Board of Directors (In Public)

Schedule	Friday 30 July 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, 30 July 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 07 30 July.docx

9:15 GENERAL BUSINESS
Presented by Sheila Childerhouse

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

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

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

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

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

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6. Minutes of the previous meeting
   To APPROVE the minutes of the meeting held on 25 June 2021
   For Approval - Presented by Sheila Childerhouse

   Item 6 - Open Board Minutes 2021 06 25 June Draft.docx

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

   Item 7 - Board action points - Open.pdf

   Item 7 - Board action points - Complete.pdf

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8. Staff story (verbal)
   To reflect on the experience shared with the Trust
   For Report - Presented by Susan Wilkinson and Natalie Bailey

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

   Item 9 - CEO Board report July 2021 - updated.docx

10:00 DELIVER FOR TODAY

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

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

- Item 10.1 - Board report Cover sheet - M03.docx
- Item 10.1 - Finance Report- June 2021.docx

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

- Item 10.2 - Operational Board update July 2021.doc
- Item 10.2 - Operational Board update July 2021 - Slide deck.pdf

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10.3. IQPR
To NOTE report
For Approval - Presented by Craig Black, Helen Beck and Susan Wilkinson

- Item 10.3 - IQPR Trust Board Report - Data May 21.pdf

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11. Integration report
To receive the report
For Report - Presented by Kate Vaughton

- Item 11 - WSFT Board_Integration Paper July 21_Final.docx
- Item 11 - App 3_VCSE Charter May 2021.pdf

Comfort Break - 10 minutes

10:45 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

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12. Involvement Committee Report
To APPROVE the report
For Approval - Presented by Alan Rose and Jeremy Over

- Item 12 - Involvement committee report.docx.doc

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

- Item 12.1 - People OD highlight July 2021.doc
- Item 12.1 Appendix 1 - Evaulation framework July 2021 update.doc
- Item 12.1 Appendix 2 - July 21 App and MT appendix board.docx
- Item 12.1 Appendix 3 - Safe staffing Guardian Quarterly Report April - June (003).docx
- Item 12.1 Appendix 4 - ICA Delivery Plan Summary_.pdf

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13. Improvement Committee Report
To APPROVE the report
For Approval - Presented by Susan Wilkinson and Paul Molyneux

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

- Item 13.1 - Maternity Quality and performance report July 2021.docx
- Item 13.1 Annex B - IEA3 Q20 Anaesthetic report 2021 update Safety Action 4.pdf
- Item 13.1 Annex C - WSH Continuity of Carer roll out plan template July 2021.pptx
- Item 13.1 Annex D - SBLCB East of England WSH RGR v2 Survey 5 June 2021.pdf
- Item 13.1 Annex E - 05 ATAIN monthly report May 2021.docx

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

- Item 13.2 - July 21 COVID IPC assurance framework.docx

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

Item 13.3 - Nurse staffing report - Board July 2021 Final.docx

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13.4. Nurse staffing strategy review
To APPROVE the update
For Report - Presented by Susan Wilkinson

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14. Supporting Junior Doctors Out of Hours in the Surgical Division
To APPROVE the report
For Approval - Presented by Paul Molyneux and Andrew Dunn

Item 14 - Supporting Junior Doctors - Board Jul 2021 V2.7 FINAL.doc

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11:25 BUILD A JOINED-UP FUTURE

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

Item 15 - Future System Public Board overview July 2021.doc

11:35 GOVERNANCE

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

Item 16 - Governance report.doc

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17. Board Assurance Framework
To APPROVE report
For Approval - Presented by Ann Alderton

Item 17 - BAF Summary July 2021.doc

11:45 ITEMS FOR INFORMATION

18. 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

19. Date of next meeting
    To NOTE that the next meeting will be held on 3 September in West Suffolk Hospital
    For Reference - Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

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

AGENDA

Presented by Sheila Childerhouse

Board of Directors

A meeting of the Board of Directors will take place on **Friday, 30 July 2021 at 9:15**. The meeting will be held virtually via video conferencing.

Sheila Childerhouse
Chair

Agenda (in Public)

9:15 GENERAL BUSINESS		
1.	**Resolution** The Trust Board is invited to adopt the following resolution: "That representatives of the press, and other members of the public, be excluded from the meeting having regard to the guidance from the Government regarding public gatherings."	Sheila Childerhouse
2.	**Apologies for absence** To note any apologies for the meeting and request that mobile phones are set to silent.	Sheila Childerhouse
3.	**Declaration of interests for items on the agenda** To note any declarations of interest for items on the agenda	Sheila Childerhouse
4.	**Questions from the public relating to matters on the agenda** (verbal) To receive questions from members of the public of information or clarification relating only to matters on the agenda	Sheila Childerhouse
5.	**Review of agenda** To agree any alterations to the timing of the agenda.	Sheila Childerhouse
6.	**Minutes of the previous meeting (attached)** To approve the minutes of the meeting held on 25 June 2021	Sheila Childerhouse
7.	**Matters arising action sheet (attached)** To accept updates on actions not covered elsewhere on the agenda	Sheila Childerhouse
8.	**Staff story (verbal)** To reflect on the experience shared with the Trust	Sue Wilkinson / Natalie Bailey
9.	**CEO report (attached)** To receive an introduction on current issues	Steve Dunn
10:00 DELIVER FOR TODAY		
10.	**Insight Committee Report (verbal)** To approve the report **10.1 Finance and workforce report (attached)** To approve report **10.2 Operational report (attached)** To approve the report **10.3 IQPR (attached)** To note report	Richard Davies/ Craig Black/ Helen Beck Craig Black Helen Beck Craig Black/ Helen Beck/ Sue Wilkinson
11.	**Integration report (attached)** To receive the report	Kate Vaughton

	Comfort break – 10 minutes	
10:45 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP		
12.	**Involvement Committee Report (attached)** To approve the report **12.1 People and OD Highlight Report (attached)** To approve the report	Alan Rose/ Jeremy Over Jeremy Over
13.	**Improvement Committee Report (attached)** To approve the report 13.1 Maternity services quality and performance report (attached) To approve the report 13.2 Infection prevention and control assurance framework (attached) To approve the report 13.3 Nurse staffing report (attached) To approve the report 13.4 Nurse staffing strategy review (verbal) To approve the update	Sue Wilkinson/ Paul Molyneux Sue Wilkinson/ Karen Newbury Sue Wilkinson Sue Wilkinson Sue Wilkinson
14.	**Supporting Junior Doctors Out of Hours in the Surgical Division (attached)** To approve the report	Paul Molyneux/ Andrew Dunn
11:25 BUILD A JOINED-UP FUTURE		
15.	**Future system board report (attached)** To approve report	Craig Black
11:35 GOVERNANCE		
16.	**Governance report (attached)** To approve report	Ann Alderton
17.	**Board Assurance Framework (attached)** To approve report	Ann Alderton
11:45 ITEMS FOR INFORMATION		
18.	**Any other business** To consider any matters which, in the opinion of the Chair, should be considered as a matter of urgency	Sheila Childerhouse
19.	**Date of next meeting** To note that the next meeting will be held on 3 September 2021 in West Suffolk Hospital	Sheila Childerhouse
RESOLUTION TO MOVE TO CLOSED SESSION		
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For Reference

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6. Minutes of the previous meeting

To APPROVE the minutes of the meeting held on 25 June 2021

For Approval

Presented by Sheila Childerhouse

DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 25 JUNE 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)*		
Daniel Spooner	Deputy Chief Nurse		
Governors in attendance (observation only): Florence Bevan, Allen Drain, Joe Pajak, Jane Skinner, Liz Steele, Clive Wilson			

Action

GENERAL BUSINESS

21/101 RESOLUTION

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

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

The Chair recorded her thanks to David Wilkes and Rosemary Mason who had recently resigned from their respective positions of Non-Executive Director and Associate Non-Executive Director.

She welcomed Ann Alderton who was acting as interim Trust Secretary in the absence of Richard Jones; Christopher Lawrence who had joined the board as a Non-Executive Director and Paul Molyneux, interim Executive Medical Director.

21/102 APOLOGIES FOR ABSENCE

There were no apologies for absence.

21/103 DECLARATION OF INTERESTS FOR ITEMS ON THE AGENDA

No declarations of interest were received.

21/104 QUESTIONS FROM THE PUBLIC RELATING TO MATTERS ON THE AGENDA

Liz Steele, on behalf of the governors, congratulated the maternity team on the start of a long journey in the improvement of the service they provide.

Q At the March Board meeting she asked about the low results for mandatory training in maternity and in particular foetal monitoring. The reply indicated that there was an 18 month period during which this could be done. In the papers this month there is once again a very low take up for foetal monitoring training. The explanation was that compliance changed in January and was now a monthly requirement thus causing confusion. Could an update be provided on why this figure is still very low and assurance that this figure will improve swiftly now?

A This question would be addressed under agenda item 15.1.

Q Re the national headlines about the increased pressure in A&E and the fact that WSFT was currently limited in capacity due to the work going on with the structure, was there a danger that patients who required emergency treatment would have to be taken directly to other hospitals?

A This question would be addressed under agenda item 10.

21/105 REVIEW OF AGENDA

The agenda was reviewed and there were no issues.

21/106 MINUTES OF MEETING HELD ON 28 MAY 2021

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

21/107 MATTERS ARISING ACTION SHEET

The ongoing actions were reviewed and the following noted:

Ref 1915; Community services leaders to recommend appropriate community effectiveness metrics for future reporting. An update would be provided in the integration report next month. A lot of work was being undertaken with therapists and nurses and a further workshop was planned.

Ref 1929; When clearer on national reset expectations (standards/targets) develop local metrics for IQPR to support local innovation and drive improvement. It was requested the target date for this should be revised.

Ref 1976; Invite Natalie Bailey to a future board meeting to present on the work she is doing around mental health. Sue Wilkinson to confirm date. **S Wilkinson**

No completed actions were recorded.

21/108 PATIENT OR STAFF STORY

- The board heard a story from a 64 year old patient with a learning disability. He had suffered three heart attacks in 2010 and had had to give up work. He also had a number of other ailments and had been in hospital 120 times over the years. He said that staff needed to read his hospital record so that they understood him and his hospital passport which let staff know what was important to him.

A number of staff knew him well and often visited him when he was in the hospital. He needed this contact and adjustments that needed be made to help him cope when he was an inpatient.

- The board were shown a video about reasonable adjustment. This featured people with learning disabilities and autism and the adjustments that needed to be made to help them.
- It was very important to acknowledge and manage all patients, especially those with learning disabilities. WSFT was committed to ensuring that patients with learning disabilities received appropriate care and a learning disability nurse had recently been recruited who had already made a significant difference and was supporting staff on how to look after patients with learning disabilities.

Q It was very important to support nursing staff in caring for patients with learning disabilities as this could be quite challenging. Was additional support available for staff, eg from the mental health team, to help them manage patients coming into A&E?

A The Trust was working to build relationships and to work collaboratively with members of the mental health team.

- The ICS board was also in discussions about prioritising patients with learning disabilities on elective waiting lists. Paul Molyneux was following this up with Ed Garrett and a specific task and finish group was being set up to look at how to provide better care to these patients. Feedback from this also needed to be taken into account when considering the design of the infrastructure of the new hospital and future system.

Q This applied to all staff, not just nursing and clinical staff, could this video be included as part of the induction for all staff?

A **ACTION: consider how the video re reasonable adjustment could be made available to all staff, eg as part of induction.** **J Over / S Wilkinson**

- This was a reminder that a key focus of the work around equality, disability and inclusion was to ensure that everybody got the best outcomes.
- Everybody had different needs and people should be treated as individuals. This also needed to be taken into account when setting and living the values of the Trust, although it was recognised that this could be challenging.
- The outcome of the formal audit/review would be fed back to a future board meeting, following discussion with the CCG. **S Wilkinson**

21/109 CHIEF EXECUTIVE'S REPORT

- The easing of lockdown restrictions had been delayed by a month due to concerns about the Delta variant and the link between increased hospital admissions and death rates. Everyone in the Trust remained vigilant.
- The organisation continued to be very busy with a considerable increase in activity compared to two years ago, including paediatric demand.
- The ongoing structural work was resulting in reduced capacity and challenges to both staff and patients. This week the new area in the emergency department had opened which would facilitate quicker, more effective review and triage of patients on arrival in ED

- The new decant facility was on track to open mid July which would further help to relieve pressure on capacity and staff.
- There was a big focus on recovery, however theatre capacity was reduced due to the structural issues. Activity was being moved to day cases where possible.
- Discussions continued to take place around the Trust's proposed updated values and feedback would be welcomed on this. Policies were also being updated to align with the Trust's culture and values.
- A new phase on engagement on the new healthcare facility had begun and feedback from as many people as possible would be welcomed. A series of engagement events would be taking place over the next few months and it was anticipated that construction would start in 2025 and be completed in 2028. However, if funding was available it was hoped to bring this forward.
- Clement Mawoyo had recently been appointed director of integrated community health and adult social care. This was a joint appointment between the Trust and Suffolk County Council and would help bring community teams and social care together.
- The CQC report on maternity services had been published this week. The team had been doing a great deal of work which had been regularly reported to the board. The new leadership team was making good progress and considerable improvements had been made, however there was still work to be done.
- Yesterday feedback had been received from the MHRA inspection on the Trust's blood transfusion service. The verbal feedback was that there were no critical or major deficiencies and substantial progress had been made since the last inspection, although there was still some work to be done. Formal written confirmation of this was still awaited.
- This was the first positive step on a journey for the pathology team as it moved forward and the board thanked the team for all the work and progress that had been made. It was noted that the pathology team were very grateful for the investment that had been made into the service over the last few months.

Q Re current paediatric capacity in the Trust; paediatrics was likely to get very busy and would continue to do so. As well as the capacity in the emergency department was there any further inpatient and staff capacity to manage the increase in admissions at a time when this was not expected?

A This would be addressed under agenda item 10.

DELIVER FOR TODAY

21/110 OPERATIONAL REPORT

- Activity through the front door, both attendances and admissions, was now at above pre-pandemic levels.
- The emergency department was under a great deal of pressure but coping very well. The new isolation area was helping with this and the second phase of the additional capacity had opened earlier this week.
- However, the organisation remained under a considerable amount of pressure and this would continue due to the constraints in bed capacity. The teams were managing this with great resilience during the time when the failsafe programme meant that there was the greatest reduction in capacity in the organisation.

- In response to the question relating to the incident that was referred to in the local press where a patient was taken directly to Addenbrookes; this was normal practice when it was considered to be the best place for their clinical care. This happened on a regular basis, but if a patient needed to be stabilised at WSFT first they would receive urgent/emergency care and then be transferred to Addenbrookes for their ongoing care. No patient requiring urgent care had been sent to another hospital as a result of WSFT's constraints on capacity.

Q Over the last couple of years WSFT had piloted new measurement systems for emergency care. This had paused during Covid but were there any guidelines that the board needed to be aware of that may constrain or change what the organisation did?

A The new metrics had been consulted on and an announcement was expected soon on a date for formal implementation of a range of new measures which the Trust was preparing for.

The first metric would be time to initial assessment and the new rapid assessment and triage (RAT) area worked well during the pilot and the emergency department now had a specifically designed area for this.

The Trust would continue to report both admitted and non-admitted average journey time and there was no indication of a change to what the standard metric might be. It continued to monitor against the 200 minutes standard, although this was not quite being achieved due to the current capacity pressures that previously been discussed.

There was a new metric, 'ready to ward', and the teams were putting together a working group to look what the impact and implication of this standard would be.

ACTION: A full report on the new metrics to be taken to the board when the final details received. **H Beck**

Q Re managing demand as the organisation moved through the summer and into autumn and taking into account the increase in paediatric demand and increased emergency department attendances, were there consistent messages across the whole of the alliance and health system about how people could access the most appropriate healthcare, ie not automatically go to A&E?

A There was now clear evidence that the usual messages asking people to stay from A&E were having a reverse effect as it was raising awareness of this service. There were a lot anecdotes around people not being able to get a GP appointment, however GPs, the 111 service and community services were also very busy due to pressure across the whole system.

There had been an increase in walk-in attendances due to the fact that GP demand was also above pre-pandemic levels, therefore a lot of work was being undertaken on this at a national level. ESNEFT was also planning a very detailed piece of work around this which WSFT would look at the learning from.

As well as advising people to stay away from A&E, WSFT was looking at ways of simplifying how people could access other services and their confidence in the treatment and advice they would receive from these. WSFT would continue to put out messages and try to understand what was causing pressure in the system.

- This was a point in time when the increase in paediatric activity was occurring at the same time as the failsafe work planned in this area. It had been agreed that when G10 opened in mid-July paediatrics would temporarily move into this area, although it would not be ideal due to the lack of side rooms. As part of the ITU work a specific

side room had been allocated to paediatrics which would also help with higher acuity patients.

- The critical care team and paediatrics team had been working more closely together. They were very aware of the forthcoming challenges and were planning for this within the limits of the estate. Their resources would be stretched to the maximum and they were linking with the paediatric network for mutual aid support whilst the area was decanted.
- The final column in the activity data showed performance across all areas which was a very positive position. The IQPR had been included, although the insight committee had not yet met to consider this. A report would be taken to the board meeting next month.
- Two issues had previously been discussed by the insight committee; endoscopy investigation performance and two week wait for breast symptom patients which were areas of ongoing focus.
- It was explained that the two week breast symptom wait was due to a 70% increase in referrals to this service recently, possibly due to a media story, therefore demand had been challenging. However, when people attended their appointment they received a full one-stop shop which meant that although the two week wait standard was not being met the Trust was at over 90% of the 28 day diagnostic standard in breast services. Patients were currently being seen at three rather than two weeks and performance was improving.

21/111 REPORT FROM 3i COMMITTEES: IMPROVEMENT & INVOLVEMENT

Improvement committee

- This continued to be an iterative process. At the recent meeting a very comprehensive review was received around deteriorating patients.
- Work continued with the team and a proposal was being put together for the committee moving forward. A meeting was taking place this afternoon to look at communication and links between the 3i committees to ensure that everything was being picked up but without duplication of work.
- This was considered to have been a very positive meeting and the overall approach was to ensure that this was streamlined for reporting committees and that the issues that were important to the Trust was dynamically and appropriately measured. Staff who delivered services should also be empowered to take the lead to deliver change and improvements to services.
- In the future the committee would be looking at issues that were important to the Trust and to clinicians.

Involvement committee

- Two issues had been considered; the patient experience team had raised the fact that there was not a systematic approach or toolkit to ensure there was patient and stakeholder engagement across the whole organisation. Therefore, Cassia Nice would be putting forward a proposal to build a better systemic approach to this.
- The committee were also advised that it would be possible to measure involvement and engagement better in the future. There would be more rapid quarterly staff surveys which would allow visiblity as to whether initiatives/actions that had been implemented were having the appropriate impact or results.
- The committee was updated on the roll out of the freedom to speak up champion role that had been presented to the board at a previous meeting. This information had been circulated to staff and a number of nominations had already been received.

- It was considered that the vision for the new committee structure was bold, exciting and different but this could also be a bit daunting. There was a lot of work to do to articulate what the board wanted from these committees and the interface with the board assurance framework (BAF) and the risk appetite of the board.
- The most important piece of work that needed to be done was the reporting and information flow to ensure that issues that needed to be escalated were escalated to the right committee in order to provide assurance to the board.
- There was more work to be done on the terms of reference and looking at the board work programme and how the committee programmes would feed into this.
- There was a very good correlation between these three committees and the key lines of enquiry in the well led governance framework. This needed to be reflected in the terms of reference.

21/112 FINANCE AND WORKFORCE REPORT

- There had been a significant focus over the last month on finalising the accounts and financial position for last year. This process had very nearly been completed and the figures remained as presented to the board previously.
- Trusts had been given certainty around their income position for the first six months of this year which meant that WSFT was projecting a breakeven position and this being achieved to date.
- A degree of additional certainty around the second six months of the year was anticipated within the next few weeks and it was expected that this would be a breakeven position.
- The board had signed off a more limited cost improvement programme (CIP) than in previous years due to the ongoing issues that the organisation was dealing with and it was currently broadly on target to deliver this CIP.
- The cash position was better than in previous years as the Trust had received income in advance of expenditure. However, this year there were significant items of expenditure that had been included in last year's financial plan which had yet to materialise, ie annual leave accrual. When staff took this leave it would incur costs which would deplete the cash position, therefore over the next few months the cash position was likely to return to normal levels,
- Capital expenditure was severely constrained this year which would have consequences on the organisation. The exception was around the improvements being made to the structure of the building which constituted the majority of the capital programme; apart from this capital expenditure would be very limited.
- The audit committee had met prior to this meeting to review the annual accounts and there were still some issues that needed to be worked through. It had been a challenging year for the auditors as they were auditing the accounts remotely and like other organisations also had staffing issues.
- The audit committee were satisfied that the outstanding issues were not material and would not change the final position. Therefore, their recommendation was that the board should approve the annual accounts subject to changes and delegate approval of any changes and the signing off of the final accounts on behalf of the board to the chair, chief executive and finance director for submission next Tuesday (29 June).
- The board thanked the finance team for all their work in preparing these accounts during a very challenging period.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

21/113 PEOPLE AND OD HIGHLIGHT REPORT

- The HR policy framework was about improving people management culture through more compassion.
- The Trust's disciplinary policy had been completely reviewed and was very much about embedding a change in culture and learning lessons from mistakes made in the past and from elsewhere in the NHS. This was about learning from something that went wrong, understanding what happened and the issues that contributed to this, rather than focussing on individuals.
- There had also been a national focus on this in the last 18 months and trusts had been asked to review their disciplinary frameworks and present them at public board meetings and on their websites.
- Details were provided in this report about the steps being taken to make these changes. Actions that had already been implemented and embedded had been reported to the board, eg a change in culture around investigations etc.
- The new policy would be launched to staff jointly by Claire Sorenson and Paul Molyneux in July. This would highlight the partnership working to co-create the new policy,
- HR representatives were now embedded in each of the divisions to support all staff and help and advise in resolving issues etc. All managers would be required to consult a member of the HR team if they wished to adopt the disciplinary processes detailed in the policy. This would ensure that everyone received appropriate support.
- It would be important to ensure that the processes in this policy were followed and adhered to and there was a need to look at how to evaluate the changes that had been made.
- An update was given on the people plan and how it was proposed to combine the priorities in the national people plan with those that were important to WSFT. The draft goals were highlighted in this report.
- Putting You First Awards had been received by the following staff members in June: Sheryl Pidgeon – Ward Manager, F3; Kelly Phillips–Occupational Therapist; Emily Box – Physiotherapist; Danielle Offord, nursing recruitment lead; Harriet Jump, recruitment assistant; Elizabeth Keegan, SCARC, ICPS.

  The board congratulated these individuals and noted the power of teamworking in making things happen, alongside hard work and compassionate and sensitive care.
- It was noted that the role of the involvement committee was not a decision making committee or to formally endorse things. It was to test whether changes had followed appropriate processes and engagement with staff, as well as looking at best practice.
- The board noted the appointment of two consultant microbiologists, Dr Daniel Greaves and Dr Michelle Toleman. This was a further example of investment in the team and was a very good achievement as these positions were not easy to recruit to.
- The board noted and acknowledged the excellent work of the Trust's library service.

21/114 MEDICAL REVALIDATION ANNUAL REPORT

- The board welcomed Dr Katherine Rowe who had recently been appointed as medical appraisal lead, as a result of Paul Molyneux moving to responsible officer (RO),
- From March to October 2020 all medical appraisals had been cancelled due to Covid, however in the following six months, during the second Covid phase, doctors were required to undertaken their appraisals. There had also recently been a significant change in staff in the team responsible for managing and monitoring the appraisal process.
- Over 50% of appraisals had been completed on time, or slightly late. There were large proportion of doctors (219) in the category three section (appraisal incomplete/missed but not approved by RO). Each of these was being reviewed in detail to ensure they were in the correct category and address any data quality issues .
- During the last year several new appraisers had started in the Trust and a quality assessment of appraisals would be undertaken in accordance with the new framework to ensure that appraisals were of a good and valuable standard. The board considered this to be a very good step forward.
- Progress for 2020/21 was noted together with development plans for 2021/22.

Q The Trust should use every opportunity to listen and learn from staff; could this provide an opportunity to gain feedback from doctors about the quality of leadership they experienced and listening to their views on the Trust's management and leadership?

A The purpose of the appraisal was about quality assessment and fitness to practise. They were also able to feedback their views about the culture of the organisation but this was a confidential document.

There were other ways of finding out this information and Paul Molyneux's work around wellbeing had been undertaken as a result of soft intelligence from lead appraisers. Using appraisals to gain this information would not necessarily be the best way of doing this as this feedback was confidential.

The medical engagement scale was also being looked at as a tool to gain this sort of information and a report would be coming back to the board in September.

There were fundamental differences between the purpose of medical and non-medical appraisals. It was important to focus on the reason for medical appraisals and not get distracted from this but use soft intelligence to gain further feedback.

- The board accepted the Annual Report, noted the contents and approved it for submission to the higher-level Responsible Officer.
- The Board approved the statement of compliance confirming that the West Suffolk NHS Foundation Trust is compliant with relevant legislation and regulations.

21/115 QUALITY AND SAFETY REPORTS

115.1 Maternity services quality and performance report, including Ockenden report

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

- With reference to the governor's question about low uptake for foetal monitoring training, it was explained the issue around this was that s staff were expected to do this in their own time, particularly when they were very tired. This was through e-learning which took approximately ten hours to complete.

- There had also recently been a change in how this was reported. Previously this was reported as an annual figure on a monthly basis.
- The Trust had applied for Ockendon funding to backfill staff to do their mandatory training but it was not known if this would be successful The Trust needed to be able to enable staff to do this in work time.
- It was acknowledged that this training was absolutely crucial which was why this had been moved to monthly reporting as annual reporting meant that could have up to two years to complete this training and would therefore be non-compliant.
- The attachments to the report were highlighted. The Ockenden compliance supporting evidence was due for submission by the end of June 2021 and CNST Maternity incentive scheme two weeks later. A CNST paper would be presented to the executive team prior to submission.
- The draft CQC report had been received and the recommendations had already been incorporated into the maternity improvement plan.
- Focus groups were being held for band 5 and 6 staff so that they could feedback any issues.
- A lot of work was being undertaken with e-care and it was hoped that data could be produced in the near future.
- The board received and noted the annual report on midwifery workforce.
- Completion of the WHO checklist this month and last month had fallen below 95% compliance by a small margin (94%). These continued to be completed but not everyone was signing them.
- Swab count compliance was a major concern despite the communication that had been undertaken on this. Therefore, spot checks were now being carried out so that issues could be identified that were being experienced by staff, eg recording on e-care rather than on paper. This week every procedure had been looked at and there had been 100% compliance, therefore there was a need to ensure that everyone was using the same system in the future, ie e-care.
- It was noted that the approach to address the swab count issue was through the new culture, ie supporting staff rather than blaming them.
- The board acknowledged the work that was being undertaken by the team for the Ockendon report. The Trust continued to receive further requests which was time consuming and support would be need to be provided to the team so that they could continue to provide safe care and also responds to requests for information.

  This was a national issue and it was noted that smaller units were being asked to provide as much information as larger units who had more support staff.

115.2 Infection prevention and control assurance framework

- There were no Covid positive patients in the organisation at present, however the Trust was currently managing an outbreak of VRE which was an organism that was present in 1-2% of the population but caused no issues in fit healthy individuals. This issue had been highlighted due to an increased number of specimens that had tested positive for this organism.
- Work was being undertaken with the microbiologists, infection control team and public health consultant to review every case and manage the situation. Infection control processes were being reviewed and enhanced cleaning carried out. Patients had been informed and were being screened where necessary.
- The area of concern was F6 but F3 was also being monitored together with other areas that were currently clear.

- This had been declared as an outbreak and the Trust was working with the CCG. An assurance visit would be taking place next week to look at infection control mechanisms and cleanliness. An update would be provided to the next board meeting.

115.3 Nurse staffing report

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

- Overall fill rates for nurses and healthcare assistants was very positive, ie above 95% across the Trust for both days and nights.
- The total registered nurse vacancy rates had improved but there had been a small increase (0.1%) in the vacancy rate in inpatient areas.
- Total substantive figures had slightly reduced this month following a number of months of improvement.
- A future pipeline report would be presented to the board, however producing this information was challenging.
- Nurse turnover had reduced to 8% this month which was positive.
- Nursing sensitive indicators had improved in both falls and pressure ulcers and incidents were reducing in correlation with capacity.

Q Was there a danger that the Trust could lose members of the nursing workforce due to pressure over the past year?

A This was always a risk; currently staff were very tired but high numbers were not yet leaving. The main concern was the constant uncertainty, particularly in areas were staff were consistently being moved around. This was more of a concern than staff recovering from the pandemic and work had been undertaken with these teams and the wellbeing team.

BUILD A JOINED-UP FUTURE

21/116 DIGITAL BOARD REPORT

- The board received and noted the content of this report which provided details of the digital board meeting that took place on 6 May 2021.

21/117 FUTURE SYSTEM BOARD REPORT

- The digital fortnight had established a programme that would be worked to as the organisation progressed through the future system programme.
- There was potential to develop a blueprint that would be used by the rest of the new hospitals programme.
- Work was progressing well around the clinical model and the way that this would feed into the schedule of accommodation. This work would continue throughout the next few months prior to submission of the planning application at the end of the year.

GOVERNANCE

21/118 GOVERNANCE REPORT

118.1 Council of Governors report with Foundation Trust Engagement Strategy

- The Chair thanked the governors for their commitment and ongoing attendance at formal and informal meetings.
- The board approved the revised membership strategy for 1 April 2021 to 31 March 2023.

118.2 Certificate for NHS Improvement licencing

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

ITEMS FOR INFORMATION

21/119 ANY OTHER BUSINESS

- There was no further business.

21/120 DATE OF NEXT MEETING

Friday 30 July 2021, 9.15am

RESOLUTION TO MOVE TO CLOSED SESSION

21/121 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
1915	Open	29/1/21	Item 12	Community services leaders to recommend appropriate community effectiveness metrics for future reporting	At April meeting it was proposed that this action should remain open as community metrics had not yet been fully resolved. It was noted that this was work in progress and updates would be provided to the board - update scheduled for May (or timing for completion). Working group of community team members established and work is progressing. Work on-going. A workshop with nurses and therapists to be held on the 13th July. **An update would be provided in the integration report for 30 July 21.**	HB	~~28/5/21~~ ~~26/3/21~~ 30/7/21	Amber	
1929	Open	26/2/21	Item 11	When clearer on national reset expectations (standards/targets) develop local metrics for IQPR to support local innovation and drive improvement	IQPR pack being developed but the revision (taking out) and update (adding in) will take more time. This is also impacted changes in roles and options being considered. Unfortunately we have again needed to second a key member of the team to support CRT for the RAAC works. We are actively looking for external support to backfill this gap. Matter on-going. **Recruitment continues to find suitable support.** Helen to advise of revised target date.	HB	30/04/21	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**.	SW	25/06/21	Green	

1943	Open	26/3/21	Item 10	Set timeline for develop SPC charts at Trust, division and specialty level	Reviewed date proposed following review with information team and head of performance. Potential for some earlier iterations as the Insight work progresses as we as some different/additional metrics to be reported to the Board. **Report going to Insight committee on 5 July; outcome of this would be fedback to board meeting on 30 July.**	CB	~~30/04/2021~~ 30/07/21	Red	
1944	Open	26/3/21	Item 12	Consider how to develop information on the quality of training provided in the 6-monthly education report		JMO	01/10/21	Green	
1958	Open	30/4/21	Item 14.3	Provide visibility for future recruitment pipeline within report	**Future pipeline being created by DCN and DHRD with completion anticipated for reporting at July board.**	JO / SW	30/07/21	Green	
1959	Open	30/4/21	Item 14.3	Provide visibility of the developing national safety nursing care tool for community	**National Development detail awaited.**	SW	30/07/21	Green	
1970	Open	28/5/21	Item 12	Provide details of the CIP programme for the second half of the financial year to a future board meeting.	**Clarity on the income position anticipated within the next month. Overall assessment (including CIP) to come to July Board meeting.**	CB	30/07/21	Green	
1971	Open	28/5/21	Item 13	Improvement committee reports to the board to include update on progress of actions arising from FTSU self-assessment.		JO/AR	30/09/21	Green	
1972	Open	28/5/21	Item 13.1	Surgical team to be asked to submit a paper on actions taken and proposals to mitigate the out of hours issue in surgery prior to the intake of junior doctors in August.	**Paper being submitted for July Board Meeting.**	PM	30/07/21	Green	

1974	Open	28/05/21	Item 14.3	Provide further information to the board on the ward accreditation programm	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.	SW	~~30/07/2021~~ 03/09/21	Amber	
1978	Open	25/6/21	Item 8	Consider how the 'Reasonable Adjustment' video could be made available to all staff' eg staff induction.		JO/SW	03/09/21	Green	
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.		SW	03/09/21	Green	
1980	Open	25/6/21	Item 10	Provide details to board on new ED metrics, when available.		HB	03/09/21	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
1973	Open	28/05/21	Item 14.1	Circulate final CQC report on maternity visit as soon as it is received.	Published by CQC and available on CQC website	SW	25/06/21	Complete	30/07/2021
1975	Open	28/05/21	Item 14.4	Consider how quality walkabouts could be reintroduced.	**Work in progress, first meeting undertaken 17.6.21.**	SW	30/07/21	Complete	30/07/2021
1976	Open	28/05/21	Item 14.4	Invite Natalie Bailey to a future board meeting to present on the work she is doing around mental health.	**Natalie Bailey invited attend open board meeting on 30 July 2021.**	SW	30/07/21	Complete	30/07/2021

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. Staff story (verbal)

To reflect on the experience shared with the Trust

For Report

Presented by Susan Wilkinson and Natalie Bailey

9. Chief Executive’s report

To RECEIVE an introduction on current issues

For Report

Presented by Stephen Dunn

Board of Directors – 30 July 2021

Agenda item:	9			
Presented by:	Steve Dunn, Chief Executive Office			
Prepared by:	James Goffin, Communications Manager Helen Davies, Head of Communications			
Date prepared:	23 July 2021			
Subject:	Chief Executive's Report (updated version)			
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

I open this report on a very personal note. As the board will be aware, I have decided to step down from my role as chief executive.

I joined the Trust seven years ago when it was a standalone hospital. We were uncertain of our future, whether we would be merged with other local hospitals and lose essential services that local people depend on. Instead, we developed our strategy and mission to deliver the best care for our community, and began integrating community and GP services.

We were one of the first digital exemplar trusts and we have massively invested in our facilities and people with an upgraded emergency department, a new acute assessment unit, cardiac centre, urology unit, and staff accommodation. Most recently we have secured the guarantee of a new hospital building for the people of West Suffolk.

However, this last 18 months has presented operational, structural and cultural challenges within the Trust, with a challenging Care Quality Commission inspection locally and the overwhelming impact of the pandemic taking a toll on us all. I have been thinking about my position for some time but felt it was my duty to our amazing staff to lead the Trust through one of the most difficult times that it had ever faced.

The Trust needs to keep moving forward on its journey of improvement. So now is the right time to step down, as we emerge from this brutal pandemic and refresh our strategy for the future. For me personally, it is a time to step back and use my knowledge of the Trust and my previous experience to contribute to national policy making across the health and care sector.

West Suffolk is a brilliant place to work and has wonderful, committed staff. I have loved working here, but it is now the right time – after seven years and as we look towards a new hospital – to hand over the reins to ensure we maintain momentum on the journey of improvement. Craig Black, our deputy chief executive, will be taking on the role of interim chief executive, whilst a recruitment process for the substantive post takes place over the coming months.

This month, the removal of most Covid-19 legal restrictions that have restricted all of our daily lives for more than a year has had surprisingly little effect on the NHS - the service that many of those measures were intended to help protect.

Our infection prevent control guidance has remained unchanged and we are still asking our staff to wear enhanced personal protective equipment and follow additional cleaning procedures, asking our patients to wear masks when in our premises and maintain social distance wherever possible, and asking relatives and friends to understand the need for continued visiting restrictions as we do all we can to protect the vulnerable people in our care. Many of these are not the easiest to do, and I am extremely grateful for the support we continue to receive internally and externally as we do our best through the still uncertain times of the pandemic.

While the effect of that latest unlocking on the impact of case numbers is still to be seen, we have recently seen a renewed surge in cases locally, with West Suffolk reporting 296 cases per 100,000 people compared to a national average of 490. There does seem to be a slowing and slight reduction in recent days, but the outlook remains uncertain through the summer and into winter, when respiratory diseases tend to peak. Thankfully the number of Covid-positive in patient currently remains low, but we have very sadly seen **two deaths from Covid-19** within the Trust after many weeks without any. Inbetween all the statistics it is worth remembering – as our dedicated staff see all too starkly – these are individual people, with families and friends whose lives will be blighted by losing their loved ones. I continue to urge everyone to get vaccinated as soon as possible, and to make sure you get both doses for maximum protection: it remains the best defence we have.

With that in mind, we are again preparing our **winter vaccination programme** for staff. The exact nature of this is still uncertain. For many years we have offered free flu vaccines to staff and we will do so again – this year it looks likely to be joined by a Covid-19 booster jab. We are waiting on the outcomes of research trials and advice from Government on whether these will be given at the same time, and indeed whether they may be compulsory for healthcare staff. The Government has already said it intends to legislate to compel social care staff to be Covid-19 vaccinated – which may impact

on some of our community staff who work in these settings – and it will consult on the same for frontline NHS staff. Whatever the outcome, we will work sensitively to support our staff and our planning is already underway to make the process as straightforward as possible. This builds on our highly successful vaccination programme earlier this year which saw 16,000 local health and social care staff receive their jabs in Quince House, and was recognised with a Lord Lieutenant's award.

We continue to make good progress with our **estates maintenance programme**. As is well known, the main West Suffolk Hospital building is many years past its original expected lifespan and, in common with other hospitals built around the same time, we have particular concerns about a method of concrete construction used for the roofs and walls. Working with external structural experts our estates team has been overseeing the installation of preventative measures to provide extra reassurance. This work has already been completed in several wards and corridors and we expect the programme to last for several months yet. It is, unfortunately, disruptive and noisy and in most cases requires the temporary relocation of patient care and offices. I would like to give my thanks to the fantastic efforts of not just our estates team and contractors, but also our nursing and medical staff, porters, and housekeeping teams for everything they are doing to support this process. Moving whole wards through the building is complex, and it is their excellent teamwork that has been crucial to making it happen with a minimum of hitches.

One unmistakeable impact of the programme is our **new G10 decant ward**. This modular extension has been designed and built in just a few months, and we moved the first patients in just a few days ago. The ward will initially be a temporary home for the young patients of our Rainbow Ward while work is carried out in that area but will also be used to give us additional flexibility for other areas as the estates programme progresses and we respond to whatever pressures we face in the months to come.

Along with the second phase of our emergency department extension – our rapid assessment and treatment area, which opened just ahead of last month's board meeting - the new ward shows the kind of modern healthcare facilities we can expect to see in our **new hospital facility**. As a Trust we have been extremely keen to ensure that what we build reflects not just the views of a few senior staff, but the needs and experiences of our people right through the organisation, partners that we worth with across the integrated care system, and our patients and residents. We have already done a great deal of work to understand the clinical and operational parameters, and this month we have been asking for views on environmental and planning issues. Through a series of online and in-person engagement events we have been explaining how we came to the choice of our preferred site at Hardwick Manor and asking for feedback. This includes the impact that any building will have upon the ecology, landscape and archaeology of the site, as well as issues like roads, traffic flows and parking. Our online survey for this part of the consultation closes on 5 August, so please do take part; details are on our website. We will be providing further opportunity for public and stakeholder comment as we firm up our plans over the coming months, with the intention of submitting an initial planning application by early 2022.

As I mentioned last month, we are pleased to welcome **Clement Mawoyo** as director of integrated community health and adult social care at the West Suffolk Alliance, as a joint appointment between the Trust and Suffolk County Council. Clement was previously area director for adult and community services in north Suffolk, and brings with him 20 years' experience in health and social care. I know Clement shares our ambition of integrated care systems which put the person at the centre of their care, with professionals shaping the response to meet individual needs. He will build on the good work and partnerships that have already been developed through alliance working in Suffolk, beyond community health and social care, and fully appreciating the value of other sectors, including VCSE, primary care, mental health, and district and borough councils. Clement will be working alongside Kevin McGinness and Jayne Harvey, our alliance delivery leads for health and social care respectively; and Gylda Nunn in integrated therapies and Tim Jennings in service development and contracts. The integrated children's paediatric services will continue reporting into our chief operating officer and work closely with Clement and the adult teams on the transition to adult care.

Clement joined just in time to help us celebrate the **NHS's 73rd birthday** on 5 July. Many departments joined with our MyWiSH charity to take part in the NHS Big Tea. Outpatients, endoscopy, housekeeping, and the chapel all held events to share a cuppa and a slice of cake, and the charity worked with our head chef Luke Nobbs and the rest of the catering team to distribute 500 slices of cake to our inpatients at West Suffolk Hospital, Newmarket Hospital, and Glastonbury Court.

A slightly different treat has been provided on some of the hottest days of the year, with the Trust providing **free ice lollies** to staff and patients to help them keep in high spirits during the heatwaves. Working in warm temperatures is never ideal, and the added discomfort of enhanced PPE makes it all the trickier. A big thanks to our facilities manager Brod Pooley and his team for keeping our freezers topped up with lollies – air conditioning is definitely on my list for our new hospital!

One example of the changing nature of health services is the use of digital technology. The Trust was an early adopter of digital patient records, and our use of online tools to communicate with patients massively accelerated during the pandemic. Our **maternity team** have really taken to online, hosting their own Facebook page and running a number of live drop in events. As this month's board meeting is wrapping up they will be holding their first online event for fathers, in partnership with Bury St Edmund's support group EPIC Dad. It's great to see us providing this wrap-around support that goes beyond the traditional expectations of NHS care.

On **employee pay**, the government last week confirmed a 3% consolidated award, backdated to 1 April 2021, for all staff directly employed under the NHS terms and conditions of service. It also announced a 3% consolidated award for doctors and dentists, apart from those on multi-year pay deals. These deals cover the junior doctor and speciality and associate specialist (SAS) doctor groups and involved significant contract reform, as well as investment in other terms and conditions.
We are awaiting further details from the government on this - including how this will be funded, given the still uncertain outlook for the financial year.

I was also very pleased to read the blog on the Trust website from Sam Holloway, the chair of the Trust's LGB&T+ Network, reflecting on **Pride month** in June. While this year's celebrations were again more muted due to the restrictions imposed by Covid-19, it remains important that we are always aware of different viewpoints and needs – whether from those accessing our care or those working alongside us.

We regularly highlight the great work of our staff through our Putting You First awards, and I'm always taken by how many examples there are of people going above and beyond to look after our patients. As part of **Suffolk Day** last month, both our staff psychology support team and our community equipment contract manager Laura Rawlings were recognised as Suffolk Heroes in an award scheme run by our local MPs. The team offers a wide range of support to individuals and teams across the Trust, and have helped hundreds of people through the difficult days of the pandemic. Laura, who has been with us for 10 years, works with her team to ensure our patients have the right equipment to live independent lives at home, something made all the more challenging by the restrictions and logistical challenges Covid-19 imposed.

There has also been renewed recognition for our **clinical helpline team**. Introduced in response to tightened visiting rules, the service for relatives has taken more than 40,000 calls in its first year helping relatives keep up to date with the treatment their family member is receiving. The service has been shortlisted for Patient Safety Team of the Year at the Health Service Journal Patient Safety Awards, and for two accolades – Support for Caregivers, Friends, and Family; and Staff Engagement / Improving Staff Experience – at the Patient Experience Network National Awards.

Our staff also do much in their own time. Consultant anaesthetist **Jeremy Mauger** has been presented with the Suffolk Medal for his work volunteering with Suffolk Accident Rescue Service; the medal is the highest civic award in the county. Critical care nurse **Debbie Lavender** was out for dinner with her partner when a man at the same venue suffered a cardiac arrest – she stepped up and resuscitated him using a defibrillator, before handing over to the East Anglian Air Ambulance. Her live-saving actions have been recognised by the Royal Humane Society.

I will leave you with two more examples of just how much of a difference our people make. Our **Keeping In Touch and stroke care teams** went all out to ensure that 92-year-old Doris Smith didn't miss her daughter's wedding. In hospital and unable to attend, the teams linked up with the happy couple so Doris could watch a live stream of the ceremony. Led by ward manager Maria Musgrove, they also did Doris' hair and make up and provided cupcakes, decorations, and gifts to make the day extra special.

A much younger patient, Bryson Taylor, was born premature and with cerebral palsy. Now nine, he had surgery in February and was determined to walk to school for the first time. With massive efforts from Bryson and the support of our physiotherapist **Lorna Wickens** both in the lead up to the day and

through every step, Bryson made that half-mile walk up the hill to his school in Newmarket and rightly arrived to a hero's welcome.

If there was ever any doubt at what we mean by 'putting you first', or why what we do is so important, seeing the reactions of Doris and Bryson make it all very clear. I have been exceptionally proud to lead an organisation that helps improve the lives of our local residents in these myriad ways: from saving lives, to making the personal dreams of our individual patients come true. I will miss you all, but know you will continue to impress everyday.

10:00 DELIVER FOR TODAY

10. Insight Committee Report

To APPROVE the report

For Approval

Presented by Richard Davies, Craig Black and Helen Beck

10.1. Finance and workforce report

To ACCEPT the report

For Report

Presented by Craig Black

Board of Directors – 30 July 2021

Agenda item:	10.1			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	22nd July 2021			
Subject:	Finance and Workforce Board Report – June 2021			
Purpose:		For information	x	For approval

Executive summary:

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

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

We previously agreed a budget for 2021-22 to deliver a deficit of £10.5m, with a Cost Improvement Programme (CIP) of 1%. However, the funding arrangements for the first half of 21-22 are expected to facilitate a break-even position.

Whilst there is still uncertainty over our income for the second half of the year we expect it to cover our expenditure and are therefore forecasting a break-even position for 21-22. Given the uncertainty over our funding we will continue to review this position.

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

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

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

Recommendation:
The Board is asked to review this report.

FINANCE AND WORKFORCE REPORT
June 2021 (Month 3)

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

Financial Summary

I&E Position YTD	£0m	break-even
Variance against Plan YTD	£0m	on-plan
Movement in month against plan	£0m	on-plan
EBITDA position YTD	£4.2m	on-plan
EBITDA margin YTD	5%	on-plan
Cash at bank	£18.9m	

Executive Summary

- The reported I&E for June is break-even (YTD break-even).
- Forecast break-even position 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 continue in line with 2020-21
- Delivery of CIP programme

SUMMARY INCOME AND EXPENDITURE ACCOUNT - June 2021	June 2021 Budget £m	June 2021 Actual £m	June 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	23.9	0.8	71.8	70.7	(1.2)
Other Income	3.8	3.5	(0.3)	9.8	9.1	(0.8)
Total Income	**26.9**	**27.4**	**0.5**	**81.7**	**79.7**	**(2.0)**
Pay Costs	16.9	17.2	(0.3)	50.6	51.7	(1.1)
Non-pay Costs	8.8	8.9	(0.1)	27.4	23.8	3.6
Operating Expenditure	**25.7**	**26.1**	**(0.4)**	**78.0**	**75.5**	**2.4**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA excl STF	**1.2**	**1.3**	**0.1**	**3.7**	**4.2**	**0.5**
Depreciation	0.8	0.7	0.0	2.3	2.2	0.0
Finance costs	0.5	0.6	(0.1)	1.4	1.9	(0.5)
SURPLUS/(DEFICIT)	**0.0**	**0.0**	**(0.0)**	**0.0**	**0.0**	**0.0**

FINANCE AND WORKFORCE REPORT – June 2021

Contents:

Key:

Performance better than plan and improved in month	
Performance better than plan but worsened in month	
Performance worse than plan but improved in month	
Performance worse than plan and worsened in month	

Performance better than plan and maintained in month	
Performance worse than plan and maintained in month	
Performance meeting target	✓
Performance failing to meet target	✗

FINANCE AND WORKFORCE REPORT – June 2021

Income and Expenditure Summary as at June 2021

The reported I&E for June 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.

Whilst there is still uncertainty over our income for the second half of the year we expect it to cover our expenditure and are therefore forecasting a break-even position for 21-22. Given the uncertainty over our funding we will continue to review this position.

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	7	6	(0)	⇔	Green
EBITDA %	0.0%	0.0%	(0.0%)	⇔	Green
Clinical Income YTD	(56,343)	(54,905)	(1,437)	↑	Green
Non-Clinical Income YTD	(25,329)	(24,786)	(543)	↑	Green
Pay YTD	50,554	51,691	(1,137)	↑	Green
Non-Pay YTD	31,120	28,007	3,113	↓	Green
CIP Target YTD	1,058	958	(100)	↑	Green

Cost Improvement Programme (CIP) 2021-22

The CIP programme for 2021-22 is £3.1m (100%). In the year to June we achieved £958k (31.1%) against a plan of £1.1m (34.6%). This represents a £100k shortfall.

Recurring/Non Recurring	2021-22 Annual Plan	Plan YTD	Actual YTD
	£'000	£'000	£'000
Recurring			
Outpatients	-	-	-
Procurement	242	36	36
Activity growth	-	-	-
Additional sessions	101	60	60
Community Equipment Service	271	68	67
Drugs	51	13	13
Estates and Facilities	63	20	5
Other	280	75	59
Other Income	147	24	17
Pay controls	28	7	4
Service Review	-	-	-
Staffing Review	36	9	9
Theatre Efficiency	20	3	-
Contract Review	319	80	29
Workforce	-	-	-
Consultant staffing	-	-	-
Agency	-	-	-
Car Park income	75	19	-
Unidentified CIP	504	0	-
Recurring Total	**2,137**	**413**	**298**
Non-Recurring			
Pay controls	99	66	111
Theatre Efficiency	280	174	144
Staffing Review	-	-	-
Other	540	405	405
Estates and Facilities	-	-	-
Non-Recurring Total	**919**	**645**	**661**
Total CIP	**3,056**	**1,058**	**958**

Recurring/Non Recurring	2021-22 Annual Plan	H1 Plan	H2 Plan
	£'000	£'000	£'000
Recurring			
Procurement	242	72	170
Additional sessions	101	101	-
Community Equipment Service	271	136	136
Drugs	51	25	25
Estates and Facilities	63	34	29
Other	280	152	128
Other Income	147	132	15
Pay controls	28	14	14
Staffing Review	36	18	18
Theatre Efficiency	20	7	13
Contract Review	319	160	160
Car Park income	75	38	38
Unidentified CIP	504	0	504
Recurring Total	**2,137**	**888**	**1,249**
Non-Recurring			
Pay controls	99	87	12
Theatre Efficiency	280	280	-
Other	540	540	-
Non-Recurring Total	**919**	**907**	**12**
Total CIP	**3,056**	**1,795**	**1,262**

FINANCE AND WORKFORCE REPORT – June 2021

Trends and Analysis

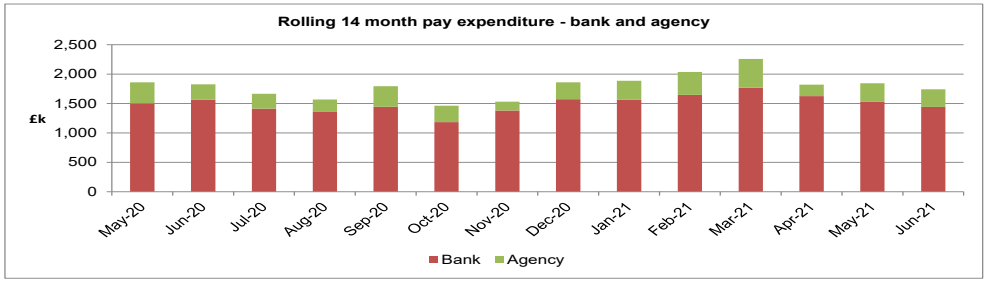
Workforce

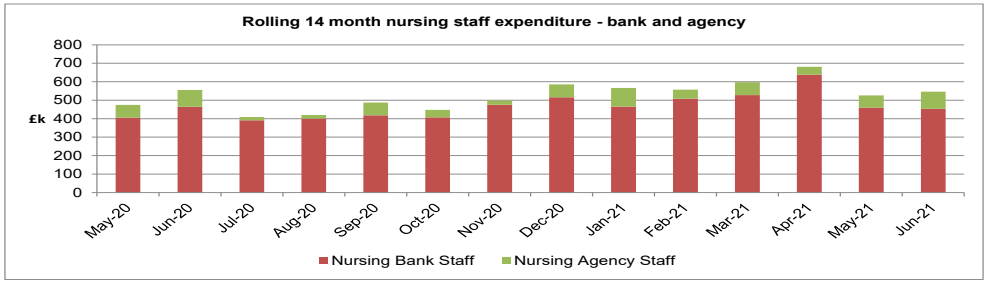
During June the Trust overspent by £0.3m on pay (£1.1m YTD).

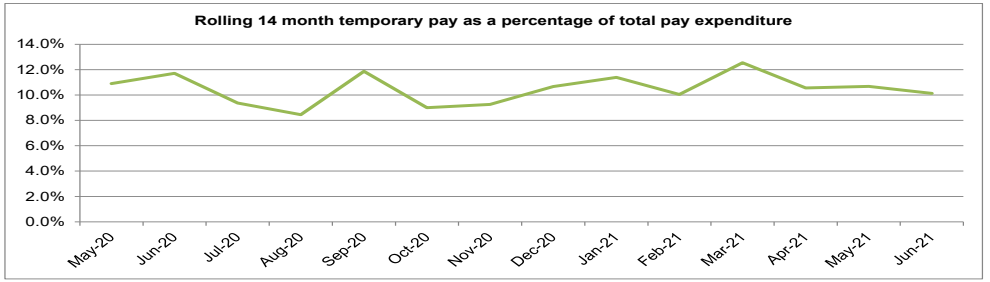
Monthly Expenditure (£)				
As at June 2021	Jun-21	May-21	Jun-20	YTD
	£000's	£000's	£000's	£000's
Budgeted Costs in-month	16,860	16,856	16,860	50,554
Substantive Staff	15,449	15,418	13,762	46,290
Medical Agency Staff	128	163	130	365
Medical Locum Staff	203	357	320	832
Additional Medical Sessions	378	276	359	836
Nursing Agency Staff	93	66	91	202
Nursing Bank Staff	453	460	464	1,552
Other Agency Staff	77	79	41	235
Other Bank Staff	189	237	201	727
Overtime	98	106	132	342
On Call	121	98	87	312
Total Temporary Expenditure	1,739	1,843	1,824	5,402
Total Expenditure on Pay	17,188	17,261	15,587	51,691
Variance (F/(A))	(329)	(405)	1,273	(1,137)
Temp. Staff Costs as % of Total Pay	10.1%	10.7%	11.7%	10.5%
memo: Total Agency Spend in-month	298	309	262	802

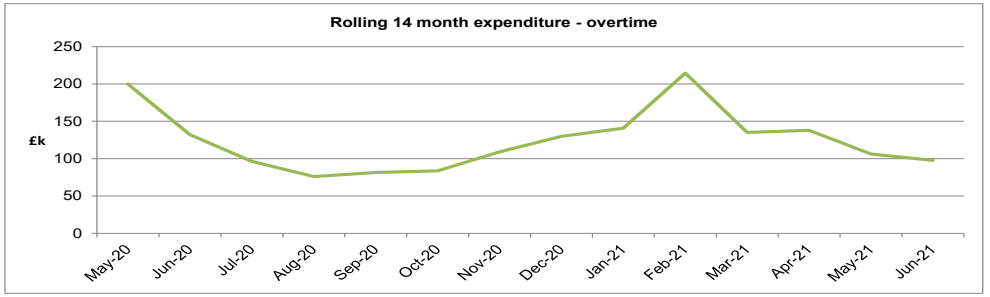
Monthly WTE				
As at June 2021	Jun-21	May-21	Jun-20	YTD
	£000's	£000's	£000's	£000's
Budgeted WTE in-month	4,371.2	4,365.3	4,371.2	14,849.7
Substantive Staff	4,063.0	4,040.9	3,811.0	12,153.1
Medical Agency Staff	9.4	0.0	16.3	16.6
Medical Locum Staff	22.8	30.5	27.7	80.7
Additional Medical Sessions	8.0	6.5	2.7	17.4
Nursing Agency Staff	9.5	0.0	11.7	29.4
Nursing Bank Staff	129.4	112.0	137.6	417.0
Other Agency Staff	25.9	0.0	8.5	42.8
Other Bank Staff	78.1	89.0	77.7	285.5
Overtime	22.5	25.3	36.4	82.9
On Call	8.2	7.1	8.4	22.7
Total Temporary WTE	313.8	270.4	327.0	995.0
Total WTE	4,376.7	4,311.4	4,137.9	13,148.2
Variance (F/(A))	(5.5)	54.0	233.3	1,701.5
Temp. Staff WTE as % of Total WTE	7.2%	6.3%	7.9%	7.6%
memo: Total Agency WTE in-month	44.7	0.0	36.5	88.8

Pay Costs









FINANCE AND WORKFORCE REPORT – June 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	(7,427)	(7,042)	(385)	(21,970)	(20,810)	(1,159)
Other Income	(291)	(258)	(32)	(872)	(770)	(102)
Total Income	**(7,718)**	**(7,300)**	**(418)**	**(22,841)**	**(21,580)**	**(1,261)**
Pay Costs	4,400	4,694	(294)	13,138	14,211	(1,073)
Non-pay Costs	1,904	1,952	(47)	4,986	5,177	(191)
Operating Expenditure	**6,305**	**6,646**	**(341)**	**18,124**	**19,388**	**(1,264)**
SURPLUS / (DEFICIT)	**1,413**	**654**	**(759)**	**4,717**	**2,192**	**(2,525)**
SURGERY						
NHS Contract Income	(5,398)	(5,388)	(10)	(15,531)	(15,138)	(394)
Other Income	(199)	(196)	(3)	(597)	(536)	(61)
Total Income	**(5,597)**	**(5,584)**	**(13)**	**(16,128)**	**(15,673)**	**(455)**
Pay Costs	3,484	3,577	(93)	10,437	10,637	(200)
Non-pay Costs	1,161	1,141	20	3,482	3,327	155
Operating Expenditure	**4,645**	**4,718**	**(73)**	**13,919**	**13,964**	**(46)**
SURPLUS / (DEFICIT)	**952**	**866**	**(86)**	**2,209**	**1,709**	**(501)**
WOMENS AND CHILDRENS						
NHS Contract Income	(2,007)	(2,108)	101	(5,846)	(5,660)	(186)
Other Income	(67)	(69)	2	(201)	(205)	4
Total Income	**(2,074)**	**(2,177)**	**104**	**(6,047)**	**(5,865)**	**(182)**
Pay Costs	1,488	1,481	7	4,465	4,428	37
Non-pay Costs	211	334	(124)	516	706	(190)
Operating Expenditure	**1,699**	**1,816**	**(117)**	**4,982**	**5,134**	**(153)**
SURPLUS / (DEFICIT)	**375**	**362**	**(13)**	**1,065**	**731**	**(335)**
CLINICAL SUPPORT						
NHS Contract Income	(636)	(693)	57	(1,791)	(1,631)	(160)
Other Income	(157)	(164)	7	(471)	(466)	(5)
Total Income	**(793)**	**(857)**	**64**	**(2,262)**	**(2,097)**	**(165)**
Pay Costs	2,037	2,107	(70)	6,166	6,191	(25)
Non-pay Costs	1,001	952	50	3,028	3,000	28
Operating Expenditure	**3,038**	**3,058**	**(20)**	**9,193**	**9,191**	**2**
SURPLUS / (DEFICIT)	**(2,245)**	**(2,201)**	**44**	**(6,931)**	**(7,094)**	**(163)**
COMMUNITY SERVICES						
NHS Contract Income	(2,677)	(2,638)	(40)	(8,032)	(7,913)	(119)
Other Income	(1,121)	(1,156)	35	(3,363)	(3,322)	(41)
Total Income	**(3,798)**	**(3,794)**	**(4)**	**(11,395)**	**(11,235)**	**(160)**
Pay Costs	2,698	2,825	(127)	8,093	8,274	(181)
Non-pay Costs	1,163	1,161	1	3,489	3,534	(46)
Operating Expenditure	**3,861**	**3,987**	**(126)**	**11,582**	**11,808**	**(226)**
SURPLUS / (DEFICIT)	**(62)**	**(192)**	**(130)**	**(187)**	**(573)**	**(386)**
ESTATES AND FACILITIES						
NHS Contract Income	0	0	0	0	0	0
Other Income	(446)	(264)	(183)	(1,339)	(752)	(587)
Total Income	**(446)**	**(264)**	**(183)**	**(1,339)**	**(752)**	**(587)**
Pay Costs	946	1,037	(91)	2,843	3,087	(244)
Non-pay Costs	665	693	(28)	1,964	1,814	151
Operating Expenditure	**1,611**	**1,730**	**(119)**	**4,808**	**4,901**	**(93)**
SURPLUS / (DEFICIT)	**(1,164)**	**(1,467)**	**(302)**	**(3,468)**	**(4,149)**	**(681)**
CORPORATE						
NHS Contract Income	(4,937)	(6,044)	1,107	(18,656)	(19,399)	743
Other Income	(1,535)	(1,336)	(199)	(2,978)	(3,042)	65
Total Income	**(6,471)**	**(7,380)**	**908**	**(21,634)**	**(22,442)**	**808**
Pay Costs	1,807	1,467	340	5,411	4,862	549
Non-pay Costs	2,591	2,660	(69)	9,595	6,281	3,314
Capital Charges and Financing Costs	1,342	1,275	67	4,033	4,114	(81)
Operating Expenditure	**5,740**	**4,126**	**1,613**	**19,039**	**11,143**	**7,896**
SURPLUS / (DEFICIT)	**732**	**3,253**	**2,521**	**2,594**	**11,298**	**8,704**
TOTAL						
NHS Contract Income	(23,082)	(23,913)	830	(71,826)	(70,552)	(1,274)
Other Income	(3,816)	(3,444)	(372)	(9,821)	(9,093)	(728)
Total Income	**(26,898)**	**(27,356)**	**458**	**(81,647)**	**(79,644)**	**(2,003)**
Pay Costs	16,860	17,188	(329)	50,554	51,691	(1,137)
Non-pay Costs	8,696	8,893	(197)	27,060	23,839	3,221
Capital Charges and Financing Costs	1,342	1,275	67	4,033	4,114	(81)
Operating Expenditure	**26,898**	**27,356**	**(458)**	**81,647**	**79,644**	**2,003**
SURPLUS / (DEFICIT)	**0**	**0**	**(0)**	**0**	**0**	**0**

Page 5

Medicine (Sarah Watson)

The division is behind plan in month by £759k (YTD £2.525m).

Clinical income is behind plan by £385k in month (£1.16m YTD). Activity has continued to improve as detailed in Table 1 below. A & E has seen significant and sustained increases since April. In June, non-elective activity has outperformed plan by 16%, the 2yr average by 23% and average 19/20 activity by 13%.

Despite being 5% behind plan, Outpatient activity is now in line with that performed in 19/20 and is outperforming the 24 month average by 6%. Elective activity is out-performing the 2yr average and at 97%, activity levels are ahead of the national expectations for activity recovery (80% of 19/20 activity by the end of M3).

Activity Type	Vs Plan	Vs 24 Mth Avg	Vs 2020 Avg
Non-Elective	16%	23%	13%
Outpatients	-5%	6%	0%
Elective	-10%	19%	-3%

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 plan in June by £374k (£1.36m YTD).

Pay costs account for £294k of the monthly overspend (£1.07m YTD) due to :

- Consultants (£41k) – The use of locums and additional sessions to cover vacancies and operational pressures.
- Junior Doctors (£51k) – Likely due to funding not yet transferred from Corporate areas
- ED Registrars (£60k) – the reduction in the use of temporary staffing to cover substantive vacancies is a continued area of focus for the division.
- Temporary Unregistered Nursing (£90k) – wards across the division have seen an increase in the need for 1:1 specialling as a result of patient mix.

Non-pay costs are £47k over budget in month. This is the result of:

- Drugs (£70k) - likely to be excluded drugs which can be reclaimed.
- £44k credit in month due to apprenticeship funding to cover study days.

Surgery (Simon Taylor)

The division is behind plan in month by £86k (YTD £501k)

Clinical income is behind plan by £10k in month (£394k YTD). Day case activity continues to exceed plan - by 5.29% in June (7.31% in May), whilst elective

inpatient activity has seen a decrease month on month from 209 to 110 patients. This is result of limited elective bed capacity to support inpatient activity. Bed capacity will increase over the coming months but this will continue to be impacted by theatre availability until the works are completed later this year. Alternatives such as the Vanguard unit and weekend sessions will be used during this period to provide additional capacity. In June, outpatient activity improved by 9.74% compared to May, with significant improvements in Ophthalmology, Orthopaedics, and Urology. Non-elective activity exceeded plan by 11.3%, with strong increases within ENT, General Surgery and Urology.

Pay expenditure reported an overspend of £93k in month (£200k YTD) due to:

- Critical Care - £70k – During the COVID pandemic additional staff were recruited fixed term to support the ward and configuration changes (additional side rooms). These remain in place to date.
- General Surgery - £33k – additional sessions

With reduction in bed capacity and main theatres due to ongoing works, non-pay expenditure was underspent by £20k in month (£155k YTD).

Women and Children's (Michelle O'Donnell)

In June, the Division reported an adverse variance of £13k (£335k YTD)

Income was £104k ahead of plan in-month (£182k behind plan YTD). Over the quarter, the neonatal unit has been busy and ante & post natal care registrations have exceeded plan. Whilst outpatient activity has continued to be 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 the paediatric non-elective admissions will increase in the future as the department is planning to receive a large number of RSV cases over the next few months.

Pay reports a £7k underspend in-month (£37k YTD). In-month, the extra staffing levels on the Paediatric Ward were maintained to cover pressures from RSV and COVID. Year to date, the large number of unfilled midwife posts have offset cost pressures from COVID and backlog recovery. The maternity service has plans to recruit to more positions as the Continuity of Carer initiative is expanded.

Non-pay reports a £124k overspend in-month (£190k YTD). In-month, the maternity service paid historic invoices for down syndrome testing and paediatric post mortems. Year to date, cost pressures in the Antenatal Clinic from additional COVID capacity and overspends on the paediatric drugs budget have persisted.

Clinical Support (Michelle O'Donnell)

In June, a favourable variance of £44k (£163k adverse variance YTD).

Income was £64k ahead of plan in-month (£165k behind plan YTD). Over the quarter, direct access radiology activity has increased to accommodate the increase in GP referrals. However, breast screening and outpatient radiology activity have 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 reports a £70k overspend (£25k YTD). Diagnostics overspent on medical and non-medical pay as the team work additional hours to address the backlog demand for imaging, and pathology has overspent from providing the COVID SAMBA testing service. YTD vacancies in pathology, pharmacy and outpatient nursing budgets have offset cost pressures from COVID and backlog recovery.

Non-pay reports a £50k underspend (£28k YTD). Underspends in pathology non-pay budgets have offset COVID related pressures in radiology and outpatients.

Community Services (Lesley Standring)

In June, the Division reported an adverse variance of £130k (YTD £386k).

Income reported £4k under recovery in June (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 first half of the year.

Pay reported an adverse variance of £127k in month (YTD £181k). Whilst the division has a favourable underlying pay position without COVID costs, agency staff were used to cover some vacant Therapy roles in Adult Physiotherapy, Occupational Therapy, Dietetics and the Early Intervention Team. Prior month costs for the peripatetic team were reclassified to Pay from Non-pay in M3.

Non-pay reported a favourable variance of £1k in June (YTD adverse £46k). Prior month costs for the peripatetic team were reclassified to Pay from Non-pay in M3. Additional community equipment costs continue in order to enable timely hospital discharges. 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 spend on dressings and consumables increasing. The position will be further impacted as a result of restoration and recovery of services, as well as the additional demand placed on Community teams due to the RAAC works; with additional activity managed in the community.

FINANCE AND WORKFORCE REPORT – June 2021

Statement of Financial Position at 30 June 2021

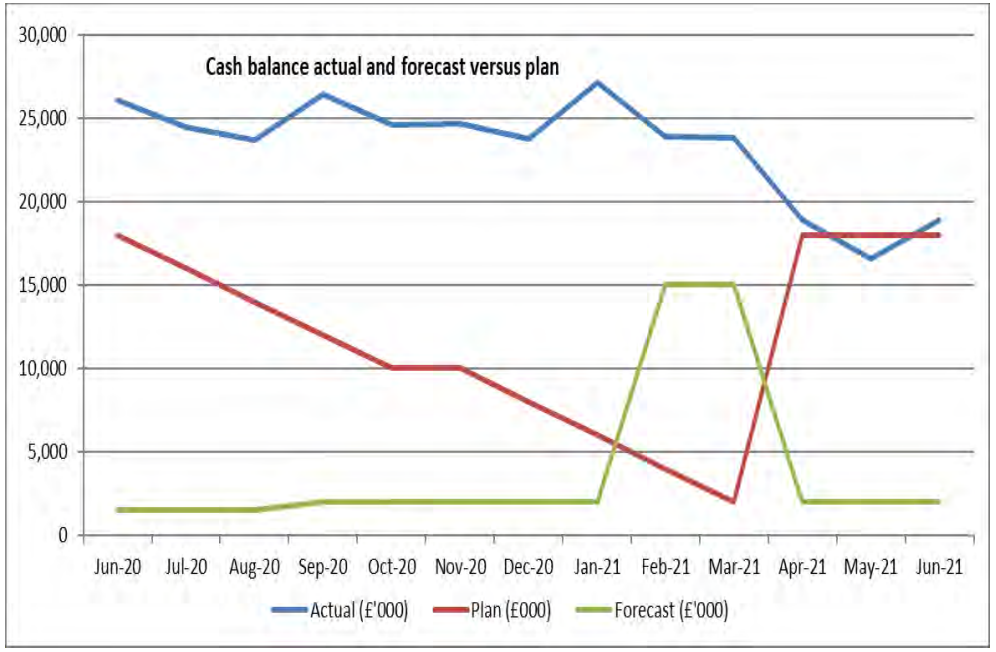
STATEMENT OF FINANCIAL POSITION

	As at 1 April 2021	Plan 31 March 2022	Plan YTD 30 June 2021	Actual at 30 June 2021	Variance YTD 30 June 2021
	£000	£000	£000	£000	£000
Intangible assets	52,198	54,398	52,598	55,099	2,501
Property, plant and equipment	137,103	168,603	138,603	145,273	6,670
Trade and other receivables	6,341	6,341	6,341	6,341	0
Total non-current assets	**195,642**	**229,342**	**197,542**	**206,713**	**9,171**
Inventories	3,481	3,481	3,481	3,516	35
Trade and other receivables	19,362	19,362	19,362	20,727	1,365
Cash and cash equivalents	23,788	2,006	18,006	18,882	876
Total current assets	**46,631**	**24,849**	**40,849**	**43,125**	**2,276**
Trade and other payables	(52,522)	(37,779)	(47,579)	(52,869)	(5,290)
Borrowing repayable within 1 year	(6,439)	(5,500)	(5,500)	(5,455)	45
Current Provisions	(46)	(46)	(46)	(46)	0
Other liabilities	(1,357)	(3,357)	(3,357)	(1,356)	2,001
Total current liabilities	**(60,364)**	**(46,682)**	**(56,482)**	**(59,726)**	**(3,244)**
Total assets less current liabilities	**181,909**	**207,509**	**181,909**	**190,112**	**8,203**
Borrowings	(47,719)	(43,319)	(47,719)	(48,922)	(1,203)
Provisions	(852)	(852)	(852)	(852)	0
Total non-current liabilities	**(48,571)**	**(44,171)**	**(48,571)**	**(49,774)**	**(1,203)**
Total assets employed	**133,338**	**163,338**	**133,338**	**140,338**	**7,000**
Financed by					
Public dividend capital	158,650	188,650	158,650	165,650	7,000
Revaluation reserve	8,743	8,743	8,743	8,743	0
Income and expenditure reserve	(34,055)	(34,055)	(34,055)	(34,055)	0
Total taxpayers' and others' equity	**133,338**	**163,338**	**133,338**	**140,338**	**7,000**

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 PDC drawdown was planned for July, however we were able to draw down £7m earlier than anticipated, which is linked to the spend on capital noted above. Payables are higher than planned, however have not moved significantly since the year end. A significant amount of this balance relates to the annual leave and study leave accruals, which will start to get released throughout the year.

Cash Balance Forecast for the year

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



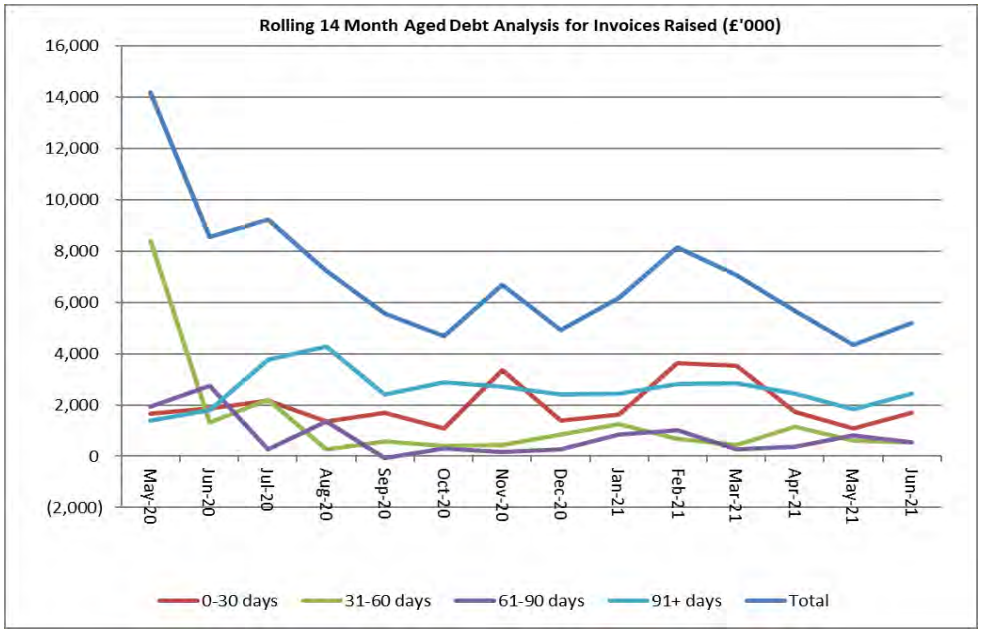
The Trust's cash balance increased significantly during the prior year and continues to be in a strong position into month 3. However the cash position will require rigorous monitoring during 2021/22 as the Trust will no longer be receiving any income in advance as it was in 2020/21 and we need to ensure that the timing of the capital payments is line with capital cash funding due to be received.

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

FINANCE AND WORKFORCE REPORT – June 2021

Debt Management

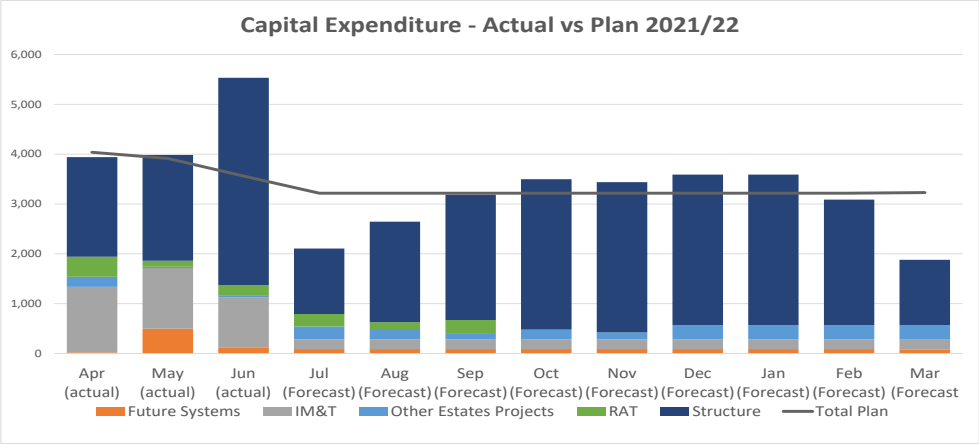
The graph below shows the level of invoiced debt based on age of debt.



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 89% of these outstanding debts relate to NHS Organisations, with 39% of these NHS debts being greater than 90 days old. We are actively trying to agree a position with the remaining corresponding NHS Organisations for these historic debtor balances and a significant amount of work has been completed in this area to help reduce these historic balances.

Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Forecast £'000	Aug Forecast £'000	Sep Forecast £'000	Oct Forecast £'000	Nov Forecast £'000	Dec Forecast £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	Total 2020-21 £'000
Future Systems	24	498	114	90	90	90	90	90	90	90	90	84	1,440
IM&T	1,316	1,219	1,016	194	194	194	194	194	194	194	194	196	5,299
Other Estates Projects	199	25	41	260	210	110	198	141	291	291	291	290	2,347
RAT	403	120	203	250	137	280	0	0	0	0	0	0	1,393
Structure	1,999	2,122	4,157	1,314	2,014	2,514	3,014	3,014	3,014	3,014	2,514	1,310	30,000
Total / Forecast	3,941	3,984	5,531	2,108	2,645	3,188	3,496	3,439	3,589	3,589	3,089	1,880	40,479
Total Plan	4,038	3,915	3,561	3,216	3,216	3,216	3,216	3,218	3,218	3,218	3,218	3,229	40,479

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

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

10.2. Operational report

To APPROVE a report

For Approval

Presented by Helen Beck

Trust Board – 25 June 2021

Agenda item:	10.2			
Presented by:	Helen Beck, Executive Chief Operating Officer			
Prepared by:	Helen Beck, Executive Chief Operating Officer			
Date prepared:	23 July 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 saw its highest recorded number of ED attendances in June 2021 at 7752. This represents a 16% increase on the June 2019 (pre-pandemic level). Overall numbers of non-admitted patients have been stable and this increase is being largely seen in the minor non-admitted category. In line with the regional and national picture we are seeing sustained increases in mental health presentations and also paediatrics. This increased level of demand is being seen across all providers in primary, community, acute and mental health. An ICS workshop has been planned to consider opportunities across the system to address this situation which is unsustainable and at WSFT we have established a task and finish group with support from the integrated transformation team to consider local opportunities. This group will also support the anticipated roll out of the new emergency care standards (date still to be confirmed) and increases in same day emergency care pathways (SDEC).

Non elective admissions fell by163 from May to June (5.5%). Whilst this is lower than the June 19 level it should be recognised that this is in the context that the Trust is operating with 3 wards closed due to the decant programme. The resultant sustained pressure on clinical and operational teams is therefore significant. Delays in ED due to lack of beds are increasing with the average journey time (July to date) has increased to 231 minutes. The number of patients waiting in ED over 12 hrs has increased again to 30 in June (4 April, 23 May). This continues to reflect our internal bed pressures and the pressures on mental health services.

The national and regional situation in relation to Covid hospitalisations is a significant cause for concern. At the time of writing there are five patients in the hospital with a confirmed Covid result and these are being managed through the identified Covid capacity available. We have seen a number of paediatric Covid admissions over the past few weeks as well as a mixture of adults of all ages and vaccination status. We currently have no Covid patients in critical care but are offering mutual aid to other units in the region who are already at capacity. However, the East of England is behind the national curve in relation to Covid hospital demand and WSFT appears to be behind the regional picture. Covid demand modelling is extremely challenging given our small numbers and the various unknowns surrounding vaccine efficacy, new variants of concern and full easing of lockdown restrictions. We have been advised by the regional team to plan for a doubling of current numbers three times over the next 4 weeks which would result in approximately 40 Covid patients in the Trust by the end of August. We have a phased plan to increase Covid capacity as numbers dictate but this would inevitably have a negative impact on the elective recovery programme. Enacting the plan will be challenging without given the current bed state and lack of flexibility.

RAAC bearing extension and operational impact

The end bearing remedial work programme is progressing well and is still on target to complete at the end of October 2021. Wave 2 is now complete and Wave 3 is underway. Ward F14 is currently on F10 and the Discharge Waiting Area has once again been relocated to the Courtyard Café area. This move provides less capacity and flexibility for the DWA which can currently only accept up to 8 patients at a time in recliner chairs, a situation which further hampers bed flow throughout the day. The F5/6 suite of 2 wards, access corridor and offices including the hospital control room, will be fully decanted by 25th July and handed over to the contractors. Ward G10, the new decant ward is now operational and F1 paediatrics moved there on 22July following an aborted move earlier in the week when some issues with the security of the area for paediatrics were identified. Whilst this was disappointing the teams, everyone has rallied round to address the issues and enact a second move within 48 hrs. Due to the complexities of relocating paediatrics this area will have the full failsafe work done at this time to avoid the need for a second decant.
The theatre failsafe programme is still on track for completion at the end of October and critical care have moved back into their main unit with the welcome addition of 2 more side rooms. This

has released a small amount of capacity on F2 which is now being used to support the elective recovery programme for orthopaedics. The following areas remain outstanding and are scheduled for Wave 4 of the programme: F4, F7, Neonatal Unit, Diagnostic Unit.

The Medical Treatment Unit has now moved to a new home within St Nicholas Hospice for the duration of the decant and failsafe programme.

Plans are currently being finalised for the second round of decants (Waves 5-7) to complete the full failsafe work. This is due to commence in October 21 and run through to March 23. The CRT are working to deliver to this already agreed timeframe whilst only taking 2 wards from the operational bed capacity from October 21 to March 22 to support winter capacity.

Accelerator Programme and Elective Recovery

The accompanying slide deck, 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 is a high degree of confidence that the system will achieve this first milestone although as noted in the slides the risks of workforce, estates and high levels of non-elective demand and Covid are growing. The impact of the theatre closure programme at WSFT is now being felt in terms of activity and waiting times as evident in the data. Collaborative working across the 2 sites is making progress although patient choice and clinical governance issues mean that progress is slow. The Vanguard Unit is currently being installed at Ipswich and is expected to be operational in August. A timetable of sessions for WSFT clinical teams to use the facility until the end of October has been agreed and work is underway to populate the lists.

Every effort is being made to use local independent sector capacity although it is recognised that this is limited in West Suffolk. We have an agreed all day list every week at the BMI which supports delivery of our breast cancer activity. In addition, we are undertaking some day case general surgery at the BMI and ad hoc sessions for plastics. We are outsourcing ophthalmology activity to a range of independent sector providers as well as sending some patients to Ipswich hospital. Discussions are ongoing about the potential for a small amount of capacity for West Suffolk patients at the Ramsey Oaks Hospital (Colchester). Patient choice is a key factor in this work with many patients electing to wait longer rather than accept the offer of surgery with an alternative provider.

The other main element of the accelerator programme is the delivery of a programme of transformation aimed at supporting future sustainability. We have recruited, (via Attain); a programme director, senior operational manager and project manager to support in the delivery of this programme. They are working alongside members of our joint transformation team to support clinicians and operational managers with this work.

There are a number of work streams sitting within this programme aimed are reducing demand and /or improving efficiency.

- Advice and guidance aimed at reducing outpatient demand by enabling GPs to seek a specialist opinion without needed to refer the patient. We already perform well but are working to improve the digital offer to clinicians to support more activity in this area and identified the time requirement for this activity so that it can be built into job plans.
- Virtual Consultations either via telephone of video link where appropriate. We currently perform above the threshold target but are looking at options to use a solution based around Teams to improve the offer to clinicians.
- Patient Initiated Follow Up (PIFU) aimed at enabling patients to determine if/ when they need a follow up appointment rather than scheduling timed regular follow ups. Recording of this activity has been challenging for us but a solution is being developed and we are working with specialties to develop their pathways.
- Patient Portal promoting increased use of the patient portal to improve communication with patients and enable them to be more proactive in their care. This work is focussed around

making the registration process easier and exploring options for greater integration with Cerner.

- High Volume Low Complexity (HVLC) pathways. These are 29 pathways developed by GIRFT and supported by the Royal Colleges aimed at delivering best practice. We have undertaken a baseline audit against the pathways applicable to WSFT and have identified strong correlation with the pathways, however there is still some opportunities for improvement. The programme team are working with individual specialties to take advantage of the opportunities identified prioritising the highest volume and therefore highest impact areas first.
- HVLC end to end pathways for MSK, ophthalmology and cardiology. Project teams have been established across SNEE and baseline mapping has been undertaken.

IT should be noted that all of the above are requirements within this year planning guidance and are therefore not just expectations of accelerator sites. We are using some of the accelerator funding to support deliver of these programmes at pace.

As a system we have successfully passed through the ERF funding gateway for June and have positive indications for July although the expectations of the national team are becoming more challenging. All trusts were written to on 9th July informing them of a change to the ERF activity levels with effect from 1st July. Trusts will now be eligible for ERF funding at 100% of tariff for activity delivered above 95% of 19/20 baseline and at 120% of tariff for activity above 100% of 19/20 baseline. This replaces the previous payment of 120% of tariff for activity above 85% of the 19/20 baseline. We continue to push forward to deliver all of the activity and efficiency schemes whilst we work to understand the financial impact of this change. The activity expectations and 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

Specialty	Total		Week ending	Wait time (92%ile)	Wait list	>18 wks	>52 wks	>78 wks	>98 wks	>104 wks	%<18wks
Base week (w/e)	11 July 2021	44	11 July 2021	63 weeks	23645	8160	2274	859	83	23	65.5%
Comparison week (w/e)	18 July 2021	44	18 July 2021	61 weeks	23562	8090	2259	915	93	30	65.7%
Trust/SNEE	WSFT		Change	-2	-83	-70	-15	56	10	7	0.2%
All/DTA incompletes	All										
			44395WSFTTotal	44388WSFTTotal	44381WSF	44374WSF	All				
			Clock stops	<=18w	>18w	Total	Crude clearance time*				
			This week	721	230	951	25 weeks				
			Last 4 weeks	749	246	996	24 weeks		3982	0.034145	

Specialty	Total		Week ending	Wait time (92%ile)	Wait list	>18 wks	>52 wks	>78 wks	>98 wks	>104 wks	%<18wks
Base week (w/e)	11 July 2021	44	11 July 2021	40 weeks	58462	18023	1971	409	30	22	69.2%
Comparison week (w/e)	18 July 2021	44	18 July 2021	40 weeks	58329	17985	1916	401	30	26	69.2%
Trust/SNEE	ESNEFT		Change	0	-133	-38	-55	-8	0	4	0.0%
All/DTA incompletes	All										
			44395ESNEFTTotal	44388ESNEFTTotal	44381ESN	44374ESN	All				
			Clock stops	<=18w	>18w	Total	Crude clearance time*				
			This week	2012	827	2839	21 weeks				
			Last 4 weeks	1949	789	2738	22 weeks		10952	0.034345	
			*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 18 July 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 MAY are based on 3 May – 30 May average, JUNE are 31 May - 4 JULY average. N.b. May figures may be overstated and June figures understated as the bank holiday fell differently in the 2019/20 baseline year. The June figure will improve slightly as coding lags are eliminated.

Key headlines:

First outpatients:			MAY	95.1%		JUNE	88.3%	
Overall	89%	was	92%	Target:	80%	(from June)		
WSFT	89%	was	92%					
ESNEFT	89%	was	91%					
Follow up outpatients:			MAY	102.8%		JUNE	94.0%	
Overall	92%	was	97%	Target:	80%	(from June)		
WSFT	89%	was	98%					
ESNEFT	94%	was	97%					
Inpatient electives:			MAY	106.1%		JUNE	81.4%	
Overall	90%	was	85%	Target:	80%	(from June)		
WSFT	47%	was	44%					
ESNEFT	101%	was	97%					
Daycases:			MAY	105.0%		JUNE	98.2%	
Overall	98%	was	99%	Target:	80%	(from June)		
WSFT	94%	was	95%					
ESNEFT	100%	was	100%					
MRI:			MAY	93.8%		MAY	95.4%	
Overall	99%	was	103%	Target:	80%	(from June)		
WSFT	82%	was	94%					
ESNEFT	105%	was	105%					
CT:			MAY	107.3%		JUNE	106.4%	
Overall	111%	was	110%	Target:	80%	(from June)		
WSFT	114%	was	112%					
ESNEFT	110%	was	109%					
Endoscopy:			MAY	105.2%		JUNE	101.6%	
Overall	98%	was	104%	Target:	80%	(from June)		
WSFT	87%	was	100%					
ESNEFT	103%	was	105%					

n.b. data from Weeks 13-15 as there is a lag in the reporting

SNEE Accelerator/ERF

Update on progress

SNEE: Latest position

The activity numbers and estimates of value suggest the system is on track to meet the 100% by end of July milestone (when IS and acuity is accounted for).
However the risks around workforce, estate and rising demand are growing.

SNEE	OPFA	OPFU	DC	IP EL
June 2021 plan	99%	94%	101%	97%
June unvalidated (31/5 to 4/7)*	88%	94%	98%	81%
July 2021 plan	101%	95%	102%	98%
3wma July 11th*	90%	94%	99%	85%

*does not include IS work

Weekly Activity Return + IS estimates**

Suffolk and North East Essex ICS	13/6	20/6	27/6	4/7
WAR + ICS value estimate	95%	95%	96%	97%

**built using WAR activity +IS estimate with a value weighting applied by POD (this is a crude methodology and will have a margin of error as increasing acuity is not built in).

ESNEFT: Update vs plan

ESNEFT	OPFA	OPFU	DC	IP EL
June 2021 plan	105%	96%	100%	103%
June unvalidated (31/5 to 4/7)*	89%	95%	99%	91%
July 2021 plan	107%	97%	102%	109%
3wma July 11th*	90%	93%	100%	97%

*does not include IS work

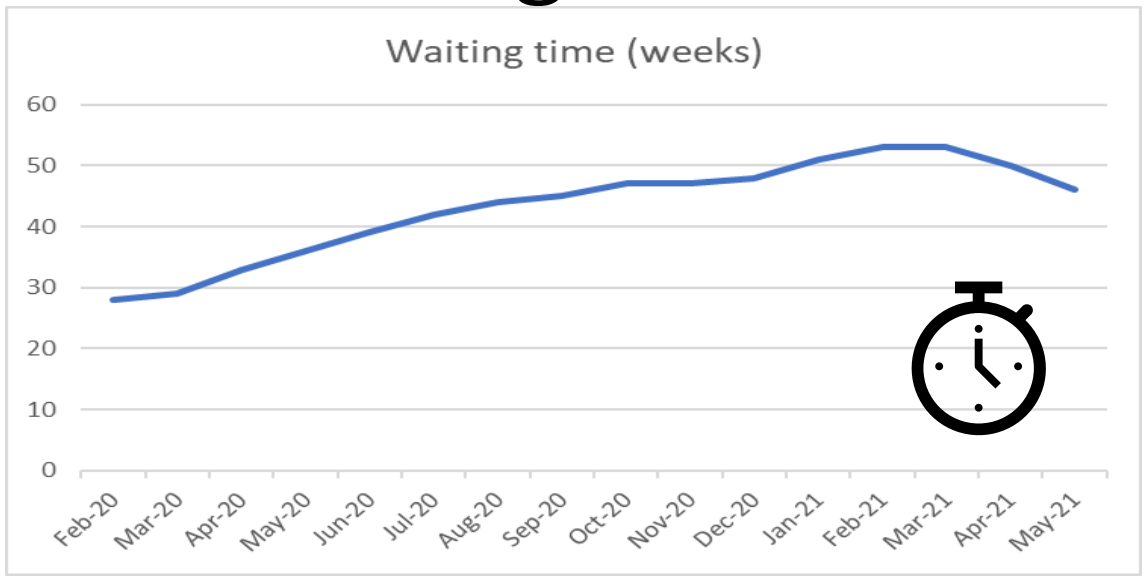
ESNEFT	Planned additional per month	Progress update
OPFA	c.1700	• Bumper weekends planned for every weekend both days for Gastro for July, as well at least one day in a weekend for gynae and urology
OPFU	c.1900	• The numbers of patients who are overdue a FU apt by 6months have decreased by 14.78% for the month of June – continuing to do a range of options with FUs
DC	c. 800	• Good progress with HVLC at weekends for ophthalmology, as well as gynae and additional activity now for Pain in July.
EL	c. 150	• Workforce has been the key constraint with weekday activity, weekend additional activity has been undertaken each weekend over June.
Any new initiatives		• Ophthalmology Bus is progressing and should be live from end of September – Vanguard due for siting mid July • Nuffield (16 T%O) likely to commence August 2021

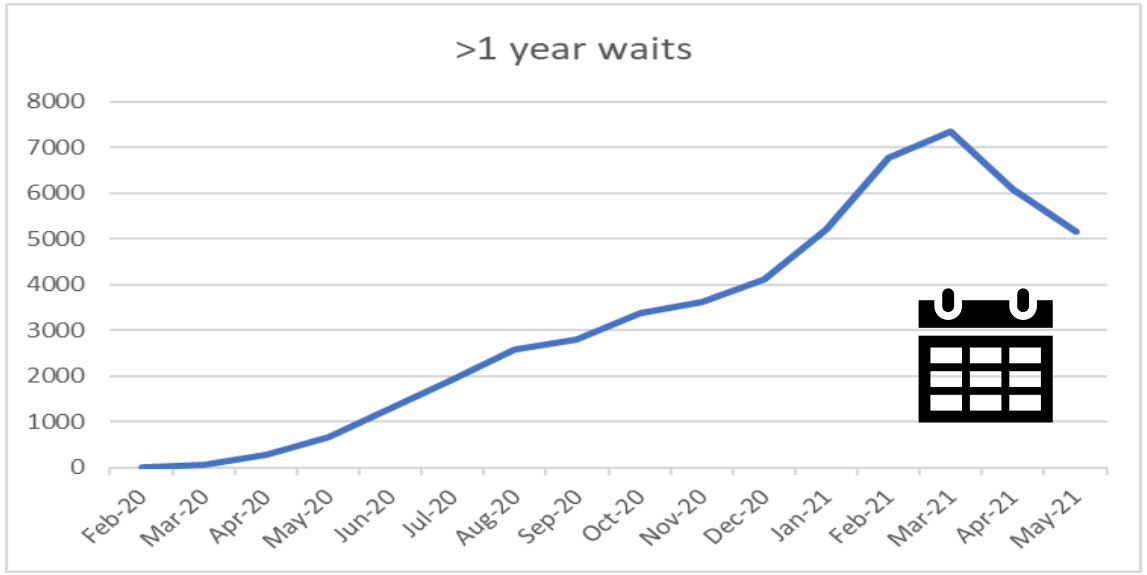
WSFT: Update vs plan

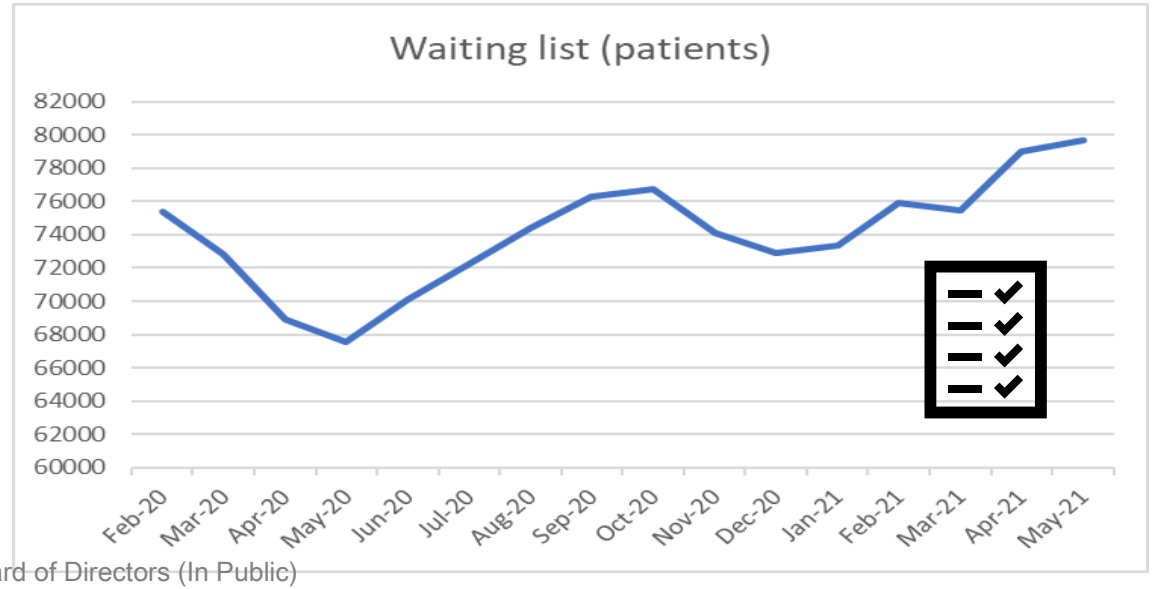
WSFT	OPFA	OPFU	DC	IP EL
June 2021 plan	84%	92%	103%	80%
June unvalidated (31/5 to 4/7)	85%	90%	96%	46%
July 2021 plan	86%	92%	96%	43%
3wma July 11th	91%	96%	95%	43%

WSFT	Planned additional per month	Progress update
Newmedica	DC: 200 (June-)	• Ramping up usage
Gen Surg	BMI DC: 20 (May-) Sunday DC: 22 (May-)	• Hi Risk • On track
ENT	DC: 22 (May-) OPFA: 54 (July-)	• On track • TBC
T&O	Saturdays DC: 27 (May-) Nuffield IP: 16 (July-) BMI IP: 16 (July-)	• On track • Hi Risk • Hi Risk
Any new initiatives		Investigating possibilities with Oaks

SNEE Progress to date







Waiting times are beginning to fall and the latest unvalidated position shows 40 weeks (from 53)

1 year waits are falling rapidly an the latest unvalidated position shows just over 4,000 waiting (from 7,336)

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

Waiting list (4 April to 11 July)

- Between April and July 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 (21 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 (17 of 23 104 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%
11 July 2021	40 weeks	58462	18023	1971	409	30	22	69.2%
Change	-7	2801	-4052	-1879	35	-2	-2	8.8%

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%
11 July 2021	63 weeks	23645	8160	2274	859	83	23	65.5%
Change	-2	2243	-763	-1044	309	62	14	7.2%

Wait time (92%ile) weeks	ESNEFT	WSFT	Difference	SNEE
Trauma & Orthopaedics	52	77	25	69
General Surgery	53	56	3	53
Plastic Surgery	40	68	28	49
Gynaecology	44	71	27	49
Urology	38	69	31	45
Ear, Nose & Throat (ENT)	35	68	33	39
Gastroenterology	40	36	4	39
Other	38	39	1	38
Oral Surgery	37			37
Ophthalmology	29	82	53	35
Thoracic Medicine	35	21	14	33
Rheumatology	33	13	20	33
Dermatology	31	16	15	30
Neurology	21	23	2	21
General Medicine	18	19	1	19
Cardiology	17	19	2	17
Geriatric Medicine	12	11	1	11
Total	40	63	23	43

10.3. IQPR

To NOTE report

For Approval

Presented by Craig Black, Helen Beck and Susan Wilkinson

Trust Board Report

Agenda Item:	10.3			
Presented By:	Helen Beck & Sue Wilkinson			
Prepared By:	Information Team			
Date Prepared:	May-21			
Subject:	Performance Report - May 21			
Purpose:	**X**	**For Information**		**For Approval**

Executive Summary:

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

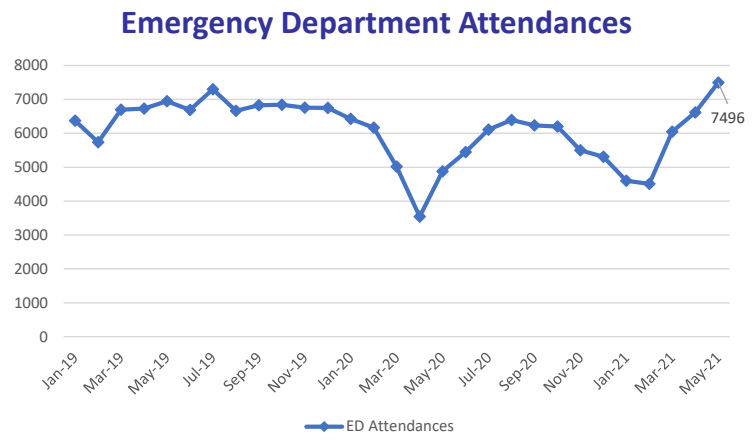
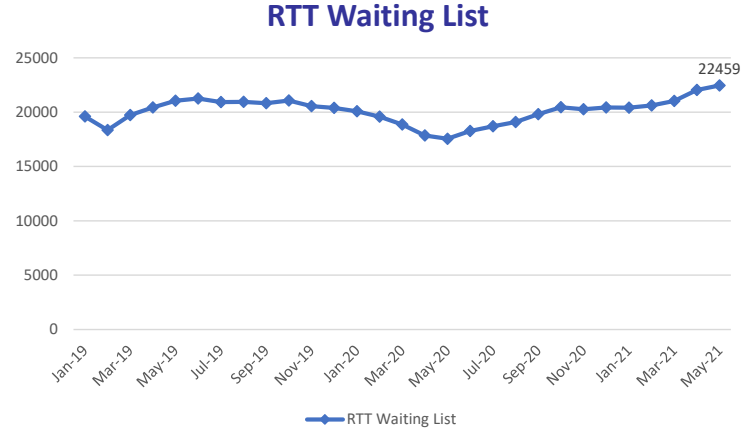
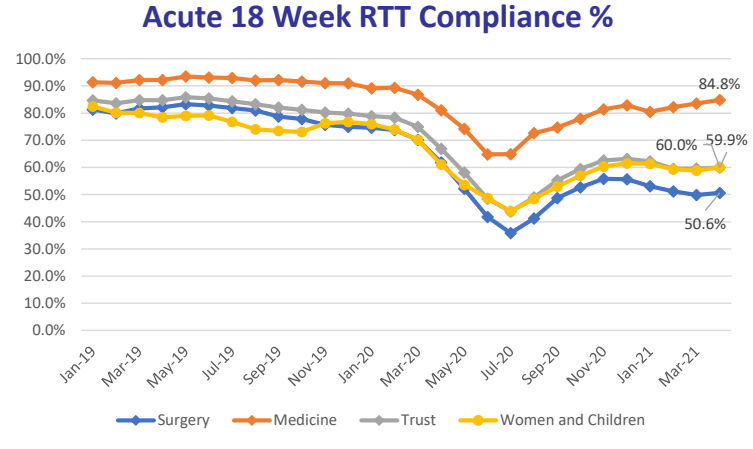
Trust Priorities [Please indicate Trust priorities relevant to the subject of the report]	**Delivery for Today**	**Invest in Quality, Staff and Clinical Leadership**	**Build a Joined-up Future**
	X		

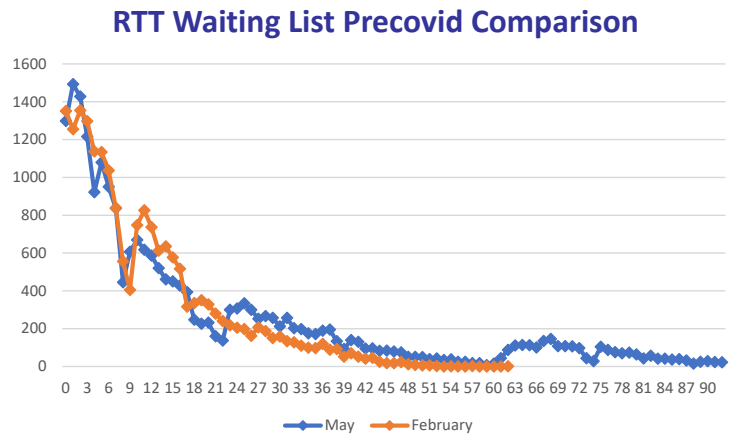
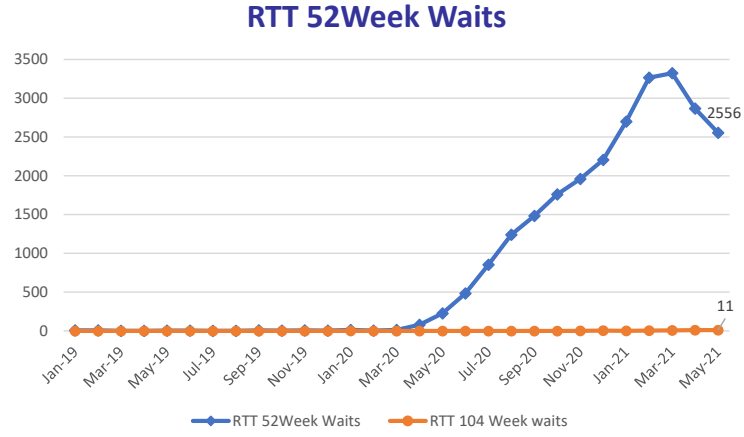
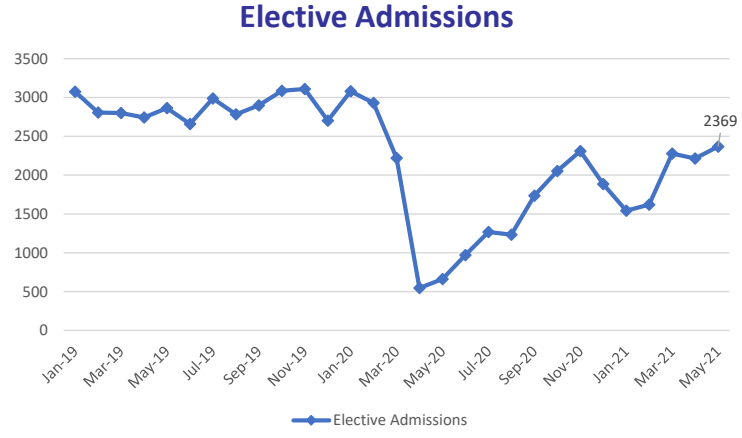
Trust Ambitions [Please indicate ambitions relevant to the subject of the report]	Deliver personal care	Deliver safe care	Deliver joined-up care	Support a healthy start	Support a healthy life	Support ageing well	Support all our staff
		X	**X**				**X**

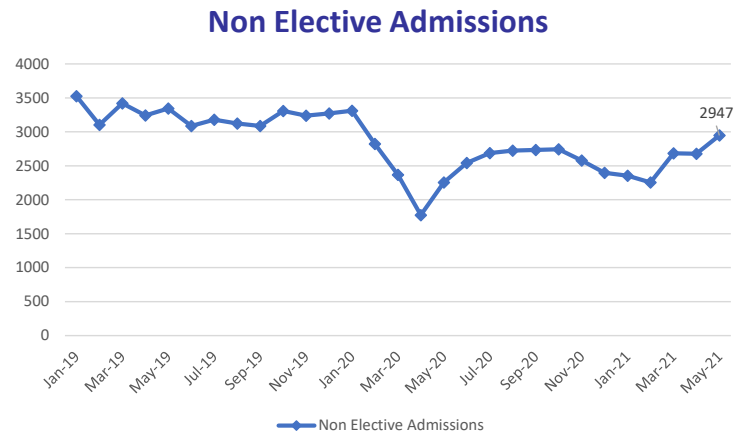
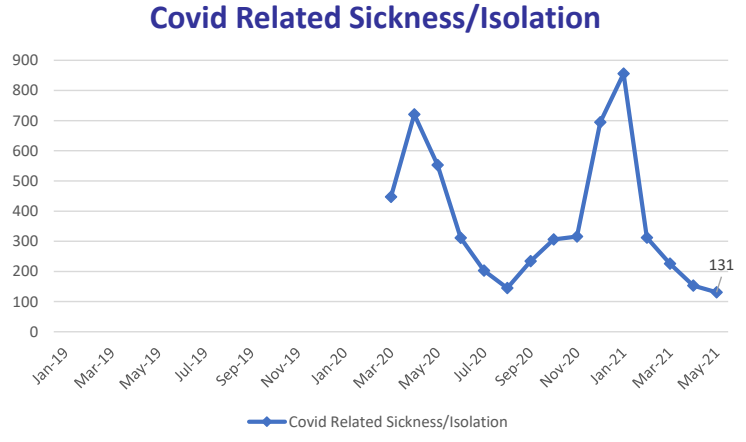
Previously Considered by:	
Risk and Assurance:	
Legislation, Regulatory, Equality, Diversity and Dignity Implications	

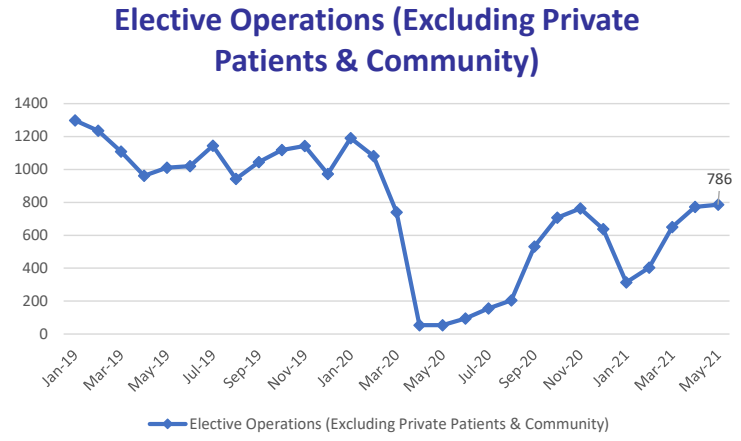
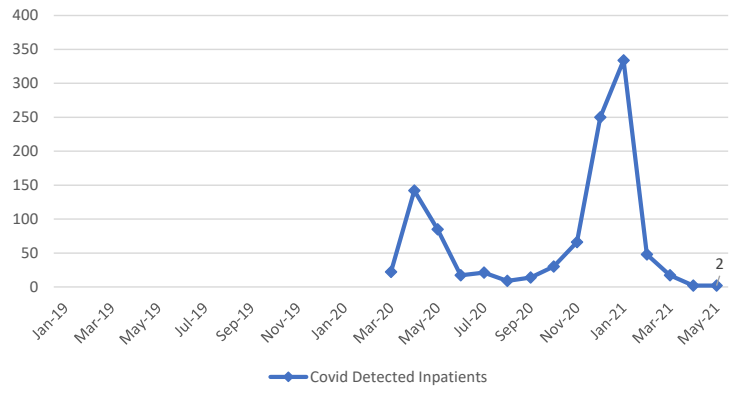
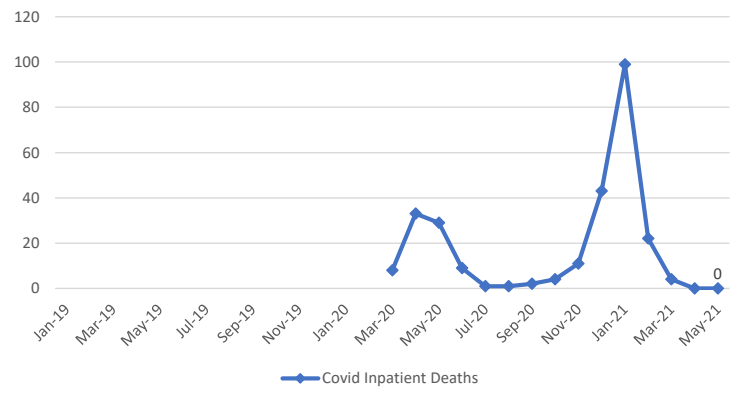
Recommendation:

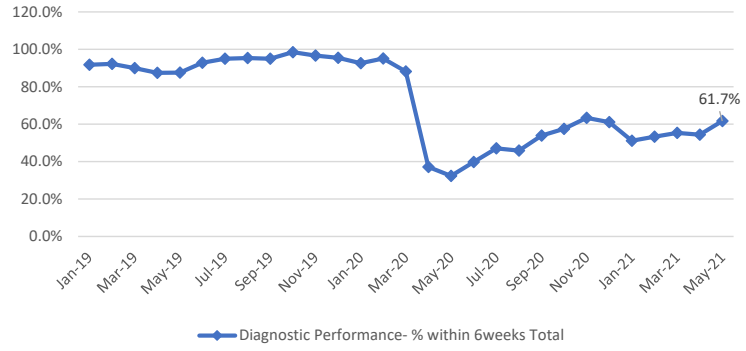
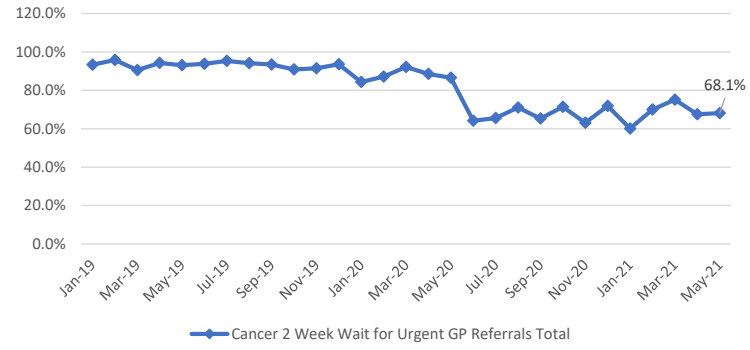
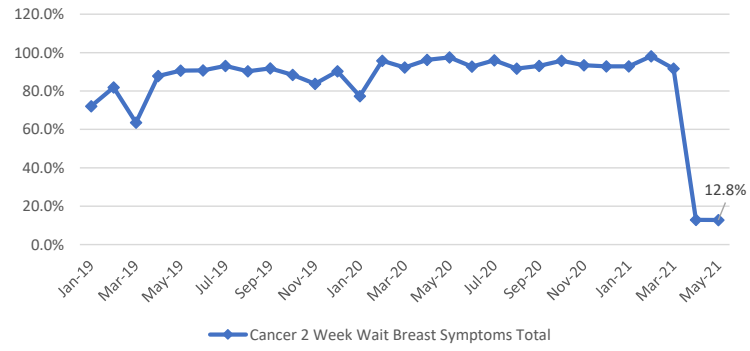
That Board note the report.

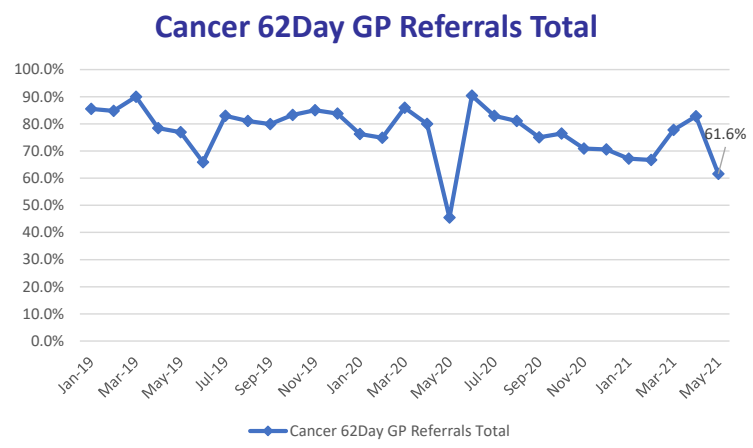
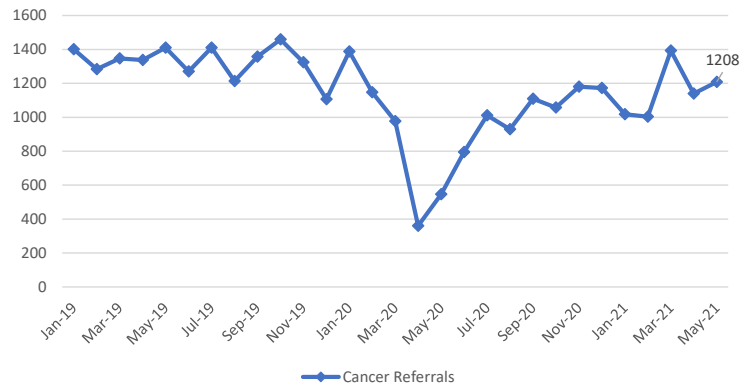
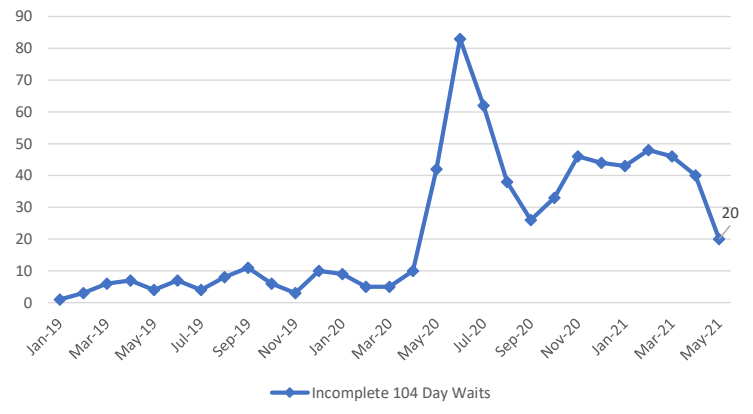
Board Report KPIs	Narratives
	There were 7496 attendances to ED in May 2021, this represents an increase of 882 attendances compared to the previous month of April 2021. This equates to a 13.5% increase. Looking at May's data we have seen an increase in both minor and major attendances of similar proportions. We are also aware that ED attendances are up nationally. We are examining data to determine any themes.
A count of the arrivals at the Emergency Department. This metric has no national target but is key to understanding demand for non elective services.	
	Overall waiting list has increased by 700 patients from April, this is mostly due to an increase in patients under 18 weeks as a reflection of an increase in referrals.
A count of the patients on the waiting list for treatment.	
	Medicine compliance continues to improve as expected. Surgery, women's and child and the trust total have all seen a very slight improvement in compliance, this is due to the larger numbers beneath 18 weeks in line with increased referrals and a reduction in the overall patients over 18 weeks. Whilst surgical capacity is a constraint this number is unlikely to improve significantly.
% of patients on incomplete RTT pathways	

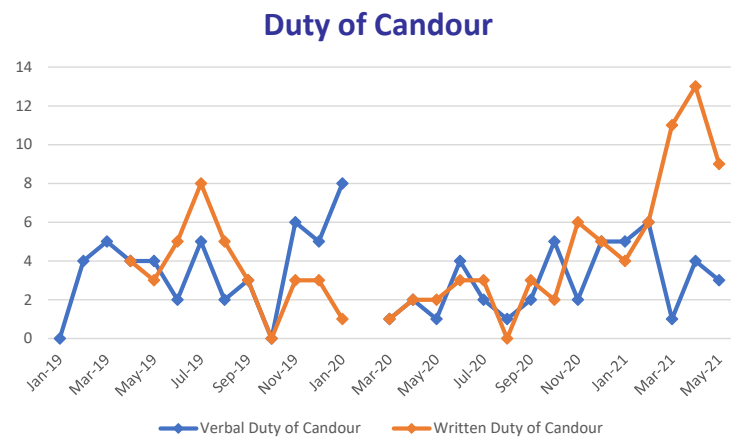
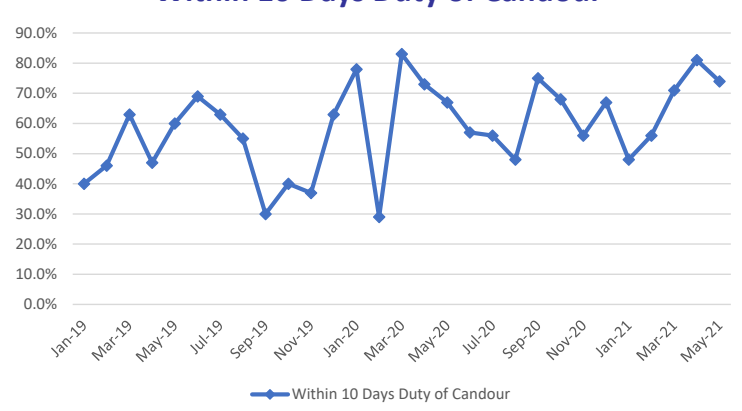
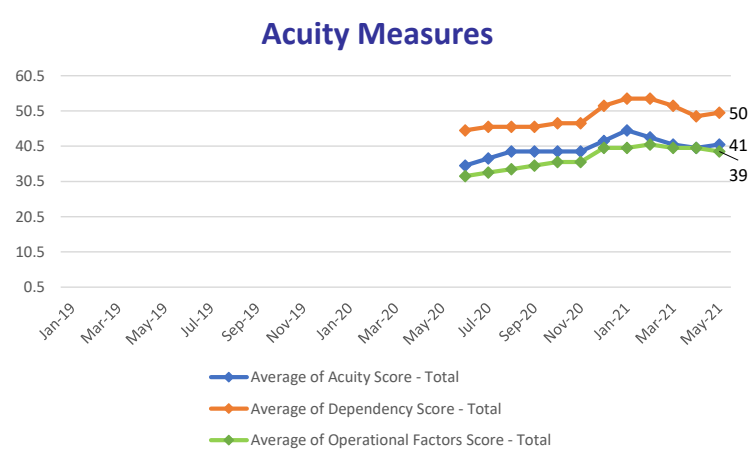
Board Report KPIs	Narratives
	The shape of the waiting list is now fairly similar to that of Pre Covid, with the exception of a much larger tail of patients waiting over 52 weeks, due to surgical constraints, patients are being treated in clinical priority before waiting time priority.
A year on year comparison of the number of patients waiting for treatment.	
	The number of patients waiting over 52 weeks has reduced significantly again this month as the theatre and ward capacity has allowed some longer waiting patients to be treated. There is a risk currently that this position will worsen over the summer whilst capacity is reduced, however there are robust plans within the system to avoid this position worsening.
A count of the number of patients who are waiting for treatment and have been waiting longer than 1 year for treatment. This is a national key performance indicator with a national expectation of 0.	
	Elective admissions increased again in May 2021, back to November 2020 levels. This will reduce again in June due to theatre constraints.
A count of the number of patients that were admitted for an elective/planned procedure. This is a local metric used to monitor changes in activity.	

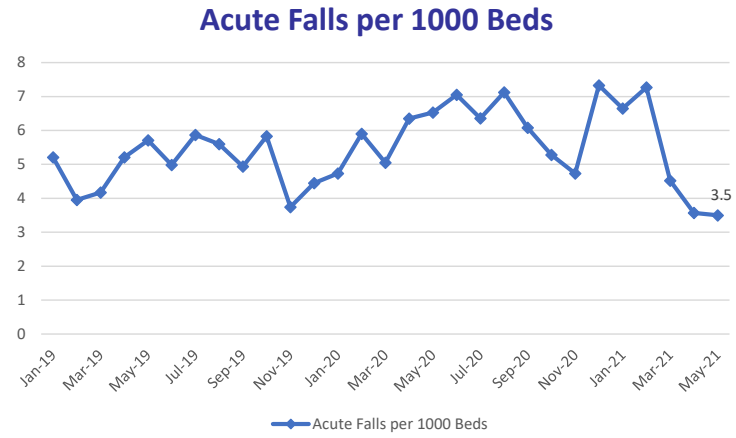
Board Report KPIs	Narratives
	There were 2947 Non-elective admissions in May 21 compared with 2679 in April 21, which represents a 10% increase. Having looked at the data we have seen the following increases in admissions per speciality comparing April to May. Medicine 11%, Surgery 9%, T and O 10%, Obs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

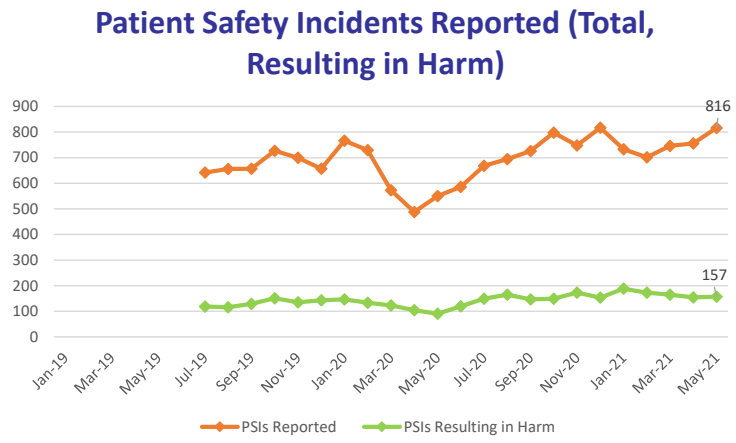
Board Report KPIs	Narratives
	Increase in elective operations in May 2021, to a higher level than was achieved in the last phase of recovery in November 2020. Restrictions in theatre will impact on this recovery, however there are plans to try and mitigate this as much as possible.
This is a count of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

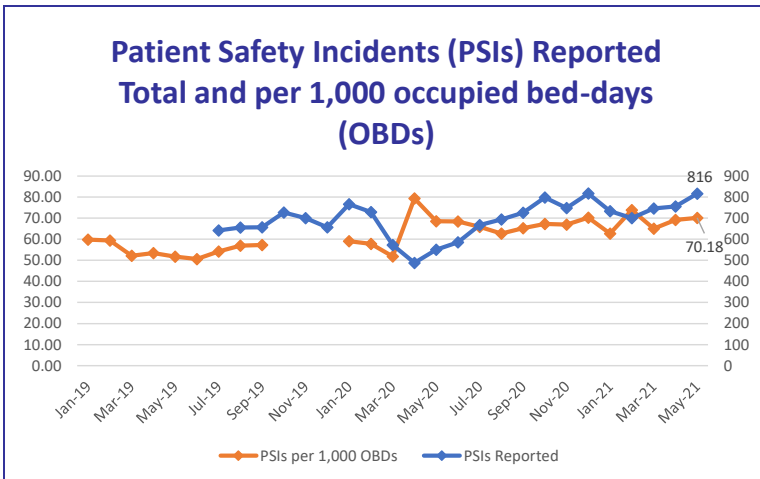
Board Report KPIs	Narratives
Diagnostic Performance- % within 6weeks Total 	Diagnostic performance remains to be a significant challenge in certain areas. Whilst MRI, CT and ECHO's have recovered their position back to achieve the 99% standard, challenges remain in the following: Ultrasound at 42.6% Audiology at 34.9% Urodynamics at 40% Colonoscopy at 36.08% Flexible sigmoidoscopy at 34.37% Cystoscopy at 48% Gastroscopy at 46.08% Trajectories for recovery are in development for Audiology, Urodynamics and Cystoscopy.
To measure compliance with the national standards for access to diagnostic treatment. This metric measures the percentage of patients who receive diagnostic treatment within 6 weeks of referral. The national standard is 99% to receive a diagnostic within 6 weeks.	
Cancer 2 Week Wait for Urgent GP Referrals Total 	Slight improvement in the bottom line performance for 2WW referrals. Breast performance continues to remain a challenge with large referral numbers as well as continued pressure within Upper and Lower GI that is reliant on endoscopy. A full recovery trajectory for 2WW performance is in place.
To measure compliance with the national standards for access to cancer diagnosis. This metric measures the percentage of patients who are seen within 2 weeks from referral from their GP for suspected cancer. The national standard is 93% to been seen within 2 weeks.	
Cancer 2 Week Wait Breast Symptoms Total 	Breast performance remains a significant constraint, with very low performance, however whilst the overall position is still low the overall waiting time has reduced to closer to 2 weeks and a recovery trajectory is in place.
This metric is a sub set of the national 2 week wait metric and measures those GP referrals specifically with breast symptoms. The target is the same as the overall 2 week wait of 93% of patients to be seen within 2 weeks.	

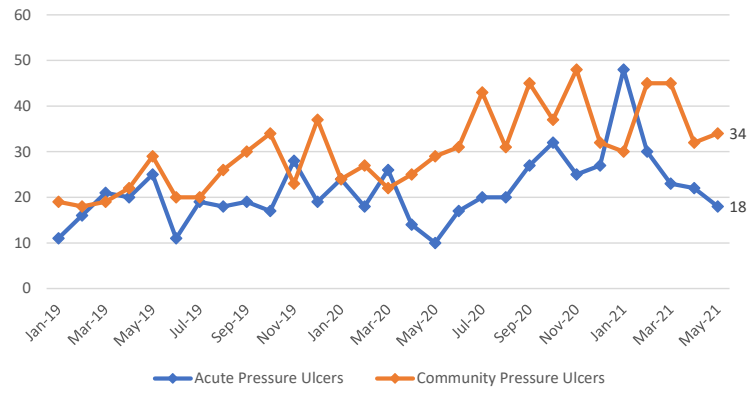
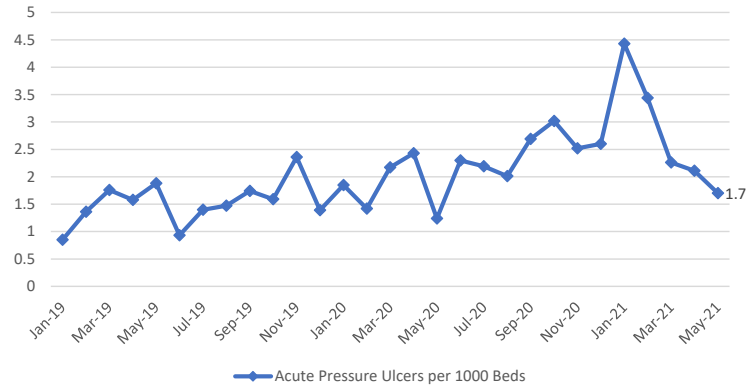
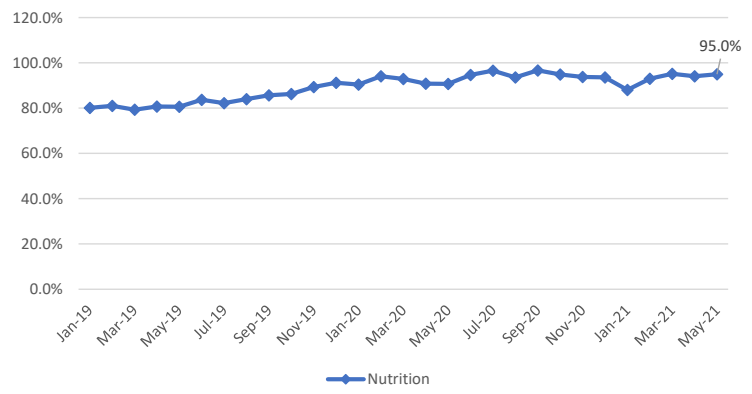
Board Report KPIs	Narratives
	Significant drop in 62 day performance, however this is due to large number of our long waiting patients being treated and working through additional cancer surgery and treatments in May, which is turn has reduced our patients waiting over 104 days.
To measure compliance with the national standards for access to cancer treatment. This metric measures the percentage of patients receive cancer treatment within 62 days of referral by their GP. The national standard is 85% to have received treatment within 62 days.	
	Two week wait referrals up from April 2021, with larger numbers being received in Breast, Skin and Lower GI.
A count of the number of patients referred to the hospital with suspected cancer, requiring investigation. This metric shows the activity by month for cancer services, which informs the national metric which measures the number of these patients that were seen within 2 weeks (further in the performance pack).	
	104 day waits reduced by half from April to May, due to additional treatments in May.
A count of the number of patients who have waited longer that 104 days for treatment for cancer from GP referral. This is a national standard and is expected to be 0.	

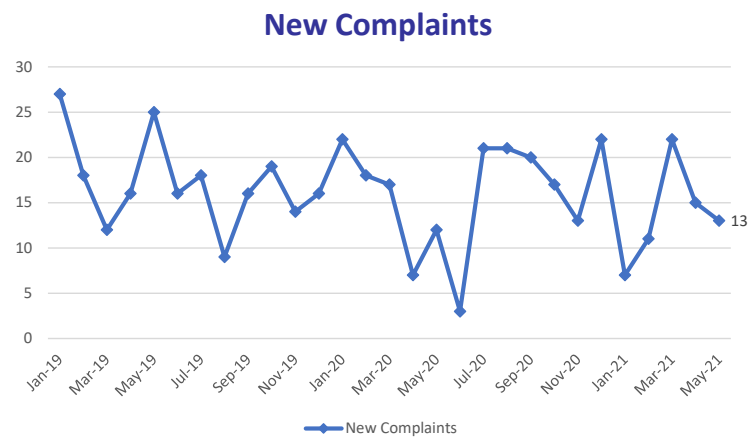
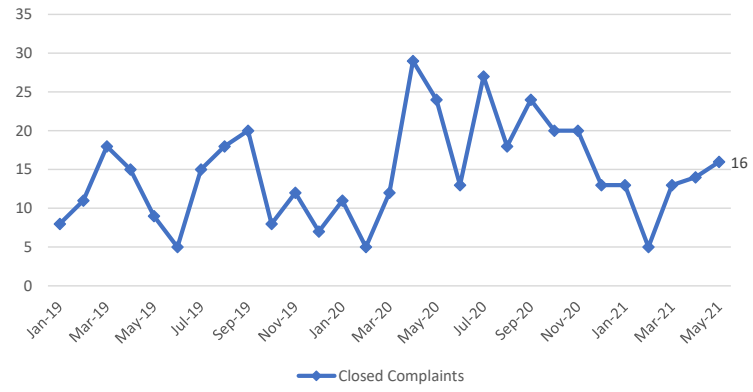
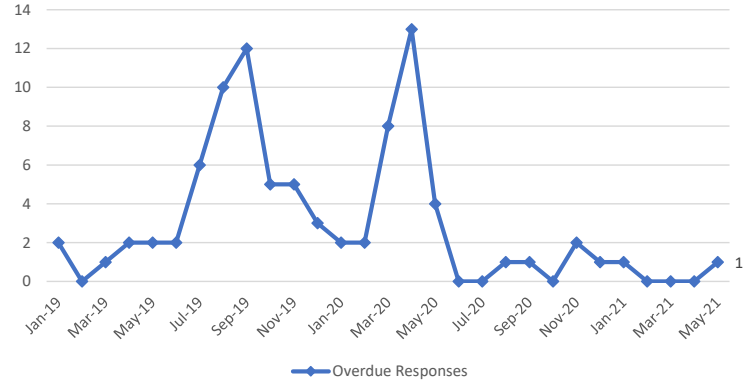
Board Report KPIs	Narratives
	We continue to work through our improvement plan which was presented and discussed at the improvement committee this month
This is a count of the number of verbal and written duty of candour overdue for the reporting month (and earlier) as at the date of report issue	
	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

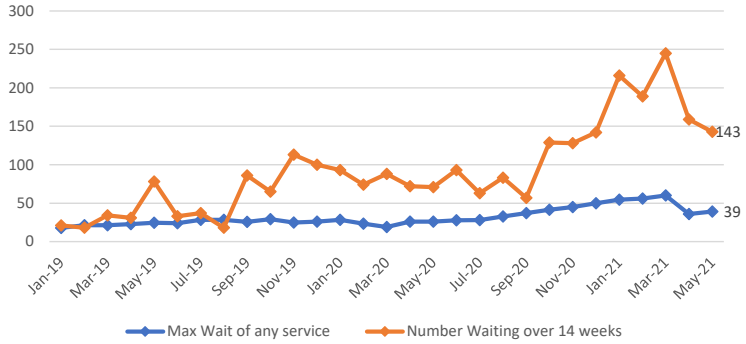
Board Report KPIs	Narratives
	This is now reported in Staffing paper.
A measure of the number of falls in the acute hospital measured per 1000 bed days. Community falls are excluded from this metric.	

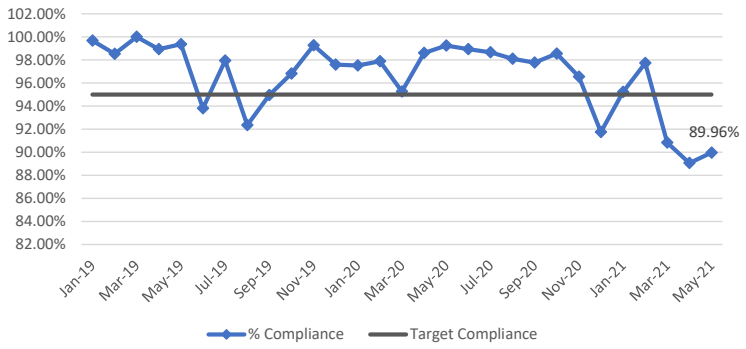
	The number of patient safety incidents reported in May to the highest level since December reflecting the increase in incident reporting in the previous 12 months (excluding the first few months of the pandemic). Higher reporting levels are seen as an indicator of a positive reporting culture and therefore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

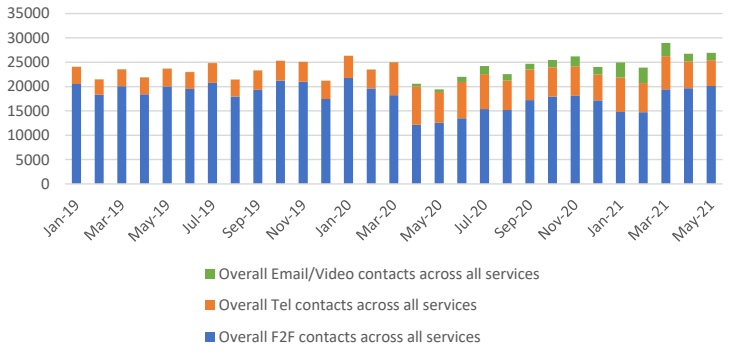
	The incidents reported per 1,000 bed days rose in May but remains within the normal limits of the recent 12 months.
The number of patient safety incidents reported as a percentage of occupied bed days to measure reporting rates	

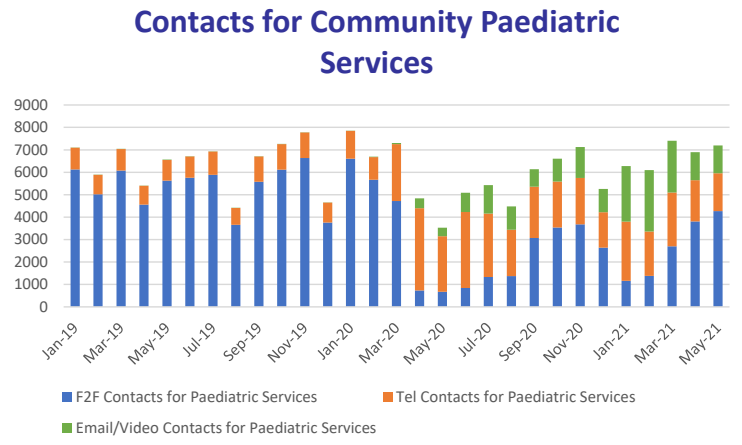
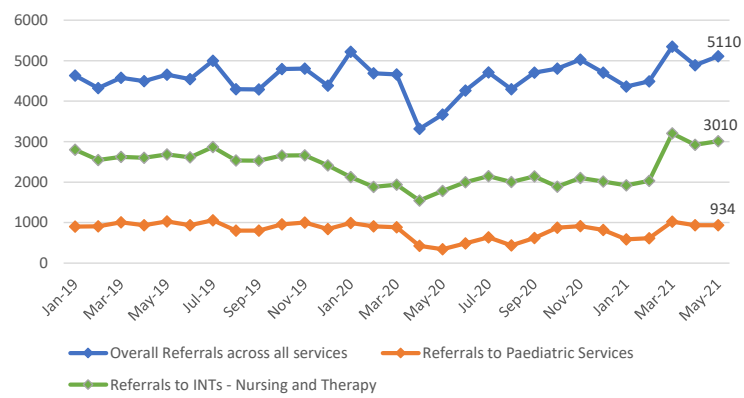
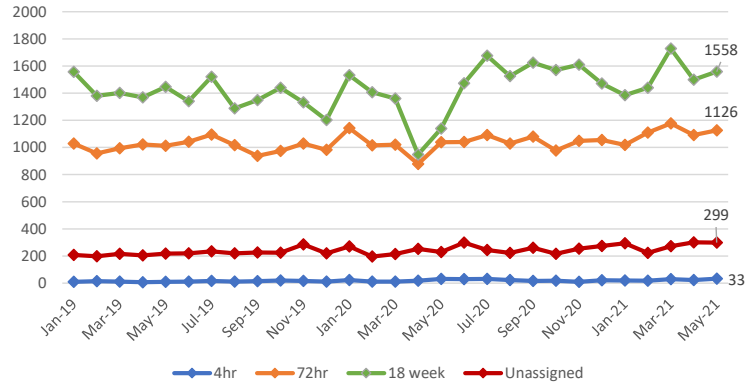
Board Report KPIs	Narratives
Pressure Ulcers  A count of the number of recorded new pressure ulcers across the Trust. This metric will include those recorded in the acute hospital and community settings	This is now reported in Staffing paper.
Acute Pressure Ulcers per 1000 Beds  A measure of the number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

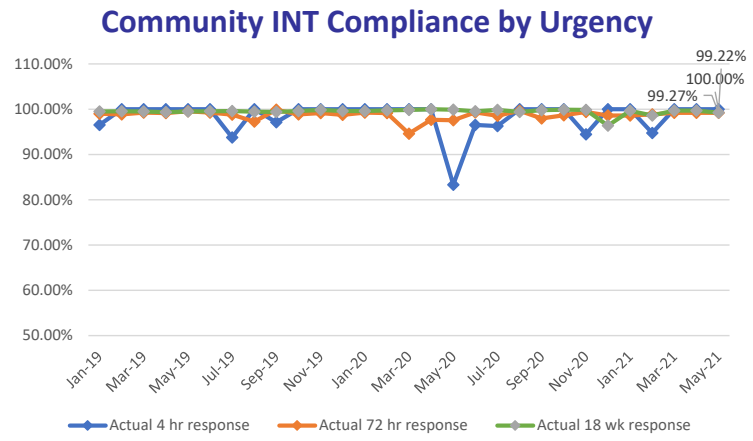
Board Report KPIs	Narratives
	13 formal complaints received in May which is still below average compared what we would normally receive pre-Covid. (c21). A trend we have been seeing lately is in regards to communication, with 7 complaints involving communication from providing the incorrect information,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

Board Report KPIs	Narratives
Community Non Consultant Led 18week Max Wait 	The number of services with patients waiting over 18 weeks has decreased back to 2 from 3 in May. At the end of May these services were: Paed SLT and Wheelchairs. The maximum wait for each of these services are: Paed SLT - 29 weeks (decreased from 31) Wheelchairs - 39 week (increased from 36 weeks) Paed SLT and Wheelchair services were both exceeding the wait times prior to COVID, these 2 services have papers and support from the CCG both in understanding demand and increasing resources. The lack of face to face group work and restrictions in schools etc are having a continued profound effect on Paed SLT activities, as are vacancies within the service. Wheelchairs has a high number of patients who are shielding or just unwilling to have home visits at this time, access to Special Schools and Care Homes has been limited because of COVID, staff numbers have been affected because of COVID and BREXIT has affected the supply of equipment that has been stuck at ports. The number of child breaches may be increasing but the number of handovers is actually increasing significantly.
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.	

Community Non Consultant Led 18week Compliance 	The aggregated % of patients treated within 18 weeks for all community services in May was 89.96% with the lowest individual service being Wheelchairs at 84.31%.
Services covered: Adult SLT, Heart Failure, Neurology Service, Parkinson's Nursing, Wheelchairs, Pead OT, Pead Physio and Pead SLT. RTT nationally is for consultant led services but the community services are required to report on compliance to 18 week Referral to Treatment locally to our CCG. Target is 95% of referrals are given a first definitive treatment within 18weeks	

Contacts for ALL Community Services (Adults and Paediatrics) 	The total activity for community services has returned to pre-COVID levels and exceeded the values although the ratio of face to face and other means of contact (telephone, video and email) have altered. March, April and May have been exceptionally above the levels of either March, April and May in the last 2 years of 2020 and 2019.
Activity is counted as a face to face/telephone/email/video contact with a patient/carer/parent which is clinically relevant. This means activity that a clinician carries out which is writing reports, liaising with other healthcare professionals is NOT counted as activity. This is in line with acute systems where there is an assumption that clinicians will carry out related activities that result from contact with a patient.	

Board Report KPIs	Narratives
	The Paediatric services have moved a high proportion of their activity to telephone and email/video contacts but they are still unable to carry out any group work due to social distancing requirements. There are also shortages in clinic availability in certain locations. The wearing of masks and social distancing means Speech and Language therapy is particularly hard to do. The services are reviewing all possible options.
Activity is counted as a face to face/telephone/email/video contact with a patient/carer/parent which is clinically relevant. This means activity that a clinician carries out which is writing reports, liaising with other healthcare professionals is NOT counted as activity. This is in line with acute systems where there is an assumption that clinicians will carry out related activities that result from contact with a patient.	
	Referrals to the majority of the community services has exceeded the levels of March, April and May 2019 and 2020.
There should be one reason per referral, i.e. if a patient is referred in to the INTs for 2 requirements either simultaneously or over time, eg leg ulcer dressing and phlebotomy, then there are 2 referrals.	
	Referrals to the INT services have returned to pre-COVID numbers or exceeded them.
Referrals into the Integrated Neighbourhood Teams have urgencies of Red (within 4 hours), Amber within 72hrs) and Green (within 18 weeks). These contractual urgencies are locally agreed pan Suffolk with the CCG and there is a 98% response target for Red, Amber and Green response times have a 95% threshold (These are local contractual targets)	

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

11. Integration report

To receive the report

For Report

Presented by Kate Vaughton

West Suffolk NHS Foundation Trust Board Meeting
Friday 30th July 2021

Agenda item:	11			
Presented by:	Kate Vaughton, Director of Integration			
Prepared by:	Jo Cowley, Senior Alliance Development Lead, WSCCG Sandie Robinson, Associate Director of Transformation, WSCCG Lesley Standring, Head of Operational Improvement, WSFT Rebecca Jarvis, Deputy Director of Integration, WSCCG			
Date prepared:	20/07/2021			
Subject:	West Suffolk Integration Update			
Purpose:	X	For information		For approval

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

1. Strengthening the support for people to stay well and manage their wellbeing and health in their communities
2. Focusing with individuals on their needs and goals
3. Changing both the way we work together and how services are configured
4. Making effective use of resources

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

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

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

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

West Suffolk Integration Update

West Suffolk NHS Foundation Trust Board Meeting

30th July 2021

1.0 Introduction

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

1.2. Information is loosely grouped under each of our four Alliance ambitions although of course most of the initiatives support the delivery of more than one area.

1.3. Note we have refreshed the Alliance vision and mission, considering learning from COVID-19, the opportunities we have with the Future System Programme and the upcoming health reforms. ***Appendices 1 and 2*** give a high-level summary of this work.

2.0 Alliance Ambition 1 – empower people to lead healthy and connected lives (people)

2.1. This section updates on two initiatives introduced in the previous Board paper – a project to increase fitness and physical activity across West Suffolk, particularly for those with a long-term condition, and the work we are doing as part of the vaccination programme to reach people who are facing barriers in accessing their vaccination.

2.2. **Active Living update:** As a system we recognise that physical activity is core to health and wellbeing and recovery from COVID-19. As a result of this we are galvanising leaders across the system to think differently about how we work together to support people to recover and to reconnect back into their communities.

2.3. The partnership between West Suffolk Foundation Trust, West Suffolk Council, Allied Health Professionals Suffolk and Abbeycroft Leisure (ACL) to deliver activity programmes and support into patient pathways to improve health and wellbeing for those with long term health conditions has now gone live.

2.4. **Supporting our communities to get vaccinated:** The West Suffolk Alliance #WhatAreWeMissing (#WAWM) group continues to work to remove barriers to vaccination for people in West Suffolk, alongside, and with the support of, the mainstream vaccination programme. In the last month we have put together partnerships to arrange bespoke vaccination clinics to people who have been identified through our data analysis, the Equalities Impact Assessment and our local intelligence as not coming forward for the vaccination.

2.5. Funding has been made available from Suffolk County Council's Covid Outbreak Management Fund to support this work. We have recruited to a post, based in the West Suffolk Council Families and Communities Team, who will create a plan to take forward partnership work to promote the vaccine and booster jabs and to engage communities around health inequalities more generally.

2.6. Inequalities and work to promote equity of outcomes is getting greater prominence in Alliance plans and across the Integrated Care System (ICS). There are several strands

to this work, including understanding the data around vulnerable groups, using insights gathered through the pandemic, working and engaging with people who have poor health outcomes and ensuring actions identified in our equalities impact assessment are taken forward. The ICS are promoting a *100-day health equity challenge* approach as a framework for action, offering training for staff across the ICS as well as online resources. Ed Garratt, Chief Executive of the West Suffolk Clinical Commissioning Group told our teams in a letter *"This initiative builds on our ICS Higher Ambitions, our system learning from Covid19 and #WhatAreWeMissing by recognising the urgency and importance of moving the culture in our health and care system towards one of health equity and justice.*" The Alliance is committed to taking this work forward, looking at specific issues that our local communities face which lead to poorer health outcomes.

3.0. Alliance Ambition 2 – Create environments that enable people to thrive (place)

3.1. There is so much going on in our communities in West Suffolk and two areas of recent work are highlighted in this section. One is a co-production piece around the voice of young people with West Suffolk College and the other is a Volunteering Strategy with three key objectives, Suffolk-wide, but key to us in West Suffolk.

3.2. Listening to the voice of young people: West Suffolk College are leading an Alliance project to capture the voice of young people to underpin our local conversations and embed co-production at the heart of the curriculum.

3.3. Two projects have been agreed to start this piece of work:

- Project 1 – new students joining the college in September studying Art and Design will participate in round table discussions exploring some of their key challenges following the last year, their worries about starting a new course and looking into their future. This insight will be captured and used as the platform for further co-production and action.
- Project 2 – new students will undertake a project exploring their personal connections to happiness. Asking them to express what makes them happy in life with the aim of capturing dreams, ambitions and moments young people have experienced. The intention is to then showcase this work with the young people involved and to use this to shape the future roadmap of the Alliance and long-term change across health and care.

3.4. **Suffolk Volunteering Strategy:** At its meeting in July, the Alliance System Executive Group (SEG) reviewed the Volunteering Strategy, which has been developed with people in Suffolk and with the Voluntary, Community and Social Enterprise (VCSE) sector by Community Action Suffolk. The vision for volunteering in Suffolk is that: People living in Suffolk are inspired, encouraged, and empowered to volunteer.

3.5. This vision is underpinned by four values:

1. Inclusivity and equality – volunteering is open to everyone
2. Volunteering is voluntary – volunteering is a choice that is freely made
3. Mutual benefit – volunteering benefits those that volunteer ad those that are helped
4. Volunteering is diverse – volunteering can be formal and informal, both have equal value

3.6. The strategy then goes on to set out three objectives:

- To raise the profile of volunteering in Suffolk CCG
- To support people to volunteer and be more engaged in their community
- To engage employers and business leaders in providing and promoting volunteering opportunities

3.7. Once the strategy has been signed off by the Health and Wellbeing Board it will be available on the Community Action Suffolk website - www.communityactionsuffolk.org.uk

4.0. Alliance Ambition 3 – Develop services that are joined up accessible, responsive, and wrapped around people and families in the communities in which they live. (Collaborate)

4.1. As part of our revised governance and framework for action, the Alliance has launched an **Integrated Health and Care Programme Board** to provide strategic leadership for the delivery of Integrated Health and Care Services, (including Physical Health, Primary Care, Mental Health, Children and Young People and with the wider voluntary sector) in West Suffolk.

4.2. The board will hold shared accountability for the delivery of programmes of work to develop and deliver a fully integrated model of health and care in the community, which will improve population outcomes and system sustainability over the next 10 years. This will be key to ensuring West Suffolk can deliver transformation, such as building a new hospital by 2025.

4.3. **Developing our Integrated Neighbourhood Teams (INTs):** Action continues within this programme and the key activity for this period is around the implementation of the new integrated structure. Clement Maywoyo has been appointed as the joint Director of Integrated Services, effectively the operational lead for community health services and adult social care. He comes from a social care background, previously leading the adult social care teams in Waveney.

4.4. Following on from his appointment, a programme of work has begun to align the teams and work through the barriers/challenges to full integration. The programme is designed in three phases which will run as a continuum over the next 18 months, starting with alignment and moving through merger to full integration. One of the initial aspects of this work will to review the different boundary arrangements between adult social care and community health teams and make recommendations on the need for alignment. A more detailed update on this programme of work will be included in the next integration report.

4.5. While this is underway the operational leads have asked that the re-baselining of the INT Maturity Matrix is paused.

4.6. System Leaders came together to discuss the opportunities of working closer with Community Pharmacy. The following areas of opportunity were identified:

- Communications and engagements – Raising awareness of the services Pharmacists deliver and the role they can play in connecting with a diverse range of people in their community. Re-imagining and re-positioning the role of Community Pharmacy both in the system and within communities to build trust and ways of working.
- INTs – Formalise the role of Community Pharmacy as part of INT and improve ways of working between Community Pharmacy and Social Care
- Quality Improvement approach – Explore how we use tools in the system to support the integration of community pharmacy into health and care.
- Future Systems – Better link Community Pharmacy into the future vision for health and care in West Suffolk, exploring how we can utilise pharmacies to add capacity into the community and improve outcomes for the population.

5.0. Alliance Ambition 4 – Organising resources from across the Alliance to deliver action to contribute to these ambitions and towards the Alliance vision (resources)

5.1. SEG discussions are increasingly about how we can use our resources more effectively, as a genuine partnership, to meet our ambitions as an Alliance. At their meeting on 7th July, SEG reviewed two key areas where there is an opportunity to do this – voluntary and community sector commissioning, and work around data and insight.

5.2. **VCSE Charter for Action:** The charter was put together by a small group of VCSE sector leaders, building on results of an industry wide survey and one-to-one interviews. The aim was to explore how the Integrated Care System (ICS) could strengthen the relationship between the statutory sector and the VCSE.

5.3. The paper proposes steps needed for the VCSE sector to become an equal partner with the ICS – developing a strategic, sustainable, and joined up approach which involves engagement in decision making and shaping services and the development of long term joined up investment, with a deadline for sign up and commitment to meeting the commitments by March 2023.

5.4. The Charter for Action's five commitments are:

1. **Genuine VCSE sector investment** which is simple, inclusive, accessible, joined up and long term
2. **A funding model** which involves the integrated care systems in conjunction with the VCSE sector coproducing at place, neighbourhood and system level services which meet local needs ensuring alignment with the local health and care system without duplication, overlap or additional bureaucracy
3. **Delivery of quality services**
4. **Shared back-office resource**
5. **VCSE training investment** in Social Value, Theory of Change and leadership

5.5. The charter has been adopted by the Suffolk and North-East Essex Integrated Care system, and at the SEG meeting on 7th July they decided to do further work to explore how it can be put into practice locally. A Copy of the charter is attached as ***Appendix 3.***

5.6. **Data and Digital** are two of critical enablers in not only achieving this vision but in the day-to-day management and delivery of services. Data helps to better understand a problem, to enable better decision making, operationally and strategically, drive better outcomes for people, improve services and create efficiencies. Likewise, digital solutions not only change how services are delivered, how people connect and interact, but how people live and thrive.

5.7. System Leaders, including involvement from data, analytical and digital leaders from across the system came together to explore how we could better align and maximise our collective resources. This identified the following opportunity areas:

- Drive culture change, (confidence and capability) both in the community and across the workforce.
- Deploy digital solutions to people at home to enable independence and improve outcomes.
- Think differently about patient records and manage demand more intelligently.
- Co-ordinate data analytical resource to maximise the skills and expertise across the workforce.

5.8. Next steps are to continue to develop an options paper for discussion at the Integrated Health and Care Programme Board. This work will continue to develop, and further updates will be provided.

5.9. **Update from WSFT community digital programme ("Pillar 3") –** The community digital programme has continued to build on the progress made following the exit from the NEL CSU IT support contract, including infrastructure upgrades at WSFT sites for Wi-Fi and telephony and working with other partners on an 'anchor tenancy' model. This model aims to provide a seamless experience when connecting to your organisation regardless of which location you are working from. The team are continuing our work with ESNEFT to improve and develop the SystmOne functionality as well as planning the implementation of an auto-scheduling platform called Malinko, which allows for scheduling of community visits based on staff experience, availability, and clinical need; this is due to go live in a rolling programme from the autumn of 2021 and will provide live visibility of capacity and demand for community nursing teams. A programme of digital transformation projects is also underway and includes digital dictation, implementation of an online learning management platform for both staff and patients, virtual consultations, and further consolidation of our use of Microsoft 365 which was recently deployed.

5.10. **Update from WSFT community and integrated services outcome measures workshop –** It is well recognised that measuring the impact and effectiveness of our services within health care is vital in the delivery of quality care across the NHS. Although the importance of utilising appropriate outcome measures to convey this effectiveness is well known amongst health professionals, it is also recognised that it requires development in some areas.

5.11. Data currently reported relates to referral numbers, activity, and responsiveness, whilst patient outcome reporting focusses on adverse incidents, complaints, and compliments. Patient outcomes regarding health improvement, wellbeing, and quality of life, if collected, is not routinely reported at executive level. To address this, The Quality Improvement Team are working with clinicians to produce a set of patient outcome measures that will provide meaningful and valuable data.

5.12. Inspiration was taken from a recent Allied health Professions (AHP) NHS webinar, covering the topic of 'outcome measures in quality improvement'. A workshop involving community nursing and AHP teams was a great success, with good attendance and engagement.

5.13. A working example delivered by Early Supported Discharge for stroke team, facilitated discussions around what clinicians would like to measure and how they will do so in practice. The process has been guided by an outcome measure checklist, developed by the AHP Outcome measures UK Working Group, to help decision making in this varied field.

5.14. Further smaller workshops are planned to identify appropriate outcome measures for our services adult community services and how these would be implemented in practice.

5.15. Although this project is still in its early stages, it is predicted to have a positive impact on improving patient outcomes and therefore a positive impact on the trust as a whole

6.0 Recommendation

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

Appendix 1 – Draft Alliance plan on a page

DRAFT

People and Place ambitions

Pause and Reflect

VALUES AND WAYS OF WORKING

- Recognise everyone's contribution to the Alliance vision
- Listen and learn from people living in West Suffolk
- Promote health, wellbeing and independence
- Be inspired and ambitious for the people of West Suffolk
- Learn from what's not worked and build on what's strong
- Recognise and respond pro-actively to inequality

Vision: Working together to make lives in West Suffolk better

		Alliance mission	Outcomes
Strengthening the support for people to stay well and manage their wellbeing and health in their communities. Building local integrated working, across all ages and across both physical and mental health	**COVID-19 Pandemic** How can we sustain the level of partnership and community involvement to continue to promote health and wellbeing, reduce inequalities and protect the longer term sustainability of health and care?	Create environments that enable people to thrive	• There is a co-ordinated approach to invest back into the community to improve longer-term outcomes for citizens in West Suffolk • Young people are actively involved in shaping the future of lives in West Suffolk.
Focusing with individuals on their needs and goals. Looking at how we co-ordinate services to help people of all ages keep well, get well and stay well.	**Integration White Paper** How can we develop a place-based response to health and care?	Empower people to live healthy and connected lives	• The population of West Suffolk is protected from COVID-19 • People with complex needs can sustain accommodation • All citizens can access opportunities that enable them to live a healthy and well lifestyle • Localities in West Suffolk are connected, supported and resilient
Changing both the way we work together and how services are configured so that health and care services are sustainable into the future and work well for people.	**Future Systems** How can we maximise the opportunity of the future systems programme to drive transformation in the community?	Develop services that are joined up, accessible, responsive and wrapped around people/families in the communities they live	• Physical and mental health and care services are Integrated • Urgent care is response and delivered closer to home and there is a co-ordinated approach to and from specialist, (acute), provision • People have choice and control of the care they receive • The workforce in West Suffolk is diverse and see the value of working together as part of the Alliance
Making effective use of resources. We will use the West Suffolk pound in the best way locally, reducing duplication and waste. All our organisations face challenging finances and if we work together we can use our resources better	**Integration White Paper** How can we organise ourselves differently to enable better use of our collective resource to achieve the Alliance vision?	Organise resources from across the alliance to deliver action to contribute to these ambitions and towards the Alliance vision	• Data and Insight is used in support planning, operational delivering and transformation across the whole system • People are actively using digital to support health, wellbeing and remain independent

Appendix 2 - Final Alliance Visual graphic

The VCSE Charter for Action - the case for resilience and sustainable investment

Executive Summary

> "The VCSE sector needs to be viewed as an integral part of health and care service delivery"
>
> Voluntary organisation in SNEE

Overview

The VCSE in Suffolk and North East Essex is a critical partner working alongside communities to tackle the root causes of health inequalities which delivers:

- Flexibility and adaptability to enable significant reach to marginalised communities and the ability to respond quickly to need using a whole person approach to health and wellbeing.
- Cost effective solutions which improve the health of the local population and reduce demand on statutory services.

The VCSE sector employs around 14,000 people with a total income of £275 million.

This report informs the steps required for the VCSE sector to become an equal partner with the integrated health and care system developing a strategic, sustainable and joined up approach which involves engagement in decision making and shaping services and the development of long term joined up investment.

This Executive summary sets out the proposal for a Charter for Action. It is informed by the attached supporting report [page 5 onwards] which provides the evidence gained from a VCSE Resilience survey and more detailed accounts received from several voluntary organisations and grant funders. Discussions were also held with the ICS VCSE System Leadership Design Panel, the ICS VCSE Strategy Group, Healthwatch Suffolk and Healthwatch Essex as well as the Anchors Programme Board all of which informed the supporting report and the proposed Charter for Action.

The VCSE sector therefore proposes a Charter for Action that all ICS partners and VCSE organisations sign up to and commit to meeting by March 2023.

The Charter for Action's 5 commitments are:

1. **<u>Genuine VCSE sector investment</u> which is simple, inclusive, accessible, joined up and long term**
2. **<u>A funding model</u> which involves the integrated care systems in conjunction with the VCSE sector coproducing at place, neighbourhood and system level services which meet local needs ensuring alignment with the local health and care system without duplication, overlap or additional bureaucracy**
3. **<u>Delivery of quality services</u>**
4. **<u>Shared back-office resource</u>**
5. **<u>VCSE training investment</u> in Social Value, Theory of Change and leadership**

What each of these commitments mean in practice

1. <u>Genuine VCSE sector investment</u> which is simple, inclusive, accessible, joined up and long term.
   This means:
   - Production of commissioning intentions 6 months in advance of commencement of funding
   - Local funders to produce funding intentions 6 months in advance of commencement of funding
   - Early market engagement by funders when considering investment in the VCSE sector
   - Collaboration between the statutory sector, funders and the VCSE sector to design the service delivery prior to agreeing investment which includes a VCSE day rate payment to resource all voluntary organisations who will be involved irrespective of size
   - Contracts under general circumstances to be no less than 3 years increasing to 5 to 10 years which incorporate regular [quarterly] 2-way reviews
   - Contract changes, extensions or terminations given 6 months' notice
   - Incorporation of 20% social value [with aspirations to increase the % over time] for a contract or grant, making organisations aware of the model to be used for social value when advising of commissioning intentions and/or in early market engagement. For voluntary organisations who are new to social value they will be expected to incorporate 10% social value initially building up to 20% by the end of year 2.
   - Investing in VCSE data systems which align with the statutory sector to simplify data and information sharing

2. A funding model which involves the integrated care systems in conjunction with the VCSE sector coproducing at place, neighbourhood and system level services which meet local needs ensuring alignment with the local health and care system without duplication, overlap or additional bureaucracy.
   This means:
   - Collaboration to inform need and future investment by sharing and analysing data in order to develop and identify the right service delivery for place, neighbourhood and system
   - Front loaded funding to allow investment in staff and systems, a limit on payment by results funding
   - Aligning funding amounts to match the level of work involved in delivering, monitoring and assessing impact and outcomes of the agreed service
   - Grant and statutory led contracts need to produce a clear monitoring schedule which includes 2-way dialogue on the data received to ensure agreed outcomes are being met
   - Built in consideration of next steps and sustainability beyond the investment

3. Delivery of quality services
   This means:
   - Access to all party data which clearly demonstrates impact and outcome
   - Quality assurance requirements which include evidence of policies, workforce requirements including statutory and non-statutory training and leadership investment and evidence of business resilience and continuity
   - Access to annual accounts
   - Agreement of charter marks which indicate achievement of quality standards and support to develop these quality standards
   - Quality checks which are part of a 2-way dialogue
   - Evidence of continuous improvement which includes risk management and lessons learnt
   - Healthwatch to act as a conduit for continuous improvement by providing a place for issues to be fed back in relation to contracting and service delivery.
   - Healthwatch supporting a panel which consists of statutory sector and VCSE partners as well as clients to consider the quality information and feedback received and make recommendations which inform the Charter for Action review

4. Shared back-office resource
   This means:
   - VCSE use of anchors including HR, finance and estates to support the delivery of services. The offer of a shared resource will demonstrate that the VCSE is seen as an equal partner

5. VCSE training investment in Social Value, Theory of Change and leadership
   This means:
   - Investing in understanding what training the VCSE needs to fulfil the Charter for Action requirements
   - Investment to fund the VCSE's access to training within statutory organisations as well as the ability to buy in external training
   - Investment in statutory sector and voluntary sector leaders to shadow each other to develop knowledge and understanding that will maximise and benefit the system partners

The ICS/STP Board is asked to:
• Note the content of the report and commit to the Charter for Action • Commit individually to signing the Charter for Action • Note the need for longer term investment to enable this work to continue

On behalf of the ICS VCSE Design Panel:

- Simon Prestney, Chief Executive – Age Concern North Essex
- Fiona Ellis, Chief Executive – Survivors in Transition
- Tara Spence, Chief Executive – Home-Start in Suffolk
- Jon Neal, Chief Executive – Suffolk Mind
- Christine Abraham, Chief Executive – Community Action Suffolk
- Sharon Alexander, Chief Executive – Community Voluntary Services Tendring
- Simon Glenister, Chief Executive – Noise Solutions
- Keith Whitton, Chief Executive – Anglia Care Trust
- Sally Shaw Director – Firstsite Gallery
- Sam Glover, Chief Executive – Healthwatch Essex
- Nicky Willshere, Chief Executive – Citizens Advice Bureau

The VCSE Charter for Action: the case for resilience and sustainable investment

"If 2020 has taught us anything it is the importance of our connection to communities. It has also shown us that no matter what challenges 2021 brings, the community and voluntary sector can rise to them. There was a time when charities were the icing on the cake but in times of crisis we are the cake, often the first to react and respond to local need.

During these times we work in partnership with other organisations, and we provide ongoing insight and intelligence to the local authorities, commissioners, and funders. We inform them what is happening on the ground, what the need is, the gaps in service provision, the themes and the trends and this helps to develop future services. We are the grass roots, trusted eyes and ears of our local community."

Voluntary organisation in SNEE

1.Introduction

The voluntary, community and social enterprise [VCSE] sector aim to achieve equal and effective system partnership with ICS partners.

VCSE organisations in Suffolk and North East Essex [SNEE], supported by the Integrated Care System [ICS] Board, are currently working with statutory partners and grant funders to build VCSE resilience by developing a strategic, sustainable and joined up approach which involves engagement in decision making and shaping services and the development of long term joined up investment.

The VCSE is a vital part of SNEE ICS providing often bespoke place based and people-based services which are integral to the health and wellbeing of the local population. It provides a myriad of marginal and major gains in conjunction with statutory services and grant funders, which produced at scale aim to provide a collective and robust response to the needs of the local population. To unlock and maximise the collective potential of the VCSE as part of the ICS requires formal recognition and process change to ensure the VCSE is a truly equal and effective partner.

This paper examines issues in relation to VCSE contracts and grants, the use of social value and the Theory of Change which inform a proposed Charter for Action.

The VCSE sector proposes a Charter for Action containing 5 commitments that all ICS partners and VCSE organisations are asked to sign up to and commit to meeting by March 2023. The Charter for Action which is informed by the findings in this report and recommended to the ICS Board is set out in the Executive summary of this paper.

2. Process

The ICS needed to commit to strengthening the integral relationship between the statutory sector and the VCSE to ensure sustainable VCSE services by reviewing the following:

- Contract length
- Contract management
- Grant monitoring
- Use of Social Value
- Use of Theory of Change

In order to understand the VCSE experience in these 5 identified areas the VCSE sector was asked to complete a survey. This was designed to help inform the next steps for strengthening how VCSE organisations would work with statutory partners in Suffolk and North East Essex.

In addition, 4 grant funders and 4 voluntary organisations were either interviewed or provided more detailed written information based on their experience stating what works well and what works less well in relation to the 5 identified areas. Some illustrative case studies of what worked well and what worked less well were also provided by voluntary organisations and can be viewed in the Appendix on pages 13-15.

Discussions were also held with the ICS VCSE System Leadership Design Panel, the ICS VCSE Strategy Group, Healthwatch Suffolk and Healthwatch Essex as well as the Anchors Programme Board, all of which informed the report and the proposed Charter for Action.

3. Evidence for a Charter for Action: a summary of the findings

A summary of the VCSE experiences and feedback and the subsequent recommendations are set out below, however the key consistent messages were:

- simplify the contracting process so it is fair and manageable for all
- where appropriate increase the length of contracts and grants to enable sustainable outcomes
- underpin these developments by investing in VCSE training in Social Value and the Theory of Change
- explore the idea of access to a back-office facility to avoid draining voluntary sector resources unnecessarily or ensure the VCSE sector can levy an operational fee as part of the contract in recognition of the monitoring resource required

3.1 VCSE Resilience survey feedback

The findings of the survey completed by 38 VCSE organisations [26% response rate] showed that whilst the sector was relatively positive about contract and grant monitoring, it was keen for the contracting process and contracting management relationship to be reformed to improve VCSE resilience. This started with the need for longer contracts of 3years, 5years and 10years and the incorporation of social value and use the theory of change as part of

the contracting process. The survey detailed feedback is set out below in relation to the 5 identified areas.

3.1.1 Contract length

- 68% held public sector contracts with a contract length range from 1yr-3 yrs.
- 70% stated this contract length was not suitable and would rather move towards 3yrs-10 yrs in order to:
  - Reduce costs of applying for funds
  - Increased security
  - Allow for longer term planning
  - Improve impact measurement
  - Provide better client outcomes
  - Improve staff recruitment
- There was an overall negative response to not being involved in agreeing the contract outcomes.

3.1.2 Contract monitoring

- Contract monitoring was perceived by 55% as on occasion putting the organisation under pressure but organisations understood contract monitoring was needed to measure funded outcomes, help influence future commissioning intentions, help map against community needs and understand gaps in provision.
- Areas for change in relation to contract monitoring included, providing information to funders the VCSE felt was relevant, having 2-way feedback, being supported with the financial resource to enable the VCSE to do effective contract monitoring and being able to provide data from their own systems.

3.1.3 Grant monitoring

- When asked why grant officers undertake the VCSE grant monitoring respondents stated it was to measure funded outcomes, to map against community needs, understand gaps in provision and so they could satisfy the donor.
- The majority stated they were not involved in agreeing grant outcomes.
- There was a 50:50 split of respondents between those who felt the grant monitoring process was about right and those who felt on occasion it was putting the organisation under pressure.
- Areas to change in relation to grant monitoring included, providing relevant information to grant organisations, having 2-way feedback, being supported with the financial resource to enable the VCSE to do grant monitoring and being able to provide data from their own systems.

3.1.4 Use of Social Value

- 34% said they measured Social Value and 32% said they did but not regularly.
  34% said they did not measure Social Value because either:
  - they didn't have the capacity to do so [48%]
  - or they didn't have the experience to do so [21%]
  - or they didn't understand enough about social value to use it [24%]
- 62% of respondents stated that staff did not have sufficient knowledge or training to undertake social value measures with 9% saying they would buy in expertise.

- In order to improve the social value offer respondents requested:
  - Training 36%
  - Have a SNEE social value single measurement structure 29%
  - New monitoring software 15%
  - Dedicated staff member 15%

3.1.5 Use of the Theory of Change

• Only 32% of respondents stated they used the theory of change model and 15% said they had never heard of it.

3.2 Summary of the detailed discussions with the VCSE sector

The detailed discussions with the VCSE sector reinforced the findings of the VCSE Resilience survey and identified the following issues:

- Short term contracts and funding lead to constant uncertainty regarding investment, staffing and ability to deliver.
- Short term funding is damaging to the continuation of complex pieces of work
- Many VCSE organisations need ongoing support to provide the quantitative and qualitative data regarding activity and outcomes required for robust monitoring.
- The resource required to fulfil this obligation is often not considered as part of the funding awarded and can also be disproportionate to the size of the contract.
- Funding is often not assigned as part of a contract or grant to cover the core costs of the voluntary organisation
- There were examples of the statutory sector asking the VCSE to develop a proposal which was not followed through. Developing a proposal on request which is not followed up uses existing VCSE resource which would otherwise deliver the core activity.
- There is a lack of understanding of the commissioning process by the VCSE and a lack of understanding by the statutory sector as to how to effectively commission VCSE services

3.2.1 What the VCSE sector had to say about:

[i] Resourcing preparatory discussions with the statutory sector

VCSE respondents stated there was often a lack of understanding from the statutory sector about how to engage the VCSE sector in the preparatory phase of contracting,

“We had a conversation with our local statutory organisation where we presented evidence based work we had undertaken in schools. As a result we were asked to develop a proposal which would scale this work up to 40 schools. This involved a lot of work up front to develop the proposal but our submission didn’t go anywhere. That request involved one week of management staff time to develop a proposal. The work was undertaken at their request but progressed at our expense with no recognition of the resource our organisation had put in.”

[ii] Application timescales

> "Then comes the funding pot - To bid or not to bid? That is the question."
> Voluntary organisation in SNEE

VCSE organisations consistently reported that too often they are not permitted realistic timescales when applying for grant funding. This quote was typical of all the discussions held and accounts received,

"often a weeks' notice of a deadline and the duration of the grant (average of 1 year) does not allow for any meaningful coproduction [at the outset] or post grant evaluation which must take place during the grant term and does not allow for realistic appraisal"

In addition all the contributors wanted a recognition of the need to include core costs as part of the contract or grant,

"not being able to use any of the grant funding for core costs means that these restrictions can exclude the very organisations that would benefit and contribute richly to the community. Charities are inevitably under significant pressure to ensure that their costs are as lean as possible in that kind of environment, which has the unintended consequence of placing pressure on them, in some cases, not to apply for their core and running costs. That concerns us, because it can disguise the true cost of delivering a very important service."

[iii] Contract management often not being proportionate to the contract size

Respondents stated that smaller grants often have the same monitoring requirements as the larger grants without the resource to match. In addition the monitoring costs needed to be recognised and at least 1% of the grant should fund monitoring.

In terms of general costs it was felt that the grant should include core costs, delivery fees and operational costs. As one organisation stated,

"We delivered a small contract which was a 3 year contract of £30k per annum as part of a £4.5m contract which involved often more interrogation than the bigger projects. The amount of input and resource required to do that did not feel proportionate."

[iv] Longer term contracts needing to become the norm

Whilst it was recognised that some projects are completely appropriate for a short-term grant such as teaching children to swim or running a summer rambling group to promote wellbeing, all of which have a beginning, middle and end, many contributors expressed concerns that short term contracts were often the norm irrespective of what was expected to be delivered.

This short-term approach had consequences for organisations and their ability to recruit and retain as these two respondents explained:

“When you can take on a member of staff to deliver the service, if you cannot retain them beyond the grant duration they may never be fully dedicated to the organisation in question, and they spend the last 2 months of their contract looking for future employment. The time and money the organisation has invested in essential training, supervision and welfare support is like whistling in the wind as you cannot train and sustain.”

“Grant lengths have a huge impact on the quality of delivery, staffing and the need to increase capacity.”

It was also stated that short term funding often meant that those people who were helped received intensive support for a short period of time only. This worked against an organisation’s ability to provide a complex service,

“When working with vulnerable people, particularly the seldom heard, they often present with a range of complex issues and challenges which have intensified over many years, the latter often a result of limited engagement and service intervention. To be able to resolve and empower people towards self-help and self-reliance within a short period of time is unrealistic.”

Whilst another respondent said,

“Often proven success has no value if the funding dries up. There is no mechanism to have that conversation and it does not rank in terms of delivery against that funding. We should be able to have a discussion about the potential for funding to continue when effectiveness has been proven”.

3.3 What grant funders said

[i] Suffolk Community Foundation:

- The average grant length is 1 year but it can be up to 3 years if the programme is successful
- We offer extensive help and support to organisations in the development phase
- The key to working well is the preparation of the programme and understanding funders needs and outcomes
- Grant making can lead to new ways of working

[ii] Essex Community Foundation:

- Grant length is mainly 12 months [although some have multi-year funding] which is sometimes ringfenced to an area.
- Whilst lines can get blurred between grants and contracts, contracts are often more prescriptive regarding outcomes.
- In terms of grant monitoring, requests are made for the VCSE to describe inputs, outputs, outcomes, learning and challenges. It is reasonable for grants to incorporate up to 10% to cover VCSE sector costs.

- An impact framework is being developed and the Community Foundation is looking to use the Theory of Change. It is important from the outset to clarify what the grant requirements are, however some grant funders can pose difficulties by changing their requirements half way through the grant term.

[iii] The National Lottery:

- It is important to build a relationship with the grant holder through regular meetings and conversations which includes a light touch contact every 6 months with a detailed report at the end of the year
- Funds can be moved between agreed budget lines offering flexibility but this must be agreed in advance
- Grant length is flexible but typically runs for between 3-5 years
- The areas that work well include a conversational approach, light touch monitoring, local knowledge, flexible outcomes, making sure organisations measure their outcomes well and investing in the organisation as much as the project itself

4 Enablers identified from the feedback

- Important to recognise and understand the VCSE landscape despite and because of its size and diversity
- Important to embrace the reality of a VCSE landscape which is diverse and complex as a strength
- An open and honest dialogue between partners
- Genuine partnership and agreement of roles and a way of working early on
- Match funding gives the potential for more equal partnerships.
- The length of contracts has a direct impact on how the project is delivered and the sustainability and growth of the organisation.
- Access to data systems and internal skills to develop data and monitoring.
- Early engagement and coproduction are key to effective commissioning and contracting
- Would be good to do joint social value training with the VCSE and statutory sector to improve understanding of each other
- Explore ability to work in partnership where appropriate with other VCSE organisations to deliver a contract

5.How can we make a difference by contracting differently in health and care?

- Reduce Barriers
- Actively Incentivise
- Promote Appropriately
- Provide Support and Advice
- Set Targets Holding Ourselves to Account

6.VCSE Recommendations

- Include social measures in contracts, let us help you see the additionality that we bring to the table and allow us to use our social impact as evidence in the bidding/tender process
- Increase contract lengths to 3 years+ allowing us to employ experienced staff and great leaders and recruit good volunteers so we focus mainly on people rather than funding bids.
- Jointly agree contract outcomes with support to measure real impact and change
- Promote more local partnership working and coproduction between other VCSE organisations and statutory sector partners to meet the needs of local people. Ask the VCSE sector "what part of this contract can you deliver?"
- We should demonstrate the value of what we do to attract funding to secure a more sustainable income
- We need to assess the willingness to develop a VCSE back-office function and/or build in 1% for the costs incurred by the VCSE sector to provide monitoring
- ICS investment in VCSE social value and Theory of Change training

Tara Spence Chair of the VCSE Resilience Group and CEO Home-Start in Suffolk

Sara Bradley Enable East

May 2021

Appendix: VCSE Case Studies

What has worked well

Case Study 1

Tendring Community Transport [TCT] have secured funding over the next 2-3 years to provide general transport services for people in Tendring where public transport links do not currently exist.

As a 3 year grant has been secured from the National Lottery there has been no need to negotiate a grant extension with Essex Community Foundation.

TCT also went to the CCG for financial support and were awarded a 2 year contract which was originally due to start in April 2020. Owing to the Covid-19 restrictions this funding was received in October 2020 however due to the ongoing impact of Covid-19 TCT is in discussions with the CCG to delay the start of the contract further until the Covid-19 roadmap is clear at which point the transport service agreed can start.

The CCG has been very flexible and sympathetic about the reasons for the delay in starting the service and have given assurance [verbally at this stage] that they understand and will accommodate the situation. Receiving this assurance in writing is currently being followed up by TCT with the CCG.

All 3 funders have been positive in their approach recognising, given the circumstances, the need for flexibility.

It did take time to agree the contract with the CCG but since the agreement has been reached dialogue with the CCG has been positive despite the delays.

Case Study 2

Home Start in Suffolk [HSiS] is a volunteer-based family support charity based in Suffolk, working with families with children aged 0-12 across the county.

As part of a contract award HSiS had to provide match funding. They match funded the contract by 100% which meant of the total outcome delivery they 'owned' 50% of the contract and the additional 50% liability helped to support a greater partnership dialogue and increased motivation for the organisation to deliver as they 'owned' the outcomes.

Suffolk County Council has further invested in the service by supporting HSiS to achieve individual outcomes, supporting their PR and publicity, helping them to develop additional funding streams and celebrating the achievements of volunteers. They have been involved in all levels of the service as a true partner and champion and celebrate the outcomes HSiS deliver.

What has worked less well

Case Study 1

Summit manage, provide and facilitate a range of services and work in partnership with other organisations, serving the learning disabled community and adults with mental illness. A grant was awarded to provide services for vulnerable woman who are victims of domestic abuse and violence, vulnerable woman who have additional needs such as a learning disability or mental illness and woman who are isolated.

The aim

The project aimed to provide and deliver services such as group advocacy (helping them to find their voice and speak up) regarding their rights and responsibilities, deliver training on confidence building and self-esteem, create a peer and social support network to reduce loneliness and isolation, raise awareness on health and wellbeing, provide appointment support to GPs and Well Woman clinics, provide links, information and navigation to services and future opportunities that can improve their quality of life such as volunteering and employment support.

The reality

15 females attended two sessions weekly. It took six weeks to promote, recruit and ensure a robust and appropriate referral route. The females also benefitted from 1-1 support and after 9 months outcomes were positive with the beneficiaries growing in confidence, reporting a reduction in their stress and anxiety and genuinely looking forward to coming to the sessions and meeting their peers. Towards the end of the 12 months the organisation was invited to apply for continuation funding but this was rejected. The rationale was that although Summit had submitted a good bid the fund needed to meet other new criteria. The bid did not now tick all of the boxes as the newly identified theme was to increase fitness and use of outside spaces. The females were navigated to statutory providers but many of their referrals were rejected on the basis that they were not a priority.

The impact

The females tried to sustain their meetings in the local community using the library and café, but they could not sustain it without some light touch support and help to organise their schedule. They found it impossible to participate in the sessions without some adjudication. After a few months they stopped meeting. One female returned to an abusive relationship, another began to self-harm. The charity tried to provide some ongoing light touch support but the demands on their service meant this could only be short term.

Conclusion

There are some significant and critical issues that the voluntary and charitable sector support and address on short term grants such as complex mental health needs, disability rights, abuse and deprivation. We are often asked what the legacy will be from the grant award. A legacy that can create significant and lasting change would be more achievable if

scaling down grants over a longer period were awarded, so that outcomes and longer-term achievements can be met and measured realistically.

Case Study 2

Tendring Community Transport [TCT] has provided a Hospital Hopper service for people in Tendring since 2004. This service is specifically designed to transport local people to hospital and other health care settings. This service ensures local people who do not have access to private transport or reliable public transport are able to get to building based healthcare services for their appointments or visit relatives and friends in hospital when possible.

TCT often has to apply for grants to fund the cost of this service and grant funders query, as do we, why the service is not commissioned by the statutory sector on a long term [5years +] contract basis.

Comfort Break - 10 minutes

10:45 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

12. Involvement Committee Report

To APPROVE the report

For Approval

Presented by Alan Rose and Jeremy Over

Board of Directors – Friday 30 July 2021

Agenda item:	12			
Presented by:	Alan Rose, Non-executive Director and chair of Involvement Committee			
Prepared by:	Jeremy Over, Executive Director of Workforce & Communications			
Date prepared:	22 July 2021			
Subject:	Involvement Committee report			
Purpose:	✓	For information		For approval

The Involvement Committee met for the third time on 19 July 2021 and focused on a number of areas of development related to staff support, inclusion and organisational culture.

Denise Pora, deputy director of workforce was in attendance to brief the committee on the organisation's work programmes related to **equality, diversity and inclusion,** and **staff health and well-being.** Steering groups that oversee the design and delivery of these work programmes are well-established, and involve key staff. The committee was provided with updated versions of the delivery plans for each which are comprehensive and trackable, including our position with the related national reports (WRES and WDES).

The group discussed the challenges that arise with converting these organisational-level plans and activities into day-to-day reality for all of our staff and teams and how this was the ultimate test of their success. The staff survey is a crucial component of this assurance although it can be difficult to ascertain if a score has changed because of, or in spite of, any of the specific actions that we have implemented. From an involvement perspective the committee noted the formation of three staff network groups for Black, Asian and minority ethnic staff, LGBT+ colleagues, and those with a disability, and recognised that the chairs of those networks would be ideal people to hear directly from as part of our future work programme. The group also assured the workforce team that they would welcome more challenging analysis of our weak spots to ensure we are tackling all the right priorities.

Helen Davies, head of communications attended the meeting to brief members on the work that had been ongoing to review and refresh WSFT's set of organisational ("FIRST") **values**, sitting within the wider piece of work of forming our next 5-year strategy. It was apparent that this work had sought to involve a significant number of staff whose feedback had informed various iterations of a refreshed values statement. The committee agreed that, following confirmation, the next stage was even more important in terms of embedding those values into various policies and processes – to ensure they are hardwired into our infrastructure. *How* this is done presents yet another opportunity for wider involvement and to ensure staff and teams feel they have a stake in what is being developed. The importance of upholding the right behaviours lies at the heart of this, and members noted that, in order to challenge the behaviours we don't wish to see, it would be helpful to explicitly set these out – informed by staff's experience and involvement.

Ann Alderton, interim board secretary, updated the committee on the work ongoing to **strengthen the governance arrangements** underpinning the new board sub-committee structure, including the terms of reference for this committee, which would be finalised in due course. This also included the search for clarity on which existing "feeder" committees or groups contained involvement aspects we should take note of. In addition, we discussed the desire to be sure we effectively differentiated the Committee's assurance role from the ongoing operational line management of the Trust's activities.

<table>
<tr><td colspan="8">Our next meeting is on 16 August.</td></tr>
<tr><td rowspan="2">Trust priorities
[Please indicate Trust priorities relevant to the subject of the report]</td><td colspan="2">Deliver for today</td><td colspan="2">Invest in quality, staff and clinical leadership</td><td colspan="3">Build a joined-up future</td></tr>
<tr><td colspan="2"></td><td colspan="2">X</td><td colspan="3"></td></tr>
<tr><td rowspan="2">Trust ambitions
[Please indicate ambitions relevant to the subject of the report]</td><td>Deliver personal care</td><td>Deliver safe care</td><td>Deliver joined-up care</td><td>Support a healthy start</td><td>Support a healthy life</td><td>Support ageing well</td><td>Support all our staff</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td>✓</td></tr>
<tr><td>Previously considered by:</td><td colspan="7">N/A</td></tr>
<tr><td>Risk and assurance:</td><td colspan="7">Well-led line of enquiry: “are the people who use the services, the public, staff and external partners engaged and involved to support high quality sustainable services?”</td></tr>
<tr><td>Legislation, regulatory, equality, diversity and dignity implications</td><td colspan="7">Certain themes within the scope of this report relate to legislation such as the Equality Act.</td></tr>
<tr><td>Recommendation:</td><td colspan="7">For information and discussion.</td></tr>
</table>

12.1. People and organisational development (OD) highlight report

To APPROVE a report

For Approval

Presented by Jeremy Over

Board of Directors – Friday 30 July 2021

Agenda item:	12.1			
Presented by:	Jeremy Over, Executive Director of Workforce and Communications			
Prepared by:	Members of the Workforce & Communications directorate			
Date prepared:	21 July 2021			
Subject:	People & OD Highlight Report			
Purpose:	✓	For information		For approval

The People & OD highlight report was established during 2020-21 as a monthly report to strengthen the Board's focus on how we support our people, grow our culture and develop leadership at all levels. This format will continue to be developed to incorporate Board colleagues' feedback and to reflect more of the work that is ongoing, bringing together various reports that the Board has routinely received into one place.

In addition to discussing the content of the report, and related issues, continued feedback is welcomed as to the structure and content of this report and how it might be developed in future.

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

- Putting You First Awards – celebrating and appreciating the contribution of our staff
- Exploring and supporting the impact of Long Covid
- Evaluation of our staff health and well-being services
- Quarterly mandatory training and appraisal update
- Guardian of Safe Working Hours quarterly report
- Development of Suffolk's Integrated Care Academy
- Update on supported return for our Volunteers
- Consultant appointments

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

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

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	Certain themes within the scope of this report relate to legislation such as the Equality Act, and regulations such as freedom to speak up / protected disclosures.
Recommendation:	For information and discussion.

Putting You First – July awards

Fran Sunderland, Pathway 1 Therapy Lead
Nominated by Kevin McGinness

For her commitment to continuous quality improvement within the P1 D2A pathway. Fran has been tireless in her work regarding data collection, audit, patient review and staff liaison. This has resulted in closer links with acute and community teams and enhanced care delivery. She always goes the extra mile when requested always placing patients at the centre of her care. Fran is an outstanding therapist. She is fully supported by Lisa Enright and Rosie Finch our Therapy Leads who have the insight required to meet the current challenges required within Alliance working. They make a great team.

Jackie Brown, ward manager F11
Nominated by Brittany Meggett (G3)

When I was on the maternity ward Jackie went above and beyond to get me connected with my mum who had come to WSH for an outpatient appointment and been told that that she would need surgery and should be admitted straight away.

I was very upset but Jackie made sure I was okay and also made it possible for me and my mum to see each other before she was transferred to the ward.

Jackie also made sure that mum got to meet her new grandson (she was worried she would never see him).

I honestly can't thank Jackie enough - her care went above and beyond, as did the other midwives working that day to make sure I was comforted.

Exploring and supporting the impact of Long COVID

Long COVID is a new challenge for both those experiencing it and their managers. Our Freedom to Speak up Guardians and workforce team have heard from a number of staff and managers with concerns about how they are being affected and seeking advice and guidance. We are currently aware of 10 WSFT colleagues we believe are absent due to long COVID (i.e. people who have new or ongoing symptoms four weeks or more after the start of acute COVID-19).

We are following all available national guidance on how to support staff with long COVID from the perspectives of their physical and mental wellbeing and pay. Trust teams with responsibilities for supporting staff with long COVID met in June to review what we are doing and how we might work closer and better together. Our Freedom to Speak up Guardians, workforce, wellbeing and staff support psychology service shared anonymised details of what they are hearing from staff and future plans for support. Dr Richard Davies also attended as our Senior Independent Director and Guardian of Wellbeing. A number of concerns are emerging and these include difficulties managing symptoms, adjustment to changes in identity/role and a lack of consistent treatment pathways/validation of individuals' experiences, concerns about their future personally as well as worries about pay.

It is clearly vital that the Trust is aware of all staff who have long COVID and it is important that managers are clear on how to report it. Good communication is key and the Green Sheet will be used in the coming weeks to explore long COVID and ensure all staff have a sound understanding of what they can and should expect from their employer around support, their pay and other terms and conditions of employment. We hope to be able to share the stories of some of our staff with long COVID as part of this. In addition, the staff support psychology team are setting up a support group for long COVID sufferers and will be working closely with the workforce and wellbeing teams and Freedom to Speak up Guardians to provide information and help to those participating. As well as internal collaboration we are working closely with Suzahn Wilson, WSFT Respiratory Physiotherapist who is leading the Long Covid Service in in Suffolk & North East Essex, to ensure we share services and support staff with resources and signposting.

Evaluation of our staff health and wellbeing services

Our health and wellbeing offer to staff is monitored and evaluated through a range of process, output and outcome measures. These are bought together in our evaluation framework and dashboard (June 2021 update attached as appendix 1).

The board received an update on the ongoing evaluation of our staff support psychology service in March and this continues to offer a high quality, accessible service to staff in need of emotional and psychological support. One unintended impact of introducing this service, as well as local and national helplines/services, is that we have seen a very significant drop in use of the telephone counselling services provided via our employee assistance programme (EAP) 'Care First'. Our current service is provided via our contract for occupational health services from CUH, and we will take the opportunity resulting from our change to a new OH provider in October 2021 to review our need for the range of services provided under our EAP.

In addition in May 2021 the 'tea and empathy' service was reviewed with those providing the service and the Health and Wellbeing Steering Committee agreed this service should be discontinued due to lack of use. Again, this is believed to be the result of staff having access to a much wider range of emotional and psychological support services as a result of the pandemic.

Appraisal

Supportive, productive appraisal conversations between managers and their staff members provide an opportunity to build relationships and improve the focus on well-being, at a time when many colleagues will be feeling the impact of working during the pandemic.

The overall trust appraisal compliance rate was 80.7% at the end of June which is below the target compliance rate of 90%. Divisions continue to work against their agreed action plans and trajectories to reach compliance. All divisions, except Estates and Facilities (no change) and Surgery (increase of 1.2%), saw a small decrease in the last month. The Corporate Division has the lowest compliance (65.14%) and also the largest decrease (3.06%) in June. Staffing difficulties due to the pandemic and disruption due to building works and ward moves in West Suffolk Hospital have proved challenging when arranging annual appraisals. However, HR business partners report that considerable effort is being made by managers to catch-up with overdue appraisals. Appendix 2 provides more detail.

Mandatory training

Our mandatory training programme brings together the essential knowledge and skills that our teams must possess, as required by law, statute and / or wider NHS policy. Fundamentally it contributes to our number one priority as an organisation - safety: for patients, individual members of staff, and their colleagues, helping to demonstrate that we are up to date.

Overall mandatory training compliance has been at 91% since April, above the Trust 90% target. All divisions, with the exception of Estates and Facilities, have achieved overall compliance of at least 90%. Estates and Facilities are just one percentage point below target overall. In July Clinical Support Services had the highest overall compliance rate at 95%.

Work continues to achieve compliance across all subjects in all divisions and temporary staff banks. Our temporary staff banks face particular challenges in achieving mandatory training compliance. Action plans are in place and progress is being made, for example medical locums have been producing a month on month gain in compliance with only four of the 18 subject areas at 70% or below. All staff groups are above 90% compliance except estates and ancillary (88%), medical and dental (81%) and students (81% NB: overdue n=7). The Education and Training Team and subject matter leads are providing support to help achieve divisional and staff group compliance across all subjects. Appendix 2 provides analysis at staff group and subject level (by division) basis to provide assurance that we are focused on hot spot areas of concern. The most significant challenge is posed for subjects where face to face training is essential, in that capacity is constrained due to ongoing requirements around social distancing.

Guardian of Safe Working Hours report

The latest quarterly report from Dr Francesca Crawley, Guardian of Safe Working Hours is attached as appendix 3 and will be presented for discussion at the meeting of the Board.

Development of an Integrated Care Academy for Suffolk

Appendix 4 provides an update on the development of an ICA for Suffolk, hosted by the University in partnership Suffolk and North East Essex (SNEE) Integrated Care System (ICS), Suffolk County Council, district councils, Healthwatch Suffolk and others from the voluntary and community sector, such as Suffolk Mind and local hospices. Here at WSFT we recognise the huge benefit of working with our partners to support the development of our existing health and care workforce, and growing the workforce we need for the future.

We will strive to be an active player in its development and it is suggested that a focus on the opportunities posed by the ICA is explored further through the work of the Involvement Committee, with representatives from UoS presenting to us on how they envision the contribution of WSFT to the work they are leading.

Our valued Volunteers

Our volunteers are an integral part of our team at West Suffolk and by the end of July we will have around one hundred of them back working in the Trust in non-clinical and outpatient areas, including DSU, pathology, gardeners and wheelchair volunteers. Further to the more detailed updated provided to the Board last month, plans for the return of volunteers to all areas are being monitored and adapted in the light of the development of the pandemic.

Recent Consultant Appointments

Post:	Consultant Haematologist
Interview:	16 July 2021
Appointee:	Dr Tom Bull
Start date:	1 November 2021

Current post: Haematology Registrar trainee: Norfolk & Norwich University Hospitals FT
August 2020 to September 2021

Previous Position:
August 2018 – August 2020
Haematology Registrar Trainee, Cambridge University Hospitals NHS FT

West Suffolk Wellbeing 2019 – 2021: update July 2021

Staff health and wellbeing evaluation framework and dashboard

Structures and Processes	Outputs	Outcomes
Physical wellbeing		
NHS health checks delivered	Staff set quit dates with on-site stop smoking service Flu vaccine coverage	NHS Staff survey - % experiencing work-related MSK problems
Emotional and mental wellbeing		
Tea & Empathy rota Trusted Partner role Staff Supporters promoted To be combined into the new Speaking up champions which will include Health & Wellbeing support.	Uptake of Care First Staff attend training supporting health and wellbeing	NHS staff survey - % experiencing work-related stress
Overall		
Quarterly staff focus groups Greensheet articles Staff led initiatives enabled Resources for staff in intranets Regular targeted health and wellbeing promotions/campaigns Better Working lives group	NHS Staff survey – health and wellbeing and morale themes – overall Trust performance in comparison with other similar organisations (possible from 2020 survey) NHS staff survey - % of staff believing the Trust takes positive action on health and wellbeing	Sickness absence rate • Total • 0-3 days • % declared stress, anxiety, depression Turnover (as an indicator of staff satisfaction) NHS staff survey - % coming to work despite not feeling well enough NHS staff survey - % agree or strongly agree immediate manager takes interest in health and wellbeing

1. Structures and processes
NHS Health Checks Delivered **Target:** 10 clinics available with 70 checks carried out per annum **Progress:** Health Checks re started after pause due to COVID in June 2021. High demand and 8 clinics booked between June and August 2021 (7 checks per clinic). Monthly clinics will follow for the remainder of 2021.
Tea and Empathy rota: Following a review of the demand for this support service and feedback from the volunteers on the rota, the Health & Wellbeing Steering group agreed that the rota would stop from August 2021. The staff on the rota will be encouraged to look at the new role of Speaking up Champions to continue to provide support to staff from the summer of 2021.
Trusted Partner role: Additional Trusted Partners recruited from October 2018 to broaden range of lived experience of staff available to provide support to others through this role. Trusted Partners have reported a total of 23 concerns raised October 2018 to February 2020. Trusted partner role being reviewed and relaunched Speaking up Champions in Summer 2021
Staff Supporters: 'Staff Supporters' branding developed and promoted throughout the trust via intranets and posters to provide staff with a single point for accessing support. Branding extended to include the Guardian of Safe Working Hours, staff support psychology service and Senior Independent Director and to provide access to resources via the HR and people team for staff without easy access to the intranets.
Quarterly staff focus groups/market places: This activity was paused during 2020 due to the COVID-19 pandemic and has now been replaced by 'Love yourself week'. First week held February 2021 next scheduled for September 2021 due to be held twice yearly.
Green Sheet articles: Regular items covering all aspects of health and wellbeing in the branded 'Your Health and Wellbeing' section.
Enabling staff led initiatives: Staff feel able and encouraged to initiate activities to support other staff: LGB&T+ network

Disabled staff network BAME network established in summer 2020 Period boxes in trust toilets to support ‘end period poverty’ My Pause, menopause support network,
Resources for staff on intranets: Information about additional wellbeing resources on extranet for COVID. A single intranet hub of wellbeing resources available from June 2021.
Better Working Lives Group: Better working lives group set up in October 2018 as a sub-committee of the Health and Wellbeing Steering group focusing on the health and wellbeing of medical staff

2. Output indicators

Staff set quit dates with on-site stop smoking service: One Life Suffolk currently unable to provide data

Flu vaccination coverage (frontline staff) CQUIN – Improve update of 'flu vaccination. Measure is uptake by frontline clinical staff *Cut-off date for calculation of total was end December in 2016/17 but end February in following years	**2016/17***	**2017/18**	**2018/19**	**2019/20**	**2020/21**
	Target = 75%	Target = 70%	Target = 75%	Target = 80%	Target = 90%
	64.6%	74.67%	75.1%	80.3%	67.0%

Care First: new clients accessing care first services	**May 2020**	**Jun 2020**	**Jul 2020**	**Aug 2020**	**Sep 2020**	**Oct 2020**	**Nov 2020**	**Dec 2020**	**Jan 2021**	**Feb 2021**	**Mar 2021**	**Apr 2021**
	28			13			15			5		

1st May 2020 to 30th April 2021

Care First: Total calls – telephone counselling	55	12	10	4
Care First: Face to face session	42	0	0	0
Care First: Total calls – telephone information service	2	0	3	1

		Best	**WSFT**	**Average**	**Worst**
National NHS Staff Survey Morale theme	**2018**	6.7	6.4	6.1	5.4
	2019	6.7	6.6	6.1	5.5
	2020	6.9	6.4	6.2	5.6

		Best	WSFT	Average	Worst
National NHS Staff Survey Health and wellbeing theme	**2018**	6.7	6.4	5.9	5.2
	2019	6.7	6.4	5.9	5.3
	2020	6.9	6.2	6.1	5.5

		2016	2017	2018	2019	2020
National NHS Staff Survey Does your organisation take positive action on health and wellbeing?	**Best**	52.2%	51.5%	46.7%	45.4%	51.1%
	WSFT	40.1%	42.0%	39.3%	38.5%	34.7%
	Average	32.0%	31.7%	27.8%	28.2%	31.7%
	Worst	18.2%	19.1%	15.3%	16.0%	20.3%

Comments: It is disappointing to see that the % of staff believing the Trust is taking positive action on health and wellbeing fell again (by 3.8%) in 2020. Further work is needed to understand why less than 40% of staff believes the Trust takes positive action on health and wellbeing – whether this is an issue of perception, communication or the value and appropriateness of what is provided – or a combination of all three. Staff Survey engagement session results and a feedback option on the website will be used to evaluate the current provision.

3. Outcome indicators

Sickness absence:

Most sickness absence time lost remains due to:

1. Anxiety, stress, depression, other psychiatric illness
2. Cold, cough, flu/influenza
3. Gastro-intestinal problems
4. Other known causes, not classified elsewhere
5. Other musculoskeletal problems

In the period December 2020 to May 2021 the total absence % FTE ranged between 3.42% and 5.83%, average 4.07%. The Trust stretch target is 3% total absence FTE. East of England average for total absence FTE was 4.7% (NHS Digital Sep 2020 to Feb 2021).

Uncertified 0 – 3 day sickness absence

Dec 20: 0.47%	**Jan 21:** 0.54%	**Feb 21:** 0.44%	**Mar 21:** 0.55%	**Apr 21:** 0.50%	**May 21:** 0.52%

Staff turnover rate: 8.20% (January 2020)
Trust target: 10.00%

National NHS Staff Survey		**2016**	**2017**	**2018**	**2019**	**2020**
In the past 12 months have you experienced musculoskeletal problems as a result of work activities?	**Worst**	34.4%	34.6%	37.8%	36.2%	37.4%
	WSFT	22.8%	21.3%	24.7%	23.1%	29.5%
	Average	25.6%	25.8%	28.7%	29.7%	28.8%
	Best	18.6%	19.7%	20.2%	21.5%	18.7%

Comments: Although WSFT figures remained consistently below the national average we have seen an increase since the 2019 survey of 6.4%

which has taken us above national average for 2020. Referral rates to our staff physiotherapy service dropped in the last 12 months by 28%. Working from home, postural problems and increases in stress and anxiety seen throughout the last 12 months are all known to negatively impact the risk of injuries.

		2016	2017	2018	2019	2020
National NHS Staff Survey In the last 12 months have you felt unwell as a result of work-related stress?	**Worst**	44.2%	45.9%	46.7%	46.3%	51.5%
	WSFT	34.4%	32.9%	34.9%	36.5%	43%
	Average	35.3%	36.7%	38.9%	39.8%	44.1%
	Best	25.3%	27.9%	28.9%	31.3%	32.6%

Comments: Although WSFT figures remain just below the national average for comparable organisations the upward trend on this indicator seen in the 2018 survey continues, which is of concern.

		2016	2017	2018	2019	2020
National NHS Staff Survey In the last three months have you ever come to work despite not feeling well enough to perform your duties?	**Worst**	62.9%	63.0%	64.3%	62.3%	54.2%
	WSFT	54.0%	51.4%	51.0%	51.9%	45.6%
	Average	55.2%	56.4%	56.9%	56.8%	46.6%
	Best	47.6%	47.6%	47.6%	48.0%	38.3%

Comments: WSFT figures remain consistently below the national average for comparable organisations which is positive.

		2016	2017	2018	2019	2020
National NHS Staff Survey My immediate manager takes a positive interest in my health and wellbeing	**Worst**	57.2%	59.1%	57.6%	55.5%	61.6%
	WSFT	66.8%	67.8%	68.4%	71.3%	69.4%
	Average	65.6%	66.8%	66.9%	68.1%	69.2%
	Best	73.3%	72.4%	74.1%	77.8%	76.9%

Comments:
WSFT figures remain consistently just above national average for comparable organisations. The introduction of wellbeing conversations between line managers and staff and a more streamlined wellbeing provision advertised on the staff intranet is hoped will see an improvement.

Divisional Appraisal Summary

Reporting date: 12/07/2021
Report period: JUL 20 - JUN 21
Prepared by: Workforce Information Team

NHS
West Suffolk
NHS Foundation Trust

Division	Total Assignments	Total Applicable Staff	Total Applicable Staff Expired	Total appraisals due within 3 months	Total New Starters	Total Maternity	Divisional Compliance Rate	Movement (on last month)	Trend (Rolling 6 months)
Clinical Support Division	583	410	75	81	163	10	81.71%	-1.83%	
Community Division	994	817	164	192	150	27	79.93%	-0.63%	
Corporate Services Division	435	370	129	47	60	5	65.14%	-3.06%	
Estates & Facilities Division	425	381	29	96	40	4	92.39%	0.64%	
Medical Division	1021	849	158	204	146	26	81.39%	-1.86%	
Surgical Division	683	595	109	170	80	8	81.68%	1.18%	
Women and Child Division	307	263	48	48	35	9	81.75%	-0.03%	
Trust total	**4448**	**3685**	**712**	**838**	**674**	**89**	**80.68%**	**-0.84%**	

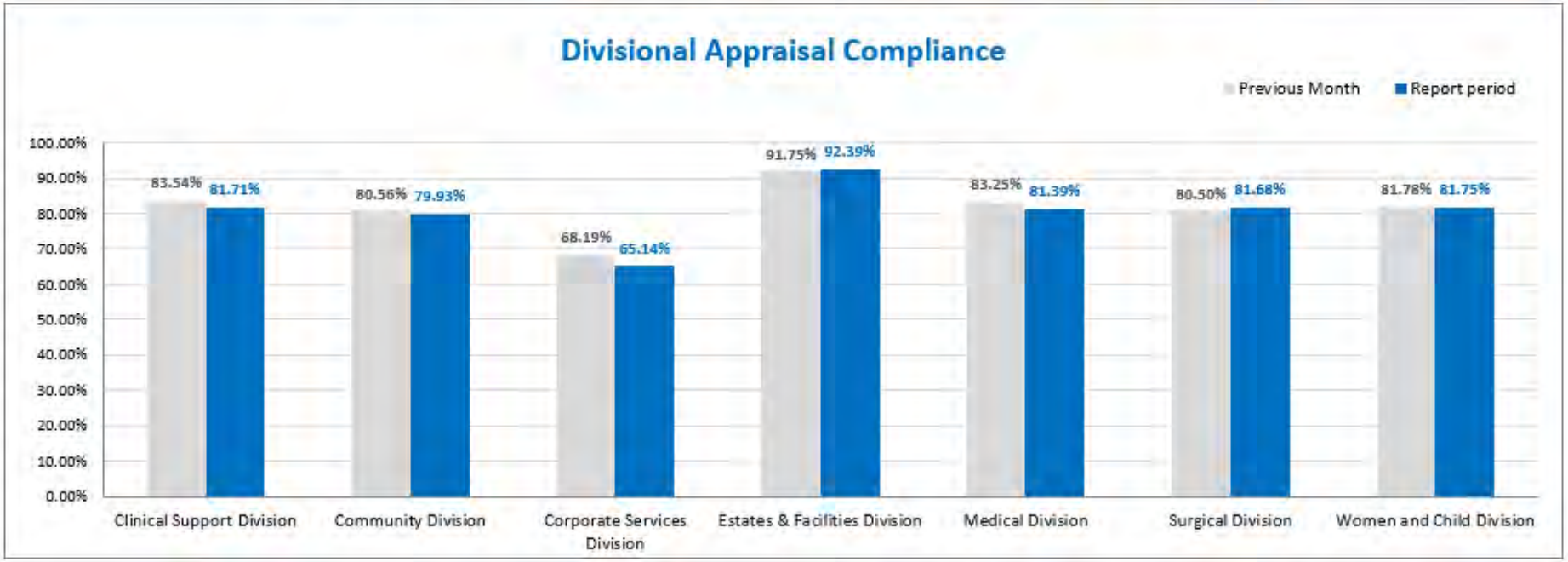


Table 2: divisional mandatory training analyses

Division	July %	Red-rated subjects (less than 70%)	Change from June %
Overall	91%	None	No change
Clinical Support	95%	CR (64%); MHNC (69%)	+1%
Community	93%	MHNC (49%); BPT (28%)	No change
Corporate Services	90%	BPT (62%), CR (60%), Safeguarding children level 3 (50% n=2)	+1%
Estates & facilities	89%	BLS (38%), CR (13%), MHC (47%)	-1%
Medicine	90%	None	No change
Surgery	91%	None	No change
Women and Children	94%	None	No change

Key: CR = conflict resolution; MHNC = manual handling non-clinical; MHC = manual handling clinical; BLS = basic life support; BPT = blood products and transfusion

Table 3: staff group mandatory training analysis

Staff group	Complete	Overdue	Requirement	July %	Change from June %
Add Prof Scientific and Technic	3218	280	3498	92%	-1%
Additional Clinical Services	15805	1054	16859	94%	+1%
Administrative and Clerical	13497	1170	14667	92%	No change
Allied Health Professionals	7232	331	7563	96%	+2%
Estates and Ancillary	4776	678	5454	88%	-1%
Healthcare Scientists	1508	34	1542	98%	+1%
Medical and Dental	7769	1767	9536	81%	+1%
Nursing and Midwifery Registered	23708	1783	25491	93%	-1%
Students	29	7	36	81%	No change

Item 12.1 Appendix 3

QUARTERLY REPORT ON SAFE WORKING HOURS

DOCTORS AND DENTISTS IN TRAINING

1st April 2021 – 30th June 2021 Executive Summary

Introduction

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

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

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

Summary data

Number of doctors in **training on 2016** TCS (total):	143 (includes p/t trainees)
Amount of time available in job plan for guardian to do the role:	1 PAs / 4 hours per week
Admin support provided to the guardian (if any):	0.5WTE
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee[1]
Amount of job-planned time for Clinical Supervisors:	0, included in 1.5 SPA time[1]

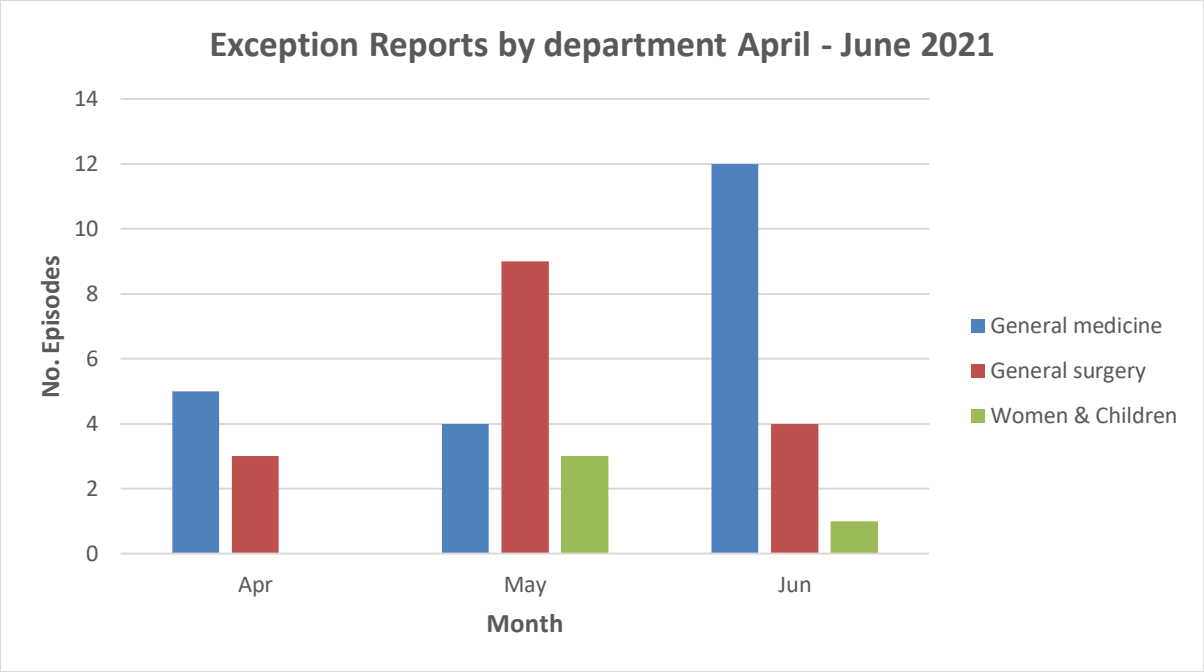
1. Exception reporting: 1st April – 30th June 2021

a) Exception reports (with regard to working hours)

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

Exception Reports by EXCEPTION TYPE						
Department	Grade	Pattern of Hours worked	Educational Opportunities or available Support	Support available during Service Commitments	Hours of Work	Total overtime hours claimed
Medicine	F1	0	0	0	14	23.5
	F2	0	0	0	7	13
Surgery	F1	0	0	0	2	1.75
	F2	0	0	0	14	20.25
Women & Children	ST2	0	0	0	4	7.25
Total		0	0	0	41	65.75

Exceptions reports by month and department



ER are likely to have risen a little across these three months as we moved out of the pandemic and in patient work has become busier and more varied/complex.

b) Work schedule reviews for period 1st April 2021 – 30th June 2021

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

No work schedule review requests were received during this period.

The work schedules are annually reviewed in April by PGME, the College Tutors and Service Managers.

2) Immediate Safety Concerns: 1st April 2021 – 30th June 2021

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

There have been no ISC in this period.

3) Locum Bookings: 1st April 2021 – 30th June 2021

TABLE 1: Shifts requested between 1st April 2021 – 30th June 2021 by 'reason requested'

Department	Maintain Minimum Numbers, Additional Beds/Clinics, Rota Compliance, Shadow Shift and Induction Cover	Leave (Annual, Carers, Maternity, Paternity, Study, Unpaid)	Sickness and Reduced Duties	Extra	COVID-19 Additional Dependency	COVID-19 Self-Isolation	Vacancy	Grand Total
Anaesthetics	25	3	1					**29**
Emergency Medicine	7	135	25	56	10		274	**509**
ENT			2					**2**
General Medicine	20	24	47	27		6	4	**128**
General Surgery	50	16	61	2		3		**132**
Obs & Gynae	2	3	6	10			8	**29**
Ophthalmology	2	6					3	**11**
Paediatrics	1	1	20	2		2		**26**
T&O		2	3					**5**
Theatre/Outpatients Schedule			8	14				**22**
Urology		1						**1**

TABLE 2: Shifts requested between 1st April 2021 – 30th June 2021 by 'Agency / In house fill'

Filled by NHS / Agency		
Department	**NHS**	**Agency**
Anaesthetics	29	0
Emergency Medicine	427	82
ENT	2	0
General Medicine	128	0
General Surgery	132	0
Obs & Gynae	29	0
Ophthalmology	11	0
Paediatrics	26	0
T&O	5	0
Theatre/Outpatients Schedule	22	0
Urology	1	0
Grand Total	**812**	**82**

4) Vacancies – 1st April 2021 – 30th June 2021

Department	Grade	April	May	June
Emergency Dept	ST3+	2.5	2.5	2.5
Anaesthetics	ST3+	1	0	0
Medicine	ST3+	1.2	1.2	1.2
O&G	ST3+	1.3	1.3	1.3
Total		**6**	**5**	**5**

5) Fines – 1st April 2021 – 30th June 2021

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

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

There have been no fines this quarter and the total breach fines paid by the Trust from August 2017 to date are £13,137.75. The Guardian Fund currently stands at £7,033.14.

Matters Arising

- The issues around surgery at night is being addressed and a separate report will be presented to the board. I appreciate that there is progress, but remain concerned about the new intake of juniors in August, the inexperience of some of these (having had disrupted medical school experience secondary to the pandemic) and think that this remains a potential risk for patients and for staff.
  The surgical juniors are repeating the survey about working out of hours and I will ask them to continue to do this until I am satisfied that safety issues are resolved.
- There is still an issue with clinic rooms. In Medicine internal medical trainees and specialist trainees have to do a fixed number of clinics a year in order to progress to the next year of training. For example, for IMT this is 40 a year- almost one a week. These need to be done within a normal working week (and not at the weekend or out of hours). There is not capacity in OP to accommodate this. This has been discussed between OP management, the CD for medicine and the college tutor.
  The Post Graduate Dean has aware of this issue for several years. We were given flexibility during the pandemic, but this is no longer the case and I am concerned that these trainees could be withdrawn by HEE if we do not provide the opportunities for them.
  There is no clear solution that I can see.
  I have asked the college tutor for medicine and for surgery to ask trainees to exception report (ER) as a 'missed educational opportunity' if they cannot get to clinic due to capacity. This would highlight the size of the problem to me as GOSW.
- I am speaking to all new doctors at induction in August to explain about our positive culture around safe staffing and around ER.

Dr Francesca Crawley
Guardian of Safe Working Hours

INTEGRATED CARE ACADEMY
Delivery Plan Summary – July 2021

A word from our Director

The Integrated Care Academy (ICA) is an exciting new partnership - the first of its kind in the country. Hosted by the University of Suffolk (UoS) the partnership extends across UoS, Suffolk and North East Essex (SNEE) Integrated Care System (ICS), Suffolk County Council, district councils, Healthwatch Suffolk and others from the voluntary and community sector, such as Suffolk Mind and local hospices. We are working together to respond to a rapidly changing health and care landscape, as typified by the current global pandemic exposing stark inequalities.

The ICA is for everyone with an interest in integrated care, whether you are pursuing a career, open to life-long learning, interested in research, developing technology or looking for help to get your ideas off the ground.

The ICA's three priority areas are:

- **Optimal mental health and emotional well-being across the lifespan**
- **Best quality of life as we grow older**
- **Care and support towards end of life for young and old**

Extending across these priority areas is the ICA's overarching aim ***to reduce inequalities***.

In this summary, we bring you up to date with the ICA's delivery plan and set out the many opportunities to be part of our joint venture.

Director of the ICA, Professor Chantal Ski
Supporting best integrated care for all

What is the Integrated Care Academy (ICA)?

The Integrated Care Academy is a bold ambition to create excellence in integrated care.

The ICA aims to be the **lead academic partner** for all organisations and people who are involved in planning and providing integrated care, including self-supporting service users, their families and carers for Suffolk and North East Essex.

The ICA offers five core programmes:

Education, training and development – to add capacity, competence and capabilities in integrated care

Workforce development – to strengthen integrated care through team-based development across the employed and voluntary workforce

Leadership and cultural change – to develop and enhance local talent in integrated care

Digital, data and technology – to create and implement cutting edge integrated care initiatives

Research and innovation – to best support our communities through smarter ways of thinking.

The ICA Co-production Hub

Co-production has paved the way for the ICA and is embedded throughout our five core programmes. In collaboration with Healthwatch Suffolk and others in our local communities, we have developed an **ICA Co-production Hub**; a place where we listen, respect and value citizens' voices to champion change. The Hub offers professional support in training, education, research and expert consultancy.

Equality and diversity

Promoting and supporting diversity and equality is paramount within the ICA. The ICA provides an inclusive environment where everyone is supported to achieve their true potential.

ICA initiatives for 2021 – 22

Education, training and development
Integrated care to be added to all health and care training courses during 2021/22, to be available to students from 2022 onwards.
Development of a Masters in Integrated Care for health and social care workers with a first degree or equivalent.
Workforce development
In collaboration with Health Education England the ICA offers a pilot programme to support the transformation of the mental health workforce (paid and unpaid) to improve care for adults and children.
Leadership and cultural change
36 places available for GPs and primary care clinicians to join an Integrated Care Fellowship programme (sponsored by Health Education England) to develop leadership skills in integrated care.
Continued offer of the "One Team" leadership programme, which is currently active in Suffolk and North East Essex. The programme develops effective teamwork with people in a wide range of roles to make integrated care culture a reality.
Research and innovation
PAtient Self-care uSing eHealth In chrONic Heart Failure (PASSION-HF) An avatar to support older rural heart failure patients with 24/7 access to personalised medical advice. This user-friendly app simulates a 'doctor at home' to check health status and give advice and education.
An integrated care approach to specialist mental health provision Funded PhD scholarship to co-produce recommendations for integrated mental health care across neighbourhood, community and primary care.
Long COVID Optimal Health Programme – randomised controlled trial An Optimal Health Programme (OHP) to empower those with Long COVID through enhanced self-management, mental health and quality of life.
World Health Organisation ICOPE UK Pilot The ICA has been accepted as the first UK pilot site in an international network of collaborators to promote person-centred integrated care for older people and their carers.
Digital, data and technology
The ICA is working with local partners, such as BT DigiTech, to explore and realise the benefits of technology in integrated care.

If you would like a copy of the full draft ICA delivery plan, or any other background documents, please email us ica@uos.ac.uk

Our people

Director: Professor Chantal Ski

Professor of Integrated Care: Dr Mark Shenton

Honorary Professor: Professor Ian Philp

Senior Research Fellow: Dr Karen Windle

Research Associate: Dr Hiyam Al-Jabr

Programme Manager: Nicole Smith

Administrators: Jude Gammer and Dawn Jordan

Advisory support: Stephen Welfare and Wendy Smith

Inclusive networks and partnerships

The ICA is an inclusive network of people and activities across Suffolk, North East Essex and beyond.

While the University campus provides facilities, the ICA's support extends to other venues in local communities and across a diverse virtual network open to everyone who has an interest in integrated care.

The ICA organises its network, supported by the ICA Co-production Hub, with the aim of building creative and supportive relationships to enhance local self-sufficiency in the development of integrated care.

The ICA and its network participants will gain mutual benefits from:

Access to resources – services in kind, facilities and expertise

Access to partnerships – local, regional, national, international, public services and commercial ventures

Knowledge sharing – learning from local, regional national and international collaborators

Ideas generation and testing – in an independent, safe space

Expert integrated care support – for projects and initiatives.

We look forward to growing the ICA network in a way that encourages all people to get involved.

Find out more about the ICA

Take a look at our YouTube channel to see the latest vlog and more https://www.youtube.com/channel/UCK7oRYQ9qooqTAeF5mm8BbA/featured

Check out our website https://www.uos.ac.uk/ica

Email us at our Programme Office ica@uos.ac.uk

@IntegratedCare6

https://www.linkedin.com/company/integrated-care-academy/

youtube.com/channel/UCK7oRYQ9qooqTAeF5mm8BbA

13. Improvement Committee Report

To APPROVE the report

For Approval

Presented by Susan Wilkinson and Paul Molyneux

13.1. Maternity services quality & performance report

To APPROVE the report

For Approval

Presented by Susan Wilkinson and Karen Newbury

Trust Open Board – 30th July 2021

Agenda item:	13.1			
Presented by:	Sue Wilkinson, Executive Chief Nurse/ Karen Newbury, Head of Midwifery			
Prepared by:	Karen Newbury – Head of Midwifery / Rebecca Gibson Head of Compliance & Effectiveness			
Date prepared:	July 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
- Strategy update
- Maternity improvement plan
- Safety champion feedback from walkabout/virtual session
- National Staff Satisfaction Survey Results
- Service user feedback
- External assurance and oversight
- National best practice publications and local HSIB reports
- Reporting and learning from incidents
- CNST Maternity Improvement Scheme
- Maternity Clinical and Quality dashboard (Annex A)
- Anaesthetic Staffing Paper (Annex B – to formally minute)
- Continuity of Carer Trajectory Report (Annex C – to formally minute)
- Saving Babies Lives Care Bundle version 2 quarterly survey (Annex D – to formally minute)
- ATAIN Monthly report (Annex E – to formally minute)
- PRMT – see closed report (to formally minute)

<u>eCare</u>
Issues regarding data collection are on-going. The majority of issues are due to workflow and user input. The eCare and Information team are working closely with maternity team to change workflows, focus training and undertake data corrections/cleansing.
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 been advertised and interviews will take place in August.

<u>Quality and Safety Framework / Strategy update</u>
The Maternity Quality and Safety Framework includes all aspects of Clinical Governance and reflects the Trust's overarching policies and processes. Having been approved by the directorate the Framework was presented to the Scrutiny committee which delegated powers to the Board to officially sign-off.

<u>Maternity improvement plan</u>
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 incorporated the recommendations from the more recent CQC report and will capture 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 02/07/2021. Issues raised identified staffing issues as a priority, including numbers and skill mix and how senior managers and speciality midwives were bridging the gaps, but they are not as familiar with eCare etc. 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.

The issue of equability across the Trust regarding the roles of Band 2 care assistants was highlighted. Currently there is a national project to address this to standardise Band 2, 3 and 4 roles in Maternity across England.

Neonatal unit highlighted the need for a supernumerary shift co-ordinator on the NNU to enable closer communication and support to maternity.

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 will continue 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 June, the maternity service received 62 FFT returns. 100% of women would recommend our service.

External assurance and oversight
Following visits from the CCG in February and the CQC in April, the overarching Maternity improvement plan is being updated to incorporate the findings of both. The final CQC report was published 22/06/21 and request for action plans regarding concerns completed and returned within the requested timeframe.

National best practice publications and local HSIB reports
MBRRACE-UK provides a national reporting framework for the surveillance and investigating the causes of maternal deaths, stillbirths and infant deaths. Rapid report 2021:Learning from SARS-CoV-2-related and associated maternal deaths in the UK has been published this month, gap analysis to be completed and will be shared in future board reports.(reports can be found at https://www.npeu.ox.ac.uk/mbrrace-uk/reports)

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

Reporting and learning from incidents
An external thematic review which will review all maternity's serious incidents including HSIB cases has now been agreed by NHSE to be for the last year and not the last two years. 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 June.

Maternity dashboard (see Annex A)
Indicators of maternity safety & quality are regularly reported and reviewed at monthly Maternity Governance meetings. A sub-set are provided for board level performance (the Performance & Governance dashboard). In March due to changing from one IT system to another (eCare) the data is delayed and therefore the data included is to May 2021. Until the new system is fully embedded it is anticipated there will be a delay in data reports. 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 A highlighted the red rated domains for June 2021.

Indicators	Narrative
Grade 2 section decision to delivery time	7 were delayed – 4 of these by 3 mins or less. 1 case admitted to Neonatal Unit, but this due to septic screen. All other cases no adverse outcomes. Ongoing QI project
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.

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

Local audit / monitoring
Following the warning notice under Section 29A of the Health and Social Care Act 2008 on the 14th

November 2019 by CQC, local audit and monitoring has been scrutinised and robust processes put in place. The CQC report in June 2021 states that the trust is now compliant with all aspects of the S29A warning notice. Local audit and monitoring will continue to be verified via the maternity quality dashboard and governance process

CNST Maternity incentive scheme
Now in its third year, the maternity incentive scheme supports the delivery of safer maternity care through a '10 steps to safety' framework underpinned by an incentive element to the trust's contributions to the CNST (clinical negligence scheme for trusts. It should be noted that the Ockenden review and essential actions include a degree of overlap with the CNST scheme and therefore progress with one will aid the other. The CNST (MIS) declaration form has been submitted within the requested timeframe.

Anaesthetic Staffing within Maternity Services (Annex B)
The paper as part of the evidence for MIS provides assurance that the anaesthetic support provided to the Maternity Unit meets the standards expected to provide safe effective care. Further recommendations have been identified and action plan in place.

Continuity of Carer Trajectory roll out plan (Annex C)
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.

Saving Babies Lives Care Bundle version 2 quarterly survey (Annex D)
The brief assurance survey is designed to gather information on progress towards full implementation of SBLCBv2. The results of this semi-qualitative self-assessment will enable NHS England, commissioners and providers to identify common problems and barriers to implementation and share effective solutions. All elements show compliance or mitigation in place to ensure care bundle is being delivered.

PMRT

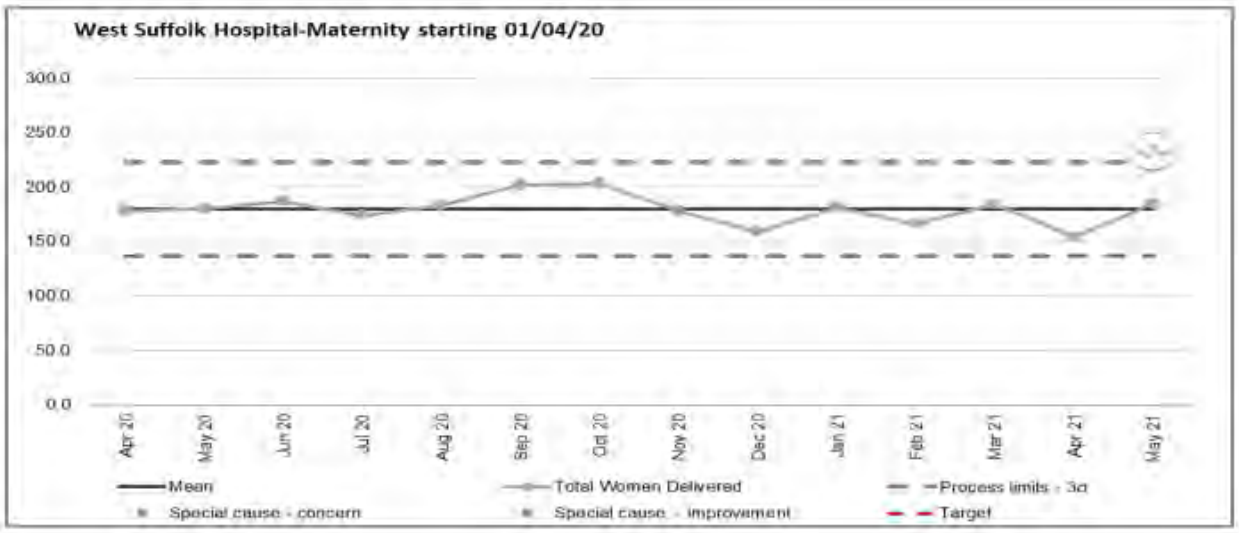
ATAIN (Avoiding Term Admissions into Neonatal Units) monthly report (Annex E)
The report is a review of all term admissions to the NNU to ensure that intervention is appropriate, timely and where possible optimises the wellbeing of both mother and baby. All of the admission in the month of May 2021 were appropriate and in accordance with current guidelines. Themes were identified and action plan in place.

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

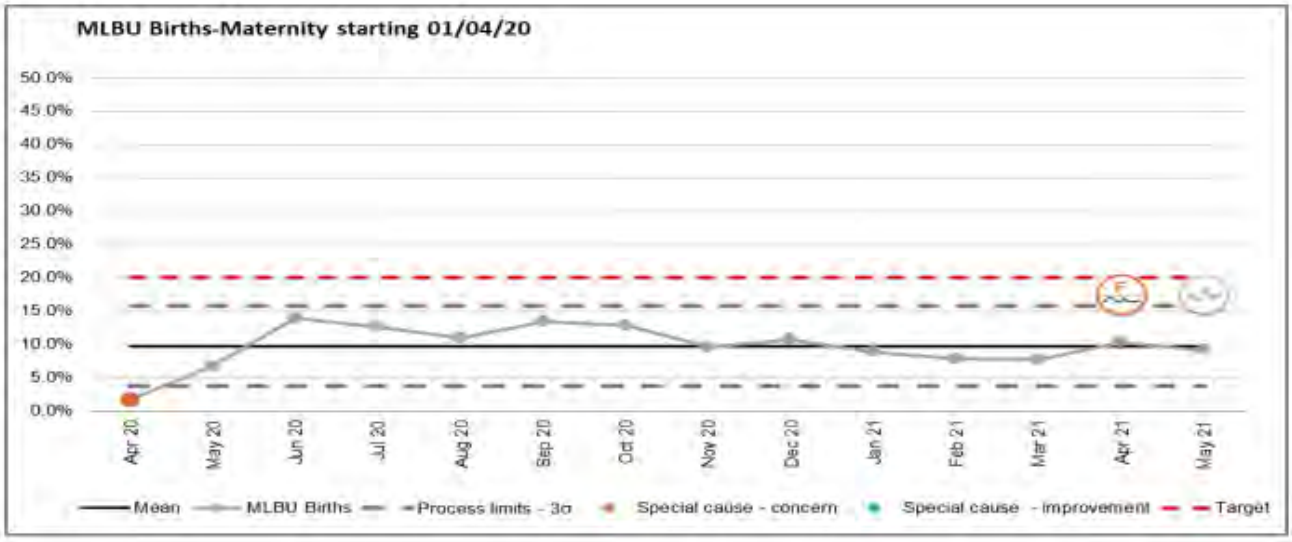
Recommendation:
The Board to discuss content

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

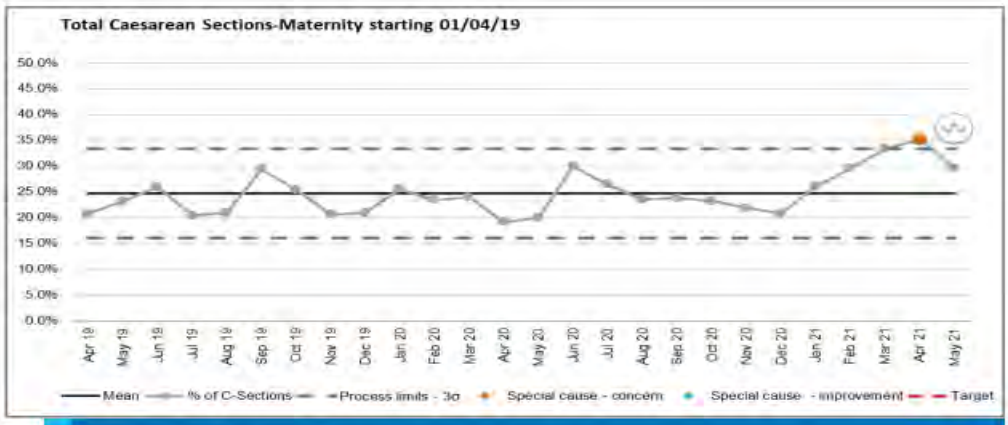
All Births at WSH



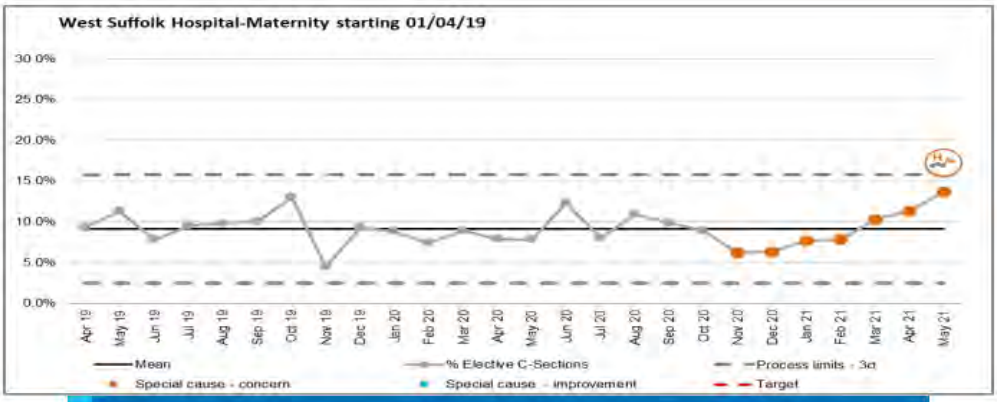
MLBU Births



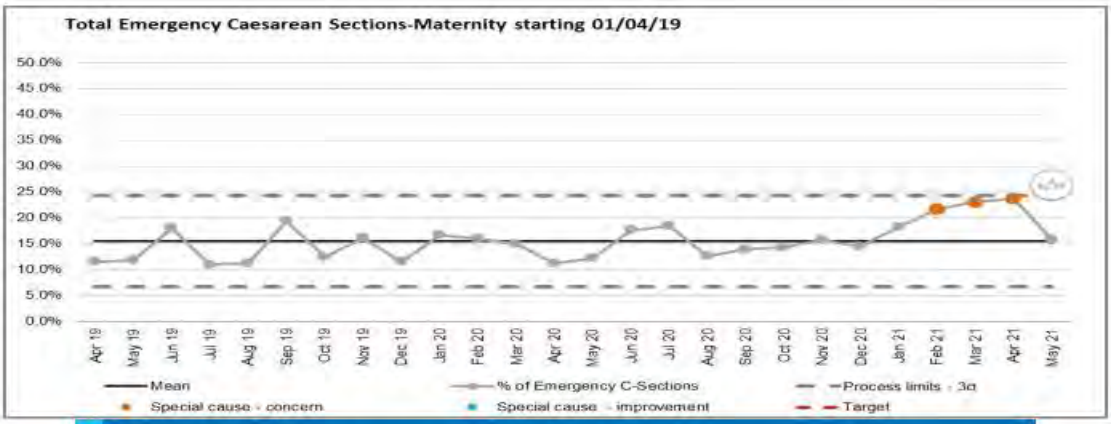
ALL LSCS



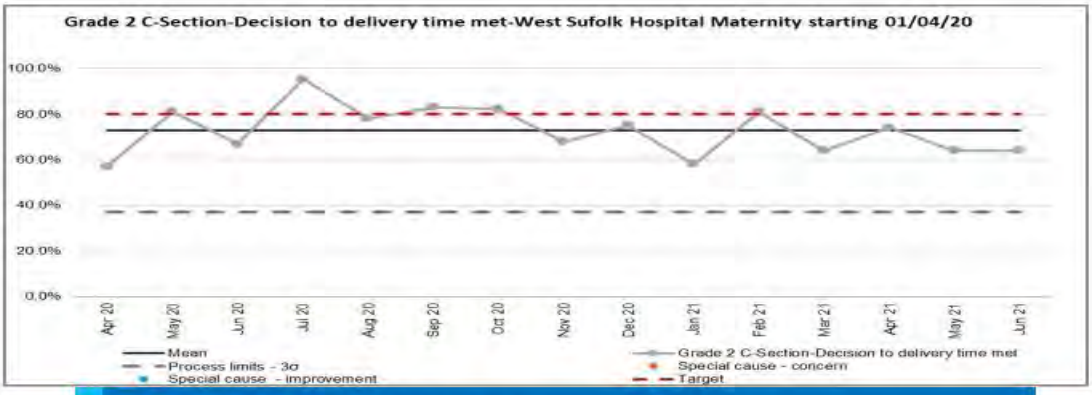
Elective LSCS



Emergency LSCS

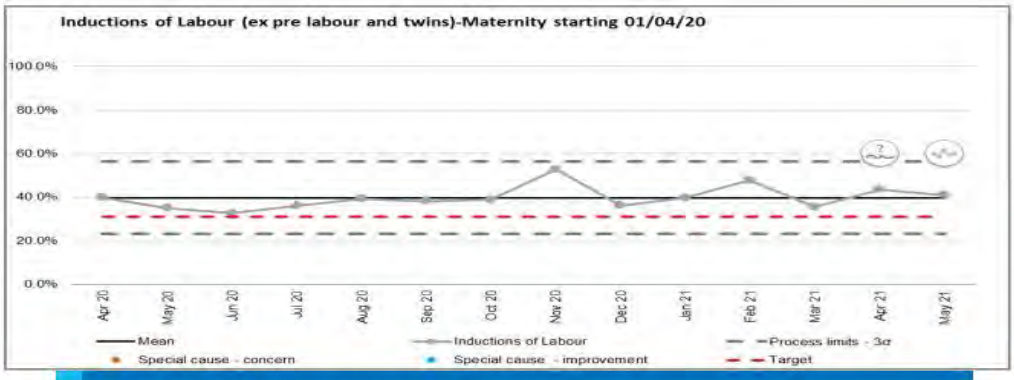


Decision to delivery – grade 2 LSCS



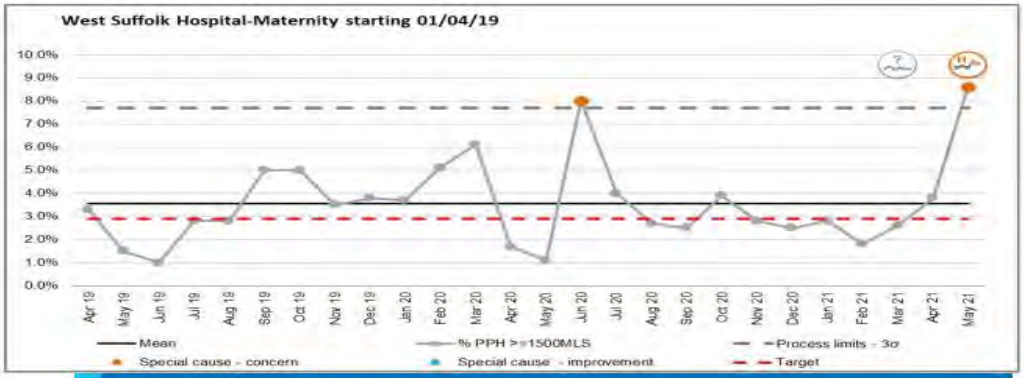
Delivering high quality, safe care, together

Induction of Labour



Delivering high quality, safe care, together

PPH – 8.1% (11 x 1500ml-2499ml and 5 x >2500ml)



Delivering high quality, safe care, together

Quality Dashboard

NHS West Suffolk NHS Foundation Trust

Appraisal completion	Oct	Nov	Dec	Jan	Feb	March	April	May	June
Midwives Hospital % in date	97%	100%	89%	82%	87%	80%	96%	91%	81%
Support Staff Hospital % in date	84%	72%	76%	81%	85%	81%	90%	88%	84%
Medical Staff (Consultant) % in date							82%	80%	94%
Mandatory Training Overview	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**	**April**	**May**	**June**
Midwives: % compliance with **GAP** training	96.0%	96.0%	96.0%	96.0%	89.0%	87.0%	86.0%	78.0%	77.8%
Midwives: % compliance with **All Fetal Monitoring** training				68.6%	75.9%	78.1%	86.3%	56.3%	66.6%
ANC Midwives: % compliance with **All Fetal Monitoring** training				42.9%	71.4%	100.0%	100.0%	85.7%	85.7%
Anaesthetic compliance with **PROMPT** training	50.0%	53.9%	38.9%	60.0%	64.3%	73.3%	57.9%	70.0%	75.0%
Checking of Emergency Equipment	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**	**April**	**May**	**June**
Community: Emergency Bags	94%	82%	100%	96%	100%	94%	94%	97%	94%
Checking of Fridge Temperatures	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**	**April**	**May**	**June**
Labour Suite	100%	93%	97%	97%	96%	97%	97%	100%	93%
Ambient Room Temperature (where medication is stored)	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**	**April**	**May**	**June**
Labour Suite	100%	93%	97%	97%	96%	97%	97%	100%	93%
	Oct	**Nov**	**Dec**	**Jan**	**Feb**	**March**	**April**	**May**	**June**
LSCS decision to delivery time met									
Grade 2 LSCS	82.3%	58%	75%	58%	81%	64.0%	74.0%	64.0%	64.0%
Weekly hours of dedicated consultant cover on LS	90	99	93	Discontinued	Discontinued	Discontinued	Discontinued	Discontinued	

Annex B – Anaesthetic Staffing Paper

Annex C – Continuity of Carer Trajectory Report

Annex D – SBLCBv2 Quarterly Survey

Annex E – ATAIN Monthly Report

West Suffolk NHS
NHS Foundation Trust

Report on Anaesthetic Staffing within Maternity Services

Report Title	**Report on compliance with Safe Obstetric Anaesthetic staffing from December 2019**
Report for	**Information and Approval of Actions**
Report from	Women's & Children's Services in collaboration with Theatres & Anaesthetics
Report Author	Beverley Gordon, Project Midwife, WSH

Report Title
Evidence of safe standards of obstetric anaesthesia in the Maternity Unit of WSH NHSFT.

1. Purpose of the Report

To provide assurance that the anaesthetic support provided to the Maternity Unit meets the standards expected to provide safe effective care.

2. Background
NHS Resolution is operating a third year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. There are 10 safety actions for Trusts to have in place to assure the women, families and the NHS of their commitment to safety.

3. Standards to be met

Safety action 4:
Can you demonstrate an effective system of clinical workforce planning to the required standard?*

This report relates directly to the anaesthetic element of clinical staffing. The requirement for this element is as follows:

Anaesthetic medical workforce
Trust Board minutes formally recording the proportion of ACSA standards 1.7.2.5, 1.7.2.1 and 1.7.2.6 that are met.
Where Trusts did not meet these standards, they must produce an action plan (ratified by the Trust Board) stating how they are working to meet the standards.

The period of time this report relates to any six month period between December 2019 and 15th July 2021

Anaesthesia Clinical Services Accreditation (ACSA) standards and action

March 2021

1.7.2.5
A copy of rotas and lists showing dedicated theatre lists with a named consultant, or SAS (Staff Grade, Associate Specialist and Specialty Doctors) doctor who is able to work without consultant supervision, with no other clinical commitment should be provided.

1.7.2.1
The rota should be seen to allow obstetrics to take priority where the duty anaesthetist has other responsibilities. A
policy should be made available at staff induction regarding prioritising and junior staff should provide verbal confirmation that they have been inducted in this way.

1.7.2.6
A copy of the rota to demonstrate duty consultant anaesthetist or SAS (Staff Grade, Associate Specialist and Specialty Doctors) doctor who is able to work without consultant supervision availability at a time when labour ward rounds are taking place.

Trusts who do not meet the ACSA standards must produce an action plan (ratified by the Trust Board) stating how they are working to meet the standards. This will enable Trusts to declare compliance with this sub-requirement.

4. Current Compliance with Standards

Clinical Workforce Group	Standard to be met	WSH compliance	Progress Report	Evidence Source
Anaesthetic medical workforce	**Anaesthetic medical workforce** Trust Board minutes formally recording the proportion of ACSA standards 1.7.2.1, 1.7.2.5, and 1.7.2.6 that are met. Where trusts did not meet these standards, they must produce an action plan (ratified by the trust Board) stating how they are working to meet the standards.	**Yes**	**GREEN pending approval**	Need Trust Board sign-off
	1.7.2.5 Where there are elective caesarean section lists there are dedicated obstetric, anaesthesia, theatre and midwifery staff. A copy of rotas and lists showing dedicated theatre lists with a named consultant with no other clinical commitment should be provided. An audit demonstrating minimal delays to elective procedures and	**Yes**	**GREEN**	• Evidence received in the form of rotas but not clearly outlining the consultant anaesthetists being allocated to the elective CS list. No junior rotas seen • Daily weekday CS lists staffed with dedicated obstetric / midwifery / anaesthetic / theatre staff • Continue review of the reasons the decision to delivery times for emergencies are not met (Cat 1 and Cat 2) and also review any cases where harm is caused by delays to elective lists.

	rapidness of emergencies to support local arrangements.			• Review red flag incidents reported for delays in pain relief and present reports on compliance with standards of epidural anaesthesia being delayed more than 30 minutes from the request. **1.7.2.5** A copy of rotas and lists showing dedicated theatre lists with a named consultant, or SAS (Staff Grade, Associate Specialist and Specialty Doctors) doctor who is able to work without consultant supervision, with no other clinical commitment should be provided.
	1.7.2.1 A duty anaesthetist is available for the obstetric unit 24 hours a day, where there is a 24 hour epidural service the anaesthetist is resident If this service is offered, rotas should be provided as evidence. If this service is not provided, patient information should be seen which relays exactly what services can be offered	**Yes**	**GREEN**	• Evidence from rotas re staff allocated to obstetric cover. • Needs input on dashboard • Anaesthetist's handbook and induction book reviewed – role of on call doctor extensive out of hours. • Audit of request to epidural times **1.7.2.1** The rota should be seen to allow obstetrics to take priority where the duty anaesthetist has other responsibilities. A policy should be made available at staff induction regarding prioritising and junior staff should provide verbal confirmation that they have been inducted in this way. SOP re anaesthetic duties and on call responsibilities. Rotas available on request.

	1.7.2.6 The duty anaesthetist for obstetrics should participate in labour ward rounds. A copy of the rota to demonstrate duty consultant availability at a time when labour ward rounds are taking place.	**Yes**	**GREEN**	• Rotas reviewed, SOP/guideline awaiting sign off • No record of any attendance on ward rounds. – needs addressing on Labour Ward **1.7.2.6** A copy of the rota to demonstrate duty consultant anaesthetist or SAS (Staff Grade, Associate Specialist and Specialty Doctors) doctor who is able to work without consultant supervision availability at a time when labour ward rounds are taking place.

5. Conclusions

The obstetric anaesthetic rotas reflect the 24/7 cover of the obstetric services. The staffing plan has been developed into 2 standard operating procedures – one for the staffing plan and one for the role of the bleep holder 770. These describe the services provided and these will be subject to monitoring through examination of rotas and attendance at ward rounds.

6. Recommendations

1. Review of processes and escalation to ensure any delays in elective or emergency caesarean sections are managed safely. Mitigations put in place need to be monitored and further steps taken as required.
2. Monitoring of Decision to Delivery Times for category 1 and 2 caesarean sections.
3. Recording of delays in elective CS through incident monitoring and analysis of root causes that need to be addressed.
4. Review of waiting times for women requesting epidural anaesthesia in labour.
5. Handbooks of guidance about roles and responsibilities and induction handbook to reflect current practices and be consistent with maternity guidance.
6. Clarify specific duties of the on call anaesthetist to include attendance at Labour Ward Rounds.

7. Action Plan

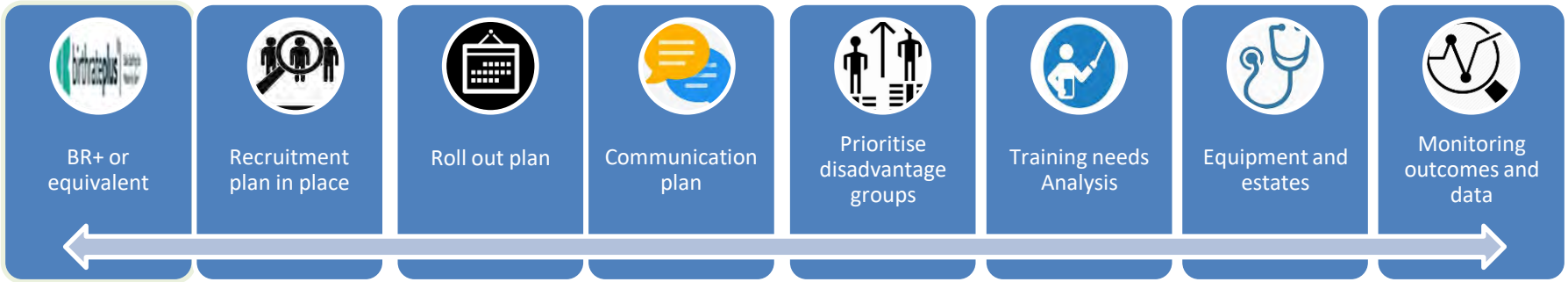
Action plan lead	Name: Helen Boys	Title: Consultant Obstetric Anaesthetist	Contact:

Recommendation	Actions required	Action by date	Person responsible	Comments/action status
1. Review of processes and escalation to ensure any delays in elective or emergency caesarean sections are managed safely. Mitigations put in place and further steps taken as required.	SOP developed	30/6/21	Clinical Lead anaesthetics	Delay in elective CS not usually reported unless harm caused or disruption of services persist. SOP developed to describe the processes and staffing plan. Maternity Anaesthetic Staffing
2. Monitoring of Decision to Delivery Times for category 1 and 2 caesarean sections.	Regular audits of DTD times and identify root causes of any delays and any remedial actions required through the clinical dashboard	Ongoing record on dashboard each month	Clinical Effectiveness Midwife Audit lead obstetrics/anaesthetics	Completed reviews on missed DTD times attached to dashboard. Which is sent to the HoM and reported at Governance meetings.
3. Recording of delays in elective CS through incident monitoring and analysis of root causes that need to be addressed.	Review of incidents or red flag data reporting delays in elective CS with harm caused.	Ongoing record on dashboard and datix if near miss	Risk Midwives	Not recorded as a red flag or incident unless harm caused by delay. As above
4. Handbooks of guidance about roles and responsibilities and induction handbook to reflect current practices and	MDT review of documents supporting practices of obstetric anaesthetists	30/6/21	Clinical Lead anaesthetics / Clinical Effectiveness Midwife	SOP approved and duties of bleep 770

be consistent with maternity guidance.				Maternity Anaesthetic Staffing
5. To clarify specific duties of the duty on call anaesthetists to include attendance at labour ward rounds.	SOP.	30/6/21	Anaesthetic lead Clinical lead – Obstetrics Lead Midwife – Labour Ward	SOP and staffing plan to be approved Maternity Anaesthetic Staffing SOP 770 Duties (1).docx
6. Review of waiting times for women requesting epidural anaesthesia in labour.	Review exception reports – possibly related to red flags	Ongoing monitoring Audit as part of 2021/22 audit plan	LW leads Anaesthetic lead IT support for dashboard reporting	Ongoing monitoring on dashboard and datix for red flags and annual audit to be completed
7. Review of processes for recording the presence of all clinical personnel on the maternity ward rounds.	Handover of care guideline	31/3/21	LW leads Anaesthetic lead	Handover of care guideline updated

Continuity of Carer Plan West Suffolk NHS Foundation Trust

Developed by East of England
Continuity of Carer Midwife Leads
A. Weatherley and G. Hickford
June 2021



Actions

Identify staffing gap	Ensure adverts all align with CoC roll out	Complete planning tool with refreshed BR+ staffing	Maternity leadership aligned	Identify cohort at greatest disadvantage	Team building	Order laptop tele phone, midwifery equipment in time to prevent delay to roll out	Develop ability to progress electronically and report to MSDS
Approve recruitment at board	Involve HR and shop floor union rep early in discussions	SOP agreed via clinical governance process and pay uplift agreed	Planning tool shared with staff	Ensure data captured	Individual TNA and upskilling time	Consider estates required	Adopt standardised criteria for collection to enable consistency
	If significant vacancy, ensure lack of CoC is on risk register	Complete exel spreadsheet/similar in line with national principles	MVP and stakeholders involved				

	09/21	10/21	11/21	12/21	01/22	02/22	03/22	04/22	05/22	06/22	07/22	08/22	09/22	10/22	11/22	12/22	01/23	02/23	03/23
	On	Go	Ing																
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	On	Go	Ing																
			√																
	On	Go	Ing																

BR+ or equivalent

Action	Owner	Completion date (RAG)
Refreshed staffing review in Jan 2021 identified shortfall of 19 WTE midwife posts.	Karen Newbury	Jan 2021 Complete
Funding bid submitted for 7 WTE posts to be funded by NHSE	Karen Newbury	March 2021 Complete

Recruitment plan in place

Action	Owner	Completion date (RAG)
Recruitment of 12 WTE B6 midwives approved by Board March 2021 – Recruitment to start Q2	Karen Newbury	March 2021 Complete
Rolling programme of recruitment in place. To ascertain if new posts are eligible for relocation expenses	Karen Bassingthwaighte	Ongoing

Roll out plan

Action	Owner	Completion date (RAG)
Review SOP following roll out of first 3 teams	Karen Bassingthwaighte	Sept 2021
Complete WSH excel spreadsheet in line with national principles - to include refreshed staffing	Sarah Spall	July 2021
Review roll out plan and geographical boundaries for 9th and 10th teams	Karen Newbury and Team	April 2022

Communication plan

Action	Owner	Completion date (RAG)
Set up CoC steering group – to include HR and MVP to oversee roll out plan	Sarah Spall	Sept 2021
Communicate plans to all staff	Sarah Spall	Sept 2021

Prioritise disadvantaged groups

Action	Owner	Completion date RAG
Cohort of women in areas of deprivation identified	Sarah Spall	Complete
LSOA postcode data set up as a data field on eCare	Sarah Spall	Complete

Training needs Analysis

Action	Owner	Completion date (RAG)
Individual staff to complete TNA prior to 'go live' and priorities upskilling time	PDMs	Ongoing
PMA to support teambuilding during start up phase	PMAs	Ongoing

Equipment and Estates

Action	Owner	Completion date (RAG)
Order additional equipment needed	Karen Bassingthwaighte	Nov 21

Monitoring outcomes and data

Action	Owner	Completion date (RAG)
Continue to assure teams data with eCare to ensure greater accuracy of data collection	Sarah Spall	Ongoing
Review Birth Rate as this will determine whether 10th team needed or not	Karen Green	April 2022

Guidance notes

Recruitment plan

- Workforce establishment agreed at board?
  BR+ or equivalent undertaken or date of planned assessment included in trust board reports
- Identification of a recruitment plan to address workforce vacancy, part time, mat leave, those working with adjustments, including timetable
- Is CoC identified on your risk register?
- Are you considering or have you undertaken a staff consultation? Engagement with key stakeholders ie. HR, local union rep, is pay agreed?
- Are job descriptions aligned with CoC rollout as the default model of care?
- What is the approach for recruiting newly qualified midwives?

Rollout plan

- Phases rollout detailed within tool kit or similar
- Clinical governance – SOP/ operational guidance
- Evidence of co-design
- Is a business plan required or completed?
- Targeted approach in line with national principles
- Timeline for CoC team rollout including:
  - Staff engagement- they know the plan, and when it will be rolled out
  - Staff aware what is being asked and how will affect them
  - Communications to support the launch
  - Do the teams have their birth availability published on E-roster?
  - Have midwives been able to self-identify learning needs and given the opportunity to upskill?
  - Do teams have their equipment?

Guidance notes

CoC model recommendations

- Standard Operating Policy written and agreed via governance processes
- 6.8-8WTE per team (max 8 headcount)
- Geographical mixed risk teams
- 1:36 caseload – births per year
- Provide 3 elements of care (AN IP PN)
- Midwives work contracted hours flexibly and monitored over 4 week basis
- Midwives book 3-4 women per month, attend 3 birth per month (averaged)- consider attrition rate and imports/exports (42 bookings annually = 15% attrition, 40 = 10%)
- Roll out staffing redeployment using exel spreadsheet
- Teams pick up whole compliment of women immediately (not 'growing' caseloads)
- Trusts roll out 2-3 teams and then review SOP to iron out glitches
- 1 or 2 band 5 per team
- Named obstetrician
- Estimated COC 60% of staff in teams / Core 40% in core (will depend on number of OOA, geography and tertiary referrals)
- Consider escalation processes-include detail within SOP, hospital on call, band 7 on call, CoC rotated on call
- https://continuityofcarer-tools.nhs.uk/

Guidance notes

Communication plan

- United executive and senior maternity leadership team all clearly communicating the plan
- Ongoing communication to all maternity staff, MVPs, NED, safety champions, GP, HVs
- Involve HR and union reps and enable discussions

Prioritise disadvantaged groups

- Identify the cohort

English indices of deprivation 2019: Postcode Lookup (opendatacommunities.org)

- Prioritise those most likely to experience poorer outcomes, including Black Asian backgrounds and most deprived on CoC pathway by March 2022
- Ensure accurately reportable to MSDS data

NHS England » Targeted and enhanced midwifery-led continuity of carer

Guidance notes

Training Needs Analysis

- Induction which may include upskilling
- Team building (CoC teams and wider teams building)
- Safeguarding supervision and specialist roles linked into teams
- Cultural competency
- PMA as a supportive and QI role

Equipment and Estates

- Ensure equipment ordered and ready for roll out for staff
- Laptop, phone and standard midwifery equipment
- Consideration of locations to facilitate clinics, team meetings, parent craft
- Consider transport- using own car, lease car, pool car
- Lone working policy

Guidance notes

Monitoring outcomes and data

- Teams monitor own data and outcomes
- Assess flexibility of workforce
  - Using BR+ acuity tool
- Report up to maternity clinical governance board and share learning
- Use EPR to report into MSDS
- Achievement measures:
  - Placed on pathway
  - In receipt of COC (70% AN, PN) and birth
  - Include ethnicity and bottom decile postcode

	Outcome measures women
	Stillbirth
	Neonatal death
	Pre-24 week loss (23 weeks & 6 days)
	Gestational age
	Birth weight
	Unassisted vaginal birth
	Instrumental delivery
	Elective C/S (cat 4)
	Emergency C/S
	Length OS
	Destination post birth? Home/PNW
	Epidural
	Induction of labour
	Episiotomy Y/N
	3 and 4 degree tear
	Booking by 10/40
	Breast feeding at birth
	Breastfeeding at discharge
	Skin to skin for 1 hour
	Apgar < 7
	Smoking – booking
	Smoking at birth
	Were you ever left alone at a time that made you feel frightened?
	Woman's experience based feedback
	Outcomes measures staff
	Sickness midwives
	Satisfaction-mw/obs/MSW
	Stress levels (NHS survey)
	Compliments and complaints
	Vacancy and retention rates

Saving Babies Lives - Updates & Action Planning

The implementation survey gives a good insight into implementation trends but does not in itself increase levels of implementation of the care bundle. This action planning section is designed to complement the survey and support an increase in the levels of implementation by encouraging the development of explicit actions that outline how progress will be made and address the specific barriers faced by a particular trust.

Action Plan

R	Red: Immediate remedial action required to progress this activity
A	Amber: Action required for successful delivery of this activity
G	Green: Activity on target
B	Black: Completed activity

Recommendation Number	Recommendation	Action plan to address recommendation	Action progress against plan	Action priority 1 = Critical (Under 1 Month) 2 = Essential (1-3 Months) 3 = Recommended (over 3 months)	Action owner	Baseline date	Forecast date	Closure date	Current status
1	The maternity service has moved from paper records onto E care maternity system. We are currently experiencing some initial issues of data collection which	IT are working to resolve these issues as soon as possible.	Ongoing until issues reaolved.	1	IT department				
2	Preterm and Labour Guideline includes multidiciplinary inclusion of the paediatric team however requires more clarity around 23-24 weeks gestation in relation toi	Further review of the guideline to include clearer description relating to vi		2	K Croissant	Current guideline reviewed December 2020	Sep-21		Under review
3									
4									
5									
6									

West Suffolk NHS
NHS Foundation Trust

ATAIN meeting to review term NNU admissions for
May 2021
NNU Office, WSH
Date: 22nd June 2021

Name	Title
Ian Evans	Consultant Paediatrician (Apologies)
Karen Ranson	NNU Manager
Sarah Paxman	Clinical Risk Midwife
Christine Portelli	Consultant Obstetric Lead for Labour Suite

The following link provides more information behind the rationale of the ATAIN project, which seeks to reduce separation of mothers and babies. The aim for reviewing cases is to ensure that any additional intervention is appropriate, timely and where possible, optimises the wellbeing of both mother and baby. The work of the ATAIN programme summarised in this report highlights opportunities for care delivery and service improvements.
https://improvement.nhs.uk/documents/764/Reducing_term_admissions_final.pdf

Following a review of patient safety reports, neonatal hospital admission data and litigation claims data, the focus is on four areas of significant potential harm to babies:

- Respiratory conditions
- Hypoglycaemia
- Jaundice
- Asphyxia (perinatal hypoxia-ischaemia)

There were 10 term admissions during the month of May 2021, which represents 5.8% of all term births for the month.

All cases were reviewed in advance of the meeting using the agreed audit tools, and were discussed with those present at the meeting.

Conclusions
All of the admissions were appropriate and in accordance with current guidelines. In two of the cases, the babies required admission to the NNU for observation (grunting), but they did not need to have respiratory support. These are cases which could potentially avoid separation from their mothers if the TC unit on F11 was able to be staffed consistently by a neonatal team member. Because this is not how TC currently functions, it is safest for these babies to be admitted to NNU.

There was a clear theme this month as five of the babies were identified to have a low admission temperatures:

- Three of the babies were admitted directly from birth / resuscitation (two from theatre, one from Labour Suite)
- One baby was admitted from the postnatal ward at 5 hours of age
- One baby was a re-admission from home on day 3

A series of actions was agreed to help to address this. Neonatal and midwifery staff have been informed immediately via Wise Words and Take 5 handover messages.

The theatre team leader for the obstetric department will be notified that NNU records show a persistently low temperature in the obstetric theatre. During the summer, this is often a problem as staff keep the theatre cool for working, but may not understand the implications for vulnerable newborn babies. A poster will be displayed next to the air conditioning control panel to raise awareness and discourage any changing of the temperature from the range of 24-26 degrees Celsius.

Two babies were admitted after being born in poor condition. In one of those cases, there was some learning identified by the Lead Consultant for Labour Suite. This is case will be included the fetal monitoring programme as a case study in order to share the learning messages.

Rolling action plan updated.

Sarah Paxman
Clinical Risk Midwife

Appendix 1: ATAIN Term admission review May 2021

No	Gest	Birth wt	Admitted from	Principle reason for admission	Admission temp	Reason not for TC / Was transfer timely?	Other comments / Conclusion
	41+0	[redacted]	LS	Infection		Data error-TC	
1	40+1	[redacted]	Postnatal Ward	Resp. Dis	36.3	Respiratory support To TC in a timely fashion	Sepsis confirmed **Appropriate admission**
	39+0	[redacted]	Home	Jaundice		Data error-TC	
2	39+4	[redacted]	Postnatal ward	Suspected sepsis	37.0		Low SATS recorded on F11 ? required admission. SATS not recorded low on NNU, but H/O Mat Gp B Strep. **Appropriate admission with current TC limitations, but separation could have been avoided with improved staffing in TC**
3	40+4	[redacted]	Postnatal Ward	Infection	36.8	Treatment continued @ Rosie-Maternal transfer (maternal ? PE / abnormal cardiac scan)	Maternal & neonatal pyrexia CRP 18- confirmed Sepsis **Appropriate admission**
4	37+0	[redacted]	Theatre	Resp. Dis	36.4	Respiratory support To TC in a timely fashion	**Appropriate admission**
5	37+0	[redacted]	Theatre	Other	36.4	Could have gone straight to TC (did not require any respiratory support), but stayed on with brother for first day	Twin 1 Stayed on NNU with brother initially **Appropriate admission**
6	37+0	[redacted]	Theatre	Poor Condition	36.8		Twin 2 **Appropriate admission with learning about theatre temperature – see rolling action plan**
7	As no. 5			Jaundice and weight loss	36.4	Required NGT feeds for > 4 hours (does not meet the criteria for TC)	Re-admitted with 12% weight loss and treated for jaundice. **Appropriate admission**
8	38+6	[redacted]	Theatre	Resp. Dis	36.8	Respiratory support Not to TC as persistent apnoea & bradycardia	**Appropriate admission**
	37+6	[redacted]	Home	Feeding/WL		Data error-TC	

	37+0	[redacted]	Home	Jaundice		Data error-TC	
9	38+1	[redacted]	Postnatal ward	Grunting at 5 hours of age	36.7	Persistent grunting (did not require respiratory support, but needed close observation)	On NNU until grunting subsided 14hrs **Appropriate admission with current TC limitations, but separation could have been avoided with improved staffing in TC**
10	42+0	[redacted]	Labour Ward	Poor condition	36.5	Respiratory support To TC Day 1 Timely Transfer	**Appropriate admission** **Learning for the maternity team about the management around delivery and the room temperature – see action plan**

Review of individual cases

1. MRN	[redacted]	**Datix no.**	**No Datix**	**Other comments**
Mode of birth	Cat 2 em. LSCS	**Gestation**	37+4	Previous LSCS – otherwise uncomplicated. Planned VBAC SOL Cat 2 em. LSCS at 5cm due to scar pain Grunting @ 14hrs of age ? Pneumothorax (not noted on discharge summary) Sepsis confirmed – peak CRP 44 Blood cultures grew Grp B Strep
DOB / Time	[redacted]	**Weight**	[redacted]	
Date / time of transfer to NNU		[redacted]		
Principle reason for admission		Respiratory support		
Treatment		HFNCO IV Fluids IV Abx		
If infection was the underlying cause, were intrapartum antibiotics given?		Not indicated		
Did the level of intervention warrant separation of mother and baby?		Yes		
Length of stay on NNU		1 HD, 6 SC days		
Could this baby have been cared for in TC?		Not initially		
Step down care on TC? Timely?		Yes		
Appropriate admission?		Yes		
Learning points identified:	• LSCS record missing (Lead Consultant and surgeon notified and this has been corrected)			

2. MRN	[redacted]	Datix no.	No Datix	Other comments
Mode of birth	SVD	**Gestation**	39+4	SOL, SVD, GBS positive (very rapid labour) No known PROM, maternal pyrexia or other known risk factors for sepsis Apgar 7.10.10 Required 5 inflation breaths SaO2 88% at 1 hour. Paediatric review took place (? Where is this documented) Baby went to NNU for just over 1 hour for observations and review (normal SaO2) AMBER TEDDY care pathway. low saturations were reported with tachypnoea on the 12/5/21 morning while the baby was on the postnatal unit. Therefore, baby was admitted to the neonatal unit, partial septic screen was performed and started on IV antibiotics ? required admission. SATS not recorded low on NNU, but H/O Mat Gp B Strep.
DOB / Time	[redacted]	**Weight**	[redacted]	
Date / time of transfer to NNU		[redacted]		
Principle reason for admission		Sepsis screening SaO2 monitoring		
Treatment		IV Abx due to ↓ SATS and Mat h/o Gp B Strep		
If infection was the underlying cause, were intrapartum antibiotics given?		Not indicated		
Did the level of intervention warrant separation of mother and baby?		No		
Length of stay on NNU		1 HD day, 2 SC days		
Could this baby have been cared for in TC?		Yes (see below)		
Step down care on TC? Timely?		[redacted]		
Appropriate admission?		Yes (but see below)		
Learning points identified:		• Could have gone to TC with SaO2 monitoring if an NNU member of staff present (Appropriate decision with the current limitations to the TC service)		

3. MRN	[redacted]	Datix no.	No Datix	Other comments
Mode of birth	Cat 1 Em LSCS	**Gestation**	40+4	Unsuccessful trial of forceps Apgar 10.10.10 No risk factors for sepsis At 1 hour of age temperature 38.5, which was thought to be environmental. At 7 hours of age temperature 37.9. Mum became unwell and was transferred back to Labour Suite – suspected Sepsis / PE / cardiac problem Baby admitted for sepsis screen and started on antibiotics (initial CRP 7) Peak CRP 18- confirmed Sepsis, therefore unsuitable for TC Mother and baby were transferred to CUH due to maternal condition
DOB / Time	[redacted]	**Weight**	[redacted]	
Date / time of transfer to NNU		[redacted]		
Principle reason for admission		Sepsis screening		
Treatment		IV Abx		
If infection was the underlying cause, were intrapartum antibiotics given?		Did not meet criteria but there was a mild pyrexia during second stage of labour		
Did the level of intervention warrant separation of mother and baby?				
Length of stay on NNU		1 HD day, 2 SC days		
Could this baby have been cared for in TC?		No (confirmed sepsis)		
Step down care on TC? Timely?		N/A		
Appropriate admission?		Yes		
Learning points identified:		• Need for neonatal equivalent of sepsis care bundle • Timely review from paediatrician		

4. MRN	[redacted]	Datix no.	WSH-IR-70600	Other comments
Mode of birth	[redacted]	**Gestation**	37+0	37+0 unsuccessful IOL PET; BMI >40 (Course of maternal corticosteroids was given 18th and 19th May) Apgar 6.7.8 Needed inflation breaths Poor tone and increased work of breathing at 8 minutes, Code blue, baby needed CPAP support and didn't maintain her saturations above 90% and therefore needed an admission to NNU. Cord venous gas was good (arterial failed). Initial repeat blood gas on NNU was low. 80 CTG before transfer to theatre – no evidence of hypoxia. Paediatric SHO present at delivery. Admission temp 36.4
DOB / Time	[redacted]	**Weight**	[redacted]	
Date / time of transfer to NNU		[redacted]		
Principle reason for admission		Respiratory support		
Treatment		NCPAP IV Abx		
If infection was the underlying cause, were intrapartum antibiotics given?		No labour		
Did the level of intervention warrant separation of mother and baby?		Yes		
Length of stay on NNU		1 HD day, 1 SC day		
Could this baby have been cared for in TC?		Not initially		
Step down care on TC? Timely?		To TC in a timely fashion		
Appropriate admission?		Yes		
Learning points identified:	• Good clinical reason for early IOL. Dexamethasone was given to reduce the risks of LSCS <39 weeks. • Low admission temperature discussed and NNU records checked for the theatre temperature on that day. Records indicate that the theatre temp was only 21.6 degrees Celsius. WHO recommends that the optimum temperature for the birth room is 25 – 28 degrees Celsius (although the locally agreed temp for theatre is 24 – 26 degrees). This is significant learning which needs action – see action plan).			

5. MRN	[redacted]	Datix no.		Other comments
Mode of birth	C/S Grade 2	**Gestation**	37+0	Twin 2 Emergency LSCS under GA (because of evidence fetal compromise in twin 2, i.e. this twin) Delayed cord clamping for 1 minute Apgar 6.3.6 Transferred to NNU for CPAP – weaned off within 24 hours, and then transferred to TC with twin to continue IV Abx. BC negative, peak CRP <1
DOB / Time	[redacted]	**Weight**	[redacted]	
Date / time of transfer to NNU		[redacted]		
Principle reason for admission		Respiratory support		
Apgar score		6.3.6		
Was there evidence of fetal compromise during the labour or immediately after birth, i.e. blood gases, base deficit and/or lactate within normal ranges?		Yes – pathological CTG Normal cord gases		
What were the pre-admission interventions?		Required two sets of inflation breaths, and ventilation breaths until 7 minutes of life		

What level of intervention was required on admission to the NNU?	NCPAP, HFNCO2 IV Abx	
Was the correct diagnosis ascribed at admission?	Yes	
Did the level of intervention warrant separation of mother and baby?	Yes	
Length of stay on NNU	1 HD day, 1 SC day	
Could this baby have been cared for in TC?	Not initially	
Step down care on TC? Timely?	[redacted]	
Appropriate admission?	Yes	
Learning points identified:	None	

6&7. MRN	[redacted]	**Datix no.**		**Other comments**
Mode of birth	C/S Cat 2	**Gestation**	37+0	Twin 1
DOB / Time	[redacted]	**Weight**	[redacted]	Emergency LSCS under GA (because of evidence fetal compromise in twin 2, i.e. brother) Elective LSCS was planned due to transverse lie, but pathological CTG (no labour) Delayed cord clamping for 1 minute Apgar 4.7.3 Pale and floppy – received 5 inflation breaths Recovered well, SVIA from arrival in NNU and maintaining SaO2. Low admission temp 36.4 Did not require any further respiratory support Had sepsis screening – negative, peak CRP 3 Established breastfeeding <u>Re-admitted from home on PN day 3-5</u> 12% weight loss – sleepy and not feeding well Admission temp 36.4 Breastfeeding 3 hourly. Supplemented with some NG feeds 12 hours phototherapy for jaundice
Date / time of transfer to NNU		[redacted]		
Principle reason for admission		Sepsis screening and to accompany twin brother		
Treatment		IV Abx		
If infection was the underlying cause, were intrapartum antibiotics given?		Not indicated		
Did the level of intervention warrant separation of mother and baby?		No, but choice to keep twins together initially		
Length of stay on NNU		7 hours		
Could this baby have been cared for in TC?		Yes		
Step down care on TC? Timely?		To TC in a timely fashion [redacted]		
Appropriate admission?				

Learning points identified:	• Admission temp low. Records indicate that the theatre temp was only 21.6 degrees Celsius. WHO recommends that the optimum temperature for the birth room is 25 – 28 degrees Celsius (although the locally agreed temp for theatre is 24 – 26 degrees). This is significant learning which needs action – see action plan). • Second admission was also appropriate because the need for NG tube feeding excluded the baby from the TC admission criteria. However, if the TC service was able to be staffed more consistently by the neonatal team, this baby may have met the criteria for admission to TC and avoided maternal separation.

8. MRN	[redacted]	**Datix no.**		**Other comments**
Mode of birth	Grade 4 C/S	**Gestation**	38+6	Raised BMI Previous LSCS – declined VBAC Recurrent reduced FMs so elective LSCS brought forward slightly (therefore no time for course of Dexamethasone so this baby was at increased risk of respiratory distress) Apgar 10.10.10 Increased work of breathing at 12 minutes Transferred to NNU for Respiratory support Not suitable for TC as persistent apnoea & bradycardia Peak CRP 4, but sepsis confirmed on chest x-ray ("likely right upper lobe infection") Breastfeeding with EBM top ups
DOB / Time	[redacted]	**Weight**	[redacted]	
Date / time of transfer to NNU		[redacted]		
Principle reason for admission		Respiratory support		
Treatment		HFNCO2, IV fluids and IV Abx		
If infection was the underlying cause, were intrapartum antibiotics given?		No labour No risk factors for sepsis		
Did the level of intervention warrant separation of mother and baby?		Yes		
Length of stay on NNU		6 days total		
Could this baby have been cared for in TC?		Not initially		
Step down care on TC? Timely?		N/A		
Appropriate admission?		Yes		
Learning points identified:		• "A single course of antenatal corticosteroids should be given to all women for whom an elective caesarean section is planned prior to 38+6 weeks gestation to reduce the risk of respiratory distress of the newborn". MAT0115 In this circumstances it was not possible to achieve this, as to delay IOL would have increased the risk of stillbirth.		

9. MRN	[redacted]	**Datix no.**		**Other comments**
Mode of birth	SVD	**Gestation**	38+1	IOL for GDM BMI 37 Persistent grunting at 5 hours (did not require respiratory support, but needed close observation) Escalated to paed and NEWTT observations checked. Transferred to NNU with Mum for sepsis screenings Stayed for 14 hours until grunting settled
DOB / Time	[redacted]	**Weight**	3530 (BC 81)	
Date / time of transfer to NNU		25[redacted]		
Principle reason for admission		Persistent grunting >4 hours		
Treatment		IV Abx SaO2 monitoring Close observation		

If infection was the underlying cause, were intrapartum antibiotics given?	N/A	Sepsis not confirmed: peak CRP <1
Did the level of intervention warrant separation of mother and baby?	Yes	
Length of stay on NNU	14 hours	
Could this baby have been cared for in TC?	See below	
Step down care on TC? Timely?	Yes	
Appropriate admission?	Yes	
Learning points identified:	• May have been suitable for TC, if TC was able to staffed constantly by NNU team member (appropriate with current limitations of TC criteria)	

10. MRN	[redacted]	**Datix no.**		**Other comments**
Mode of birth	SVD	**Gestation**	42+0	Induction of labour for post maturity Significant meconium during labour and at delivery (Propess removed, Oxytocin commenced) Suspicious CTG in second stage (decelerations and rising baseline) Apgar 7.9.10 Transferred for CPAP and O2 Chest x-ray showed increased lung markings in keeping with RDS. Meconium aspiration not confirmed in records, but possibly associated as cause for RDS. Stayed for approx. 36 hours Admission temp 36.3
DOB / Time	[redacted]	**Weight**	[redacted]	
Date / time of transfer to NNU		[redacted]		
Principle reason for admission		Respiratory support		
Apgar score		7.9.10 Cord gases: A. 7.011, V. 7.244 BE-14.2		
Was there evidence of fetal compromise during the labour or immediately after birth, i.e. blood gases, base deficit and/or lactate within normal ranges?		Yes – suspicious CTG in second stage of labour		
What were the pre-admission interventions?		Paed SpR called to attend and present at delivery Baby not stimulated at birth Suction, followed by 5 inflation breaths, but did not maintain SaO2. NNU nurse called to assist as midwife dealing with PPH Grunting and chest recessions		
What level of intervention was required on admission to the NNU?		Transferred for CPAP and O2		
Was the correct diagnosis ascribed at admission?		Yes		

Did the level of intervention warrant separation of mother and baby?	Yes	
Length of stay on NNU	1 HD day, 2 SC days	
Could this baby have been cared for in TC?	No	
Step down care on TC? Timely?	Yes	
Appropriate admission?	Yes	
Learning points identified:	• Low admission temp discussed. Was transferred directly from Labour Suite (room temperature not recorded). • Case reviewed by [redacted] after the meeting (same day). There is some learning about the passing of time during the second stage. • In the presence of a suspicious CTG during the second stage of labour, consideration given to reducing or stopping the Oxytocin rather than wait for review. • In order to share this learning, this case has been referred to the fetal monitoring lead midwife for inclusion in the MDT training programme.	

13.2. Infection prevention and control assurance framework

To APPROVE the report

For Approval

Presented by Susan Wilkinson

Board of Directors – 30th July 2021

Item no.	13.1			
Presented by:	Sue Wilkinson Exec Chief nurse			
Prepared by:	Rebecca Gibson – Head of Compliance & Effectiveness			
Date prepared:	July 2021			
Subject:	NHSE ICT assurance framework			
Purpose:		For information	x	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
- Updated BAF [Annex 1]

NHSE issued an updated BAF in June with eight additional indicators. This includes a requirement to consider the use of the *Supporting excellence in infection prevention and control behaviours Implementation Toolkit*. [see Annex 2]

There is a plan to bring together all aspects of the 'learning from Covid' into one integrated learning report.

The CCG quality & safety leads have been asked to input to enable cross-organisational learning (e.g. from ESNEFT as another local acute and community trust).

**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)	Jun 21	0	0	0 →
Staff work-related C19 cases reported to RIDDOR	Jun 21	0	0	See below
Incidents relating to C19 management	Jun 21	16	19	↑
Admissions swabs within 24 hours of DTA	Jun 21	97%	96%	% ↓
Day 3 and Day 5-7 swabs	See below			
C19 clusters / outbreaks	Jun 21	0	0	0 →
Staff sickness / absence due to C19	Jun 21	226	131	↓

Associated charts / tables / narrative

C-19 admission swabs

The total number of patients swabbed in June was similar to June and compliance was maintained at a similar level 95% of patients having a swab taken within 24 hours of the DTA in May and 96% in total.

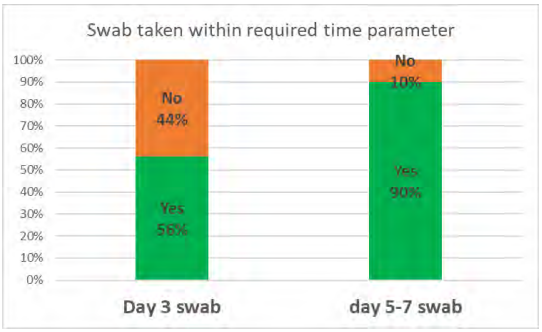
70 patients (4%) did not have a record of having a swab taken in this episode.

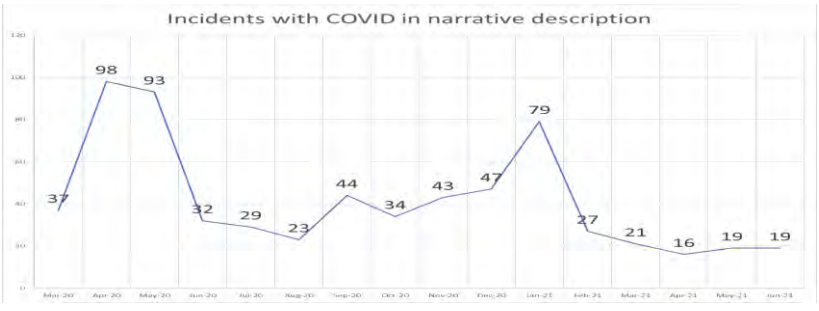
Day 3 and Day 5-7 swabs

Initial data from an audit of 97 patients with a LoS >10 days found that the Day 3 swab was not consistently being done in the required time parameters, often (but not always) because the flag was firing on eCare later in the afternoon/evening and the swab was then being taken the next morning for patient comfort.

A reminder has been sent out to staff to be mindful of the need to ensure the Day 3 swab is taken on the required day and the day 3 audit will be regularly repeated as an ongoing review with a widened audit sample of LoS >5 days.

The day 5-7 swab compliance was much higher and will be re-audited to ensure compliance remains.





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

18 reported incidents were green and there was one amber relating to a cardiology delay in Paediatrics.

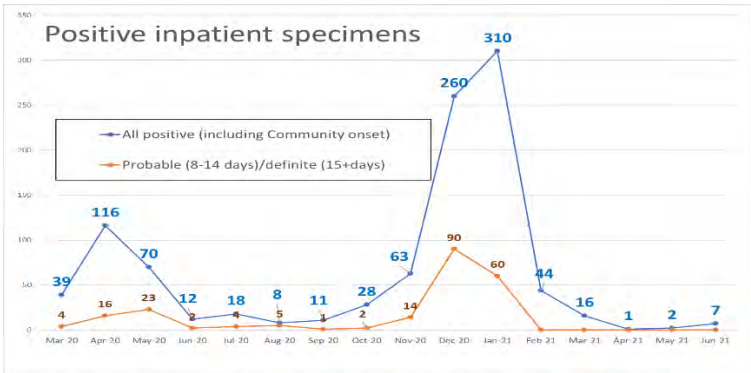
Staff work-related C19 cases reported to RIDDOR

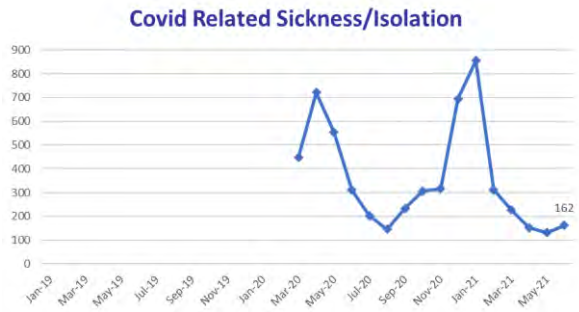
The investigation in to the staff cluster on F7 in late 2020 identified that a breach in PPE may have contributed to this, although it was recognised that there was also a high prevalence of COVID-19 in the community at that time. There were occasions when staff were not able to don full PPE before attending a confused and therefore non-compliant patient to prevent injury from falling or to prevent them from leaving to enter a non-COVID ward. This made it difficult for staff to apply full PPE in a timely manner. This was reported to RIDDOR in June as a "dangerous occurrence" namely "*Release or escape of biological agents*" (reference number FC17E14314)

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 June. This mirrors the decrease in community prevalence over the same period. The number of community onset rose slightly in June and this has the potential to further increase as the national picture is demonstrating.





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 June 2021 there were 162 episodes recorded, an increase from May (131 episodes). This is the first increase in numbers since January 2021 and is anticipated to rise further matching the national picture.

Annex 1: additions to the updated BAF

Quality standard	Key lines of enquiry
1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users	local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff;
	the documented risk assessment includes: • a review of the effectiveness of the ventilation in the area; • operational capacity; • prevalence of infection/variants of concern in the local area.
	triaging and SARS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as possible/practical following admission across all the pathways;
	when an unacceptable risk of transmission remains following the risk assessment, consideration to the extended use of Respiratory Protective Equipment RPE for patient care in specific situations should be given;
	Monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice on: patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas, unless staff are providing clinical/personal care and are wearing appropriate PPE;
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	reusable non-invasive care equipment is decontaminated: • between each use, • after blood and/or body fluid contamination, • at regular predefined intervals as part of an equipment cleaning protocol, • before inspection, servicing or repair equipment;
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion	Implementation of the *Supporting excellence in infection prevention and control behaviours Implementation Toolkit* has been considered (england.nhs.uk)
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people	individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation;

Annex 2: Supporting excellence in infection prevention and control behaviours

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/03/C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf

13.3. Nursing staffing report

To APPROVE the report

For Approval

Presented by Susan Wilkinson

Trust Board – July 2021

Agenda item:	13.3			
Presented by:	Susan Wilkinson, Executive Chief Nurse			
Prepared by:	Daniel Spooner Deputy Chief Nurse			
Date prepared:	July 2021			
Subject:	Quality and Workforce Report & Dashboard – Nursing June 2021			
Purpose:	X	For information		For approval

Executive summary:

This paper reports on safe staffing fill rates and mitigations for inpatient areas for June 2021. It complies with national quality board recommendations to demonstrate effective deployment and utilisation of nursing staff. The paper identifies how planned staffing levels were achieved and the resulting impact of these staffing levels. It will go onto review vacancy rates, nurse sensitive indicators, and recruitment initiatives.

Highlights

- Overall Trust fill rates continue to be above 90%
- Turnover rates remain static
- Nurse sensitive indicator (HAPU) further sustained improvement
- Small increase in vacancy rate seen this month for RN/RM with a small reduction in overall substantive staff

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

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 June'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 June 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 June 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 February 2021	96%	86%	97%	101%
Average Fill rate for March 21	98%	87%	95%	99%
Average Fill rate for April 21	93%	96%	97%	110%
Average Fill rate for May 21	96%	96%	98%	108%
Average Fill rate for June 21	94%	95%	95%	109%

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 G8 as working with new roster uplift and recruitment is pending.

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 and support staff has remained static this month,

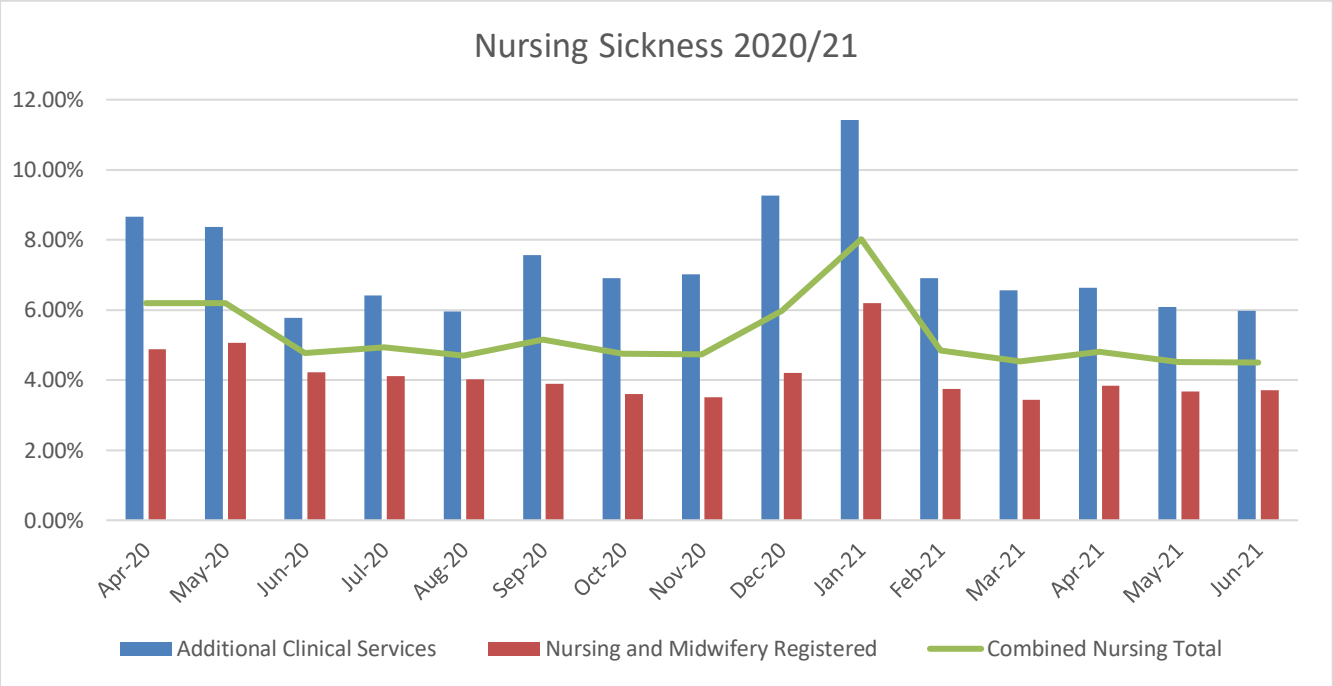


Chart 2.

	Nov	Dec	Jan 21	Feb 21	Mar 21	April 21	May 21	Jun-21
Unregistered staff (support workers)	7.00%	9.16%	11.31%	6.71%	6.34%	6.61%	6.28%	5.97%
Registered Nurse/Midwives	3.47%	4.16%	6.13%	3.67%	3.34%	3.79%	3.60%	3.70%
Combined Registered/Unregistered	**4.69%**	**5.92%**	**7.95%**	**4.71%**	**4.39%**	**4.77%**	**4.55%**	**4.50%**

Table 2b

Challenges to providing safe staffing have also been exacerbated by staff that are required to self-isolate, either due to exposure to Covid 19, or due to a member of their household being symptomatic. This is captured separately to sickness and is demonstrated below (chart 3). Despite sickness being reasonably static, self-isolation is at the lowest since April 2020 in both RNs and NAs. At the time of writing, community

prevalence is increasing and the clinical teams are reporting escalating numbers of staff that are required to self-isolate either through track and trace process or family infection. This number is expected to rise in July.

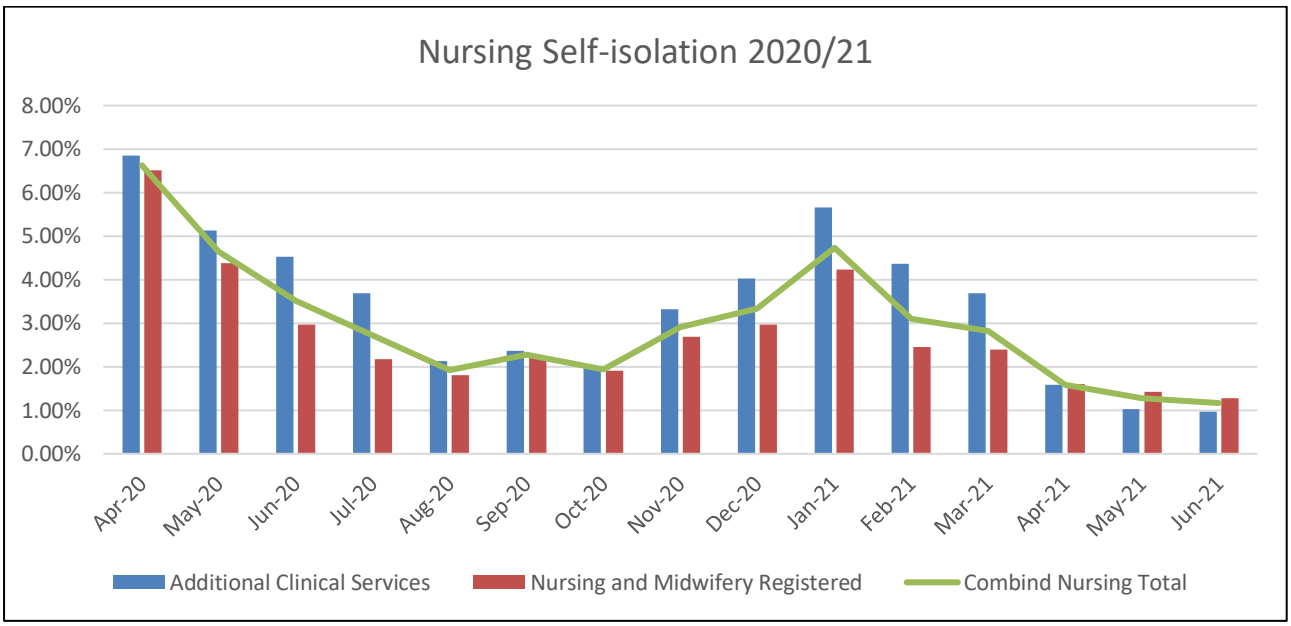


Chart 3

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 moved to F4
- F11 returned to original footprint from F9
- F8 moved to F10
- F12 moved into F9

6. Recruitment and retention

Vacancies: Registered nursing (RN/RW):

- Overall WTE establishment for inpatient RNs decreased this month however, the vacancy percentage has increased from 10% to 11.1%.
- Overall vacancy percentage for RNs (inpatient and all other areas) is 8.6%, an increase of 0.7% from last month.

	Ward RNs	Sum of Actual Period 10 (Jan)	Sum of Actual Period 11 (Feb)	Sum of Actual Period 12 (March)	Sum of Actuals Period 1 (April)	Sum of Actuals Period 2 (May)	Sum of Actuals Period 3 (June)	Sum of CURRENT MONTH VARIANCE
RN/RM Substantive	Ward	609.8	610.2	611.7	612.7	609.4	603.1	75.3
	CV19 Costs	2.0	(0.1)	1.4	1.3	1.1	0.0	0.0
Total: RN Substantive		**611.8**	**610.2**	**613.1**	**614**	**610.5**	**603.1**	**75.3**

Table 4. Ward/Inpatient Vacancies WTE.

The chart below demonstrates the total RN establishment for the organisation (wards and non wards)

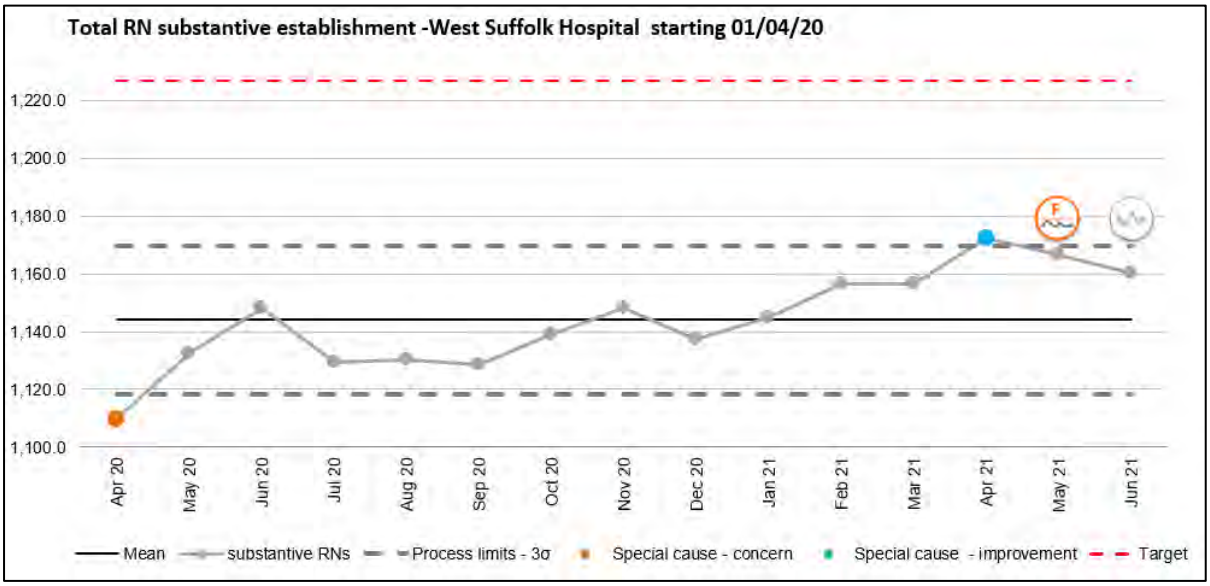


Chart 4a: SPC data adapted from finance ledger

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 to 5.7%
- Inpatient NA vacancies is more favourable and has reduced to 2.2%

	Ward Nursing	Sum of Budget Period 10 (Jan)	Sum of Budget Period 11 (Feb)	Sum of Budget Period 12 (Mar)	Sum of Budget Period 1 (April)	Sum of Budget Period 2 (May)	Sum of Budget Period 2 (May)	Sum of CURRENT MONTH VARIANCE
Nursing Unregistered Substantive	Ward	380.6	386.2	393.8	391.3	393.4	395.3	9.3
	CV19 Costs	0.0	16.9	19.5	10.8	4.3	0.0	0.0
Total: NA Substantive		**380.6**	**403.0**	**413.2**	**402.1**	**397.6**	**395.3**	**9.3**

Table 5: Ward/Inpatient NA vacancies WTE.

A review of inpatient vacancies, ward by ward, can be found in Appendix 2. Some smaller teams will demonstrate a concerning vacancy rate with only small reduction of WTE. However, areas of note include

- Maternity has increased its vacancy rate by 8% compared to last months (7.8WTE). On review with the maternity team there is only 2.4WTE that have left the trust either through retirement or other opportunities. The remaining staff remain in the trust either in specialist roles/outpatient roles or a reduction in hours.
- F6: carrying highest percentage vacancy. This is being supported by WSP, while recruitment of newly appointed staff progresses. It is anticipated that this will be resolved in September/October as all post have been recruited to

7. New Starters and Turnover

Overseas Nurse (OSN) recruitment:

Five international nurses arrived in June 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.

New starters

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

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

- In June 2021 9 RNs completed induction; of these; all were recruit for acute services
- In June 2021, 17 NAs completed induction; of these fourteen NAs are for the acute Trust and three for bank services

Turnover

On a retrospective review of the last rolling year, turnover for RNs has slightly improved from 5.83% to 5.72% but remains well below the trust ambition of <10%. NA turnover has also improved from 10.96% to 10.82 on previous rolling 12 months.

Turn Over 01/07/2020 - 30/06/2021								
Staff Group	Average Headcount	Avg FTE	Starters Headcount	Starters FTE	Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
Nursing and Midwifery Registered	1271.50	1092.13	97.00	77.03	79.00	62.43	6.21%	5.72%
Additional Clinical Services	568.50	479.92	155.00	138.26	59.00	51.91	10.38%	10.82%

Table 7.

Turnover for staff leaving within 6 months of joining the trust is 5.08% for RNs (n=3) and NAs 8.33(n=8). These are marginal improvements on previous rolling 6 months

8. Quality Indicators

Falls

Total incidences of falls have reduced marginally on last month but positively, using the falls per 1000 bed day measure, there is further improvement due to increased bed occupancy. Total falls have increased this month, but this is not an escalating trend at present. No falls this month resulted in moderate of severe harm. 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.

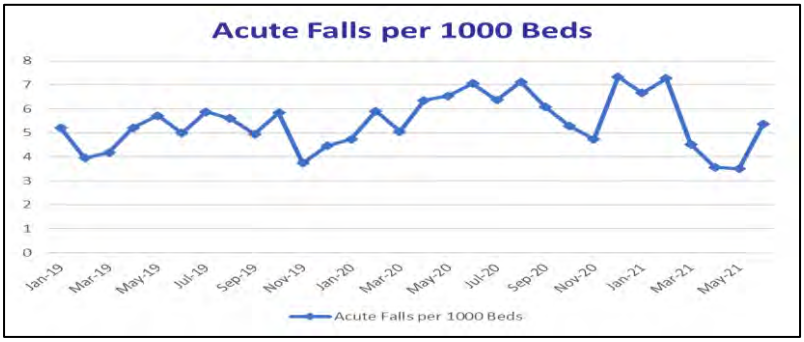


Chart 8

Pressure Ulcers

June observes the 5th month of improvement in Hospital Acquired Pressure Ulcers (HAPU) since January of this year. This month's data indicates the lowest incidence rate since May 2020 at 13 reported Pressure Ulcers. This is mirrored in occupied bed days. The team are providing bespoke training and education within the clinical environment and are developing further prevention strategies. The team have developed several wound care pathways to aid staff on the wards and provide guidance which will improve the standard of wound care at ward level.

The Tissue Viability Team are continuing to connect with the wards with bite size training, we continue to utilise one of our experienced nurses in an educational role across the acute setting. The team are currently rolling out our QI project on the renal ward to reduce pressure ulcers, the aim is to reduce Pressure ulcer incidence by 25% in 4 months as part of the Harm free Care Collaborative.

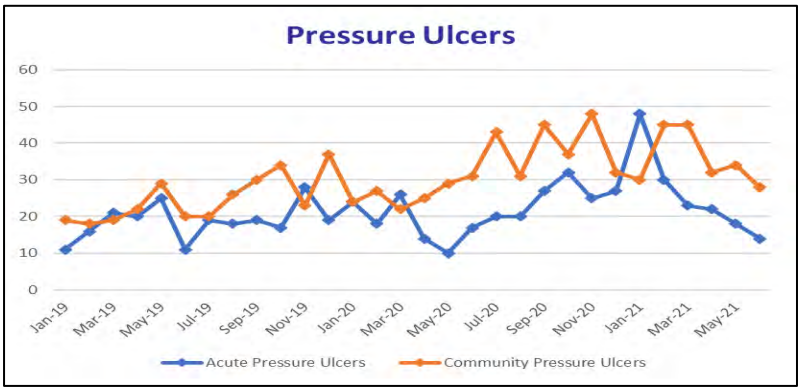


Chart 9a

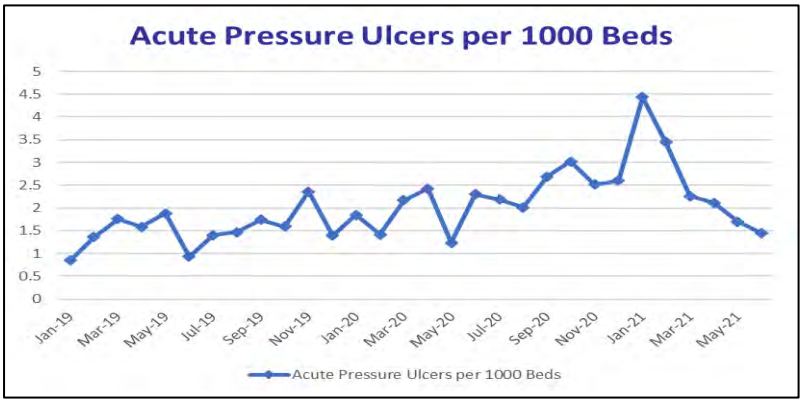


Chart 9b

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 77 calls a day to assist relatives who are unable to attend the wards to receive updates of the care of our patients. This is a reduction from last month and likely to be indicative of visiting restrictions being relaxed. Of note, the clinical helpline team have been shortlisted for the HSJ awards this year for '*Patient Safety Team of the Year'.*

	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

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 11 Datixs recorded for nurse staffing that resulted in a Red Flag event (see table 11.). No harm is recorded for these incidences.

Red Flag	Jan 21	Feb 21	Mar 21	Apr 21	May 21	June 21
Registered nursing shortfall of more than 8 hours or >25% of planned nursing hours	11	0	3	2	3	4
>30-minute delay in providing pain relief	3	1	0	0	1	0
Delay or omission of intention rounding	17	4	9	2	1	5
<2 RNs on a shift	6	1	1	3	5	1
Vital signs not recorded as indicated on care plan	3	0	1	1	2	1
Unplanned omissions in providing patient medication	4	0	1	0	0	0
Total	44	6	15	8	12	11

Table 11.

11. Maternity Services

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

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 four red flag events in June;

- X1 delay in IV antibiotic administration/review by obstetric team
- X2 Induction of labours delayed
- X1 Labour suite co-ordinator not supernumerary

No harm was recorded within Datix or found within the clinical review of these incidences

Midwife to Birth ratio

NB. Data has been unavailable for the last 2 months following maternity service's transition to eCare this has now been resolved, however only May data is available. The production of this data is anticipated to align with reporting next month. Birth: Midwife ratio in May was 1:28. 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 June 96% compliance was achieved

12. Recommendations and Further Actions:

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

Appendix 1. Fill rates and CHPPD. June 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	866.25	960	1612.5	1615	1012	966	1161.5	1055	111%	100%	95%	91%	701	2.7	3.8	6.6
Glastonbury Court	693.5	702	1029.5	960	690	684.75	525	494.5	101%	93%	99%	94%	517	2.7	2.8	5.5
AAU	2070	2112.75	2410	2001.5	1725	1843.416667	1380	1512.25	102%	83%	107%	110%	761	5.2	4.6	9.8
Cardiac Centre	2811	2578.5	1228.5	1168.5	1725	1553.5	678.5	678.5	92%	95%	90%	100%	632	6.5	2.9	9.5
G9	1380	1493	1380	1407	1380	1315.25	1035	1318	108%	102%	95%	127%	752	3.7	3.6	7.4
F12	552	688.5	345	373.75	690	641.25	345	380.5	125%	108%	93%	110%	240	5.5	3.1	8.7
F7	1725	1668.8333	1652.75	1374.25	1380	1314.75	1709.5	1616.5	97%	83%	95%	95%	683	4.4	4.4	8.7
F9	1723.5	1422.75	1721	1678	1034	999.75	1380	1617	83%	98%	97%	117%	744	3.3	4.4	7.7
G1	1364.5	1174.3333	345	325	690	665.5	345	359.5	86%	94%	96%	104%	392	4.7	1.7	6.4
G3	1716	1380	1724.25	1655.25	1012	989	1035	1455.5	80%	96%	98%	141%	864	2.7	3.6	6.3
G4	1723	1588	1802.41667	1771.8333	1035	1021	1373.5	1542	92%	98%	99%	112%	896	2.9	3.7	6.6
G8	2412.5	2042.9167	1809.33333	1595.4167	1725	1487.666667	1035	1213.83333	85%	88%	86%	117%	615	5.7	4.6	10.3
F8	1380	1446	2062	1732	1035	1014	1380	1420.5	105%	84%	98%	103%	723	3.4	4.4	7.8
Critical Care	2549.75	2304.25	253	601	2593	2141	0	148	90%	238%	83%	N/A	388	11.5	1.9	13.4
F3	1621.5	1462.5	2024.5	2001	1035	1001.5	1376.5	1376.5	90%	99%	97%	100%	732	3.4	4.6	8.0
F4	471.5	470.5	224.25	216.25	356.5	345	253	252.5	100%	96%	97%	100%	633	1.3	0.7	2.0
F5	1726	1561.75	1380	1249.25	1035	966	1035	850	90%	91%	93%	82%	698	3.6	3.0	6.6
F6	1874.5	1697	1620.5	1733.25	1368	1187	690	920	91%	107%	87%	133%	942	3.1	2.8	5.9
Neonatal Unit	1080	1014	360	168	1080	950	360	204	94%	47%	88%	57%	116	16.9	3.2	20.1
F1	1184.5	1435.5	690	660.25	1035	1239.75	0	80.5	121%	96%	120%	100%	115	23.3	6.4	29.7
F14	752	724.41667	312	292	720	720	0	95.5	96%	94%	100%	100%	106	13.6	3.7	17.3
Total	31,677.00	29,927.50	25,986.50	24,578.50	24,355.50	23,046.08	17,097.50	18,590.58	**94%**	**95%**	**95%**	**109%**	**12250**	**4.3**	**3.5**	**7.8**

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

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

Ward/Department	Registered Nursing (RN)				Ward/Department	Non Registered Nursing (HCSW)			
	Budgetted establishment	Actual establishmet	Vacancy rate (WTE)	Vacancy percentage		Budgeted Establishment	Actual Establishment	Vacancy rate (WTE)	Percentage Vacancy rate
AAU	30.1	32.0	(1.9)	-6.3%	AAU	28.3	27.0	1.3	5%
Accident & Emergency	77.3	67.0	10.3	13.3%	Accident & Emergency	34.5	27.9	6.5	19%
Cardiac Centre	40.7	38.7	2.0	4.8%	Cardiac Centre	15.7	16.6	(0.8)	-5%
Community - Glastonbury Court	11.7	10.9	0.8	6.9%	Community - Glastonbu	12.6	10.0	2.7	21%
Critical Care Services	43.0	41.8	1.2	2.7%	Critical Care Services	1.9	7.8	(5.9)	-315%
Day Surgery Wards	11.0	11.8	(0.8)	-7.7%	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	17.7	3.0	14.4%	Neonatal Unit	4.3	3.8	0.5	11%
Newmarket Hosp-Rosemary ward	16.6	14.4	2.1	12.9%	Newmarket Hosp-Rose	25.8	20.2	5.5	21%
Recovery Unit	21.9	19.6	2.3	10.3%	Recovery Unit	0.9	0.9	0.0	1%
Ward F1 Paediatrics	22.3	21.3	1.1	4.9%	Ward F1 Paediatrics	7.2	6.4	0.8	11%
Ward F12	11.9	9.6	2.4	19.8%	Ward F12	5.9	4.5	1.4	23%
Ward F3	22.2	19.7	2.4	10.9%	Ward F3	25.8	25.3	0.6	2%
Ward F4	13.6	13.7	(0.1)	-0.5%	Ward F4	14.6	13.2	1.5	10%
Ward F5	22.2	19.1	3.0	13.6%	Ward F5	18.1	16.4	1.7	9%
Ward F6	26.6	15.2	11.4	42.8%	Ward F6	17.4	19.5	(2.2)	-12%
Ward F7 Short Stay	24.9	22.1	2.8	11.3%	Ward F7 Short Stay	25.8	22.8	3.0	11%
Ward F9	21.8	17.1	4.7	21.4%	Ward F9	23.2	29.6	(6.5)	-28%
Ward G1 Hardwick Unit	28.6	28.6	0.0	0.0%	Ward G1 Hardwick Uni	10.5	11.1	(0.6)	-5%
Ward G3	22.1	18.5	3.6	16.2%	Ward G3	23.0	28.3	(5.3)	-23%
Ward G4	22.1	20.2	1.9	8.4%	Ward G4	22.8	21.2	1.6	7%
Ward G8	32.7	26.5	6.1	18.8%	Ward G8	20.6	22.3	(1.7)	-8%
Renal Ward - F8	19.5	19.5	0.0	0.0%	Renal Ward - F8	25.8	23.3	2.5	10%
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	18.4	(0.4)	-2%
Total	**600.1**	**540.3**	**59.8**	**10.0%**	**Total**	**388.4**	**381.4**	**7.0**	**1.8%**
Hospital Midwifery	60.0	47.0	13.0	21.7%	Hospital Midwifery	15.6	14.6	1.0	6%
Continuity of Carer Midwifery	18.3	14.1	4.2	23.0%	Continuity of Carer Mid	0	0	0.0	0%
Community Midwifery	19.1	18.7	0.4	2.3%	Community Midwifery	3.8	3.8	(0.0)	0%
Total	**97.4**	**79.8**	**17.6**	**18.1%**	**Total**	**19.4**	**18.4**	**1.0**	**5%**

*F10 closed due to building work, staff have been temporarily redeployed to other areas which now represent an overfill.

Appendix 3:

Ward by Ward breakdown of Falls and Pressure ulcers June 2020

HAPU

June 2021	Cat 2 (Minor)	Total
Total	13	13
Cardiac Centre - Ward	3	3
F7	2	2
Critical Care Unit	1	1
F1 - Ward	1	1
F12 Isolation Ward	1	1
G1 - ward	1	1
G3 - Endocrine and General Medicine	1	1
G8 - ward	1	1
Renal Ward	1	1
Respiratory Ward	1	1

Falls

June 2021	None	Negligible	Minor	Total
Total	**65**	**4**	**10**	**79**
F7	14	0	2	16
G8 - ward	7	2	2	11
F12 Isolation Ward	9	0	0	9
G3 - Endocrine and General Medicine	5	0	0	5
Renal Ward	5	0	0	5
Cardiac Centre - Ward	3	0	1	4
F5 - ward	3	0	1	4
F6 - ward	4	0	0	4
Rosemary Ward	3	0	0	3
Acute Assessment unit (AAU)	2	1	0	3
Gastroenterology Ward	0	0	2	2
APS	1	0	0	1
CHT Sudbury	1	0	0	1
Clinical Patient Flow Team	0	1	0	1
Eye Treatment Centre - Ward	1	0	0	1
F1 - Ward	1	0	0	1
F4 - ward	1	0	0	1
G4 - ward	1	0	0	1
Glastonbury Court	0	0	1	1
Gynaecology Outpatients	0	0	1	1
Macmillan Unit	1	0	0	1
Respiratory Ward	1	0	0	1
Winter Escalation - G5	1	0	0	1
Major Assessment Area (MAA)	1	0	0	1

Appendix 4: Red Flag Events

Maternity Services

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

Acute Inpatient Services

Unplanned omission in providing patient medications.
Delay of more than 30 minutes in providing pain relief
Patient vital signs not assessed or recorded as outlined in the care plan.
Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as: • pain: asking patients to describe their level of pain level using the local pain assessment tool • personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration • placement: making sure that the items a patient needs are within easy reach • positioning: making sure that the patient is comfortable and the risk of pressure ulcers is assessed and minimised.
A shortfall of more than eight hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift
Fewer than two registered nurses present on a ward during any shift.

13.4. Nurse staffing strategy review

To APPROVE the update

For Report

Presented by Susan Wilkinson

14. Supporting Junior Doctors Out of Hours in the Surgical Division

To APPROVE the report

For Approval

Presented by Paul Molyneux and Andrew Dunn

Trust Board – July 2021

Agenda item:	14			
Presented by:	Andrew Dunn, Clinical Director for Surgery			
Prepared by:	Simon Taylor, ADO Surgery & Anaesthetics & Nicholas Ward, Clinical Lead for General Surgery			
Date prepared:	21st June 2021			
Subject:	**Supporting Junior Doctors Out of Hours in the Surgical Division**			
Purpose:	X	For information		For approval

Executive summary:
This paper describes the actions taken to date and the future plans to support the junior doctor work force in surgery following concerns raised by the junior doctors themselves and the Guardian of Safe Working. Further potential options are discussed with an outline of the resource and other impacts that would need to be considered and supported before implementation.

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

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

Previously considered by:	Surgical Division working group on junior doctor support
Risk and assurance:	Amber Risk Assessment Datix Number 4979: http://datix/Datix/live/index.php?action=risk&recordid=4979
Legislation, regulatory, equality, diversity and dignity implications	

Recommendation:

1. The board are asked to accept this report recognising the progress made to date with this issue.
2. The board are asked to acknowledge the need for incremental change and evaluation at key stages of change in support.
3. That the board supports change in the junior doctor rota to remove the 17:00 – 20:00 gap and that this change is evaluated for its impact and effectiveness before a decision is taken on a move to a resident on call rota for the general surgical registrars.

Situation

Concerns have arisen from a number of channels regarding issues of support to the junior doctor workforce in surgery and in particular the general surgical junior doctor team out of hours. This has been raised by the junior doctors themselves and through the Guardian of Safe Working (GOSW). These concerns are also linked to incidents reported via Datix and are further related to patient care challenged by the Suffolk Coroner. The junior doctor team raised concerns about their workload and senior support out of hours.

The division holds this as an amber risk on the risk register and has been working to resolve a multifaceted and complex challenge to the service and workforce where the balance of providing a high standard of medical training needs to be maintained against effective and safe services for our patients, particularly in the out of hours period (OOH). The issue is longstanding with a number of attempts to resolve the concerns.

Background

Feedback and information gathering

A series of meetings have been held over a number of months to understand the complexities of the issue and to gain feedback from all levels of the service. Primarily this has been led by senior consultant discussion with input across T&O and general surgery, and including support from Dr Francesca Crawley in her role as GOSW. This was expanded to capture the lived experience of workload issues from the junior doctor team at F1/F2 and SpR level. The group included educational supervisors and Miss Lora Young in her role as Deputy Training Programme Director.

An action was derived from the working group for one of the general surgical consultants to undertake a shadow shift out of hours to fully understand the issues from an objective standpoint. This was completed by Mr Ami Mishra who reported process and pathway issues that added to the junior doctor workload. Mr Mishra identified medic bleep etiquette as a compounding factor in the busyness of a shift with multiple medic bleeps being received on the same subject introducing an increase in the number of interruptions to the junior doctor's work and concentration. The findings contributed to the action plan being worked on by the group.

The issue of junior doctor support has been established as being complex and multifaceted, with influences ranging from the EWTD, the junior doctor contract, quality of training experience provided, organisational and culture considerations, and the need to balance all of these against the delivery of an effective and safe service.

The following two tables describe the junior doctor work force cover in surgery during core hours (Table 1) and OOH/on call (Table 2):

T&O	5 Juniors (F2) Normal Day	Mon - Fri 08:00 - 17:00
	2 Juniors (F2) Normal day	Sat & Sun 08:00 - 17:00
Gen Surg	Urol 1 Junior (F1 or F2)	Mon - Fri 08:00 - 17:00
	UpGI 2 Junior (F1 or F2)	Mon - Fri 08:00 - 17:00
	Colo 2 Junior (F1 or F2)	Mon - Fri 08:00 - 17:00
	Pool Junior Doctor*	Mon - Fri 08:00 - 17:00
	*Post used by all specialties and assigned to help maintain minimum staffing requirements.	

Table 1

Surgery On Call Team	F1	On Take	Mon - Sun 08:00 - 20:30
	F1	Nights	Mon - Sun 20:00 - 08:30
	F1	D/C Shift	Sat & Sun 08:00 -17:00
	F2	On Take	Mon - Sun 08:00 - 20:30
	F2	Nights	Mon - Sun 20:00 - 08:30
	F2	D/C Shift	Sat & Sun 08:00 -17:00
	Spr T&O*	On Call (24 hour)	Mon - Sun 08:00 – 08:00
	Spr GSurg	Days	Mon-Fri 08:00-18:30
	Spr GSurg*†	Nights	Mon - Fri 18:00-08:30
	Spr GSurg*	Saturday	08:00-08:30 (24.5h)
	Spr GSurg*†	Sunday	08:00-08:30 (24.5h)

*non-resident on call 21:00 onwards but local enough to attend within 15 minutes
†day off following night on call

Table 2

Substantial support is already in place for the junior doctor team both in hours and out of hours. The junior doctors in General Surgery benefit from the support of a daily Consultant and/or Registrar ward round, 7 days per week including bank holidays and encompassing all surgical inpatients. A twice daily consultant led ward round is completed at the weekends and on Bank Holidays.

The working conditions for the general surgical junior doctors have been given significant attention over the last 12 – 24 months with improvements seen in the rest area available with the conversion of the F5/6 Discussion Room as a break area for staff, the provision of an improved and refurbished junior doctor's office on ward F6 with enhanced and increased IT facilities.

Actions

Current Actions

The table below (Table 3) describes current actions to address the situation and concerns raised:

Area	Action	Owner	Comment(s) / Update	Target Date/ Completed
CSPs	ADO discussion to explore the expansion of the CSP team to reduce workload on surgical juniors for routine tasks such as phlebotomy cannulation	**ADO Surg & Med**	Options being reviewed by the Medical Division who host the service	31/07/2021
Support from peers	On call/SAU consultant to check on the juniors on a regular basis to offer support.	**CL (GS)**	Proactive check in and support form both the on call consultant and SAU consultant through out the day to support junior doctors.	Completed
Medic Bleep	Shadow shift highlighted medic bleep etiquette as an issue with multiple interruptions	**ADO**	Human Factors Lead invited to review.	TBC
Pathway/ process issues	Process for booking diagnostics for on call/SAU team	**CL (GS)**	Change in process so that OOH CT scans can only be requested by the on call SpR if they have first physically assessed the patient	31/07/2021
			CCIO invited to explore e-Care improvements to aid the booking of diagnostics	31/07/2021
Change in rota	Explore change in rota, quantify costs and the impact of change to resident on call general surgical registrars.*	**ADO/CL (GS)**	Workforce and rota asessment undertaken by junior doctor rota co-ordinator	Complete
		ADO/CL (GS)	Review requirement for rota changes pending exec review and board discussion	30/09/2021
Change in rota	Additional junior at 17:00 – 20:00	**ADO/CL (T&O)**	consult and change junior doctor rota to eliminate the 17:00 handover by introducing a full shift to cover up to 20:00 thereby removing the 17:00 handover ot the general surgical junior doctor on call and the workload associated with it.	30/11/2021
Simulation Training	Simulation training for escalation and deteriorating patient scenarios including head injury/hip fracture case and acute abdominal case to be included in the surgical junior doctor induction.	**AM/KW**	Discussed with Dr Bright who delivers this trainng anf to taken forward by general surgical registrars. Potential for inclusion at induction and also in the FY teaching programme.	31/07/2021
Induction	Increased input from Gen Surg consultants in the junior induction	**CL (GS)**		Complete
Recruitment of Physicians Associate roles for General Surgery	Recruitment of two PA's for the general surgical department to support SAU and junior doctor team	**ADO**	Funding agreed, VAF's approved, posts advertised (closing date 06/07/2021 - interviews scheduled 19/07/2021).	30/09/2021
Handover	Change in handover process and use of sick patient list in T&O	**SP**		31/07/2021
Junior Doctors for general surgery	Look into increasing the number of juniors in the next financial year to support the increase in consultants	**ST**	To form part of budget setting in FY 2022/23 with supporting business case pending review of the impact of all other actions.	01/04/2022

Key	
CL (GS)	Clincal Lead General Surgery
CL (T&O)	Clincal Lead T&O
AM	Mr Ami Mishra, Consultant General Surgery
ST	Simon Taylor, ADO
SP	Mr Sam Parsons, Consultant T&O
KW	Mr Konrad Wronka, Consultant T&O

	Complete
	On track
	Delayed
	At risk

Table 3

The most significant of these actions is the move to remove the gap between 17:00 and 20:00 by changing the junior doctor rota in T&O to provide cover for this period by a T&O F2 doctor. This was reported by the junior doctor teams as one of the greatest contributing factors to their workload at this point in the day and necessitated additional handovers.

The 17:00 – 20:00 period is time of increased activity during the day for the On Take team and aligns to an often-busy period in ED. The hand over of tasks to the On Take Team from the T&O day team increases the workload and as a team the junior doctors feel that this is possibly the single most important factor contributing to their high levels of workload.

It had been anticipated that a rota change might have been achieved in time for the August handover but evaluation of the options and the need to ensure consultation takes place in line with the junior doctor contract has precluded the opportunity for August but will be achieved in time for the December change over. The change to the rota will require a change in the shift times for one of the junior doctor rota lines moving them to a later shift period. This will continue to cover the same duties as a day shift but moving it into a later period in the day avoids the gap between 17:00 and 20:00. This is being led by the Clinical Lead for T&O and does not require additional resource at this stage. An evaluation of this change and other actions will take place before considering any need for further increases in the junior doctor workforce as part of budget setting for FY2022/23.

Table 4 below illustrates the 17:00 -20:00 gap and the proposed solution mapped against the overarching OOH and on call structure in surgery:

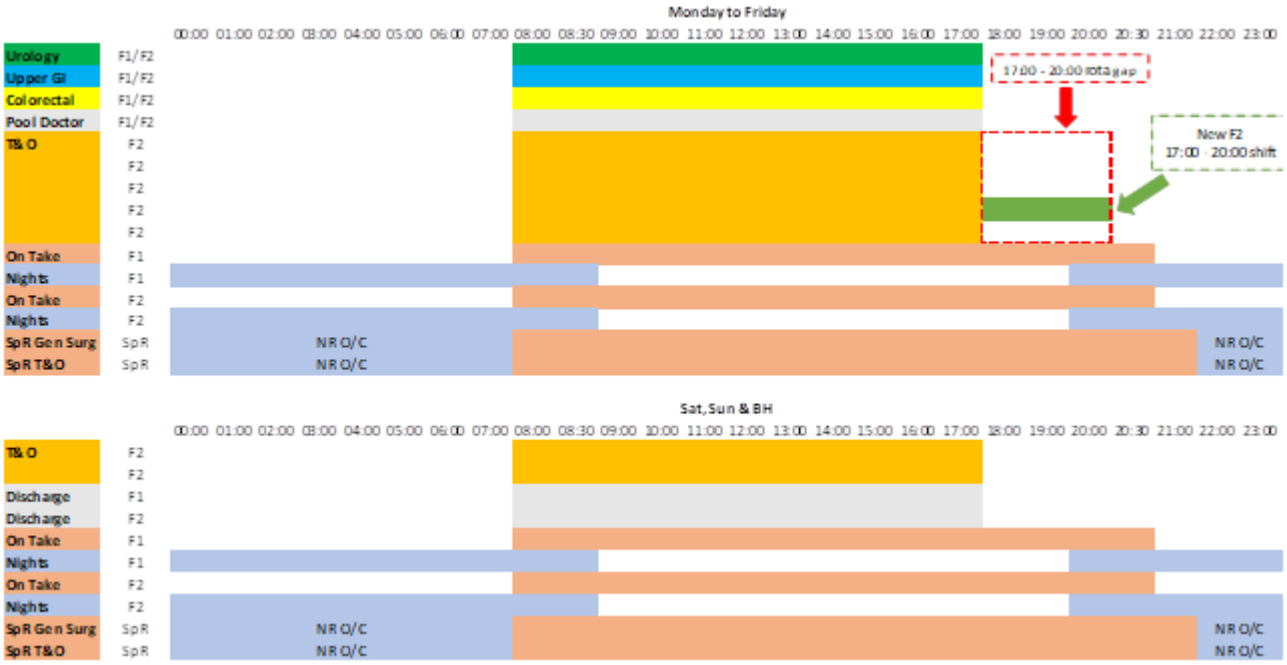


Table 4

Future actions required

In addition to the actions described above, there has been a persistent view that a move to a resident on call system for the general surgical registrars would be a pragmatic option to resolve OOH support to the junior doctor team and enhance the emergency pathway for surgical patients. Currently the T&O and general surgical registrar is on call for 24 hours and are non-resident on call from 21:00 to 08:00. Invariably the on call SpR's are on site much later than this dependent on emergency activity. The divisional senior leadership recognises the merit in moving the general surgical registrars to resident on call as a potential solution but there are a number of practical considerations to overcome:

I. **Recruitment** – it is unlikely that the deanery would be able to provide sufficient training posts to cover the number of posts needed and there would likely be reliance on staff grade roles. The calibre and experience of available candidates would need to be considered as

recruiting four specialty doctors to the service at the same time, even if available, could place an additional burden of support on the department and may in itself compromise quality and safety. Four speciality level doctors would be the minimum number required to effect the change but detailed analysis of the rota and the deployment of staff would need to be undertaken to ensure that this number would be effective in terms of rota compliance, cover, training and annual leave opportunity.

II. **Training experience** – the general surgical department has an enviable record when it comes to the quality of the training experience provided to surgical registrars at WSFT. Moving to a resident on call system would be considered as having a negative impact on the quality of this experience for the following reasons:

- Mandatory rest time after nights on call results in decreased training activity
- Increase in number of middle grades to enable shift system would further dilute training opportunities
- WSFT has a low volume of surgical interventions after 22:00 leading to very little surgical training for the overnight period

.

III. **Financial** – for four specialty doctors (on the new pay contract), at mid-point the cost would be £417k. (Bottom of scale = £295k, top of scale = £511k and inclusive of on costs). This cost would increase if the minimum number of four speciality doctors is insufficient for an effective rota exceeding the £511k top scale figure provided by the finance team.

Cultural/Organisational – The service has moved from a ward-based structure to a team-based one considerably increasing the daily support available to the junior doctor team.

The move to a resident on call system while perhaps viewed as a panacea could also have some unintended consequences that need to be recognised in weighing a decision to move to this system of on call. This is highlighted by Paul Kalanithi[1] in his book '*When Breath Becomes Air'*, describing the inevitable human behaviour associated with working shift patterns:

> '*Residency education regulations had forced most programs to adopt shift work. And along with shift work comes a kind of shiftiness, a subtle undercutting of responsibility. If he could just push it off for a few more hours, I would become somebody else's problem.'*

In addition to this it is important to ensure that the issues of consistent senior review in surgery and direct support of junior doctors are not conflated. Both are important, and ensuring effective senior reviews, particularly OOH, will undoubtedly provide support to junior doctors. However, the work to provide assurance around the senior reviews is distinctly separate to this paper and is being led by Mr Andrew Dunn in his role as Clinical Director for Surgery.

Recommendation

1. The board are asked to accept this report recognising the progress made to date with this issue.

2. The board are asked to acknowledge the need for incremental change and evaluation at key stages of change in support.

3. That the board supports change in the junior doctor rota to remove the 17:00 – 20:00 gap and that this change is evaluated for its impact and effectiveness before a decision is taken on a move to a resident on call rota for the general surgical registrars.

[1] Kalanithi, P, *When Breath Becomes Air*, (New York: Random House, 2016)

11:25 BUILD A JOINED-UP FUTURE

15. Future system board report

To APPROVE report

For Approval

Presented by Craig Black

Trust Public Board Meeting – 30th July 2021

Agenda item:	15			
Presented by:	Gary Norgate – Programme Director			
Prepared by:	Gary Norgate, Programme Director			
Date prepared:	14/07/2021			
Subject:	Update on the Future System Programme			
Purpose:		For information	X	For approval

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

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) and a plan of action has been agreed with the department of archaeology.
2. We are planning the application of a model that will allow the detailed modelling of the costs and benefits associated with our digital blueprint.
3. The engagement activities supporting our application for planning permission have commenced with a series of calls and face to face events that aim to explain why Hardwick Manor is our preferred site for a new hospital.
4. Our clinical co-production teams have completed their outline clinical visions and are in the process of sharing the outputs with our peer review panel.
5. Following confirmation that the construction of our new hospital is due in the second half of the decade, we have been re-planning activities to ensure we are truly "oven ready" by this date.
6. We continue to share information with our colleagues working on "pathfinder projects" (i.e. the first 8 of the new hospitals being built) and it is becoming clear that budgets are under close scrutiny.
7. Plans for ensuring Suffolk is ready to support the significant number of planned developments continue to be developed with The Chamber of Commerce and County Council.
8. We continue to chase the national hospital programme (NHP) for a process through which we can gain funding for our ongoing developmental works.
9. In the next month we will have completed our re-planning activities and will have a clear view of what it will take to ensure we are ready to build from the earliest possible date.

Strategic Outline Case (SOC) – We continue to chase confirmation of when our strategic outline case will be formally accepted for consideration and for the method through which we can access funding for these early stages of our project. I expect answers in July and hope to report positive progress at the next Board meeting.
The eight "pathfinder" projects (Harlow, West Herts, Leicester, Manchester, Hillingdon, Epsom and St Helier, Leeds and Whipps Cross) are all preparing outline business cases and visible signs of progress include the application for planning permission at Epsom and Whipps Cross and the acquisition of land at Harlow. Evidence of the central New Hospitals Programme (NHP) finding its feet include the launch of a national framework for construction partners, the development of central appraisal tools (such as

the digital cost / benefit tool discussed below) and the announcement of a central "design convergence review" from which we expect national standards for elements such as ward layouts and modern methods of construction to emerge.
That said, informal feedback suggests that Treasury are continuing to, appropriately, challenge proposed construction costs which will increase the pressure on the programmatic approach of the NHP to deliver significant savings.
While we wait for confirmation of our capital envelope, our strategy remains focussed on co-producing the facilities that we feel our community **need**. This will invariably result in a wish-list that outstrips our budget and this will, in turn, require a system wide response to how we are going to bridge the gap (this is discussed further within the clinical workstream update below).

Zoe Selmes continues to immerse herself in understanding the process through which our business cases will be appraised and the closer she looks, the more we realise how much work is required (benefit cases, benefit realisation plans, cost improvement plans etc.) and the more we accept that being scheduled to build from January 2025 is already a stretching target. Our re-planning exercise is well underway and although the critical milestone of applying for planning remains the same (end of December 2021) I will update the Board with a refreshed plan next month.

Estates – Work continues on the development and execution of plans to mitigate the risks to a successful planning application. In the last month we have agreed a plan for an archaeological survey and can confirm that this can be completed within our preparation for a planning application without creating delay. We have hosted several highly positive visits to the Manor site by Governors and non-executives and support remains universally positive.
Our architects, Ryder, are working closely with our Clinical Co-production Teams to understand the physical requirements of their clinical visions. A number of workshops are planned, the outputs from which will inform the outline building design and massing that will be used for our planning application. The objective is to establish a design / mass that will balance the following two requirements:

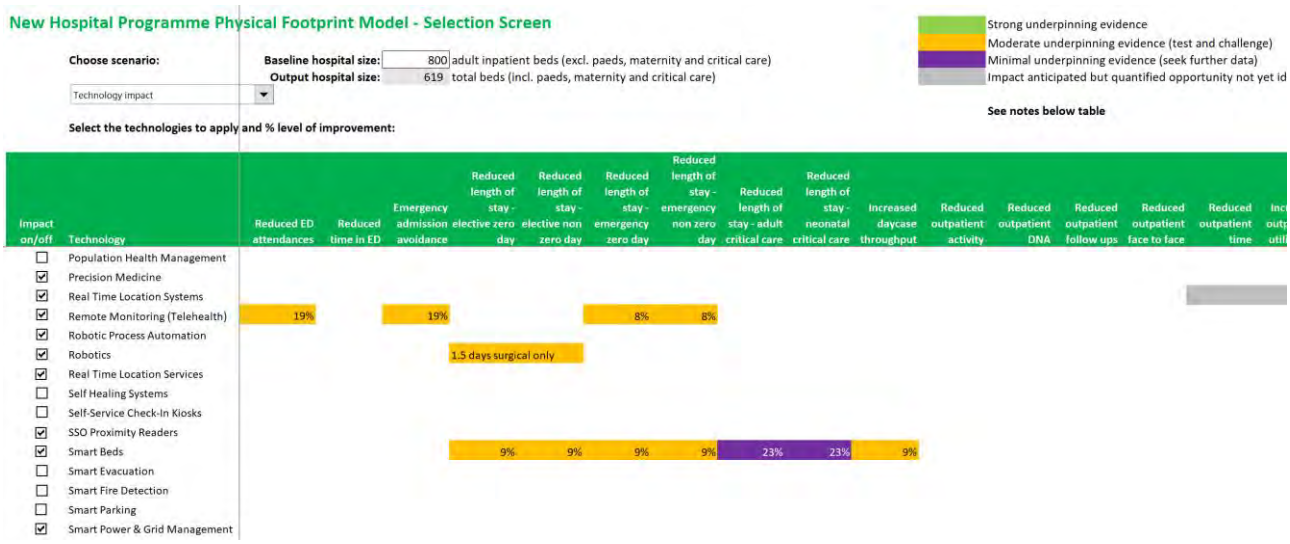
- The design / mass needs to be one that maximises our future design options without a requirement for a second planning application.

- The design / mass needs to be one that has the maximum chance of securing a successful planning outcome.

Clinical / Digital Workstream – Each of the clinical co-production teams have now completed their visions of the future of their respective specialities. These visions have been developed within the confines of each department and without commercial constraint – so we have a true view of what our teams believe is necessary for the continuation of high-quality care to our growing and changing community. The next step was to peer-review each vision and a series of workshops have already been held with a cross section of leaders representing our workforce, operations, finance, nursing, clinical and community services departments. Feedback and support for the visions has been universally positive and I feel the process will emerge with a solid, supported blueprint with which to inform our physical design process. That said, it is clear that our new hospital budget cannot afford everything within the visions. Simply translating these requirements visions into a schedule of accommodation would require a physical area that is likely to be too costly to build and operate. Consequently, the next step is for a process of co-refinement. Such a process, however, will only take us so far and there will remain a need for a system wide engagement that will aim to understand and address the gap between the capacity of the facility we can afford to build and the capacity required to meet the future needs of our community.

Another method for bridging the gap between demand and sustainable / affordable capacity is the development of efficiency-improving digital techniques.
To this end, the last month has seen us progress our work with our digital partners, ATOS, to a point where we now have access to an incredibly detailed tool for assessing the relative costs and benefits of different digital investments. The screenshot below provides an illustration of how the tool works and shows how different technologies contained within our co-produced digital blueprint might flex dimensions such as bed numbers, floor areas etc. This tool is being deployed nationally across the 8 path-finder hospital builds and so we can be assured that any conclusions drawn will have been tested

and supported by the NHP. Next step is to deploy the tool and start to model the blueprint in a way that provides a solid, methodical framework for analysis and a supportable business case for input to our Outline Business Case.



Note: 1) the wide range of technologies, 2) the colour coding of the extent to which the projected savings are underpinned by research / evidence, 3) the range of impact dimensions (reduced length of stay, reduced outpatient activity, reduced time in ED etc) and 4) the overall impact on beds (from a baseline of 800 in this purely illustrative example, to an output size of 619)

Communications and Engagement – We have now launched an engagement process in support of our planning application. Two periods of intensive engagement have been planned for July and October. The first is focussing on engaging the wider public on early plans for the new hospital and our choice of preferred site. The second of the two periods will allow the local community to find out more once further investigations have been carried out and initial plans have been developed. This process is our first opportunity to meet with our public face to face and the early events have generated feedback with several common themes:

1) Access and traffic – why not next to the A14?
2) Wildlife and the environment
3) Parking

Detailed question and answer sheets have been produced and are shared with anyone raising a concern. We are also receiving messages via email and have met local residents on request.

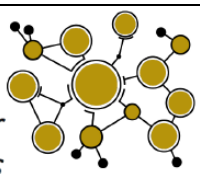
Any public communications are first agreed with the NHP (having also been discussed with WSFT / CCG / NHSI/E comms teams) and, although, outwardly supportive of our drive to secure planning consent, the NHP are clearly, and understandably, sensitive to any message that may create a false and undeliverable expectation – hence we are avoiding making definitive statements about options that have not yet been agreed.

The latest meetings with the Chamber of Commerce and the County Council have illustrated, once again, the huge amount of work needed to ensure Suffolk is ready to respond to the amazing inward investment opportunities represented by projects such as, Sizewell C, our hospital, Gateway 14, and Lakenheath. The document below summarises the situation and positions a number of engagement events aimed at providing local businesses with the confidence they need in order to invest and scale up resources.

Suffolk Growth

The Suffolk £

Developing local supply chain for major infrastructure investments



- Suffolk Growth led programme of business engagement to drive up capacity / capabilities of local firms to contract with anchor institutions / Tier 1s in delivering major projects & develop our local workforce
- Work with colleagues & partners including: skills teams, FE colleges, Suffolk Chamber & business intermediaries, sector groups, DWP
- Builds on work delivered over past 2 years – including:
  - Promotion of / awareness raising of public sector / major investment opportunities
  - 12 SME training sessions (*Get Fit to Bid)*
  - Development of an online diagnostic tool for SMEs to assess capabilities & capacity
  - Development of single joined up approach for Tier 1s (USAF / KVF at Lakenheath)
  - Skills / workforce development: Technical Skills Legacy report for the construction & engineering sector
- Programme of work to focus on:
  - Take forward the Lakenheath approach with additional projects – e.g. West Suffolk Hospital / ABP Lowestoft / Ipswich Garden Suburb (Crest Nicholson development) / Gateway 14 / GCB Cocoa
  - Meet with investor / development team and agree:
    - Understand investment proposals (e.g. WSH to invest £650m in relocating & rebuilding new hospital)
    - Work with developers and Primes to raise awareness of local supply chains & encourage local contracting where possible / work in partnership with procuring authorities to ensure minimum levels of local sourcing* are built into social value assessment frameworks
    - map out where support is needed to strengthen local supply chain uptake / local workforce development through work with partners, such as FE colleges, DWP and wider programmes, e.g. the Supply Chain Development Fund
    - Raise awareness of public sector contracting opportunities & those arising from major investments and develop series of interventions specific to each investment – e.g. meet the buyer events / training & curriculum programmes
  - Sectors skill mapping
    - Update Technical Skills Legacy work (construction & engineering) and develop this into wider sector approaches
    - Work with wider programmes – e.g. Fit for Nuclear / Nuclear Sector Deal
- What does this provide for Suffolk? – The outcomes
  - Single, joined up conversations between the Suffolk Public Sector & our major investors / Tier one businesses – look to develop a *Suffolk Pledge* for Tier 1s, *e.g. we will spend x% locally &* MONITOR and / or build commitments into S.106 agreements at planning approval stage
  - Quantified measures to be developed to track business support programmes & volume / value of contracts placed with Suffolk local firms / jobs created / environmental & social benefits accrued
  - Robust, up to date understanding of the Suffolk workforce capacity and capabilities to deliver for the future – what will be the demand for skills? How can our training providers deliver?
  - Longer term workforce development opportunities & improved employment opportunities for local businesses / residents

*see also carbon neutral criteria & job training progression & development opportunities / apprenticeships

All in all, a month in which the significant progress has been made in the development of our clinical design and the understanding of how this can be enhanced through the application of the latest digital innovations. We continue to live our goal to make this the most co-produced hospital in the HIP programme and next month will hopefully produce some clarity of the extent to which our immediate plans will be funded by the NHP.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**		**Invest in quality, staff and clinical leadership**		**Build a joined-up future**		
	X		**X**		**X**		
Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X	X	X	X	X	X	X
Previously considered by:	Future System Programme Board.						
Risk and assurance:							
Legislation, regulatory, equality, diversity and dignity implications	None						
Recommendation:							

11:35 GOVERNANCE

16. Governance report

To APPROVE the report

For Approval

Presented by Ann Alderton

Board of Directors – 30 July 2021

Agenda item:	16			
Presented by:	Ann Alderton, Interim Trust Secretary			
Prepared by:	Ann Alderton, Interim Trust Secretary			
Date prepared:	19 July 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. **Use of Trust seal** (for information)
   To note use of the Trust Seal, pursuant to Standing Order section 8. The Trust Seal was used on the following occasions:

   Seal No. 146 – Contract for refurbishment of existing area (podiatry) and formation of corridor link within footprint of existing building with West Suffolk NHS Foundation Trust and Brooks & Wood Ltd - Sealed by Craig Black & Stephen Dunn, witnessed by Karen McHugh (23 June 2021).

3. **Use of Emergency Powers** (for approval)
   The Trust's Standing Orders (Standing Order 5.2) allow an urgent board decision to be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Trust Board for noting.

   To comply with the requirements of Ockendon, CNST and the Maternity CQC improvement plan, the Trust is required to have a Maternity Quality and Safety Framework in place which has been approved by the Board. To meet a submission deadline for CQC evidence, this was considered by the Scrutiny Committee at its meeting of 15 July and the Executive Directors on 22 July, having consulted with the Chair, Chief Executive, and Non-Executive Directors Alan Rose and Richard Davies. The Board is asked to note the use of emergency powers.

4. **Governors' Nomination Committee meeting** (for information)
   The committee met on 24 June to consider the feedback from the appraisal of the Non-Executive Directors and the Chair and to approve the process for the appointment of an interim Non-Executive director. Shortlisting took place on 21 July and interviews on 28 July.

5. **Revised Committee structure 3i and Management Committees** (for information)
   Considerable work has taken place to develop the scope, objectives and work programme of the three new Board Committees – Insight, Involvement and Improvement as part of the Trust's Corporate Governance Framework. These will be confirmed in terms of reference and work programmes which will be presented to the committees during August 2021 and confirmed at the 3 September Board meeting.

   The role of the committees under the Well-led Framework has been clarified, along with the underpinning assurance and escalation framework. New terms of reference for a Senior Leadership

Team to replace TEG have been drafted, and four governance sub-groups have been established to support the Senior Leadership Team, the Board and its committees. Their terms of reference and work programmes are being developed with the first reporting cycle taking place in August.

6. **Board Assurance Framework** (for information)
   The Board Assurance Framework has been updated and is reported at this meeting. The principal risks to the Trust's strategic objectives have been allocated to Board Assurance committees to support their work programme.

7. **Quality Accounts** (for information)
   The Quality Accounts no longer form part of the Trust's Annual Report and Accounts and are subject to different reporting arrangements.

   Following approval by the Trust Board closed meeting on 25 June, Healthwatch, West Suffolk CCG and the Suffolk Health Scrutiny Committee were all sent a copy and invited to comment. Healthwatch and the Scrutiny Committee advised that they were not in a position to comment at present but wished to resume doing so in future years. The comment from Suffolk CCG has been incorporated in the final document and a final version is now available on the Trust web-site and the NHS England and NHS Improvement website.

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 reports

Annex A: Scheduled draft agenda items for next meeting – 3 September 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	SD
Operational report	✓		Written	Action	HB
Report from 3i Committees: Insight, Improvement & Involvement	✓		Written	Matrix	RD / AR /
Finance & workforce performance report	✓		Written	Matrix	CB
Risk and governance report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
Deliver for Today/Invest in Quality, Staff and Clinical Leadership					
Insight Committee Report - Finance and workforce report - Operational report - IQPR	✓		Written	Matrix	CB/HB/RD
Involvement Committee Report - People and OD Highlight Report	✓		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
People and OD highlight report - Appraisal and mandatory training report - Staff recommender scores	✓		Written	Matrix	JMO
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	SW
Build a joined-up future					
Future system board report	✓	✓	Written	Matrix	CB
Strategic update, including Alliance, System Executive Group and Integrated Care System		✓	Written	Matrix	KV / SD
Governance					
Governance report, including - Agenda items for next meeting - Use of Trust's seal - Senior Leadership Team report - Audit Committee report - Remuneration committee report - Risk appetite statement - Scope for well led developmental review	✓		Written	Matrix	AA

- Annual complaint report - Audit committee report - Annual review of reporting schedule - NED responsibilities					
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

17. Board Assurance Framework

To APPROVE report

For Approval

Presented by Ann Alderton

Board of Directors – 30 July 2021

Agenda item:	17			
Presented by:	Ann Alderton, Interim Trust Secretary			
Prepared by:	Ann Alderton, Interim Trust Secretary			
Date prepared:	19 July 2021			
Subject:	Board Assurance Framework			
Purpose:		For information	X	For approval

Executive summary:

The Board assurance framework is a tool used by the Board to manage its principal strategic risks.

Focusing on each risk individually, the BAF documents the key controls in place to manage the risk, the assurances received both from within the organisation and independently as to the effectiveness of those controls and highlights for the board's attention the gaps in control and gaps in assurance that it needs to address in order to reduce the risk to the lowest achievable risk rating.

Following the introduction of a new committee structure, this report allocates the BAF risks to the Board Committees to ensure that they feature in their future work programmes and inform future agendas

It is noted that two of the risks in the BAF have achieved the majority of their agreed actions to meet their target risk and should be considered for de-escalation, as follows:

BAF Risk 2: If we do not have a sustainable pathology service, then we will not have an accredited local service that meets the needs of the Trust to deliver safe and effective care.
BAF Risk 9: If we are not active and engaged as a key partner in the Alliance then we will not play a part in shaping and contributing to the delivery of the Alliance strategy resulting in inequitable allocation of resources to meet the care and service need of the local community

It is recommended that the risk assessments supporting these two risks are referred to the responsible committees for potential de-escalation.

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 previously considered the Board Assurance Framework in February 2021. This is the first report to the Board since the establishment of the new committee structure. It is also being reported to the Audit Committee (30 July 2021) and was previously considered at the Executive Directors' meeting on 14 July 2021.
Risk and assurance:	Failure to effectively manage risks to the Trust's strategic objectives. Agreed structure for Board Assurance Framework (BAF) review with oversight by the Audit Committee. Internal Audit review and testing of the BAF.
Legislation, regulatory, equality, diversity and dignity implications	The BAF underpins the Board's Annual Governance Statement within the annual report and is a critical part of the Head of Internal Audit's annual opinion.

Recommendation:

a) Based on the following review the Board is asked to approve the updated BAF:

- Are all relevant strategic risks captured?
- Is the level of risk rating appropriate at all three levels – Inherent, Residual and Target?
- Are the identified mitigating actions for each risk appropriate and adequate?
- Are relevant assurances, positive and negative, captured for each risk?

b) Based on the BAF risks, controls and assurances consider topics for future Audit Committee 'deep dive' review or Board development

c) Refer the risk relating to the management of Pathology (BAF Risk 2) to the Improvement Committee for a decision on de-escalation or retention on the BAF

d) Refer the risk relating to partnership in the Alliance (BAF Risk 9) to the Involvement Committee for a decision on de-escalation or retention on the BAF.

Background

The Board assurance framework is a tool used by the Board to manage its principal strategic risks.

Focusing on each risk individually, the BAF documents the key controls in place to manage the risk, the assurances received both from within the organisation and independently as to the effectiveness of those controls and highlights for the board's attention the gaps in control and gaps in assurance that it needs to address in order to reduce the risk to the lowest achievable risk rating.

This is the first time the BAF has been reported to the board since the introduction of the new structure for organisational governance, introducing three new board assurance committees, in addition to the existing Scrutiny committee. These committees are aligned with key lines of enquiry from the NHSE/I Well-led framework and will be responsible for the ongoing oversight of the strategic risks in the BAF.

Appendix 1 shows the allocation of the BAF risks to each of the Board's assurance committees.

Appendix 2 reports a summary of the BAF risks and the main changes since the previous report to the board. For the first time, each risk has been assigned to a board committee, who will be responsible for providing the board with assurances on the effectiveness of the key controls in place through their terms of reference and forward plans.

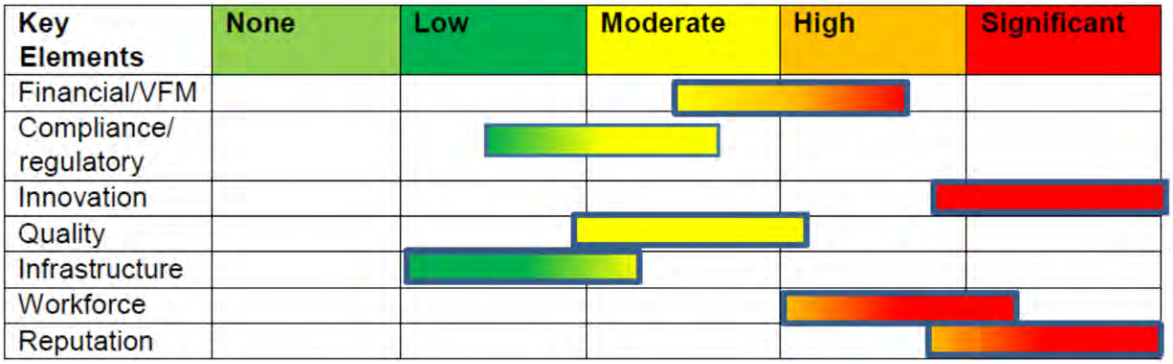
Appendix 3 provides supporting detail of current mitigating actions and the most recent assurances relating to those actions.

The Role of the Assurance Committees

Board assurance committees are responsible for considering all relevant risks within the BAF and the corporate risk register as they related to the remit of the committee, as part of the reporting requirements, and to report any areas of significant concern to the audit committee or the board as appropriate. The committees will be responsible for recommending changes to the BAF relating to emerging risks and existing entries within their remit for the executive to consider. When the target risk in the BAF is met, a full report will be made to the committee recommending its removal from the BAF, which will the committee will consider and make an appropriate recommendation to the Board.

Risk Appetite Statement

The Trust's risk appetite statement is under review. Once completed, this will be used as a tool to determine which risks should be prioritised by the board for controls assurance purposes. Where the Trust has a cautious view of risk (green to yellow), and the current risk is higher than this, this risk will be reviewed more frequently and in greater depth by the board and its committees. When a target risk is achieved and this is lower than the Trust's risk appetite, the Board will consider the removal of a risk from the Board Assurance Framework, though it will remain on the Trust's risk register for ongoing executive management.



Future Reporting Arrangements

The Board Assurance Committees will update the board at every meeting when they receive updates on any of the BAF strategic risks.

The BAF will be updated following each update and reported to the public board at every other meeting.

Recommendation

The Board is asked to approve the updated BAF, the proposed allocation to the board assurance committees for more detailed review and analysis through the committees' forward plans and future reporting arrangements

Appendix 1

Allocation of BAF Risks to Board Sub-Committees

Board Assurance Committee	Well-Led Key Lines of Enquiry	BAF Risks Assigned	Current Risk
Improvement	• **Is there a culture of high quality, sustainable care?** • **Are there robust systems for learning, continuous improvement and innovation**	1. If we do not establish effective governance structures, systems and procedures over safety and quality, this will lead to poor standards of care to all patients and service users, potential harm, service failure, reputation damage, poor patient experience and regulatory action	Quarterly x Major = Red
		2. If we do not have a sustainable pathology service, then we will not have an accredited local service that meets the needs of the Trust to deliver safe and effective care	Annual x Major = Amber
Insight	• **Are there clear and effective processes for managing risks, issues and performance** • **Is appropriate and accurate information being effectively processed, challenged and acted upon**	3. If we do not identify and deliver cost improvement and transformation plans that ensure sustainable clinical and non-clinical services then we will not meet our control total, face potential regulatory action and intervention and fail to deliver high quality and safe services	Quarterly x Major = Red
		4. If we do not deliver elective access standards based on clinical priorities in the context of Covid activity, this will affect our ability to deliver safe, effective and efficient services and care to patients	Weekly x Major = Red
		5. If we do not manage emergency capacity and demand in the context of Covid activity and delivery of the RAAC remediation plan, this will affect our ability to deliver safe, effective and efficient services and care to patients	Annual x Major = Amber
		6. If we do not progress our programme of work for digital adoption, transformation and benefits realisation, the digital infrastructure will become obsolete and vulnerable to cyber-attack, resulting in poor data for reporting and decision support, digital systems failure, loss of information and inability to provide optimum patient care, safety and experience	Quarterly x Major = Red
		7. External financial constraints may impact on Trust and system sustainability through tariff, contract and pattern of service provision in the west Suffolk system resulting in the loss of provider sustainability funding to the system	Annual x Major = Amber
Involvement	**Are the people who use the services, the public, staff and external partners**	8. If we do not value our workforce and look after their well-being, particularly in the context of the Covid-19 pandemic, this may affect patient safety and quality of care due to lower levels of staff engagement and morale, and staff choosing	Quarterly x Major = Red

Board Assurance Committee	Well-Led Key Lines of Enquiry	BAF Risks Assigned	Current Risk
	engaged and involved to support high quality sustainable services?	to leave WSFT	
		9. If we are not active and engaged as a key partner in the Alliance then we will not play a part in shaping and contributing to the delivery of the Alliance strategy resulting in inequitable allocation of resources to meet the care and service need of the local community	Annual x Major = Amber
Scrutiny	**Identifies, oversees and monitors status of risks associated with major projects, investments and business cases**	10. If we do not implement the estates strategy to provide an adequately maintained building environment suitable for patient care caused by the deteriorating state of Trust buildings, lack of access to capital to fund the remediation programme, this may result in potential harm incidences, capacity pressures and improvement notices	Quarterly x Major = Red
		11. If we do not manage the programme to build and deliver a new healthcare facility and model of service delivery to time and budget, this may result in cost pressures, potential harm incidences, capacity pressures and improvement notices (links to BAF risk 10)	Quarterly x Major = Red

Appendix 2

BAF – Strategic Risks – Summary of changes during current review

Ref	Risk	Exec Lead	Inherent Risk	Residual Risk	Target Risk	Strategic Priority	Status/Changes
Improvement Committee • **Is there a culture of high quality, sustainable care?** • **Are there robust systems for learning, continuous improvement and innovation**							
1	If we do not establish effective governance structures, systems and procedures over safety and quality, this may to poor standards of care to all patients and service users, potential harm, service failure, reputation damage, poor patient experience and regulatory action	Chief Nurse	Weekly x Major = Red	Quarterly x Major = Red	Annual x Major = Amber	Deliver for today Invest in quality, staff and clinical leadership	Risk wording updated **New Controls** • Recruitment, retention and education – pipeline, career pathways and professional development in place that meets strategic objectives • Safeguarding team and service provision in place **Risk rating** – no change
2	If we do not have a sustainable pathology service, then we will not have an accredited local service that meets the needs of the Trust to deliver safe and effective care	Medical Director	Weekly x Major = Red	Annual x Major = Amber	5-yearly x Major = Amber	Deliver for today	Risk wording updated **New Controls** • Established networking arrangements in place for WSFT in an alliance contracting arrangement • Applications for accreditation have commenced with view to receive initial assessment by November 2022 • Successful delivery of recruitment to existing vacant posts • Investment in new equipment following board approval **Risk Rating –** no change

Ref	Risk	Exec Lead	Inherent Risk	Residual Risk	Target Risk	Strategic Priority	Status/Changes
Insight Committee • **Are there clear and effective processes for managing risks, issues and performance** • **Is appropriate and accurate information being effectively processed, challenged and acted upon**							
3	If we do not manage emergency capacity and demand in the context of Covid activity and delivery of the RAAC remediation plan, this will affect our ability to deliver safe, effective and efficient services and care to patients	Chief Operating Officer	Weekly x Catastrophic = Red	Quarterly x Major = Red	Quarterly x Moderate = Amber	Deliver for today	Risk wording updated **New Controls** • Length of stay improvement programme supported by ECIST • Refurb to ward G9 to improve isolation facilities • Weekly winter planning meetings established from July 2021 • CRT established including EPRR, operational and clinical lead roles • MTU service moved to hospice building for duration of decant programme **Risk rating** - no change
4	If we do not deliver elective access standards based on clinical priorities in the context of Covid activity, this will our ability to deliver safe, effective and efficient services and care to patients	Chief Operating Officer	Weekly x Catastrophic = Red	Weekly x Major = Red	Quarterly x Moderate = Amber	Deliver for today	Risk wording updated **New Controls** • Use of the independent sector to deliver additional capacity • Joint ICS/PTL under development • Work under way to transfer patients to ESNEFT where appropriate if waiting list less than WSH • Designated accelerator site with additional funding to deliver elective activity • Developed detailed reset plan for elective services, incorporating impact of RAAC plank remediation (awaiting national clarity on clinical

Ref	Risk	Exec Lead	Inherent Risk	Residual Risk	Target Risk	Strategic Priority	Status/Changes
							prioritisation in context of access standard performance measures • Theatre dashboard implemented to support theatre productivity and resolve data quality issues **Risk rating** – no change
5	If we do not progress our programme of work for digital adoption, transformation and benefits realisation, the digital infrastructure will become obsolete and vulnerable to cyber-attack, resulting in poor data for reporting and decision support, digital systems failure, loss of information and inability to provide optimum patient care, safety and experience	Director of Resources	Weekly x Major = Red	Annual x Major = Amber	Annual x Major = Amber	Build a joined up future	Risk wording updated **New Controls** • Completion of Windows 10 desktop and Windows 2012/16/19 server migrations following end of life of Windows 7 and Windows 2008 server • Successful transition of NEL contract • Delivery of e-Care phase 4 for Maternity and closed loop medicines administration • Continued support for the Covid19 vaccination programme for second vaccinations of staff and vulnerable public populations • IT leadership and structures and team support reviewed **Risk rating –** no change, target risk achieved
6	If we do not identify and deliver cost improvement and transformation plans that ensure sustainable clinical and non-clinical services then we will not meet our control total, face potential regulatory action	Director of Resources	Quarterly x Catastrophic = Red	Quarterly x Major = Red	Annual x Major = Amber	Deliver for today	Risk wording updated **New Controls** • ICS received £10m in relation to the accelerated programme and WSFT will be allocated a share • Clarified financial reporting and monitoring as part of the new

Ref	Risk	Exec Lead	Inherent Risk	Residual Risk	Target Risk	Strategic Priority	Status/Changes
	and intervention and fail to deliver high quality and safe services						committee structure and performance regime (replacing transformation steering group role) • PMO reviewed and consultation on structures with focus on embedded delivery roles within divisions and corporate areas **Risk rating** – no change
7	External financial constraints may impact on Trust and system sustainability through tariff, contract and pattern of service provision in the west Suffolk system resulting in the loss of provider sustainability funding to the system	Director of Resources	Quarterly x Catastrophic = Red	Annual x Major = Amber	Annual x Major = Amber	Deliver for today Build a joined up future	New controls • 20/21 year end position delivered • Financial position for 2021/22 agreed with system and regional team • Budget for 2021/22 agreed by Board in February 2021 • New actions identified for 2022/23 **Risk rating** – no change
Involvement Committee • Are the people who use the services, the public, staff and external partners engaged and involved to support high quality sustainable services							
8	If we do not value our workforce and look after their well-being, particularly in the context of the Covid-19 pandemic, this may affect patient safety and quality of care due to lower levels of staff engagement and morale, and staff choosing to leave WSFT	Director of Workforce	Weekly x Major = Red	Quarterly x Major = Red	Annual x Major = Amber	Invest in quality, staff and clinical leadership	Risk wording updates **New controls** • BAME staff network established • New Freedom to Speak Up Guardian arrangements in place • Implementation of manager self-service supporting appraisal and mandatory training capture and reporting • Executive appraisal informed by 360 feedback

Ref	Risk	Exec Lead	Inherent Risk	Residual Risk	Target Risk	Strategic Priority	Status/Changes
							Risk rating – no change
9	If we are not active and engaged as a key partner in the Alliance then we will not play a part in shaping and contributing to the delivery of the Alliance strategy resulting in inequitable allocation of resources to meet the care and service need of the local community	COO	Weekly x Catastrophic = Red	Annual x Major = Amber	Annual x Major = Amber	Build a joined-up future	Risk wording updated **New Controls** • Transition to new management structure under way • Quality Improvement team embedded and supporting Alliance wide programme • Future systems programme fully aligned to Alliance Strategy • Update of WSFT Strategy with alignment to Alliance Strategy • Integrated Care Systems will shortly be enshrined in legislation, fully mitigating this risk **Risk Rating –** reduced to Amber
Scrutiny Committee • Identifies, oversees and monitors status of risks associated with major projects, investments and business cases							
10	If we do not implement the estates strategy to provide an adequately maintained building environment suitable for patient care caused by the deteriorating state of Trust buildings, lack of access to capital to fund the remediation programme, this may result in potential harm incidences, capacity pressures and improvement notices	Director of Resources	Quarterly x Major = Red	Quarterly x Major = Red	Annual x Major = Amber	Scrutiny Committee	Risk wording updated **New Controls** • A new John Godden panel has been installed • Emergency department expansion has been completed • G9 has been refurbished • New escalation ward G10 has been completed • Attain report completed • Future system – SOC submission to NHSE/I

Ref	Risk	Exec Lead	Inherent Risk	Residual Risk	Target Risk	Strategic Priority	Status/Changes
							Risk rating – no change
11	If we do not manage the programme to build and deliver a new healthcare facility and model of service delivery to time and budget, this may result in cost pressures, potential harm incidences, capacity pressures and improvement notices (links to BAF risk 10)	Director of Resources	Quarterly x Major = Red	Quarterly x Major = Red	Annual x Major = Amber	Scrutiny Committee	New Risk reported to the Board for the first time

Appendix 3

Summary mitigating actions and gaps in assurance

	Residual Risk	Target Risk
1. If we do not establish effective governance structures, systems and procedures over safety and quality, this may to poor standards of care to all patients and service users, potential harm, service failure, reputation damage, poor patient experience and regulatory action	Quarterly x Major = Red	Annual x Major = Amber
Description of additional controls required (actions being taken)	Lead	Due date
Safe staffing - see separate BAF risk	-	-
Build assurance dashboard and framework for quality indicators to support development of ward accreditation programme	SW	Dec '21
Development programme for ward managers and matrons to support ward accreditation	SW	Dec '21
Align accreditation framework and KPIs with Nursing, midwifery and AHP strategy	SW	Dec '21
Co-produce nursing, midwifery and AHP strategy to meet current and future system needs (reflecting the updated Trust strategy - pending)	SW	Sep '21
Appoint the Associate Director quality and patient safety (ADQ&S)	SW	Sep '21
Review of the structure and strategies for quality, safety and experience of care under the leadership of the new ADQ&S	ADQ&S	Dec '21
Embed new governance structure based on agreed structure for insight, involvement and improvement	AA	Oct '21
Review of PSIRF implementation	SW	Sep '21

Assurances

- Safer staffing - trust-wide establishment review approved by Board (Jan '21)
- Maternity reporting to Board and attendance of head of midwifery (monthly)
- Quality reporting to Board on key performance indicators e.g. infection prevention and control, maternity.
- Programme of IPB external reviews
- External review of maternity services (CCG, region and CQC) – supportive (June '21)
- Maternity external support – reported as part of maternity plans to IPB
- Regulatory PSIRF sign-off of WSFT framework
- CQC stepped down monthly review meeting to business as usual (monthly)
- NHSE/I oversight meeting (quarterly)
- Internal audit reporting:
    - Responsive internal audit programme linked to IPB assurance requirements (draft programme for 2021/22)
    - Civil Contingencies Act - Advisory (July 2020)
    - Risk Management - Reasonable Assurance (Nov 2020)
    - CQC Improvement Plan – Stage 1 Substantial Assurance (Nov 2020)
    - Data Quality – Paused Activity and Recovery Reasonable Assurance (Jan 2021)
    - Fit and Proper Persons - Partial Assurance (Jan 2021)
    - Pathology (Stage One Advisory – Nov 2020)
    - Data Quality – Paused Activity and Recovery Reasonable Assurance (Jan 2021)

<u>Gaps</u>

- Evaluation of new insight, involvement and improvement structure (expected Sep 21)
- Internal audit planned audits:
    - Nursing - Temporary Staffing and Rostering
    - Freedom to Speak Up
    - CQC Improvement Plan – Stage 2
    - Appraisals, Mandatory Training & Workforce KPIs
    - Surveillance Patients / Follow Up
    - Community – NEL CSU Exit Project Review
    - Grievance and Complaints Processes
    - EPRR / Business Continuity
    - Data Quality – RTT
    - Consultant Job Planning

	Residual Risk	Target Risk
2.If we do not have a sustainable pathology service, then we will not have an accredited local service that meets the needs of the Trust to deliver safe and effective care	Annual x Major = Amber	5-yearly x Major = Amber
Description of additional controls required (actions being taken)	Lead	Due date
Testing of new governance arrangements through internal audit programme now scheduled for 2022/23	RJ	Mar '23
GIRFT audit for WSFT, results shared to support collaboration with ESNEFT	PM	Sept '22

Assurances

- Reporting to Board and Scrutiny Committee (monthly)
- NED engagement with pathology teams and governance (ongoing)
- Pathology attendance at Board and scrutiny committee
- Board investment decision for equipment (Jan '21)
- CQC stepped down monthly review meeting to business as usual (monthly)

Gaps

- GIRFT audit for WSFT (Sep 22)
- Internal audit planned audits:
    - Testing of new governance arrangements in internal audit plan for 2022/23

	Residual Risk	Target Risk
3. If we do not manage emergency capacity and demand in the context of Covid activity and delivery of the RAAC remediation plan, this will affect our ability to deliver safe, effective and efficient services and care to patients	Quarterly x Major = Red	Quarterly x Moderate = Amber
Description of additional controls required (actions being taken)	Lead	Due date
Operational and staffing plans to safely deliver winter escalation and surge capacity (see separate BAF risk)		
Implementation of IT platforms to increase understanding and visibility of community capacity, demand, skill mix and scheduling: - Malenko (Oct 21)	COO	Oct 21
Implementation of: length of stay and discharge programme supported by ECIST to include system out of hospital capacity programme, frailty programme, the application of right to reside	COO	Sep 21
Addition decant ward (G10)	COO	Jul 21
Transformation initiatives: - review of home IV therapy to inform business case (Apr 21) - Virtual Covid ward (potential to expand to other conditions)	COO	Sep 21
Review E-Zec contract performance when we return to more normal levels of outpatient activity	COO	Sep 21 (or earlier)
Review of space allocated to paediatrics and frailty within the ED footprint	COO	Oct 21
Implement final versions of new ED access standard in line with national roll out	COO	Oct 21
System to approve community bed requirement and funding for additional community bed base	COO	Sep 21
Move MTU service to Hospice building for duration of decant programme	COO	Apr 21

Assurances

- Access and performance reporting arrangements to Board e.g. IQPR, operational report and transformation report (qrtly)
- Monitoring of new ED access standards
- External monitoring of stranded and super stranded and medically optimised for discharge
- Monitoring of bed utilisation
- Attain report – informs and validates the decant plans to support RAAC remediation
- CQC stepped down monthly review meeting to business as usual (monthly)
- NHSE/I oversight meeting (quarterly)
- Internal audit reporting:
    - Civil Contingencies Act - Advisory (July 2020)
    - Risk Management - Reasonable Assurance (Nov 2020)
    - Data Quality – Paused Activity and Recovery Reasonable Assurance (Jan 2021)
    - COVID-19 Financial Governance & Key Financial Controls - Reasonable Assurance (Jul 2020)
    - Private and Overseas Patients - Reasonable Assurance (Nov 2020)

<u>Gaps</u>

- Length of stay and discharge programme supported by ECIST (Sept 21)
- Internal audit planned audits:
    - Surveillance Patients / Follow Up
    - Building Structure Risk
    - EPRR / Business Continuity
    - Cost Improvement Programme
    - Data Quality – RTT
    - Consultant Job Planning

	Residual Risk	Target Risk
4. If we do not deliver elective access standards based on clinical priorities in the context of Covid activity, this will our ability to deliver safe, effective and efficient services and care to patients ***(emergency standard is considered separate BAF entry)***	Weekly x Major = Red	Quarterly x Moderate = Amber
Description of additional controls required (actions being taken)	Lead	Due date
Internal audit review of: - patient surveillance and follow-up - cancellation and delay due to Covid	COO	Jul 21
Theatre 1 recommissioned (delayed due to RAAC remediation and Covid)	COO / DoR	Sep 21
Shadow monitor against new 28-day standard – identify areas for improvement	COO	Sep 21
Outpatient transformation programme with focus on digital and embedding of Covid learning – delivering benefits to key milestones	COO	Mar 22
Delivery of remaining cancer and diagnostic access elements of the agreed reset plan for elective services (timing dependant on assumptions relating to national guidance and Covid/RAAC)	COO	Oct 21

Assurances

- Board reports and monitoring (monthly)
- Weekly SNEE activity level review
- Cancer and diagnostics activity progress against trajectory (monthly)
- CQC stepped down monthly review meeting to business as usual (monthly)
- NHSE/I oversight meeting (quarterly)
- Internal audit reporting:
    - Civil Contingencies Act - Advisory (July 2020)
    - Risk Management - Reasonable Assurance (Nov 2020)
    - CQC Improvement Plan – Stage 1 Substantial Assurance (Nov 2020)
    - Data Quality – Paused Activity and Recovery Reasonable Assurance (Jan 2021)
    - COVID-19 Financial Governance & Key Financial Controls - Reasonable Assurance (Jul 2020)
    - Private and Overseas Patients - Reasonable Assurance (Nov 2020)

<u>Gaps</u>

- Finalised reset plan (Apr 2021)
- Internal audit planned audits:
    - Surveillance Patients / Follow Up
    - Cancellation and delay due to Covid
    - Community – NEL CSU Exit Project Review
    - Building Structure Risk
    - EPRR / Business Continuity
    - Cost Improvement Programme
    - Data Quality – RTT
    - Consultant Job Planning

	Residual Risk	Target Risk
5. If we do not progress our programme of work for digital adoption, transformation and benefits realisation, the digital infrastructure will become obsolete and vulnerable to cyber-attack, resulting in poor data for reporting and decision support, digital systems failure, loss of information and inability to provide optimum patient care, safety and experience	Annual x Major = Amber	Annual x Major = Amber
Description of additional controls required (actions being taken)	Lead	Due date
Preparation 2022/23 digital programme plan with funding envelope to Digital Programme Board review	Craig Black	Mar 22
Agreed plan for the delivery of HIMSS 6 and 7 (with key external organisational dependencies) with NHSD/NHSX. To include closed loop blood and medication	Sarah Judge Liam McLaughlin	Mar 22
Implementation of full Infection Control solution integrated with e-Care to support mandated measures for Covid19 monitoring	Guy Hooper	Dec 21
Delivery of Closed Loop blood request and administration	Guy Hooper	Dec 21
Deliver programme for population health management in the west of Suffolk, working with local partners and Cerner to develop the solution	Helena Jopling	Mar 22
Deployment of new Antivirus solution to support further strengthening of Cyber Security defences	Rob Howorth	Dec 21
Review of digital governance structure/framework	Sarah-Jane Relf	Oct 21
Key deliverable to support Future System programme: - Support for the Future systems engagement fortnight - Commission first services from an offsite data centre - Engagement with architects and surveyors on development of a digital twin for the new buildings		Ongoing Complete Dec 21 Ongoing
Regular updates from Pillar Groups to Digital Board and onto Trust Board: - Pillar Group 1 Acute Developments - Pillar Group 2 (Wider Health Community [SNEE]) - Pillar Group 3 Community Developments - Pillar Group 4 Infrastructure	Craig Black Sue Wilkinson Craig Black Helen Beck Nick Jenkins	On-going

Assurances

- Digital Programme Board reporting to Board, including NED membership (quarterly)
- NHSE/I oversight meeting (quarterly)
- Cyber Essential Plus audit report
- Cyber security penetration test report
- E-Care Phase 4 project gateway assessments
- E-Care Phase 4 Full Dress Rehearsal plan
- E-Care Phase test plan and outcomes
- Data Security and Protection Toolkit assessment
- Internal audit reporting:
    - Risk Management - Reasonable Assurance (Nov 2020)
    - CQC Improvement Plan – Stage 1 Substantial Assurance (Nov 2020)
    - Data Quality – Paused Activity and Recovery Reasonable Assurance (Jan 2021)

<u>Gaps</u>

- Digital governance structure/framework (Jun 21)
- Internal audit planned audits:
    - Data Security and Protection Toolkit
    - Community – NEL CSU Exit Project Review

	Residual Risk	Target Risk
6. If we do not identify and deliver cost improvement and transformation plans that ensure sustainable clinical and non-clinical services then we will not meet our control total, face potential regulatory action and intervention and fail to deliver high quality and safe services	Quarterly x Major = Red	Annual x Major = Amber
Description of additional controls required (actions being taken)	Lead	Due date
Finalise CIPs to deliver financial plan for 2022/23 (dependant on response to system/regulatory framework)	COO / DoR	Mar '22
Review divisional business plans (underpinned by sustainable clinical models) to reflect the requirements to deliver additional backlog activity	COO	Dec '21
Develop a system-wide information strategy with underpinning tools to improve performance monitoring	DoR	Dec '21
Respond to national guidance for operational planning cycle for 2022/23	Trust Sec	Apr '22

Assurances

- Board reporting arrangements
- CQC stepped down monthly review meeting to business as usual (monthly)
- NHSE/I oversight meeting (quarterly)
- Internal audit reporting:
    - Risk Management - Reasonable Assurance (Nov 2020)
    - Data Quality – Paused Activity and Recovery Reasonable Assurance (Jan 2021)
    - COVID-19 Financial Governance & Key Financial Controls - Reasonable Assurance (Jul 2020)
    - Private and Overseas Patients - Reasonable Assurance (Nov 2020)

<u>Gaps</u>

- Internal audit planned audits:
    - Cost Improvement Programme
    - Budgetary Control
    - Consultant Job Planning

	Residual Risk	Target Risk
7. External financial constraints may impact on Trust's sustainability through tariff, contract and pattern of service provision in the west Suffolk system resulting in inequitable allocation of resources to meet the care and service need of the local community	Annual x Major = Amber	Annual x Major = Amber
Description of additional controls required (actions being taken)	Lead	Due date
Delivery of year end position (Board reporting) with escalation as required	DoR	Mar 22
Agree financial position with system and regional team	DoR	Mar 22
Agree budget position	DoR	Mar 22

Assurances

- Monthly reporting to Board through finance and performance reports (monthly)
- Safer staffing - trust-wide establishment review approved by Board (Jan '21)
- Increased quality reporting arrangements to Board e.g. infection prevention and controls, maternity.

- CQC stepped down monthly review meeting to business as usual (monthly)
- NHSE/I oversight meeting (quarterly)
- Internal audit reporting:
    - Responsive internal audit programme linked to IPB assurance requirements (draft programme for 2021/22)
    - Risk Management - Reasonable Assurance (Nov 2020)
    - CQC Improvement Plan – Stage 1 Substantial Assurance (Nov 2020)
    - Data Quality – Paused Activity and Recovery Reasonable Assurance (Jan 2021)
    - COVID-19 Financial Governance & Key Financial Controls - Reasonable Assurance (Jul 2020)
    - Private and Overseas Patients - Reasonable Assurance (Nov 2020)
    - Pathology (Stage One Advisory – Nov 2020)

<u>Gaps</u>

- Evaluation of new insight, involvement and improvement structure (expected Sep 21)
- National operational planning guidance for 2021/22, including financial model (expected Mar 21)
- Internal audit planned audits:
    - Nursing - Temporary Staffing and Rostering
    - Data Security and Protection Toolkit
    - CQC Improvement Plan – Stage 2
    - Community – NEL CSU Exit Project Review
    - Cost Improvement Programme
    - Budgetary Control
    - Data Quality – RTT
    - Consultant Job Planning

	Residual Risk	Target Risk
8. If we do not value our workforce and look after their wellbeing and development, particularly in the context of the Covid-19 pandemic, this may affect patient safety and quality of care due to lower levels of staff engagement and morale and staff choosing to leave WSFT	Quarterly x Major = Red	Annual x Major = Amber

Description of additional controls required (actions being taken)	Lead	Due date
Adoption of a comprehensive People Plan in support of the new WSFT Trust strategy and reflecting national priorities	JO	Sep '21
Evaluation of additional staff support measures during pandemic and agreement of next steps	JO	Oct '21
Implementation of lessons learned from external review of whistle blowing matters	JO	Dec '21
Planning and implementation of autumn staff vaccine programme	PM / JO	Oct '21
Implementation of quarterly staff survey	JO	Aug '21

Assurances

- Safer staffing - trust-wide establishment review approved by Board (Jan '21)
- Increased quality reporting arrangements to Board e.g. infection prevention and controls, maternity
- Approved WSFT people pan, with monthly reporting to Board
- Vacancy levels – reported monthly
- 5'oclock club engagement programme – key high profile (ongoing)

- National staff survey – pending full 2020 results
- Friends and family and staff recommender scores (pending)
- Sustained response to NHSE/I agency ceiling – exceeded plan
- Programme of IPB external reviews
- External review of maternity services (CCG and region) – June 21
- Maternity external support – reported as part of maternity plans to IPB
- CQC stepped down monthly review meeting to business as usual (monthly)
- NHSE/I oversight meeting (quarterly)
- Internal audit reporting:
    - Responsive internal audit programme linked to IPB assurance requirements (draft programme for 2021/22)
    - CQC Improvement Plan – Stage 1 Substantial Assurance (Nov 2020)
    - Fit and Proper Persons - Partial Assurance (Jan 2021)
    - Pathology (Stage One Advisory – Nov 2020)

<u>Gaps</u>

- National staff survey – pending full 2020 results
- Evaluation of new insight, involvement and improvement structure (expected Sep 21)
- Internal audit planned audits:
    - Nursing - Temporary Staffing and Rostering
    - Freedom to Speak Up
    - CQC Improvement Plan – Stage 2
    - Appraisals, Mandatory Training & Workforce KPIs
    - Grievance and Complaints Processes
    - Consultant Job Planning

	Residual Risk	Target Risk
9. If we are not active and engaged as a key partner in the Alliance then we will not play a part in shaping and contributing to the delivery of the Alliance strategy resulting in inequitable allocation of resources to meet the care and service need of the local community	Quarterly x Major = Red	Annual x Major = Amber
Description of additional controls required (actions being taken)	Lead	Due date
Alliance		
Working closely with Alliance partners to understand the implications of NHS centrally mandated changes as part of the recent Health and Care bill	Sarah Howard/KV	Ongoing
Roll out of Enhance Integrated Neighbourhood Teams – providing the basis future model of integrated care in the community, including community mental health – transition to new management structure under way	HB/KV	Ongoing
Shared training and development for clinical leads and operational managers as part of One Clinical Community.	KV	Ongoing
Governance review of Alliance will support further local integration of services with a view to improving outcomes for people in West Suffolk and making good use of system resources.	KV	Ongoing

Assurances

- Integrated care systems will shortly be enshrined in legislation, fully mitigating this risk
- Increased quality reporting arrangements to Board e.g. infection prevention and controls, maternity
- Quarterly integration reporting to the Board, including ICS and SEG activities
    - Ability to see Alliance system working as part of Business As Usual rather than an additional task – 'system by default'

- Representation and leadership of ICS and Alliance fora - system response to Covid, vaccination programme and reset
- CQC stepped down monthly review meeting to business as usual (monthly)
- NHSE/I oversight meeting (quarterly)
- Internal audit reporting:
    - None

<u>Gaps</u>

- Internal audit planned audits:
    - Community – NEL CSU Exit Project Review

	Residual Risk	Target Risk
10. If we do not implement the estates strategy to provide an adequately maintained building environment suitable for patient care caused by the deteriorating state of Trust buildings, lack of access to capital to fund the remediation programme, this may result in potential harm incidences, capacity pressures and improvement notices *[Linked to structural risk assessment (ref. 24) rated as Red]*	Quarterly x Major = Red	5-yearly x Major = Amber
Description of additional controls required (actions being taken)	Lead	Due date
Implementation of controls associated with red risk re RAAC planks (Datix 24) potential failure of the main building structure and front residencies structure (Oak, Cedar, Birch, Larch, Pine, Willow): - Emergency planning - Assessment and repair - Remediation (failsafe installation) - Communication - Research and development - Site and system risk (including continued occupation of WSH site)	C Black	Sept 22
Deliver approved capital programme for 2021/22, including key capacity developments	C Black	March 22
Sudbury asset disposal as part of agreed plan	C Black	March 23
Secure capacity as part of one public estate (OPE) development at six hubs across West Suffolk	C Black	March 24
Confirmation of capital loan funding for 2021-22	C Black (NHSI)	July 21
Communication strategy for structural risk based on agreed remediation plan with clinical model to support capacity requirements (linked to Attain work)	C Black	March 21

Assurances

- Reporting to Board and Scrutiny Committee (monthly)
- Monthly risk review meeting – monitors progress and escalates issues/concerns

- Legal opinions on activity undertaken (latest Jan 2021)
- Regional office Charles Hanford (pending) - Charles undertakes a quarterly review of performance in completing the surveys etc. to report to the national oversight group
- Engagement in 'best buy' hospital forums ongoing (ongoing)
- EPRR feedback from exercise Hodges (Oct 20)
- Internal audit reporting:
    - Civil Contingencies Act - Advisory (July 2020)
    - Risk Management - Reasonable Assurance (Nov 2020)

<u>Gaps</u>

- Communication plan – internal and external
- Model to deliver capacity for remediation works - estates and operational plan
- CCG structural assessment (pending, supportive indication)
- Approval of Attain report
- National research programme findings
- Internal audit planned audits:
    - Building Structure Risk
    - EPRR / Business Continuity

	Residual Risk	Target Risk
11. If we do not manage the programme to build and deliver a new healthcare facility and model of service delivery to time and budget, this may result in cost pressures, potential harm incidences, capacity pressures and improvement notices	Quarterly x Major = Red	Annual x Major Amber
Description of additional controls required (actions being taken)	Lead	Due date
Implementation of the agreed programme of work to support key workstreams for: 1. Finance Workstream 2. Clinical Workstream 3. Estates Workstream 4. IM&T Workstream 5 Communications and Engagement Workstream 6. Workforce Workstream	Zoe Selmes Helena Jopling Jacqui Grimwood Liam Mclaughlin Emma Jones Sarah Shaw	Aug '21
Develop a change log to identify the gaps in the "out of scope" work to inform proposals to strengthen governance and accountability with system partners	Tracy Morgan	Aug '21
Future system – SOC submission to NHSE/I	C Black	June '21
Assurances		
• FS Programme Board with NED membership meets monthly and reports to the Board of Directors • NHSE/I oversight and support • SOC approved Feb 2021		

11:45 ITEMS FOR INFORMATION

18. 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

19. Date of next meeting

To NOTE that the next meeting will be held on 3 September in West Suffolk Hospital

For Reference

Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

20. 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