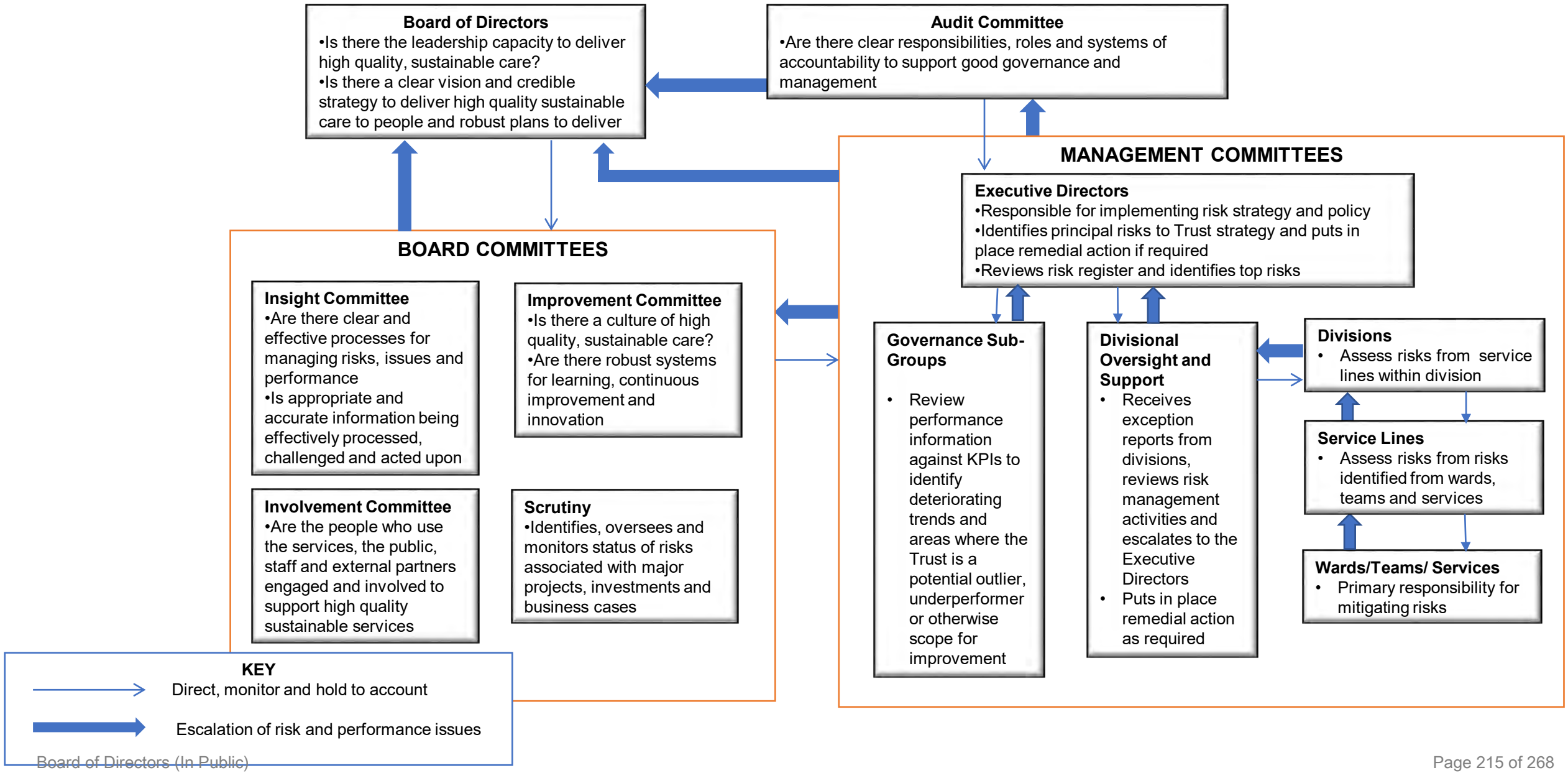
Fix June – August 2021	Test September 2021 to March 2022	Sustain
•Establish the 3i's Assurance committees as formal assurance committees of the board •Clarify scope, interdependencies and reporting relationships between the 3i committees and the Trust's management committees, across the 3i committees and between the 3i committees and the Board •Update **Schedule for the Committee meetings** and updated set of ToRs, Annual Work Programmes •Review of risk management strategy and risk appetite •Establish the Senior Leadership Team as the main management committee of the Trust	•6 monthly review of committee effectiveness and information flow to the board •Implement Board development programme •Address any issues arising from the latest Well-led review •Evaluate 3i governance processes	•"Test" and ensure that risks and issues are being escalated to the board and appropriate mitigations are being applied •Review assurance to BAF via the operational framework for governance •Support and monitor effectiveness of peer review process in relation to improved performance against key targeted areas •Increased level of performance monitoring and QA of patient safety outcomes •Continuous improvement through the recognition and application of best practice through the Quality Improvement Programme

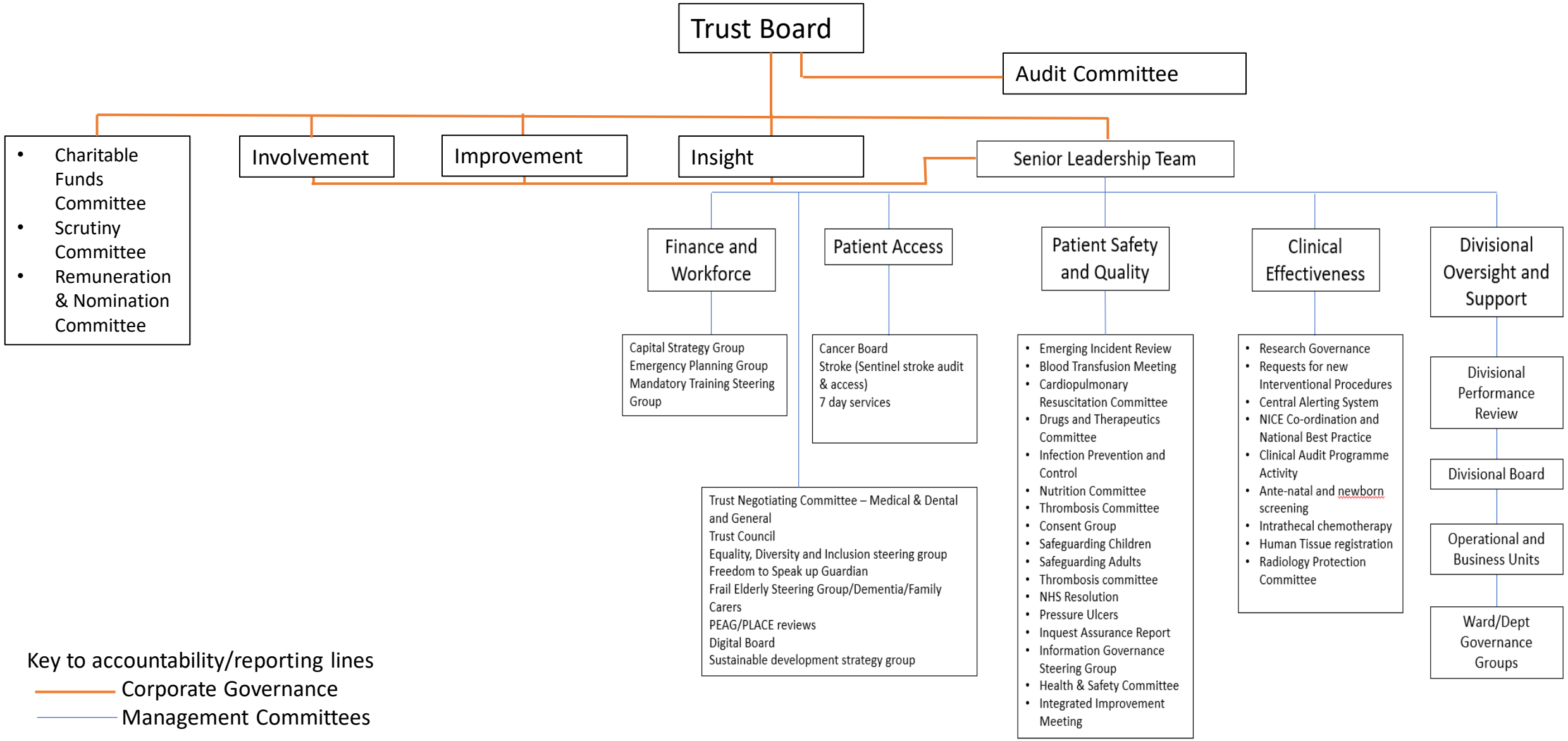
Board Level Responsibilities for Assurance

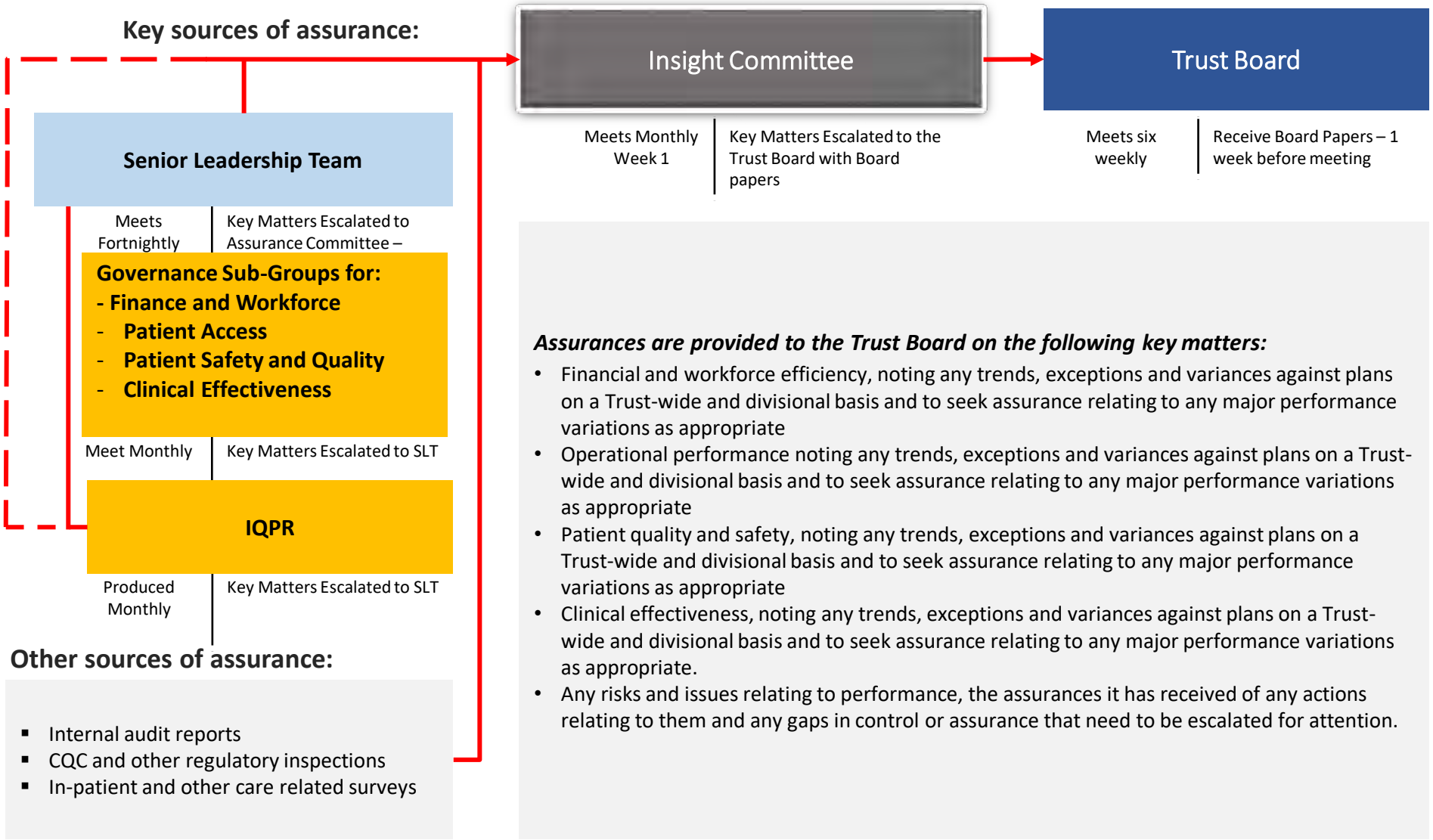
All board members share corporate responsibility for formulating strategy, ensuring accountability and shaping culture. They also share responsibility for ensuring that the board operates as effectively as possible. However there are also distinct roles for different members of the board, aligned to each of the board and management committees and reflect their organisational responsibilities. Each executive board member is responsible for leading implementation of strategy in their functional areas and takes principal responsibility for providing accurate, timely and clear information to the board.

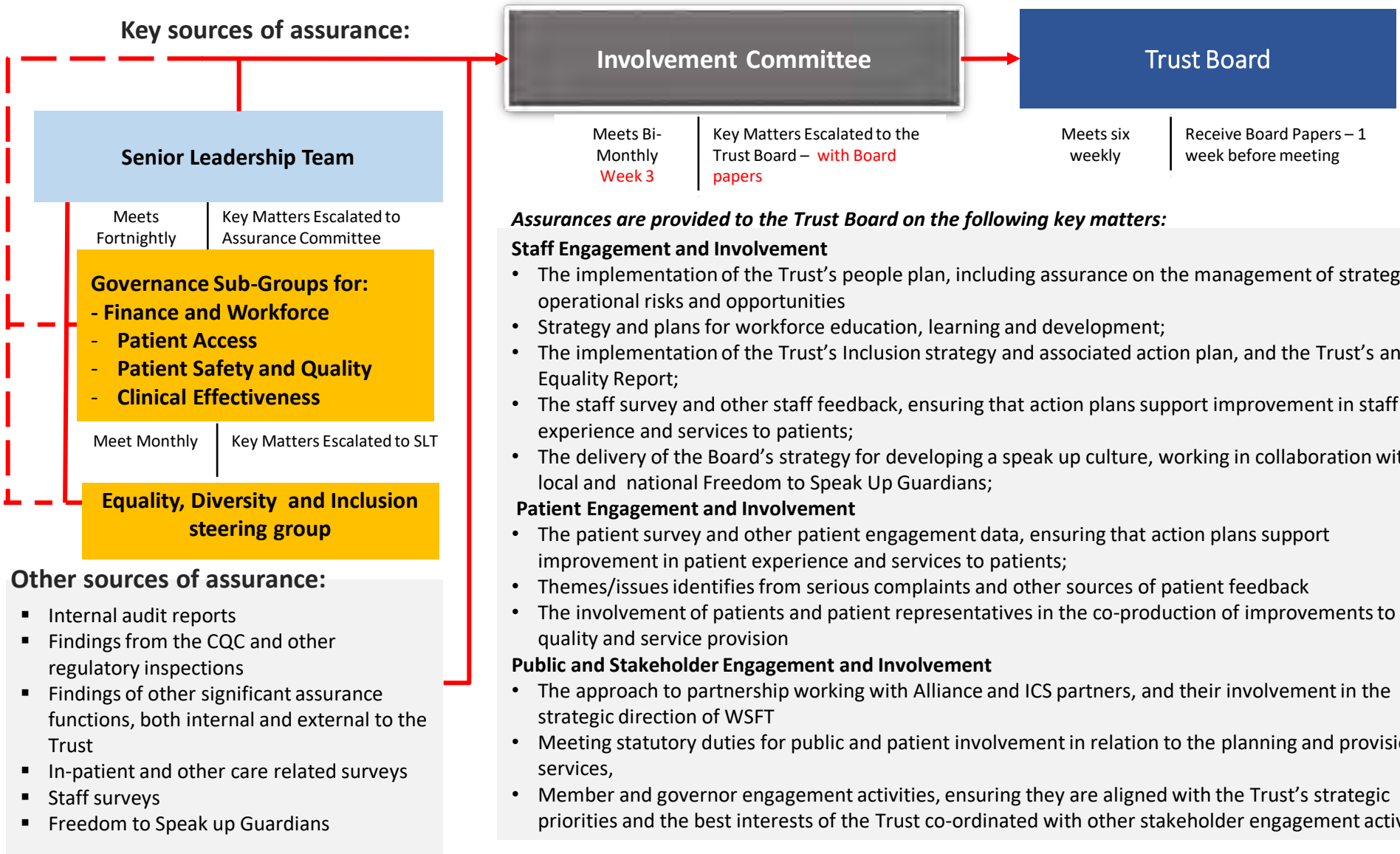


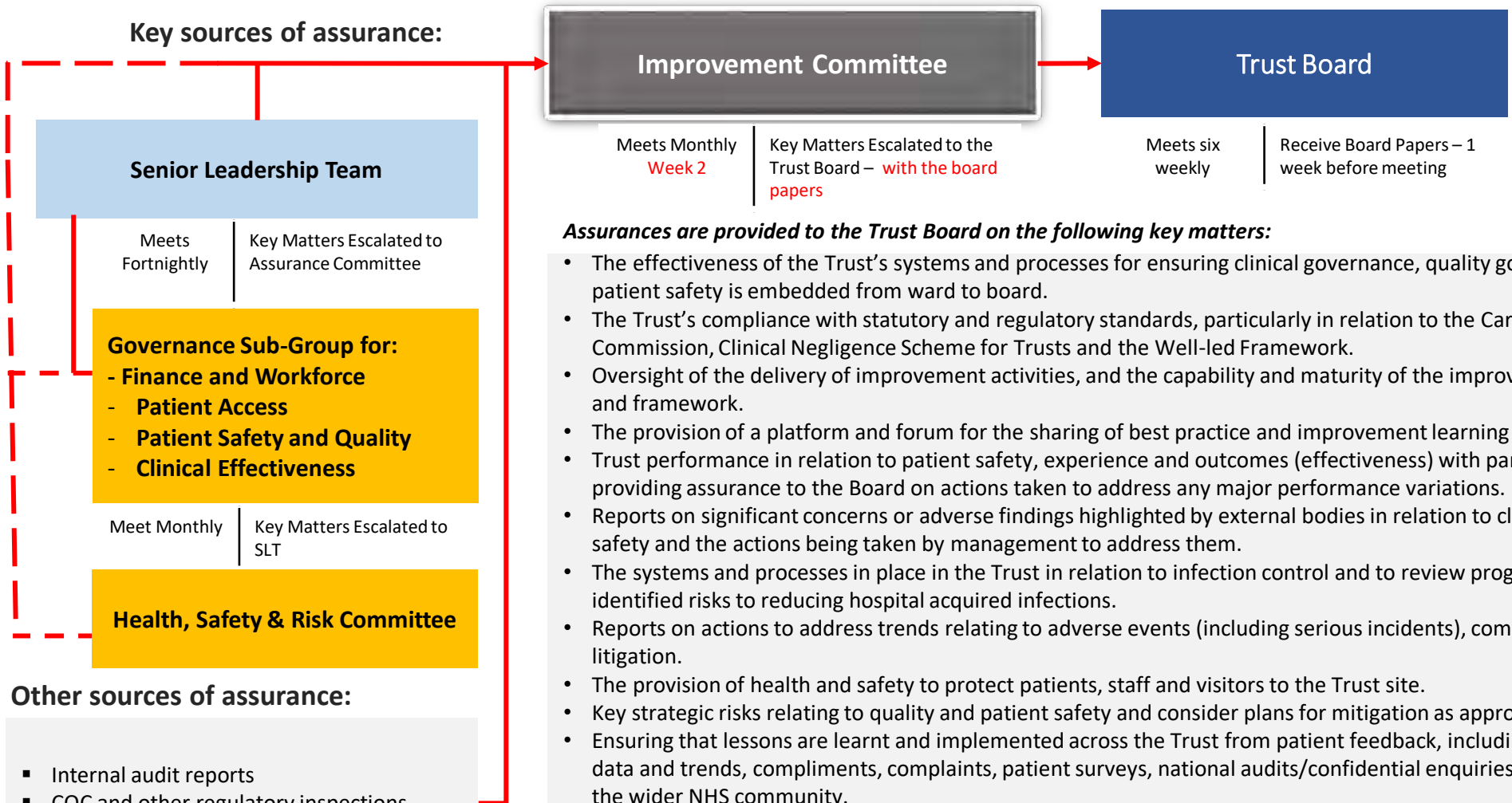
West Suffolk Hospital Well-Led Framework




Trust Board
Audit Committee
Charitable Funds Committee
Scrutiny Committee
Remuneration & Nomination Committee
Involvement
Improvement
Insight
Senior Leadership Team
Finance and Workforce
Patient Access
Patient Safety and Quality
Clinical Effectiveness
Divisional Oversight and Support
Capital Strategy Group
Emergency Planning Group
Mandatory Training Steering Group
Cancer Board
Stroke (Sentinel stroke audit & access)
7 day services
Trust Negotiating Committee – Medical & Dental and General
Trust Council
Equality, Diversity and Inclusion steering group
Freedom to Speak up Guardian
Frail Elderly Steering Group/Dementia/Family Carers
PEAG/PLACE reviews
Digital Board
Sustainable development strategy group
Emerging Incident Review
Blood Transfusion Meeting
Cardiopulmonary Resuscitation Committee
Drugs and Therapeutics Committee
Infection Prevention and Control
Nutrition Committee
Thrombosis Committee
Consent Group
Safeguarding Children
Safeguarding Adults
Thrombosis committee
NHS Resolution
Pressure Ulcers
Inquest Assurance Report
Information Governance Steering Group
Health & Safety Committee
Integrated Improvement Meeting
Research Governance
Requests for new Interventional Procedures
Central Alerting System
NICE Co-ordination and National Best Practice
Clinical Audit Programme Activity
Ante-natal and newborn screening
Intrathecal chemotherapy
Human Tissue registration
Radiology Protection Committee
Divisional Performance Review
Divisional Board
Operational and Business Units
Ward/Dept Governance Groups
Key to accountability/reporting lines
Corporate Governance
Management Committees


Key sources of assurance:
Insight Committee
Trust Board
Meets Monthly Week 1
Key Matters Escalated to the Trust Board with Board papers
Meets six weekly
Receive Board Papers – 1 week before meeting
Senior Leadership Team
Meets Fortnightly
Key Matters Escalated to Assurance Committee –
Governance Sub-Groups for:
- Finance and Workforce
- Patient Access
- Patient Safety and Quality
- Clinical Effectiveness
Meet Monthly
Key Matters Escalated to SLT
IQPR
Produced Monthly
Key Matters Escalated to SLT
Other sources of assurance:
Internal audit reports
CQC and other regulatory inspections
In-patient and other care related surveys
Assurances are provided to the Trust Board on the following key matters:
Financial and workforce efficiency, noting any trends, exceptions and variances against plans on a Trust-wide and divisional basis and to seek assurance relating to any major performance variations as appropriate
Operational performance noting any trends, exceptions and variances against plans on a Trust-wide and divisional basis and to seek assurance relating to any major performance variations as appropriate
Patient quality and safety, noting any trends, exceptions and variances against plans on a Trust-wide and divisional basis and to seek assurance relating to any major performance variations as appropriate
Clinical effectiveness, noting any trends, exceptions and variances against plans on a Trust-wide and divisional basis and to seek assurance relating to any major performance variations as appropriate.
Any risks and issues relating to performance, the assurances it has received of any actions relating to them and any gaps in control or assurance that need to be escalated for attention.
Key:
Direct oversight by the committee:
Indirect oversight by the assurance committee:

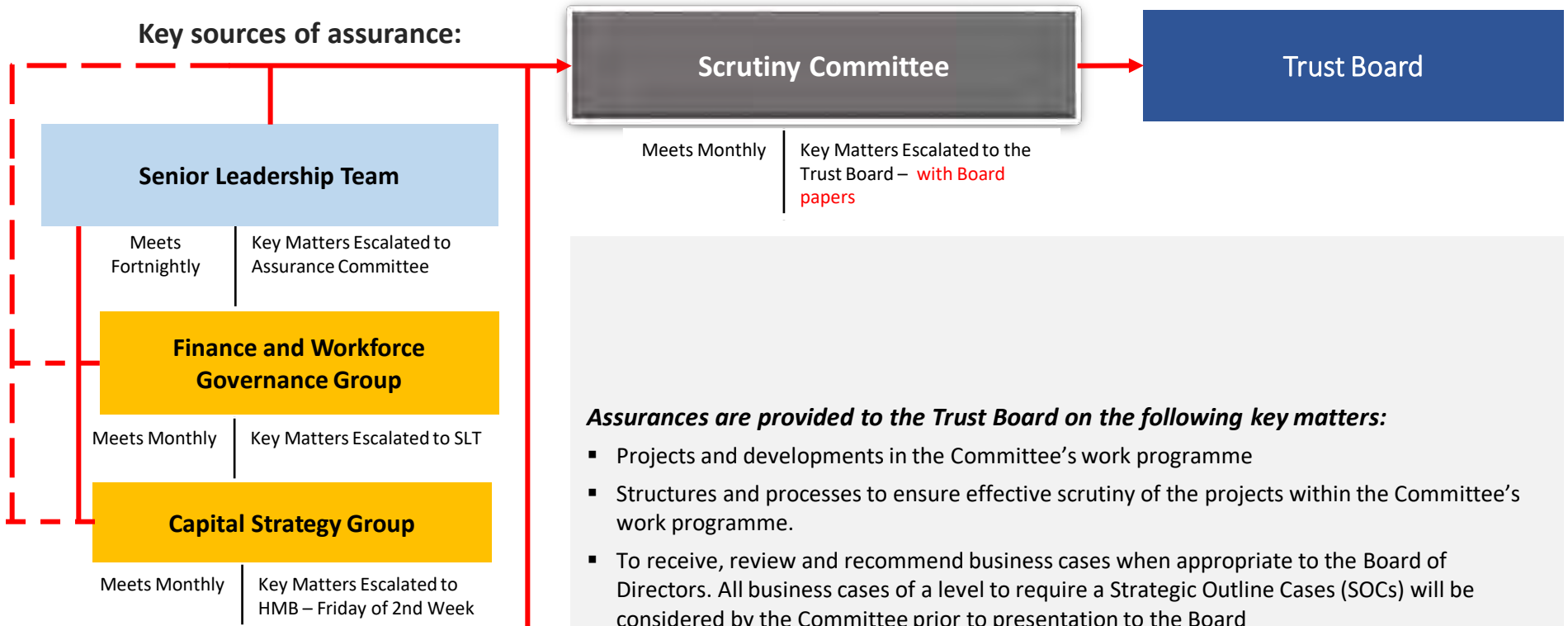

Key sources of assurance:
Involvement Committee
Trust Board
Meets Bi-Monthly Week 3
Key Matters Escalated to the Trust Board – with Board papers
Meets six weekly
Receive Board Papers – 1 week before meeting
Senior Leadership Team
Meets Fortnightly
Key Matters Escalated to Assurance Committee
Governance Sub-Groups for:
- Finance and Workforce
- Patient Access
- Patient Safety and Quality
- Clinical Effectiveness
Meet Monthly
Key Matters Escalated to SLT
Equality, Diversity and Inclusion steering group
Other sources of assurance:
Internal audit reports
Findings from the CQC and other regulatory inspections
Findings of other significant assurance functions, both internal and external to the Trust
In-patient and other care related surveys
Staff surveys
Freedom to Speak up Guardians
Assurances are provided to the Trust Board on the following key matters:
Staff Engagement and Involvement
The implementation of the Trust's people plan, including assurance on the management of strategic and operational risks and opportunities
Strategy and plans for workforce education, learning and development;
The implementation of the Trust's Inclusion strategy and associated action plan, and the Trust's annual Equality Report;
The staff survey and other staff feedback, ensuring that action plans support improvement in staff experience and services to patients;
The delivery of the Board's strategy for developing a speak up culture, working in collaboration with local and national Freedom to Speak Up Guardians;
Patient Engagement and Involvement
The patient survey and other patient engagement data, ensuring that action plans support improvement in patient experience and services to patients;
Themes/issues identifies from serious complaints and other sources of patient feedback
The involvement of patients and patient representatives in the co-production of improvements to quality and service provision
Public and Stakeholder Engagement and Involvement
The approach to partnership working with Alliance and ICS partners, and their involvement in the strategic direction of WSFT
Meeting statutory duties for public and patient involvement in relation to the planning and provision of services,
Member and governor engagement activities, ensuring they are aligned with the Trust's strategic priorities and the best interests of the Trust co-ordinated with other stakeholder engagement activities.
Key:
Direct oversight by the committee:
Indirect oversight by the assurance committee:

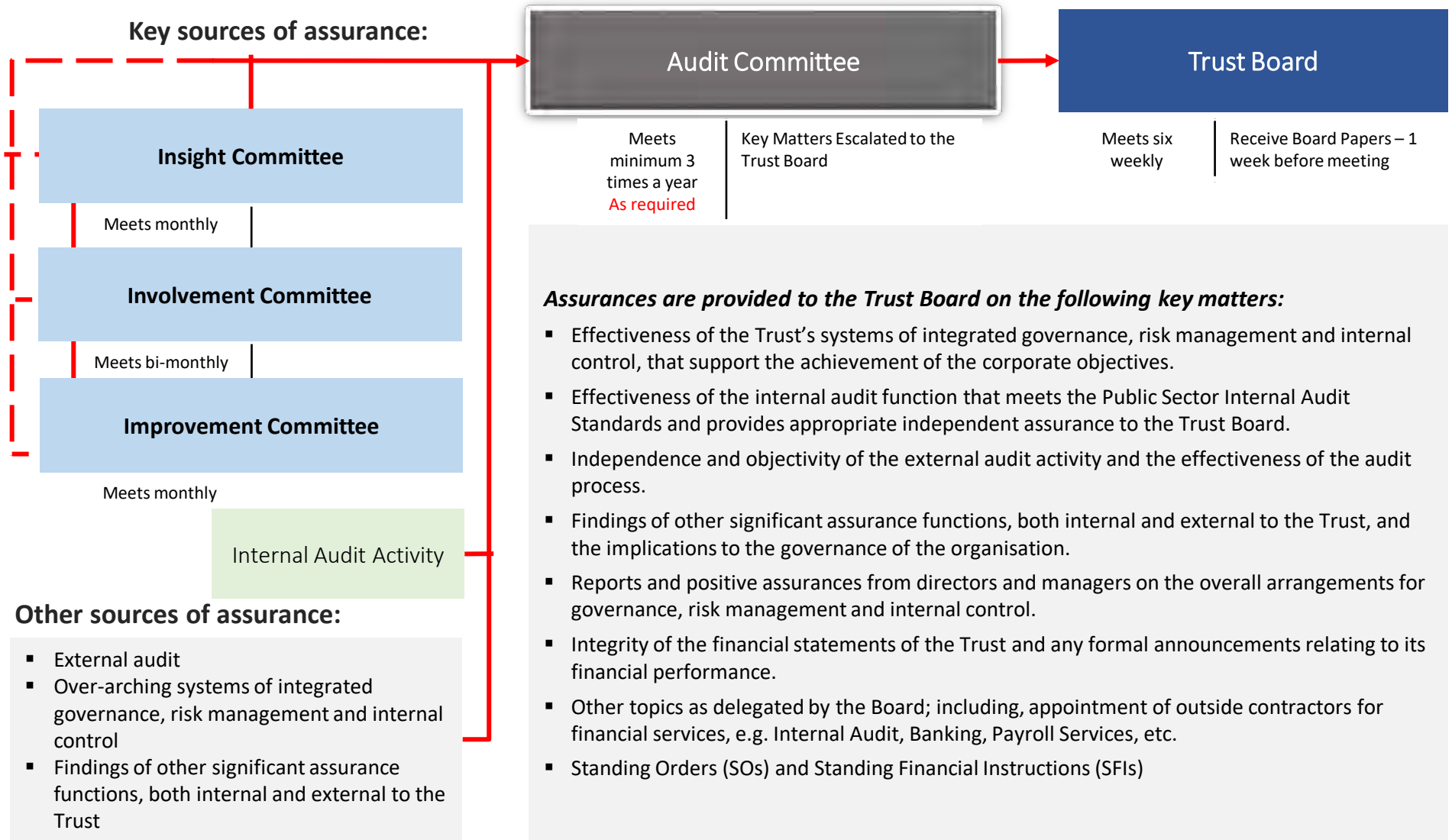


Assurances are provided to the Trust Board on the following key matters:

- The effectiveness of the Trust's systems and processes for ensuring clinical governance, quality governance and patient safety is embedded from ward to board.
- The Trust's compliance with statutory and regulatory standards, particularly in relation to the Care Quality Commission, Clinical Negligence Scheme for Trusts and the Well-led Framework.
- Oversight of the delivery of improvement activities, and the capability and maturity of the improvement environment and framework.
- The provision of a platform and forum for the sharing of best practice and improvement learning throughout the Trust
- Trust performance in relation to patient safety, experience and outcomes (effectiveness) with particular focus on providing assurance to the Board on actions taken to address any major performance variations.
- Reports on significant concerns or adverse findings highlighted by external bodies in relation to clinical quality and safety and the actions being taken by management to address them.
- The systems and processes in place in the Trust in relation to infection control and to review progress against identified risks to reducing hospital acquired infections.
- Reports on actions to address trends relating to adverse events (including serious incidents), complaints, claims and litigation.
- The provision of health and safety to protect patients, staff and visitors to the Trust site.
- Key strategic risks relating to quality and patient safety and consider plans for mitigation as appropriate.
- Ensuring that lessons are learnt and implemented across the Trust from patient feedback, including patient safety data and trends, compliments, complaints, patient surveys, national audits/confidential enquiries and learning from the wider NHS community.
- Systems within the Trust for obtaining and maintaining licences and accreditations relevant to clinical activity, receiving such reports as required.

Key:
Direct oversight by the committee: ——— Indirect oversight by the assurance committee: - - -


Key sources of assurance:
Scrutiny Committee
Trust Board
Meets Monthly
Key Matters Escalated to the Trust Board – with Board papers
Senior Leadership Team
Meets Fortnightly
Key Matters Escalated to Assurance Committee
Finance and Workforce Governance Group
Meets Monthly
Key Matters Escalated to SLT
Capital Strategy Group
Meets Monthly
Key Matters Escalated to HMB – Friday of 2nd Week
Other sources of assurance:
Internal audit reports
Findings of other significant assurance functions, both internal and external to the Trust
Assurances are provided to the Trust Board on the following key matters:
Projects and developments in the Committee's work programme
Structures and processes to ensure effective scrutiny of the projects within the Committee's work programme.
To receive, review and recommend business cases when appropriate to the Board of Directors. All business cases of a level to require a Strategic Outline Cases (SOCs) will be considered by the Committee prior to presentation to the Board
For all significant projects, and in line with Standing Financial Instructions, Department of Health and NHS England and Improvement guidance as appropriate, the Committee will ensure that, if required, a third party is engaged to undertake a process of due diligence prior to any agreement on the transfer of services
Key:
Direct oversight by the committee:
Indirect oversight by the assurance committee:


Key sources of assurance:
Insight Committee
Meets monthly
Involvement Committee
Meets bi-monthly
Improvement Committee
Meets monthly
Internal Audit Activity
Audit Committee
Meets minimum 3 times a year As required
Key Matters Escalated to the Trust Board
Trust Board
Meets six weekly
Receive Board Papers – 1 week before meeting
Other sources of assurance:
External audit
Over-arching systems of integrated governance, risk management and internal control
Findings of other significant assurance functions, both internal and external to the Trust
Assurances are provided to the Trust Board on the following key matters:
Effectiveness of the Trust's systems of integrated governance, risk management and internal control, that support the achievement of the corporate objectives.
Effectiveness of the internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Trust Board.
Independence and objectivity of the external audit activity and the effectiveness of the audit process.
Findings of other significant assurance functions, both internal and external to the Trust, and the implications to the governance of the organisation.
Reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
Integrity of the financial statements of the Trust and any formal announcements relating to its financial performance.
Other topics as delegated by the Board; including, appointment of outside contractors for financial services, e.g. Internal Audit, Banking, Payroll Services, etc.
Standing Orders (SOs) and Standing Financial Instructions (SFIs)
Key:
Direct oversight by the committee:
Indirect oversight by the assurance committee:

Risk Appetite

Risk appetite refers to the amount of risk that the Trust is prepared to accept, tolerate, or be exposed to in pursuit of its strategic objectives. The higher the tolerance, the greater the autonomy that is granted to the risk owner before the threshold is crossed for escalating issues to the board; the lower the tolerance, the greater the control that the Board will wish to exercise over its management

Risk Appetite Statement 2020/21
Defines the types and aggregate levels of risk that an organisation is willing to accept in pursuit of strategic objectives

Financial
The Trust has a flexible view of financial risk when making medium to long-term business decisions with transformative potential and is prepared to make bold, but not reckless, decisions, minimising the potential for financial loss by managing risks to a tolerable level. For other financial decisions, the Trust takes a cautious position, with VFM as the primary concern. However, the Trust is willing to consider other benefits or constraints and will consider value and benefits, not just the cheapest price. Resources are allocated in order to capitalise on opportunities.

Infrastructure
The board will take a measured approach when investing in building and equipment maintenance and replacement, based on informed analysis and assessment of risk but may take informed risks if there are identifiable mitigations that can provide reasonable alternative protection

Quality
The Board has a cautious view of risk when it comes to patient safety, patient experience or clinical outcomes and places the principle of "no harm" at the heart of every decision it takes. It is prepared to accept some risk if, on balance, the benefits are justifiable and the potential for mitigation is strong. When taking decisions involving choices between a wide range of outcomes, it will prioritise the option resulting in the greatest benefit for the most patients

Commercial
The Board has a flexible view of commercial risk. It is willing to pursue business opportunities with the potential for high returns alongside commercial activities of a more established nature, taking a balanced view of risk and reward and on the basis of earned autonomy.

Compliance/Regulatory
The Board has a minimal to cautious risk appetite when it comes to compliance and regulatory issues. Where the laws, regulations and standards are about the delivery of safe, high quality care, or the health and safety of the staff and public, it will make every effort to meet regulator expectations and comply with them and will only challenge them if there is strong evidence or argument to do so and the gain will outweigh the adverse consequences

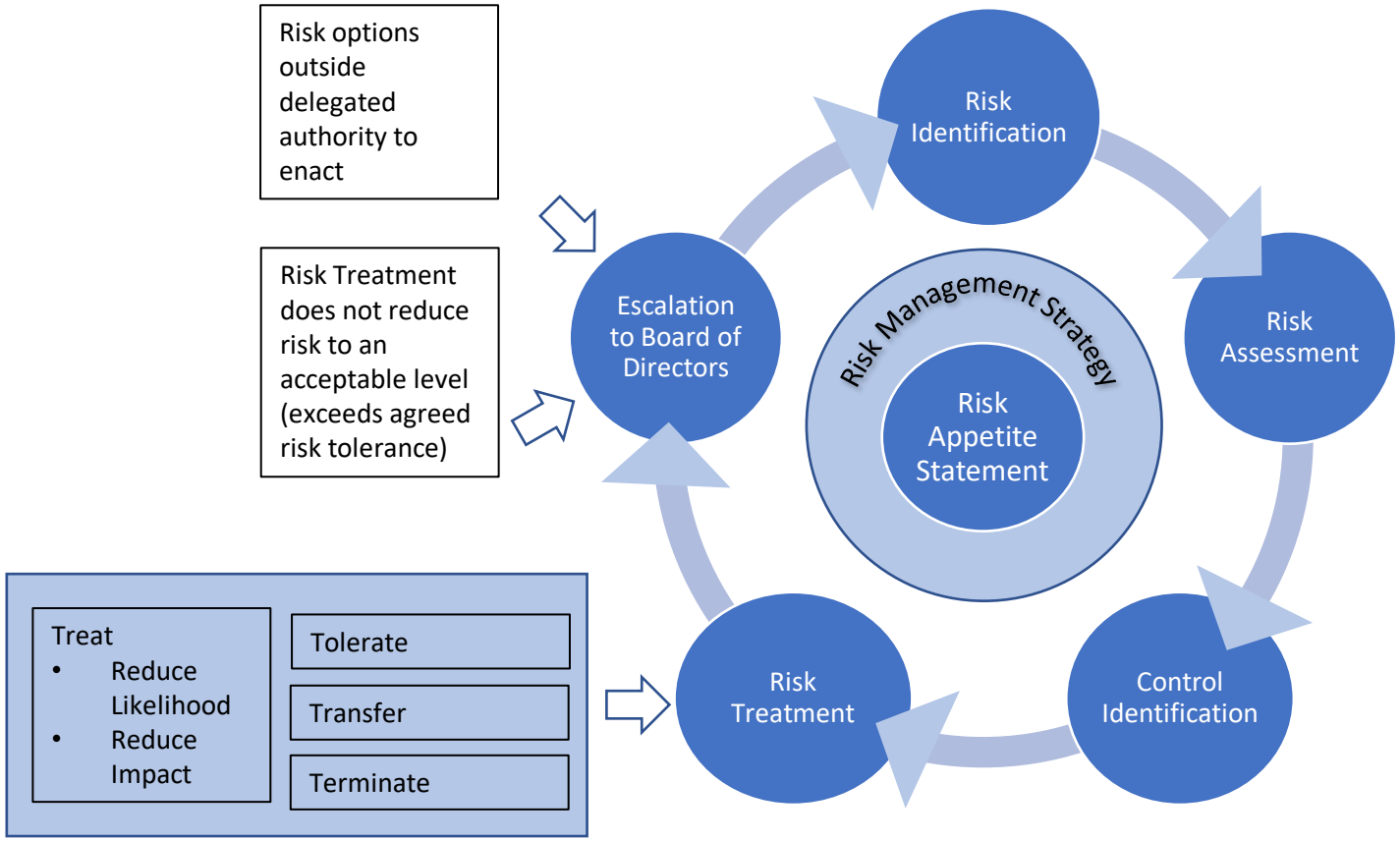
Workforce
The board is prepared to take decisions that would have an effect on staff morale if there are compelling arguments supporting change, including some decisions with a high inherent risk if there is a potential higher reward.

Reputation
The Board's view over the management of the Trust's reputation is that it is willing to take high to significant risks and is willing to take decisions that are likely to bring scrutiny to the organisation where the potential benefits outweigh the risks and sees new ideas as potentially enhancing the reputation of the organisation.

Innovation
The Board has a flexible view of innovation that supports quality, patient safety and operational effectiveness. Its strategic objective to embrace new ideas to deliver new, technology enabled, financial viable ways of working leads it to pursue innovation and challenge current working practices. It is willing to devolve responsibility for non-critical decisions on the basis of earned autonomy.

Risk Appetite

Once the Board has agreed its risk appetite statement, it should become embedded into the Trust's risk management and other reporting and decision-making processes

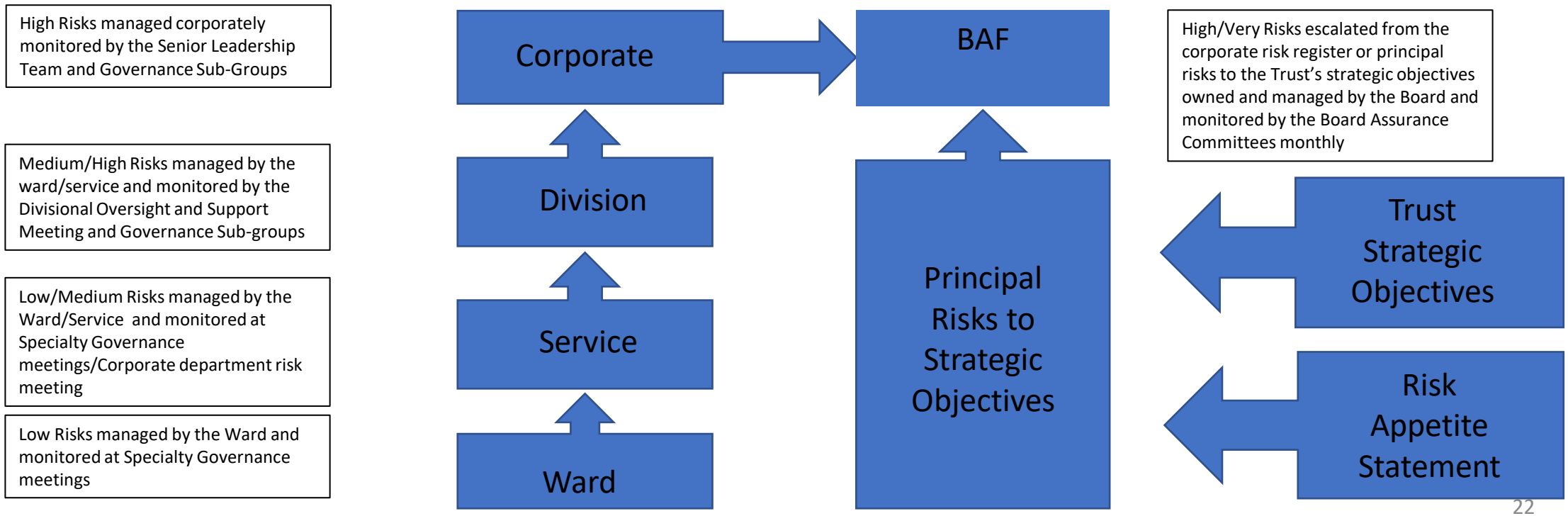


Risk Management

The board is responsible for ensuring that the organisation has appropriate risk identification and risk management processes in place to deliver strategic plans and comply with the registration and licensing requirements of key regulators. This includes systematically assessing and managing risks at all levels from ward to board.

Risk Management is the process of identifying, assessing, analysing and managing all potential risks. Decisions made within an organisation should take into account potential risks that could directly or indirectly affect patient care.

Board Assurance Framework: This is a document that sets out strategic objectives, identifies risks in relation to each strategic objective along with controls in place and assurances available on their operation.



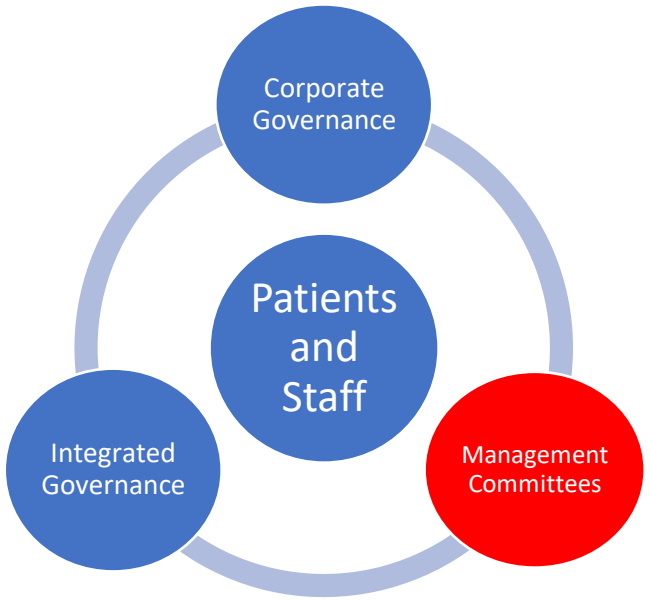
Section 2 Management Committees

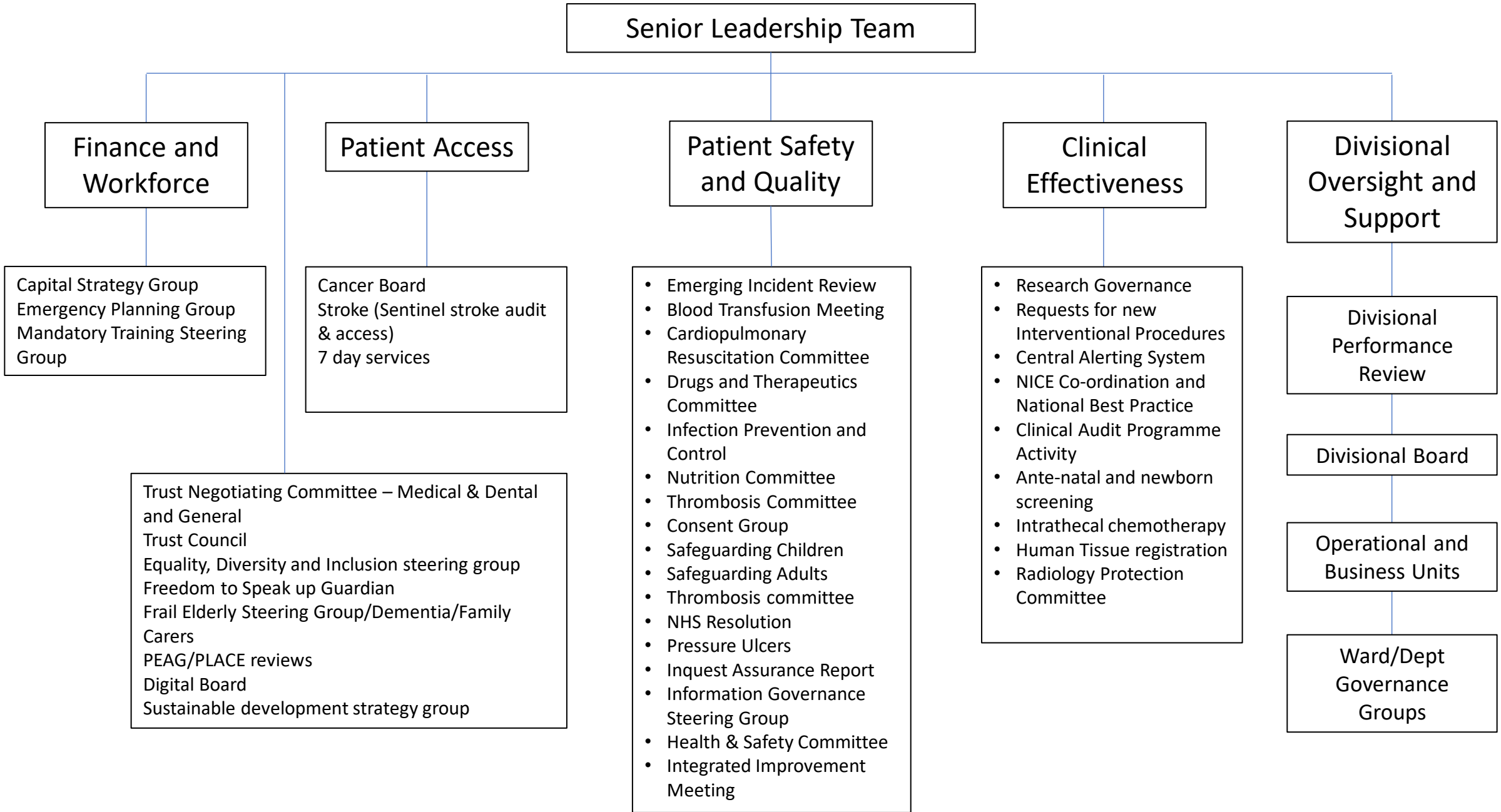
This section describes the corporate management functions led by the Chief Executive

Overseen by the Senior Leadership Team, the management committees coordinate the tactical plans for key areas, including the organisation's compliance with the core objectives of the Board. The committees includes

- Governance Groups for
  - Finance and Workforce
  - Patient Access
  - Patient Safety and Quality
  - Clinical Effectiveness
- Divisional Oversight and Support
- Other Committees with specific responsibilities for managing risk, compliance with legal and regulatory requirements and providing direction and supervision for teams and individuals

The structure and reporting relationships of the management committees of the Trust are determined by the Chief Executive, in line with the needs of the organisation and ensuring that appropriate assurance and escalation arrangements are in place for the delivery of the Trust's strategic objectives




Senior Leadership Team
Finance and Workforce
Capital Strategy Group
Emergency Planning Group
Mandatory Training Steering Group
Patient Access
Cancer Board
Stroke (Sentinel stroke audit & access)
7 day services
Trust Negotiating Committee – Medical & Dental and General
Trust Council
Equality, Diversity and Inclusion steering group
Freedom to Speak up Guardian
Frail Elderly Steering Group/Dementia/Family Carers
PEAG/PLACE reviews
Digital Board
Sustainable development strategy group
Patient Safety and Quality
Emerging Incident Review
Blood Transfusion Meeting
Cardiopulmonary Resuscitation Committee
Drugs and Therapeutics Committee
Infection Prevention and Control
Nutrition Committee
Thrombosis Committee
Consent Group
Safeguarding Children
Safeguarding Adults
Thrombosis committee
NHS Resolution
Pressure Ulcers
Inquest Assurance Report
Information Governance Steering Group
Health & Safety Committee
Integrated Improvement Meeting
Clinical Effectiveness
Research Governance
Requests for new Interventional Procedures
Central Alerting System
NICE Co-ordination and National Best Practice
Clinical Audit Programme Activity
Ante-natal and newborn screening
Intrathecal chemotherapy
Human Tissue registration
Radiology Protection Committee
Divisional Oversight and Support
Divisional Performance Review
Divisional Board
Operational and Business Units
Ward/Dept Governance Groups

Information Flow and Reporting

Trust Board

Board Assurance Committees

- Insight Committee
- Involvement Committee
- Improvement Committee
- Scrutiny Committee
- Audit Committee

Senior Leadership Team

Management Committees

Governance sub-groups for

- Finance and Workforce
- Patient Access
- Patient Safety and Quality
- Clinical Effectiveness

Management Information

Integrated Performance Report

- ED Performance
- Patient Flow
- RTT Performance
- Diagnostics
- Cancer 2ww
- Cancer 31 & 62 day
- Stroke & Cardiology
- Mortality
- Infection Control
- Patient Safety
- Patient Experience
- Workforce
- Safer Staffing
- Sickness & Turnover
- Appraisal & Mandatory Training
- Finance & Use of Resources

Divisional Oversight and Support

Performance & Accountability Framework

Divisional Boards receive management information on

- Financial Performance
- Operational Performance
- Patient safety & quality
- Clinical Effectiveness
- Incident reporting, adverse events
- Workforce

Flow of Information

- Management and divisional reports are provided to the Senior Leadership Team
- Each Management Committee has an annual workplan and calendar for reporting that aligns to the quality and compliance requirements of the organisation
- Management information aligns to the Committees' ToR, for example the Governance sub-group for Patient Safety and Quality will receive management information on Infection Prevention and Control and Incident Management; Patient Access will receive management information on ED and RTT perforamnce
- Oversight of Divisional performance is provided by the Divisional Oversight and Support that is led by the Chief Operating Officer

Escalation of Risk and Performance Issues

Section 3 Integrated Governance

The NHS uses the term “integrated governance” to mean systems, processes and behaviours by which trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of service and in which they relate to patients and carers, the wider community and other stakeholders.

Good governance is about having a framework to ensure that we:

- Provide our patients with safe and effective care and our staff with a safe and supportive work environment
- Have effective structures, systems and processes in place to ensure we meet regulatory standards and our own strategic vision, objectives and goals
- Have the capacity and capability, in terms of knowledge, skills and resources to deliver those objectives
- Are critically evaluating what we do and ensuring that we continually improve the ways we work; and
- Are transparent in how we report our performance and are accountable for our work.

The Trust has in place a consistent framework for integrated governance across all of its governance themes – clinical, financial, research, information and divisional.

Integrated Governance

Each stream within our system of integrated governance is led by a Senior Risk Owner and supported by appropriate teams and management information aiding our corporate and divisional delivery

- Clinical Governance – led by the Chief Nurse and Medical Director
- Financial Governance – led by the Director of Resources
- Information Governance – led by the Director of Resources
- Research Governance – led by the Medical Director
- Workforce and Education Governance – led by the Director of Workforce
- Divisional Governance – led by the Chief Operating Officer

Integrated Governance

Integrated Governance includes the following key activities, which are reported organisationally in the Integrated Quality Performance Report and, where relevant by division in the divisional performance reports. As well as the individual responsibilities of the senior risk owners for these areas as shown on the previous page, the board is collectively responsible for the system of integrated governance, risk management and internal control in its entirety. With executive directors as senior risk owners and non-executive director members of assurance committees overseeing the identified risks in the BAF, when the Board comes together, it takes a collective view on the inter-connectedness of these activities against the context of its tolerance for risk as articulated in its risk appetite statement

Finance and Use of Resources

- Income and Expenditure account
- Income analysis
- Pay costs
- CIP analysis
- Capital Expenditure
- Statement of Financial Position
- Fraud

Information Governance

- Incident reporting
- Data breaches
- Information Governance mandatory training compliance
- Cyber attacks

Operational Performance

- ED performance
- 12 hour breaches
- Ambulance handovers
- Bed occupancy
- Average length of stay
- Boarding
- RTT performance
- Diagnostic performance
- Cancer 2 week wait
- Cancer 31 day/62 day
- Stroke
- Cardiology
- Maternity
- Emergency planning

Clinical Governance (see next page)

Workforce and Education

- Substantive vacancies (WTE)
- Care hours per patient day (CHPPD)
- Sickness absence
- Staff turnover
- Medical appraisals
- Non-medical appraisals
- Mandatory training compliance
- Use of agency staff
- Workforce race equality standards (WRES)
- Equality & Diversity
- Equipment/Medical technology training and competencies

Research

- Number of live projects
- Commercial studies
- Non-commercial studies
- Patient participation in research

Integrated Governance (Clinical Governance)

Clinical Governance includes the following key activities, which are reported by division in the divisional performance reports and organisationally in the Integrated Performance Report

Patient Safety

- Incident Reporting
- Serious Incident Reporting
- Duty of Candour and the Being open framework
- Risk assessments (patients & staff under Health and Safety)
- Learning from deaths
- Harm Free care Indicators*
- Specialist Committee indicators*
- Claims activity
- Inquests
- Equipment management & training
- Learning from Excellence (incl. GREATix)

Patient Experience

- Friends and Family tests (including reporting levels and response rates)
- Complaints
- Patient Advice Liaison Service (PALS) contacts
- Patient Surveys
- Patient User Groups
- Patient Information
- PLACE environmental surveys

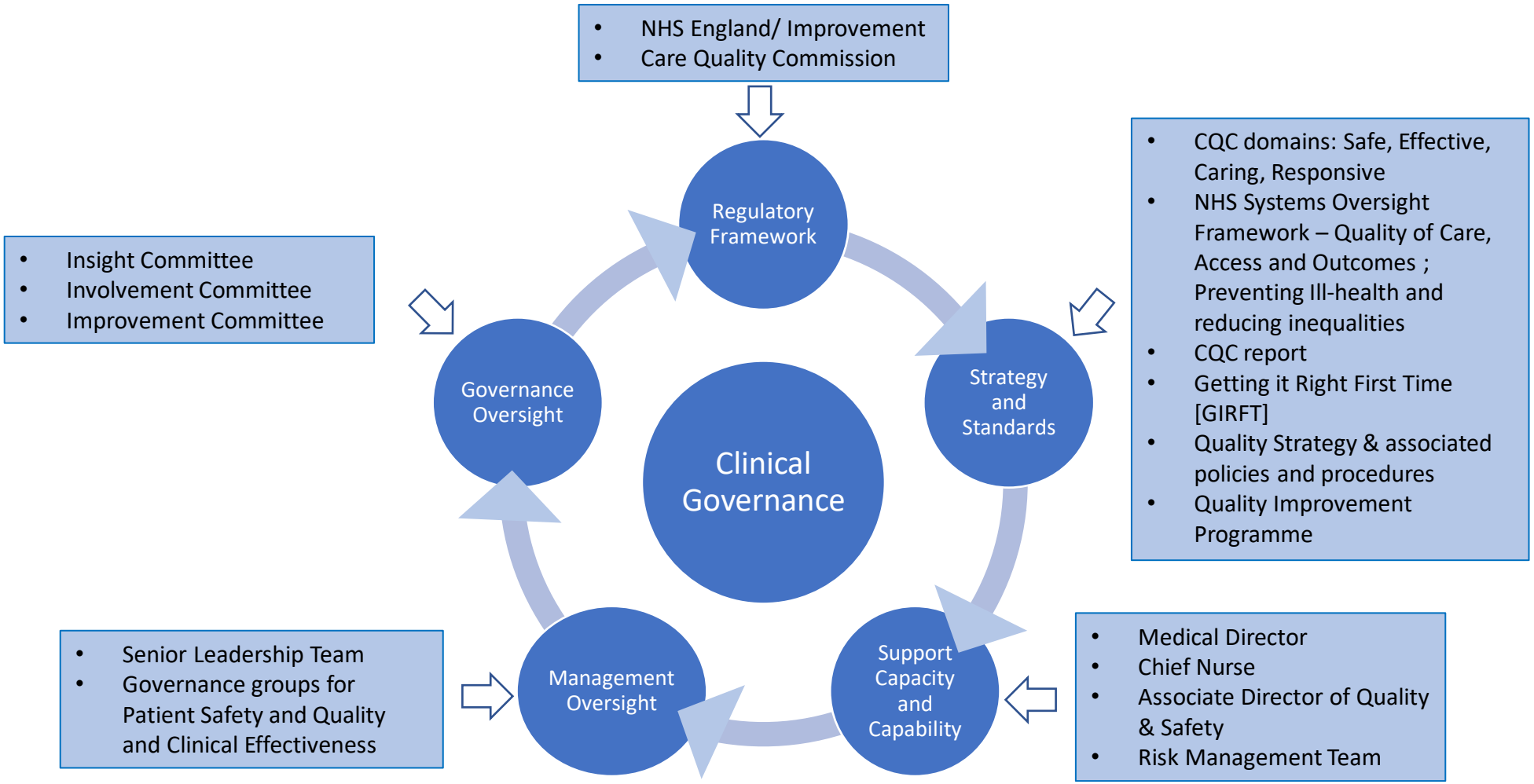
Clinical Effectiveness

- National and local clinical audits
- Implementation of evidence based clinical standards
- Patient Reported Outcome Measures (PROMs)
- National best practice publications (HSIB, CQC, NHSEI, other ..)
- Quality improvement projects (local and wider ICS wide**

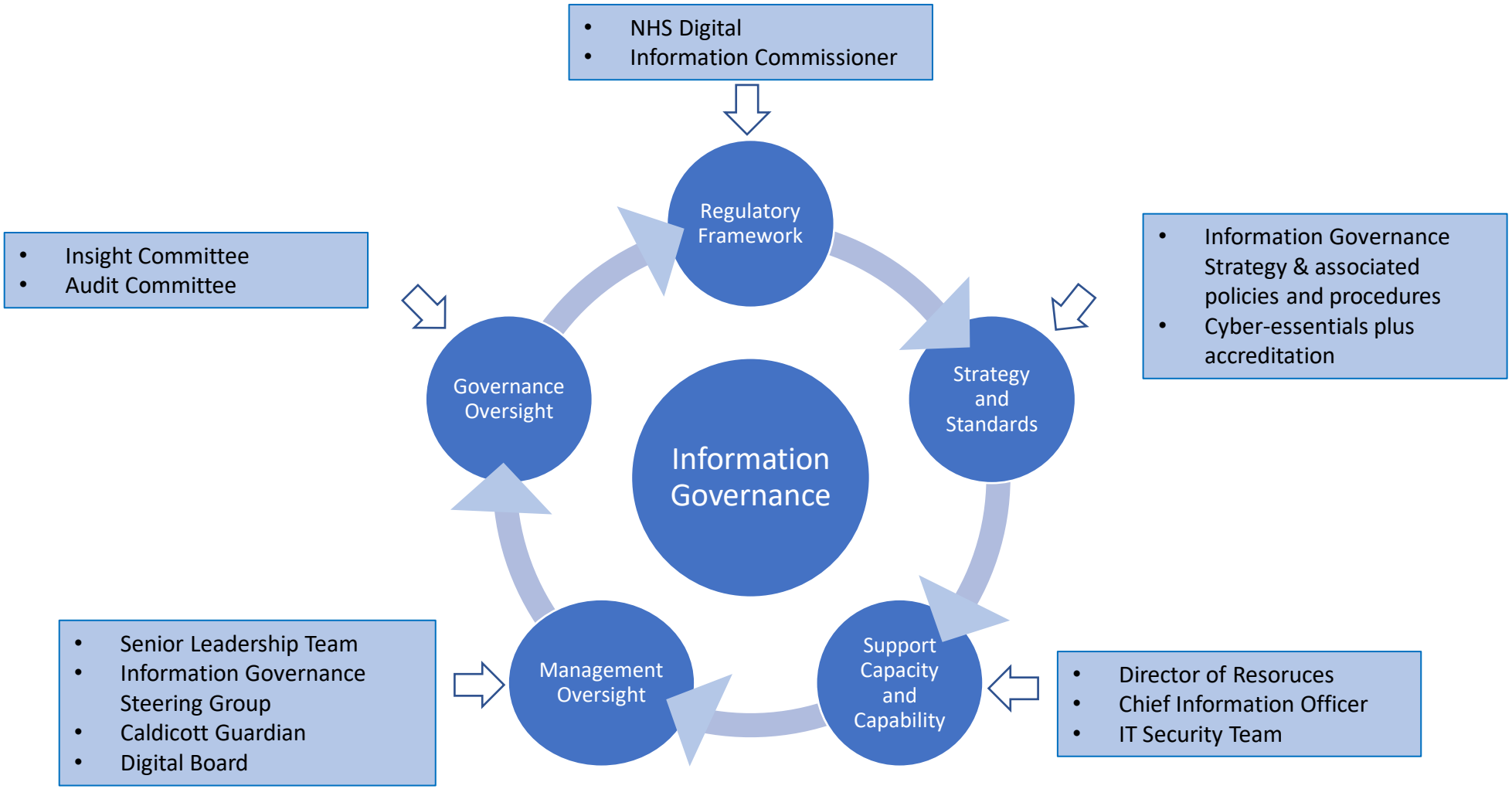
* <u>Harm free care / Specialist committee indicators</u>*

- Falls, Tissue viability (incl. pressure ulcers), Nutrition, Infection Prevention, Transfusion, Thrombosis (VTE), Infection prevention & control, Safeguarding (adults and children), Trauma, Deteriorating patients (incl. resuscitation, sepsis, etc.), Radiological protection, Medicines management, Learning from deaths & End of life, 'Safer surgery' (incl. NatSSIPs and consent), Dementia & Frailty, Mental health & learning disability

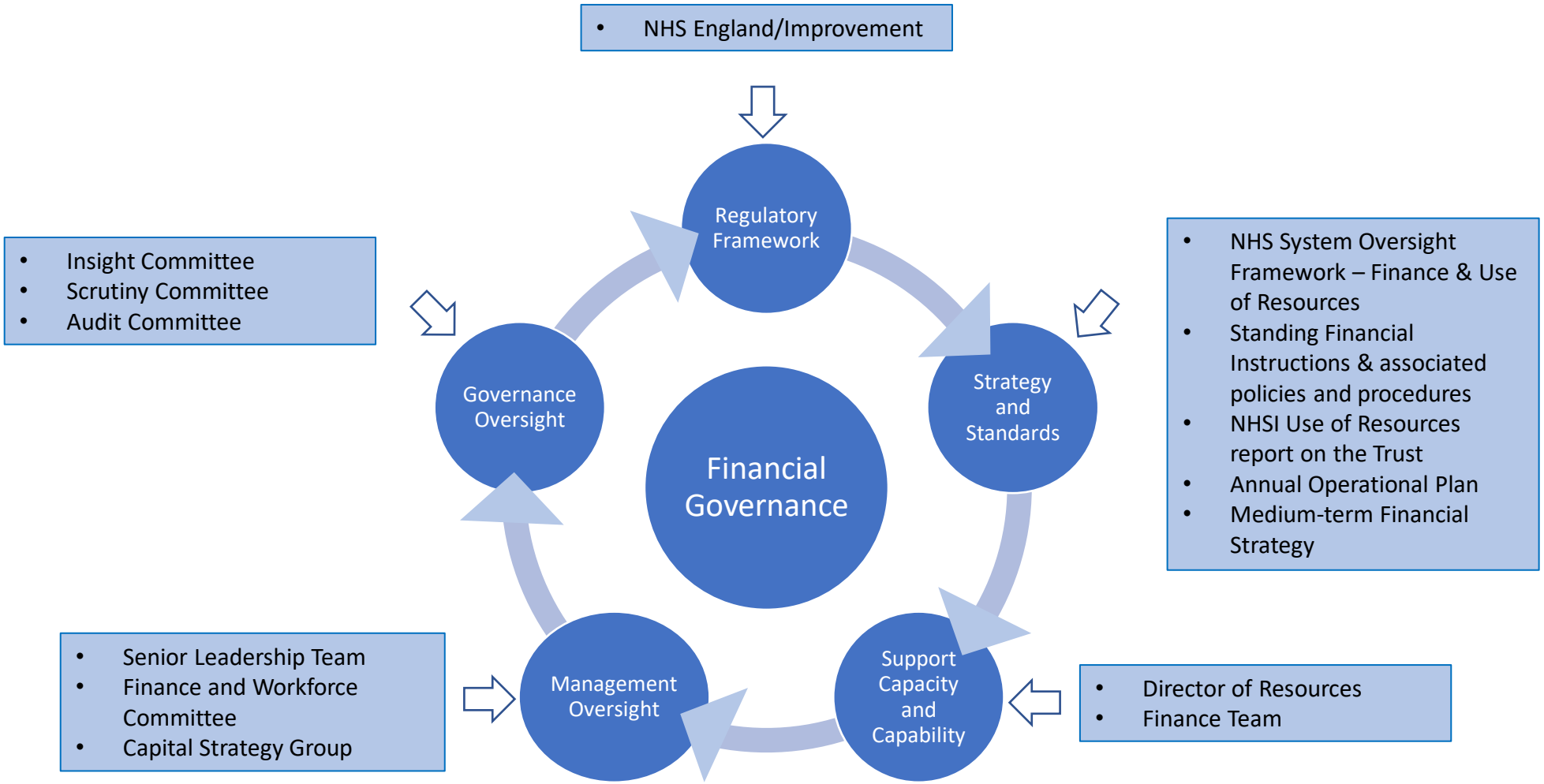
Clinical Governance



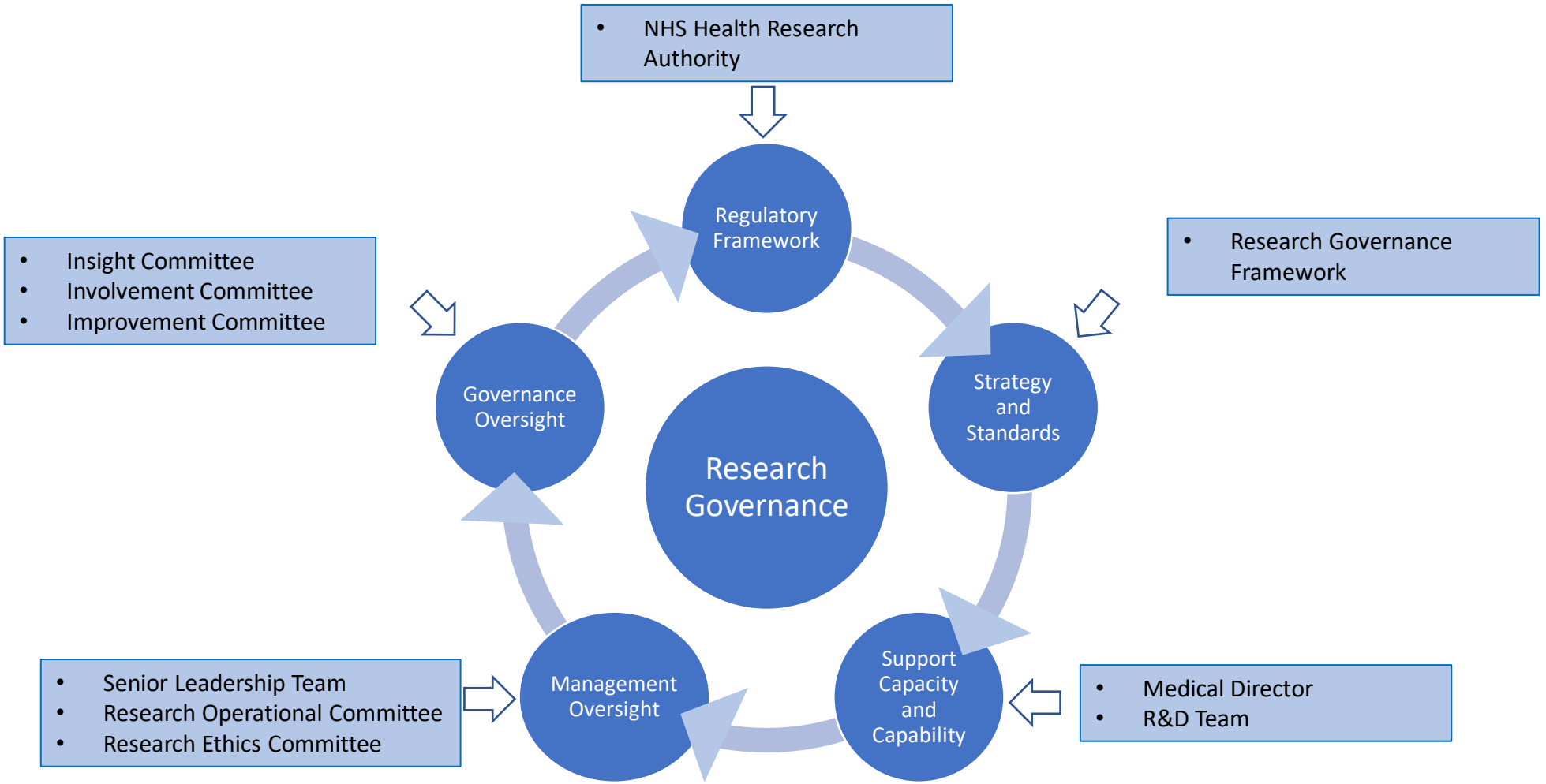
Information Governance



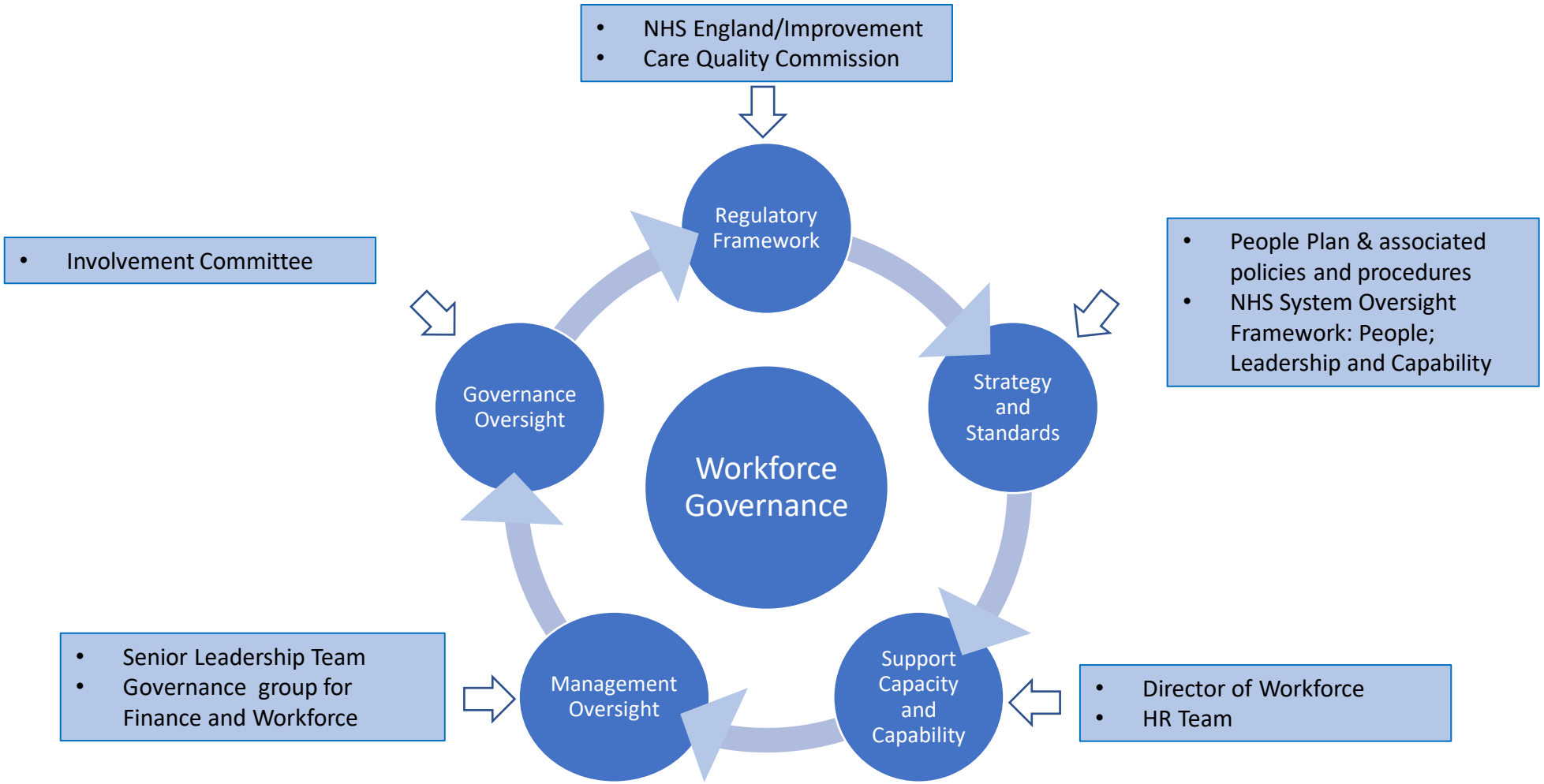
Financial Governance



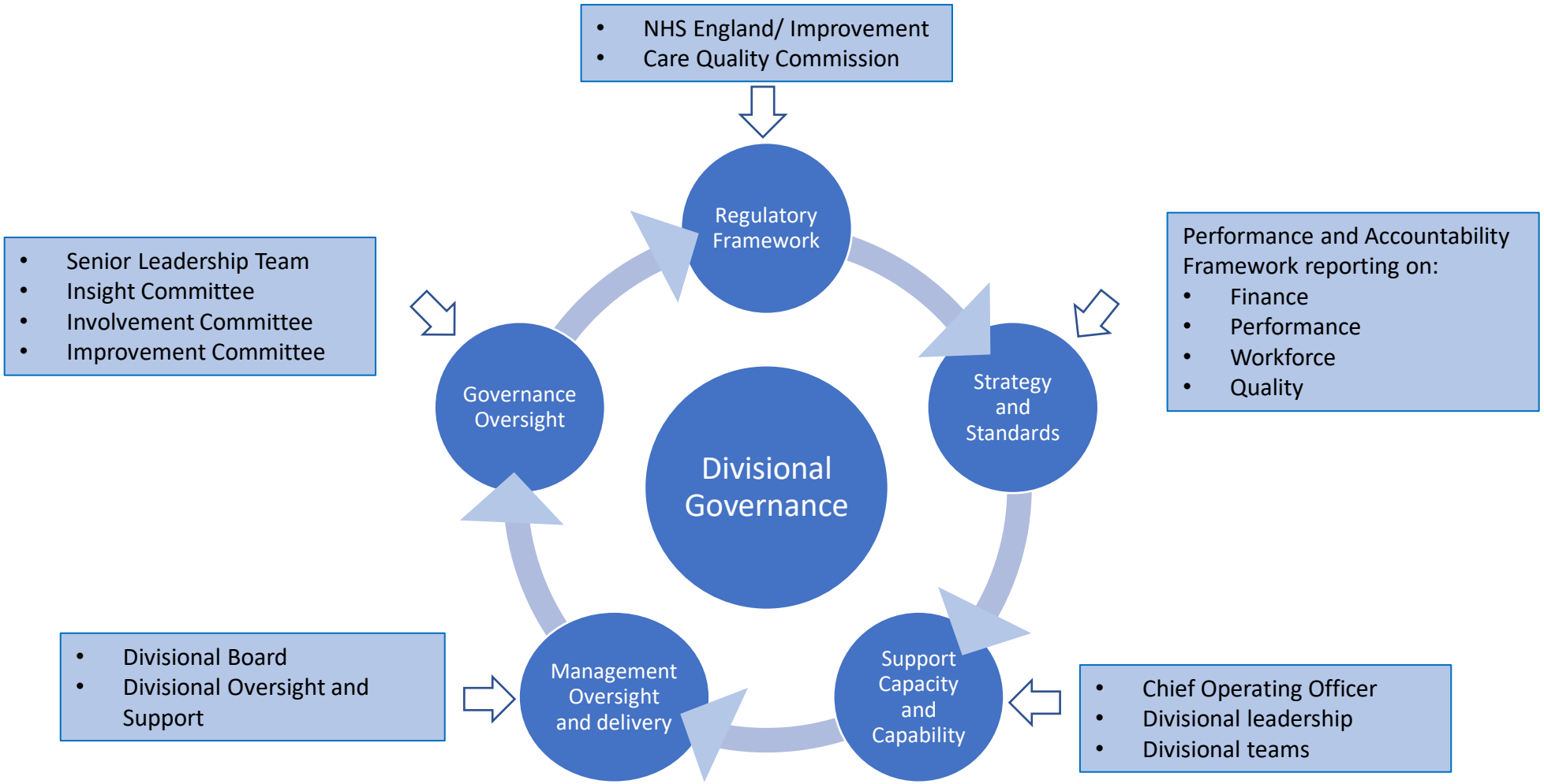
Research Governance



Workforce and Education Governance



Divisional Governance



16. Board Committee Terms of Reference

To APPROVE the terms of reference for the following committees:

- Audit Committee
- Insight Committee
- Improvement Committee
- Senior Leadership Team
- Involvement Committee
- Remuneration Committee

For Approval

Presented by Ann Alderton

Board of Directors - 3 September 2021

Agenda item:	16			
Presented by:	Ann Alderton, Interim Trust Secretary			
Prepared by:	Ann Alderton, Interim Trust Secretary			
Date prepared:	24 August 2021			
Subject:	Board Committee Terms of Reference			
Purpose:		For information	X	For approval

Executive summary:

During the review of the Organisational Framework for Governance, new terms of reference were drafted for the 3i's committees of the Board and the new Senior Leadership Team. Meanwhile, the terms of reference for two established committees of the Trust – the Audit Committee and the Remuneration Committee – were also reviewed.

The Terms of Reference for the committees are attached for Board approval, with the following status reports:

Audit Committee – approved 30 July 2021 (Annex A)
Insight Committee – approved 2 August 2021 (Annex B)
Improvement Committee – approved 9 August 2021 (Annex C)

Senior Leadership Team – approved by the Executive Directors, but subject to approval when the team meets for its first meeting in September 2021 (Annex D)

Involvement Committee – under discussion, for approval during September 2021 (Annex E)
Remuneration Committee – for approval during September 2021 (Annex F)

The terms of reference are reported collectively, so that the Board is sighted and can be assured that the scope of the committees together meets the Trust's assurance requirements. The Scrutiny Committee Terms of Reference will also be reviewed in the coming months, completing the review. The next steps will include reviewing the Scheme of Delegation and other key Trust policies, to ensure that escalation and assurance arrangements reflect the redesign of the Organisational Framework for Governance.

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:	Audit Committee Insight Committee Improvement Committee Executive Directors' meeting
Risk and assurance:	The development of and transition to a new structure for organisational governance may result in a failure to escalate significant risks to management, the executive team and the board of directors, caused by a disruption to the previous information and communication flows whilst new arrangements are being established.
Legislation, regulatory, equality, diversity and dignity implications	NHS Act 2006 Well-led Framework (NHSI) FT Code of Governance
Recommendation: To consider and approve the Terms of Reference for the above committees (acknowledging that Involvement Committee, Remuneration Committee and Senior Leadership Team Terms of Reference will be subject to further review at committee level).	

AUDIT COMMITTEE
Terms of Reference

1 Constitution

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

2 Aim

2.1 The Committee will provide an independent and objective view of the Trust's internal control environment and the systems and processes by which the Trust leads, directs and controls its functions in order to achieve organisational objectives, safety, and quality of services, and in which they relate to the wider community and partner organisations".

3 Scope

3.1 The Committee has overarching responsibility for monitoring specific elements of the systems and processes relating to governance, including financial systems, records and controls; financial information; compliance with law, guidance and codes of conduct; independence of internal and external audit; and the control environment (including measures to prevent and detect fraud). The Committee is responsible for providing an opinion as the adequacy of the integrated governance arrangements and Board Assurance Framework.

3.2 The Committee has a statutory role in respect of assurance, controls, compliance, data and probity. The aim is to ensure complete coverage while avoiding duplication by close liaison and cross-representation between these committees

4 Membership

4.1 The Committee shall be appointed by the Board of Directors from amongst the Non-executive Directors of the Trust and shall consist of no fewer than three members, one of whom has recent and relevant finance experience. One of the members will be appointed Chair of the Committee by the Board of Directors.

4.2 The Trust Chair will ensure that there is cross-representation by Non-executive directors on the Audit Committee and any of the Trust's other Board Assurance Committees.

4.3 A quorum will be two members.

4.4 The Chair of the Trust shall not be a member of the Committee.

5 Attendance at Meetings

5.1 The Director of Resources and the Trust Secretary will normally attend all Committee meetings.

5.2 The Head of Internal Audit, the Counter Fraud Specialist and a representative of the Trust's External Auditors will attend as necessary.

5.3 Other members of the Board of Directors have the right of attendance at their own discretion.

5.4 All other attendances will be at the specific invitation of the Committee.

5.5 The Committee will have the over-riding authority to restrict attendance under specific circumstances.

5.6 The Committee will meet with the External and Internal Auditors, without any other Board Director present at least once a year.

5.7 Attendance at meetings will be recorded as part of the normal process of the meeting. A record of attendance will be reported as part of the Committee's Annual Report.

6 Access

The Head of Internal Audit and representative of External Audit have a right of direct access to the Chair of the Committee

7 Frequency of Meetings

7.1 Meetings will normally be held at least three times a year.

7.2 Special meetings may be convened by the Board of Directors or the Chair of the Committee.

7.3 The External Auditors or Internal Auditors may request a meeting if they consider that one is necessary.

8 Authority

8.1 The Board of Directors authorises the Committee to investigate any activity within its duties (as detailed below) and grants to the Committee complete freedom of access to the Trust's records, documentation and employees. This authority does not extend, other than in exceptional circumstances, to confidential patient information.

8.2 The Committee may seek any information (excluding confidential patient information, other than in exceptional circumstances) or explanation it requires from the Trust's employees who are directed to co-operate with any request made by the Committee.

8.3 The Trust Board authorises the Committee to obtain external professional advice or expertise if the Committee considers this necessary.

9 Duties and Responsibilities

The duties and responsibilities of the Committee are as follows:

9.1 Governance and Assurance

9.1.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. The Audit Committee will look to the Trust's other Board Assurance Committees for assurance on items of clinical quality and corporate risk, including: health & safety, research and information governance.

In particular, the Committee shall independently monitor and review:

9.1.1.1 the Annual Governance Statement (AGS) and the assurance system for all other external disclosure statements such as declarations of compliance with the Care Quality Commission registration, and any formal announcements relating to the Trust's financial performance, together with any accompanying Head of Internal Audit opinion, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors in order to advise (when requested by the Board or as the Committee deems appropriate) on whether such disclosures taken as a whole are fair, balanced and understandable.

9.1.1.2 the effectiveness of systems of internal financial and budgetary control and the integrity of reporting statements.

9.1.1.3 the effectiveness of systems for ensuring the optimum collection of income.

9.1.1.4 the effectiveness of risk management systems.

9.1.1.5 the effectiveness of the Board Assurance Framework (BAF).

9.1.1.6 The Committee will use a programme of 'deep dive' reviews to test the BAF and its priority areas as part of an assurance programme. The Committee's assessment of the effectiveness of the BAF should be included in the Committee's Annual Report to the Board of Directors.

9.1.1.7 the Quality Report assurance and review alongside the annual report and accounts.

9.1.1.8 the systems for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements, including the NHS Constitution, as set out in relevant guidance.

9.1.1.9 the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority.

9.1.1.10 the adequacy and security of arrangements by which staff or contractors may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters, ensuring that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

9.1.2 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

9.1.3 This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

9.1.4 The Committee will receive the minutes from the Trust's other Board Assurance Committees for the purpose of ensuring: that there is no duplication of effort between the two Committees; that no area of assurance is missed and; as part of its responsibility for reviewing the Annual Governance Statement prior to submission to the Board of Directors.

9.1.5 The Audit Committee shall ensure that there is a system for reviewing the findings of other significant assurance functions, both internal and external to the organisation and consider the implications to the governance of the organisation. These will include, but will not be limited to, NHS Improvement, any reviews by The Department of Health and Social Care or arm's length bodies, regulators/inspectors (CQC, NHS Resolution etc) and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies etc.)

9.1.6 In addition, the Committee will review the work of other Board Assurance Committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include items in relation to quality, risk, governance and assurance. The conclusion of this review should be referred to specifically in the Committee's Annual Report to the Board of Directors.

9.1.7 The Committee will consider how its work integrates with wider performance management and standards compliance and include this within the Annual Report to the Board of Directors.

9.1.8 In reviewing the work of other Board Assurance Committees and issues around clinical risk management, the Audit Committee will wish to satisfy themselves on the assurance that these Board Assurance Committees gain from the clinical audit function.

9.1.9 The Audit Committee will receive assurance on the arrangements for clinical audit within the Trust, including the process by which clinical audits are selected and agreed actions implemented.

9.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management, which meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and the Board of Directors. An Internal Audit Charter will be agreed annually which will include objectives, responsibilities and reporting lines. This will be achieved by:

9.2.1 considering the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal.

9.2.2 the review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework.

9.2.3 consideration of the major findings of internal audit investigations, the effectiveness of the management's response and ensuring co-ordination between the Internal and External Auditors to optimise audit resources.

The will include exception reports of management action beyond deadline and consideration of the findings of Internal Audit "testing" of completed actions.

9.2.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the Trust.

9.2.5 assessing the quality of internal audit work on an annual basis.

9.2.6 Ensuring any material objection to the completion of an assignment which has not been resolved through negotiation is brought to the Committee by the Chief Executive Officer or Director of Resources with a proposed solution for a decision.

9.3 Counter Fraud

The Committee shall ensure that there is an effective counter fraud function established by management that meets the Standards set out by the NHS Counter Fraud Authority and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by:

9.3.1 consideration of the provision of the Counter Fraud service, the cost of the audit and any questions of resignation and dismissal.

9.3.2 consideration of the major findings of counter fraud work (and management's response).

9.3.3 ensuring that the Counter Fraud function is adequately resourced and has appropriate standing within the organisation.

9.3.4 receiving an annual review of the work undertaken by the counter fraud function.

9.4 External Audit

The Committee shall review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work.

9.4.1 Consideration of the appointment, performance and cost effectiveness of the External Auditor, making a recommendation to the Council of Governors on appointment of External Audit.

9.4.2 To ensure that the External Auditor remains independent in its relationship and dealings with the Trust and to review the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements;

9.4.3 To review the annual audit plan and to discuss with the External Auditor, before the audit commences, the nature and scope of the audit.

9.4.4 As part of the audit plan, discuss with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee

9.4.5 To review External Audit reports, including value for money reports and management letters, together with the management response.

9.4.6 To develop and implement a policy on the engagement of the External Auditor to supply non-audit services, considering the impact this may have on their independence, taking into account the relevant regulations and ethical guidance in this regard and reporting to the Board on any improvement or action required.

9.4.7 To develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm; and

9.4.8 To assess the quality of external audit work on an annual basis.

9.5 Financial Reporting

9.5.1 The Audit Committee shall review the Annual Report and Financial Statements of the Trust and its Charitable funds before submission to the Board, to determine their completeness, objectivity integrity and accuracy. This review will cover but is not limited to:

- the wording in the Annual Governance Statement (AGS) and other disclosures relevant to the Terms of Reference of the Committee;
- changes in, and compliance with, accounting policies and practices;
- explanation of estimates and provisions having material effect;
- unadjusted mis-statements in the financial statements;
- major judgemental areas;
- the schedule of losses and special payments; and
- significant adjustments resulting from the audit.

9.6 Key Trust Documents

9.6.1 Review proposed changes to Standing Orders, Standing Financial Instructions, Scheme of Delegation and Matters Reserved to the Board for approval by the Board of Directors.

9.6.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

9.6.3 To review the Standing Orders, Standing Financial Instructions, Scheme of Delegation and Matters Reserved to the Board on a two-yearly basis for approval by the Board of Directors.

9.7 Other

9.7.1 Review compliance with Standing Orders and Standing Financial Instructions through a schedule of waivers

9.7.2 Review schedules of losses and compensations

9.7.3 Monitor the process to ensure that Supply Chain Risk is identified and appropriate actions have been taken.

9.7.4 Entries recorded in the gifts and hospitality register would be considered on an exception basis as reported by the panel considering the entries made.

9.7.5 The Committee shall at its discretion request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

10 Reporting, Accountability, Monitoring and Review of Effectiveness

10.1 The Minutes of Audit Committee meetings shall be formally recorded and a summary of the minutes, which includes a report of the Committee's activities, is submitted to the Board of Directors no less often than three times a year; The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

10.2 The Audit Committee shall review its terms of reference annually;

10.3 The Audit Committee shall carry out a self-assessment in relation to its own performance no less than once every two years, reporting the results to the Board of Directors;

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

10.5 A separate section of the Trust's annual report will describe the work of the Committee in discharging its responsibilities.

10.6 The Committee will report to the Board planned future workload and priorities for approval.

10.7 The Committee will agree on an annual basis a reporting framework for all areas of it terms of reference. This determines standing items for the agenda and items for regular reporting.

10.8 Maintain and monitor performance against the agreed reporting framework.

10.9 Follow-up agreed actions to ensure these are implemented in a timely and effective manner.

Draft submitted to Audit Committee on 30 July 2021.

Item 16 Annex B

INSIGHT COMMITTEE

Terms of Reference

1. Constitution

The Trust Board hereby resolves to establish an assurance committee to be known as the Insight Committee (the committee). The committee has no executive powers other than those specifically delegated in these terms of reference.

2. Authority

The committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to request any information from any employee and all employees are directed to cooperate with any request made by the committee. The committee is authorised by the Trust Board to obtain legal advice and to secure the attendance of experts and external representatives or persons with relevant experience/expertise if it considers it necessary.

3. Membership

Membership will comprise the following:
Executive Leads:

- Director of Resources
- Chief Operating Officer

Other Members

- Two non-executive directors, one of whom will chair the meeting
- Chief Nurse
- Medical Director

The Chairman and Chief Executive have an open invitation to attend meetings of the committee.

4. Attendance

Attendees who are not members of the committee but who will be reporting to the committee on risks and assurances within their remit include the following.

- Deputy Director of Finance
- Deputy Chief Operating Officer
- Deputy Director of Workforce
- Head of Access
- Associate Director of Quality Improvement
- Deputy Chief Nurse
- Deputy Medical Director
- Head of Information Services
- Trust Secretary

The Committee may invite members of staff, other key stakeholders and advisors to attend meetings as appropriate.

5. Quorum

The quorum necessary for the transaction of business shall be four members of whom at least one must be a non-executive director. A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions invested in, or exercised, by the committee.

6. Attendance

The Committee may ask any other officials of the organisation or representatives of external partners to attend to assist it with its discussions on any particular matter. The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters

Attendance at meetings is essential. In exceptional circumstances when an Executive member cannot attend they must arrange for a fully briefed deputy of sufficient seniority to attend on their behalf. Members will be required to attend as a minimum 50% of the meetings per year.

7. Frequency and Conduct

The committee shall operate as follows:

- The committee will meet monthly until agreed otherwise
- Items for the agenda should be submitted to the committee secretary a minimum of 6 working days prior to the meeting. Papers on other matters will be put on the agenda only with the prior agreement of the chair.
- Papers will be sent out by the committee secretary at least 4 days before each meeting.
- Membership and terms of reference will only be changed with the approval of the committee and ultimately the board.

8. Main Duties

In line with the NHSI Well-led Framework, the committee is authorised to provide the board with assurance that there are clear and effective processes in place for managing risks, issues and performance and that appropriate and accurate information is being effectively processed, challenged and acted upon.

The committee will consider all relevant risks within the Board Assurance Framework and corporate risk register as they relate to the remit of the committee, as part of reporting requirements, and to report any areas of significant concern to the board as appropriate. The committee will also recommend changes to the BAF relating to emerging risks and existing entries within its remit for the executive to consider.

9. Key Responsibilities

The key responsibilities of the committee shall be to:

- Receive a regular report on financial and workforce efficiency, noting any trends, exceptions and variances against plans on a Trust-wide and divisional basis and to seek assurance relating to any major performance variations as appropriate
- Receive a regular report on operational performance noting any trends, exceptions and variances against plans on a Trust-wide and divisional basis and to seek assurance relating to any major performance variations as appropriate

- Receive a regular report on patient quality and safety, noting any trends, exceptions and variances against plans on a Trust-wide and divisional basis and to seek assurance relating to any major performance variations as appropriate
- Receive a regular report on clinical effectiveness, noting any trends, exceptions and variances against plans on a Trust-wide and divisional basis and to seek assurance relating to any major performance variations as appropriate.
- Advise the board and/or relevant board committee of any risks and issues relating to performance, the assurances it has received of any actions relating to them and any gaps in control or assurance that need to be escalated for attention.

10. Reporting and Monitoring Responsibilities

Minutes will be prepared after each meeting of the committee within 5 working days and circulated to members of the committee and others as necessary once confirmed by the Chair of the committee.

There should be a formal report from the committee to the next meeting of the Board of Directors. The chair of the committee shall draw to the attention of the Trust Board, in private or public as appropriate, any issues that require disclosure to the Board or require executive action. The speed of communication should be proportionate to the seriousness and likely impact of the issue.

The key issues of the committee will be included in the Board of Directors' agenda and papers. Once the committee has approved the full minutes, a copy will be available, for information, to the board at its next meeting.

The committee shall submit an annual report to the Trust Board within the first three months of the new financial year.

11. Monitoring Effectiveness

In order to support the continual improvement of governance standards, this committee is required to complete a self-assessment of effectiveness at least annually and advise the Trust Board of any suggested amendments to these terms of reference which would improve the trust governance arrangements.

12. Approval

These terms of reference were reviewed by the committee on [date] and approved by the Trust Board on [date]. The Terms of reference will be reviewed in August 2022.

Item 16 Annex C

IMPROVEMENT COMMITTEE

Terms of Reference

1. Constitution

The Trust Board hereby resolves to establish an assurance committee to be known as the Improvement Committee (the committee). The committee has no executive powers other than those specifically delegated in these terms of reference.

2. Authority

The committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to request any information from any employee and all employees are directed to cooperate with any request made by the committee. The committee is authorised by the Trust Board to obtain legal advice and to secure the attendance of experts and external representatives or persons with relevant experience/expertise if it considers it necessary.

3. Membership

Membership will comprise the following:

Executive Leads:

- Chief Nurse
- Medical Director

Other Members

- Two non-executive directors, one of whom will chair the meeting
- Director of Resources
- Chief Operating Officer

The Chairman and Chief Executive have an open invitation to attend meetings of the committee.

4. Attendance

- Associate Director of Quality Improvement
- Head of Patient Safety
- Project Management Officer
- Head of Compliance and Effectiveness
- Trust Secretary

The Committee may invite members of staff, other key stakeholders and advisors to attend meetings as appropriate.

5. Quorum

The quorum necessary for the transaction of business shall be four members of whom at least one must be a non-executive director. A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions invested in, or exercised, by the committee.

6. Attendance

The Committee may ask any other officials of the organisation or representatives of external partners to attend to assist it with its discussions on any particular matter. The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters

Attendance at meetings is essential. In exceptional circumstances when an Executive member cannot attend they must arrange for a fully briefed deputy of sufficient seniority to attend on their behalf. Members will be required to attend as a minimum 50% of the meetings per year.

7. Frequency and Conduct

The committee shall operate as follows:

- The committee will meet monthly until agreed otherwise
- Items for the agenda should be submitted to the committee secretary a minimum of 6 working days prior to the meeting. Papers on other matters will be put on the agenda only with the prior agreement of the chair.
- Papers will be sent out by the committee secretary at least 4 days before each meeting.
- Membership and terms of reference will only be changed with the approval of the committee and ultimately the board.

8. Main Duties

In line with the NHSI Well-led Framework, the committee is authorised to provide the board with assurance that there is a culture of high quality, sustainable care and robust systems for learning, continuous improvement and innovation.

The committee will consider all relevant risks within the Board Assurance Framework and corporate risk register as they relate to the remit of the committee, as part of reporting requirements, and to report any areas of significant concern to the board as appropriate. The committee will also recommend changes to the BAF relating to emerging risks and existing entries within its remit for the executive to consider.

9. Key Responsibilities

The key responsibilities of the committee shall be to provide assurance to the board in relation to:

- The effectiveness of the Trust's systems and processes for ensuring clinical governance, quality governance and patient safety is embedded from ward to board.
- The Trust's compliance with statutory and regulatory standards, particularly in relation to the Care Quality Commission, Clinical Negligence Scheme for Trusts and the Well-led Framework.
- Oversight of the delivery of improvement activities, and the capability and maturity of the improvement environment and framework.
- The provision of a platform and forum for the sharing of best practice and improvement learning throughout the Trust
- Trust performance in relation to patient safety, experience and outcomes (effectiveness) with particular focus on providing assurance to the Board on actions taken to address any major performance variations.

- Reports on significant concerns or adverse findings highlighted by external bodies in relation to clinical quality and safety and the actions being taken by management to address them.
- The systems and processes in place in the Trust in relation to infection control and to review progress against identified risks to reducing hospital acquired infections.
- Reports on actions to address trends relating to adverse events (including serious incidents), complaints, claims and litigation.
- The provision of health and safety to protect patients, staff and visitors to the Trust site.
- Key strategic risks relating to quality and patient safety and consider plans for mitigation as appropriate.
- Ensuring that lessons are learnt and implemented across the Trust from patient feedback, including patient safety data and trends, compliments, complaints, patient surveys, national audits/confidential enquiries and learning from the wider NHS community.
- Systems within the Trust for obtaining and maintaining licences and accreditations relevant to clinical activity, receiving such reports as required.

10. Reporting and Monitoring Responsibilities

Minutes will be prepared after each meeting of the committee within 5 working days and circulated to members of the committee and others as necessary once confirmed by the Chair of the committee.

There should be a formal report from the committee to the next meeting of the Board of Directors. The chair of the committee shall draw to the attention of the Trust Board, in private or public as appropriate, any issues that require disclosure to the Board or require executive action. The speed of communication should be proportionate to the seriousness and likely impact of the issue.

The key issues of the committee will be included in the Board of Directors' agenda and papers. Once the committee has approved the full minutes, a copy will be available, for information, to the board at its next meeting.

The committee shall submit an annual report to the Trust Board within the first three months of the new financial year.

11. Monitoring Effectiveness

In order to support the continual improvement of governance standards, this committee is required to complete a self-assessment of effectiveness at least annually and advise the Trust Board of any suggested amendments to these terms of reference which would improve the trust governance arrangements.

12. Approval

These terms of reference were reviewed by the committee on [date] and approved by the Trust Board on [date]. The Terms of reference will be reviewed in August 2022.

SENIOR LEADERSHIP TEAM

Terms of Reference

1. Purpose

The Senior Leadership Team (hereafter referred to as the Team) is the senior management decision making group of the hospital. Its purpose is to oversee the Trust's overall performance and delivery, including patient safety, patient experience, operational standards, financial performance and staff engagement.

The Team provides strategic leadership and is responsible for the implementation and delivery of the Hospital's strategic direction, business plan and associated objectives, standards and policies to ensure the delivery of safe, high quality, patient-centred services.

The Team will ensure that a cohesive decision-making process and a co-operative approach is applied to issues which have an impact across the organisation.

2. Level of Authority

The Team has delegated authority from the Trust Board to deliver its key duties and responsibilities.

The Team has authority to make decisions on behalf of the Board of Directors but in compliance with the Trust's Standing Financial Instructions and Scheme of Delegation, this is to a maximum value of £250k.

The Team may establish groups reporting to it. It shall remain accountable to the Board for the work of any group reporting to it.

3. Duties and Responsibilities

3.1 Strategy, planning and allocation of resources

To oversee the implementation of underpinning strategies and organisational and performance objectives for the delivery of the Trust's Strategic Plan.

To approve policies and plans, and allocation of management, financial and physical resources to support the implementation of the Trust's Strategic Plan.

To provide a forum by which the Board of Directors can be advised of issues/decisions that impact on both clinical and non-clinical services.

To evaluate, scrutinise and monitor revenue and capital investments for service developments and improvement plans through the approval of business cases.

3.2 Delivery and Performance

To monitor compliance and ensure delivery of statutory duties, national and local standards and targets and other obligations, and agree actions and responsibilities to address shortcomings.

To maintain business and operational performance for quality, operational and financial.

To develop and contribute to the Trust's transformation programme, linked to Trust vision, priorities and ambitions and monitor that programme.

To develop priorities and agree plans for future CIPs and efficiency programmes and monitor those programmes

To ensure the selection, prioritisation and resourcing of projects, business cases and other activities is appropriate in the context of available resource, strategic priority and relative risk.

3.3 Risk Management and Internal Control

To ensure that the principal strategic risks in the Board Assurance Framework and identified high risk entries in the risk register are appropriately articulated, assessed and mitigated to minimise their impact on the Trust's strategy and operations.

To review the relevant internal/external audit reports and ensure an appropriate and timely management response, including

- Internal/external audit reports identifying "red" recommendations
- Exception reporting of actions beyond deadline

To consider risk assessments with a risk rating of 16 or more (red) which satisfy the escalation criteria set out in the Risk Management Strategy and monitor the actions taken to reduce the risk to a level in line with the Trust's agreed risk appetite.

3.4 Policy

To approve and ratify Trust-wide policy and guidelines as set out in the Trust's Scheme of Delegation. (check this)

3.5 Workforce

To provide a focus on staffing issues, including organisational culture and the development and talent management of Trust staff.

To oversee the implementation and delivery of the priorities, strategic objectives and key performance indicators in the Workforce plan.

3.6 Quality Improvement

To drive forward the delivery of the Trust's commitment to deliver continuous development and quality improvement.

To oversee the implementation and delivery of the priorities, strategic objectives and key performance indicators in the Quality Improvement plan.

3.7 Information Management and Technology

To oversee the implementation and delivery of the priorities, strategic objectives and key performance indicators in the IM&T strategy and plan.

Membership and Quorum
Membership of the Committee will comprise:
Chief Executive (Chair)
Executive Director of Resources
Executive Director of Nursing
Executive Medical Director
Executive Director of Workforce
Chief Operating Officer
Director of Integration
Director of Adult Health and Community Care
Trust Secretary
Divisional Triumvirate

The Chief Executive will chair meetings and in their absence the Deputy Chief Executive will act as Chair. If the Chief Executive and the Deputy Chief Executive are absent the Chief Executive will nominate one of the other members of the Board to chair the meeting.

The Team may invite members of staff, other key stakeholders and advisors to attend meetings as appropriate.

The number of members required for a quorum shall be five.

Members are requested to send a deputy with the appropriate skills and knowledge to represent them if they are unable to attend a meeting.

5. Frequency of Meetings

Meetings will normally be held fortnightly.

Meetings may be held more frequently, as convened by the Chair

6. Arrangements for meetings and circulation of minutes

The Trust Office Manager will be the secretary for the committee and the agenda for meetings will be prepared by the Chair of the Committee.

Agendas and supporting papers will be circulated by the end of the week prior to the meeting date.

Items for discussion will be in accordance with an annual cycle of business that will take account of key activities and deadlines set internally by the Trust's business cycle and externally by regulators. These will be presented in the committee's forward plan.

Any member can request an item be included on the agenda, which should be submitted in writing to the Chair at least 15 days before the meeting date. Any agenda item received after this date will be considered at the discretion of the Chair.

Consideration of any urgent decisions required in between meetings will be considered at the weekly Executive Directors' meeting, representing a quorum of the Senior Leadership Team, and reported back to the next meeting of the committee.

Draft minutes will be circulated to Team members within one week of the meeting.

7. Reporting arrangements

A highlight report of the key issues discussed and decisions made will be submitted to the next Board Meeting following the Team Meeting.

8. Monitoring Compliance and Effectiveness

The Team will review its performance and effectiveness to demonstrate that it is meeting its terms of reference.

Team members will complete an Annual Self-Assessment of the Team's performance, the results of which will be collated and reported to the Team by the Trust Secretary. The Team will agree actions to make improvements which will be incorporated into the Annual Report.

These terms of reference will be reviewed no less frequently than annually by the Team members.

9. Ratification of These Terms of Reference and Review Arrangements

Reviewed at the Senior Leadership Committee Meeting [date]

To be reviewed annually: next review no later than [date]

INVOLVEMENT COMMITTEE

Terms of Reference

1. Constitution

The Trust Board hereby resolves to establish an assurance committee to be known as the Involvement Committee (the committee). The committee has no executive powers other than those specifically delegated in these terms of reference.

2. Authority

The committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to request any information from any employee and all employees are directed to cooperate with any request made by the committee. The committee is authorised by the Trust Board to obtain legal advice and to secure the attendance of experts and external representatives or persons with relevant experience/expertise if it considers it necessary.

3. Membership

Membership will comprise the following:

Executive Lead

- Director of Workforce

Other Members

- Two non-executive directors, one of whom will chair the meeting
- Chief Nurse
- Medical Director
- Chief Operating Officer

The Chairman and Chief Executive have an open invitation to attend meetings of the committee.

4. Attendance

- Associate Director of Quality Improvement
- Head of Patient Experience
- Deputy Director of Workforce
- Trust Secretary

The Committee may invite members of staff, other key stakeholders and advisors to attend meetings as appropriate.

5. Quorum

The quorum necessary for the transaction of business shall be three members of whom at least one must be a non-executive director. A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions invested in, or exercised, by the committee.

6. Attendance

The Committee may ask any other officials of the organisation or representatives of external partners to attend to assist it with its discussions on any particular matter. The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters

Attendance at meetings is essential. In exceptional circumstances when an Executive member cannot attend they must arrange for a fully briefed deputy of sufficient seniority to attend on their behalf. Members will be required to attend as a minimum 50% of the meetings per year.

7. Frequency and Conduct

The committee shall operate as follows:

- The committee will meet every other month until agreed otherwise
- Items for the agenda should be submitted to the committee secretary a minimum of 6 working days prior to the meeting. Papers on other matters will be put on the agenda only with the prior agreement of the chair.
- Papers will be sent out by the committee secretary at least 4 days before each meeting.
- Membership and terms of reference will only be changed with the approval of the committee and ultimately the board.

8. Main Duties

In line with the NHSI Well-led Framework, the committee is authorised to provide the board with assurance that the Trust is engaging and involving people who use the services, the public, the staff and external partners to support high quality sustainable services.

The committee will consider all relevant risks within the Board Assurance Framework and corporate risk register as they relate to the remit of the committee, as part of reporting requirements, and to report any areas of significant concern to the board as appropriate. The committee will also recommend changes to the BAF relating to emerging risks and existing entries within its remit for the executive to consider.

9. Key Responsibilities

The key responsibilities of the committee shall be to provide assurance to the board in relation to:

Staff Engagement and Involvement

- The implementation of the Trust's people plan, including assurance on the management of strategic and operational risks and opportunities relating to workforce, culture and leadership, staff engagement and employment practice;
- Strategy and plans for workforce education, learning and development;
- The implementation of the Trust's Inclusion strategy and associated action plan, and the Trust's annual Equality Report as it pertains to the workforce, including compliance with relevant legislation;
- The staff survey and other staff feedback, ensuring that action plans support improvement in staff experience and services to patients;

- The delivery of the Board's strategy for developing a speak up culture, working in collaboration with local and national Freedom to Speak Up Guardians;

Patient Engagement and Involvement

- The patient survey and other patient engagement data, ensuring that action plans support improvement in patient experience and services to patients;
- Effective learning from the themes/issues identified from serious complaints and other sources of patient feedback
- The involvement of patients and patient representatives in the co-production of improvements to quality and service provision

Public and Stakeholder Engagement and Involvement

- The approach to partnership working with Alliance and ICS partners, and their involvement in the strategic direction of WSFT
- Meeting statutory duties for public and patient involvement in relation to the planning and provision of services, the development and consideration of proposals for changes in the way those services are provided and decisions which affect the operation of those services.
- Member and governor engagement activities, ensuring they are aligned with the Trust's strategic priorities and the best interests of the Trust co-ordinated with other stakeholder engagement activities.

10. Reporting and Monitoring Responsibilities

Minutes will be prepared after each meeting of the committee within 5 working days and circulated to members of the committee and others as necessary once confirmed by the Chair of the committee.

There should be a formal report from the committee to the next meeting of the Board of Directors. The chair of the committee shall draw to the attention of the Trust Board, in private or public as appropriate, any issues that require disclosure to the Board or require executive action. The speed of communication should be proportionate to the seriousness and likely impact of the issue.

The key issues of the committee will be included in the Board of Directors' agenda and papers. Once the committee has approved the full minutes, a copy will be available, for information, to the board at its next meeting.

The committee shall submit an annual report to the Trust Board within the first three months of the new financial year.

11. Monitoring Effectiveness

In order to support the continual improvement of governance standards, this committee is required to complete a self-assessment of effectiveness at least annually and advise the Trust Board of any suggested amendments to these terms of reference which would improve the trust governance arrangements.

12. Approval

These terms of reference were reviewed by the committee on [date] and approved by the Trust Board on [date]. The Terms of reference will be reviewed in August 2022.

REMUNERATION COMMITTEE

Terms of Reference

1. CONSTITUTION

1.1 The Remuneration Committee (known as "the Committee" in these terms of reference) is established by the Board of Directors approved the establishment of the Remuneration Committee for the purpose of:

a. The nomination of the Chief Executive and other Executive Directors for the Trust; and

b. The determination of the remuneration, terms of service and allowances for the Chief Executive and other Executive Directors.

c. The appointment and removal of the Company Secretary does not fall within the scope of this committee but is a matter for the Chief Executive and Chairman jointly.[1]

1.2 The committee is accountable to the Board of Directors and any changes to these terms of reference must be approved by the Board of Directors.

1.3 When appointing the Chief Executive, the committee shall be the committee described in Schedule 7,17(3) of the National Health Service Act 2006 (the Act). When appointing other executive directors the committee shall be the committee described in Schedule 7,17(4) of the Act[2].

2. DUTIES

APPOINTMENTS

The committee shall:

2.1 Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the board evaluation process as appropriate and make recommendations to the Board and, where relevant, the Council of Governors, with regard to any changes;

2.2 Give full consideration to succession planning for executive board directors in the course of its work, taking into account the challenges and opportunities facing the Trust, and the skills and expertise needed on the Board in the future;

2.3 Keep under review the leadership needs of the Trust, with a view of ensuring the continued ability of the Trust to undertake its obligations under the terms of its licence;

2.4 Be responsible for identifying and appointing candidates to fill executive Board vacancies as and when they arise;

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[1] *The NHS Foundation Trust Code of Governance* Monitor July 2014 p 58

[2] NHS Act 2006 Schedule 7 17(3) It is for the non-executive directors to appoint or remove the Chief Executive.
(4) It is for a committee consisting of the chairman, the chief executive and the other non-executive directors to appoint or remove the executive directors.

2.5 Before any new appointment is made by the Board, evaluate the balance of skills, knowledge, experience and diversity on the Board, and, in the light of this evaluation, prepare a description of the role and capabilities required for new appointments to the Board. In identifying suitable candidates the committee shall:

2.5.1 Consider its advertising strategy and the need for external search consultants to support the search

2.5.2 Consider candidates from a wide range of backgrounds

2.5.3 Consider candidates on merit and against objective criteria and with due regard for the benefits of diversity on the Board;

2.6 Make recommendations to the Board concerning formulating succession plans for executive directors and in particular for the key role of Chief Executive;

2.7 Take decisions on any matters relating to the continuation in office of any executive director at any time including the suspension or termination of service of an executive director as an employee of the Trust subject to the provisions of the law and their service contract.

2.8 Select members of the committee to form an appointments panel which will be responsible for making recommendations on the appointment of Executive Directors.

REMUNERATION

The committee shall:

2.9 Have responsibility for setting the remuneration policy for all executive directors and senior managers not on agenda for change or clinical contracts, including pension rights and any compensation payments. No director shall be involved in any decisions as to their own remuneration;

2.10 In determining such a policy, take into account all factors which it deems necessary including relevant legal and statutory requirements, the provisions and recommendations of the Code and associated guidance. The objective of such policy shall be to attract, retain and motivate executive management of the quality required to run the Trust successfully without paying more than is necessary, having regard to the risk appetite of the Trust and alignment to the Trust's long strategic term goals;

2.11 When setting remuneration policy for executive directors, review and have regard to pay and employment conditions across the Trust and the NHS, especially when determining annual salary increases;

2.12 Review the ongoing appropriateness and relevance of the remuneration policy;

2.13 Within the terms of the agreed policy and in consultation with the Chair or Chief Executive, as appropriate, determine the total individual remuneration package of each executive director and the CEO;

2.14 Obtain reliable, up-to-date information about remuneration in other Trusts of comparable scale and complexity. To help it fulfil its obligations, the committee shall have full authority to appoint remuneration consultants and to commission or purchase any reports, surveys or information which it deems necessary;

2.15 Monitor, and assess the output of the evaluation of the performance of individual executive directors, and consider this output when reviewing changes to remuneration levels.

2.16 Advise upon and oversee contractual arrangements for executive directors, including but not limited to termination payments to avoid rewarding poor performance.

2.17 Review and agree the policy for authorising claims for expenses from the directors.

2.18 Scrutinise the recommendations of the Clinical Excellence Awards Committee

2.19 Where appropriate, to authorise any redundancy payments, settlements and compromise agreements as determined within current NHS rules on severance payments, including such payments which require final approval by HM Treasury/NHS Improvement.

3. MEMBERSHIP

3.1 The committee shall comprise the Chair and all Non-Executive Directors. The committee will be chaired by the Chair or one of the other Non-Executive Directors.

3.2 The Chief Executive shall be a member of the committee for the appointments or removal of executive directors only as described in Schedule 7,17 (4) of the Act (see also paragraph 1.3 above).

3.3 The Chief Executive, Director of Workforce and Trust Secretary will be in attendance at its meetings, as and when appropriate and necessary.

3.4 The committee can request the attendance of any other Director or senior manager if an agenda item requires it.

3.5 The quorum necessary for the transaction of business shall be three non-executive directors. For matters relating to executive board appointments (other than the appointment of the Chief Executive), the quorum shall include the Chief Executive.

4. REPORTING RESPONSIBILITIES

4.1 The committee chair shall report to the Board on its proceedings, as appropriate, after each meeting on all matters within its duties and responsibilities;

4.2 The committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed;

4.3 When appointing a Chief Executive, the committee shall report their decision to appoint to the Council of Governors for approval prior to reporting to the Board[3].

4.4 The committee shall produce a report to be included in the Trust's annual report about its activities, the process used to make appointments and explain if external advice or open advertising has not been used. Where an external search agency has been used, it shall be identified in the annual report and a statement made as to whether it has any connection with the Trust;

4.5 The report referred to in 4.4 above should include a statement of the Board's policy on diversity, including gender, any measurable objectives that it has set for implementing the policy, and progress on achieving the objectives.

5. OTHER MATTERS

5.1 The committee shall have access to sufficient resources to carry out its duties, including access to the company secretariat for assistance as required;

5.2 It shall be provided with appropriate and timely training, both in the form of an induction programme for new members and on an on-going basis for all members;

5.3 It will give due consideration to laws and regulations, the provisions of the FT Code of Governance and any other applicable rules, as appropriate;

[3] NHS Act 2006 Schedule 7 17(5) The appointment of a chief executive requires the approval of the council of governors

5.4 It will periodically review its own performance and, at least annually, review its constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.

6. ADMINISTRATION

6.1 The Trust Secretary shall arrange for the proceedings and resolutions of all committee meetings to be minuted, including the names of those present and in attendance.

6.2 Draft minutes of the committee meetings shall be circulated promptly to all members of the committee.

6.3 The committee will provide an annual report to the Board.

7. AUTHORITY

The committee is authorised by the Board to obtain, at the Trust's expense, outside legal or other professional advice on any matter within its terms of reference.

11:45 ITEMS FOR INFORMATION

17. Any other business

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

For Reference

Presented by Sheila Childerhouse

18. Date of next meeting

To NOTE that the next meeting will be held on 15 October in West Suffolk Hospital

For Reference

Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

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

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

For Reference

Presented by Sheila Childerhouse