Board of Directors (In Public)

Schedule	Friday 15 October 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, 15 October 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 10 15 Oct.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: Paul Molyneux (attending in parts)
   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 3 September 2021
   For Approval - Presented by Sheila Childerhouse

   Item 6 - Open Board Minutes 2021 09 03 Sept Draft.docx

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

   Item 7 - Matters Arising - Active.pdf

   Item 7 - Matters Arising - Complete.pdf

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

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

   Item 9 - CEO Board report October 2021.docx

10:00 DELIVER FOR TODAY

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10. Insight Committee Report
To APPROVE the report
For Approval - Presented by Richard Davies

- Item 10 - Insights Chairs key issues - 6 September 2021 meeting.docx
- Item 10 - Insights Chairs key issues - 4 October 2021 meeting.docx

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

- Item 10.1 - Finance Board report Cover sheet - M06.docx
- Item 10.1 - Finance Report- September 2021_Final.docx

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

- Item 10.2 - Operational Board update October 2021.doc

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

- Item 10.3 - IQPR - data for July 2021.pdf
- Item 10.3 - IQPR - data for August 2021.pdf

Comfort Break - 10 minutes

10:30 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

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11. Improvement Committee Report
To APPROVE the report
For Approval - Presented by Jude Chin

- Item 11 - Improvement Chairs key issues - September 2021 meeting.docx

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

- Item 11.1 - Maternity Quality Safety Perfomance Board Report - Oct 2021.docx
- Item 11.1 Annex B - NHSE Summer 21 Workforce Concerns Action Plan.doc
- Item 11.1 Annex C - Maternal and Neonatal service action plan.docx
- Item 11.1 Annex D - ATAIN.pdf

11.2. Midwifery whistleblowing response and action plan
To RECEIVE the report
For Report - Presented by Susan Wilkinson and Karen Newbury

- Item 11.2 - Midwifery whistleblowing response and action plan report.docx
- Item 11.2 Annex A - Midwifery Whistleblowing Action Plan.docx
- Item 11.2 Annex B - Written feedback from midwifery meetings 18.8.21 and 24.8.21.docx

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

- Item 11.3 - COVID IPC assurance framework Oct 2021.docx

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

- Item 11.4 - Nurse staffing report.docx

11.5. Quality and Learning Report
To APPROVE the report
For Approval - Presented by Susan Wilkinson

- Item 11.5 - Quality and Learning report - October 21.docx

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

Item 12 - Involvement Chairs key issues - September 2021 meeting.docx

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12.1. People & OD highlight report (attached)
To APPROVE the report
For Approval - Presented by Jeremy Over

Item 12.1 - People OD highlight report October 2021.doc

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13. Integration report – Q2
To RECEIVE the report
For Report - Presented by Kate Vaughton and Clement Mawoyo

Item 13 - WSFT Board_Integration Paper October 21_FINAL.docx

Item 13 - ESD Case Study ESD + HF.pdf

11:15 BUILD A JOINED-UP FUTURE

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14. EPRR Core Peer Review
For APPROVAL
For Approval - Presented by Helen Beck

Item 14 - WSFT - 2021 EPRR Core Standards v1.0.pdf

Item 14 - 081021- EPRR CS Report.docx

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15. Trust Strategy 2021-2026
To RECEIVE the report
For Report - Presented by Sheila Childerhouse and Helen Davies

Item 15 - WSFT Trust strategy cover sheet - Oct 2021.doc

Item 15 - WSFT strategy 2021-2016 DRAFT V.12 for 15 Oct Board.docx

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16. Future system board report
To APPROVE report
For Approval - Presented by Kate Vaughton

Item 16 - Future System Board overview Oct 2021.doc

11:35 GOVERNANCE

17. Risk Appetite Statement
    To APPROVE the statement
    For Approval - Presented by Ann Alderton

    Item 17 - Risk Appetite Statement October 2021.doc

18. BAF Summary – October 2021
    To APPROVE report
    For Approval - Presented by Ann Alderton

    Item 18 - BAF Summary October 2021.doc

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

    Item 19 - Governance report - October 2021.doc

11:45 ITEMS FOR INFORMATION

20. 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

21. Date of next meeting
    To NOTE that the next meeting will be held on 17 December in West Suffolk Hospital
    For Reference - Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

22. 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, 15 October 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: Paul Molyneux (partial attendance)** 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 3 September 2021	Sheila Childerhouse
7.	**Matters arising action sheet (attached)** To accept updates on actions not covered elsewhere on the agenda	Sheila Childerhouse
8.	**Patient story (verbal)** To reflect on the experience shared with the Trust	Sue Wilkinson
9.	**CEO report (attached)** To receive an introduction on current issues	Craig Black
10:00 DELIVER FOR TODAY		
10.	**Insight Committee Report – September & October 2021 meetings** 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 – July and August 2021 data (attached)** To note report	Richard Davies Nick MacDonald Helen Beck Helen Beck/ Sue Wilkinson
	Comfort break – 10 minutes	

10:30 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP		
11.	**Improvement Committee Report (attached)** To approve the report	Jude Chin
	11.1 Maternity services quality and performance report (attached) To approve the report	Sue Wilkinson/ Karen Newbury
	11.2 Midwifery whistleblowing response and action plan (attached) To receive the report	Sue Wilkinson/ Karen Newbury
	11.3 Infection prevention and control assurance framework (attached) To approve the report	Sue Wilkinson
	11.4 Nurse staffing report (attached) To approve the report	Sue Wilkinson
	11.5 Quality and Learning Report To approve the report	Sue Wilkinson
12.	**Involvement Committee Report (attached)** To approve the report	Alan Rose
	12.1 People & OD highlight report (attached) To approve the report	Jeremy Over
13.	**Integration report – Q2 (attached)** To receive the report	Kate Vaughton & Clement Mawoyo
11:15 BUILD A JOINED-UP FUTURE		
14.	**EPRR Core Peer Review (attached)** For approval	Helen Beck
15.	**Trust Strategy 2021-2026** To receive the report	Sheila Childerhouse/ Helen Davies
16.	**Future system board report (attached)** To approve report	Kate Vaughton
11:35 GOVERNANCE		
17.	**Risk Appetite Statement** To approve the statement	Ann Alderton
18.	**BAF Summary – October 2021** To approve report	Ann Alderton
19.	**Governance report (attached)** To approve report	Ann Alderton
11:45 ITEMS FOR INFORMATION		
20.	**Any other business** To consider any matters which, in the opinion of the Chair, should be considered as a matter of urgency	Sheila Childerhouse

21.	**Date of next meeting** To note that the next meeting will be held on 17 December 2021 in West Suffolk Hospital	Sheila Childerhouse
RESOLUTION TO MOVE TO CLOSED SESSION		
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Presented by Sheila Childerhouse

5. Review of agenda

To AGREE any alterations to the timing of the agenda.

For Reference

Presented by Sheila Childerhouse

6. Minutes of the previous meeting

To APPROVE the minutes of the meeting held on 3 September 2021

For Approval

Presented by Sheila Childerhouse

DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 3 SEPTEMBER 2021 AT WEST SUFFOLK HOSPITAL
Via Microsoft Teams

COMMITTEE MEMBERS			
		Attendance	**Apologies**
Sheila Childerhouse	Chair	•	
Helen Beck	Chief Operating Officer	•	
Craig Black	Interim Chief Executive	•	
Jude Chin	Interim Non Executive Director	•	
Richard Davies	Non Executive Director		•
Christopher Lawrence	Non Executive Director		•
Nick Macdonald	Interim Executive Director of	•	
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		
Ravi Ayyamuthu	Interim Deputy Medical Director		
Helen Davies	Head of Communications		
Georgina Holmes	Trust Office Manager *(minutes)*		
Clement Mawoyo	Director of Integrated Services		
Daniel Spooner	Deputy Chief Nurse		
Governors in attendance (observation only): Florence Bevan, Allen Drain, Amanda Keighley, Ben Lord, Joe Pajak, Margaret Rutter, Liz Steele, Clive Wilson			

Action

GENERAL BUSINESS

21/142 RESOLUTION

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

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

21/143 APOLOGIES FOR ABSENCE

Apologies for absence were noted as above.

- The Chair welcomed everyone to the meeting, particularly Craig Black who had stepped into the role of interim Chief Executive and other members of the board who had moved into interim or temporary roles following the departure of Stephen Dunn.
- She welcomed and introduced Jude Chin who had joined the Trust as interim non-executive director (NED). He gave short summary of his background and NHS experience.

21/144 DECLARATION OF INTERESTS FOR ITEMS ON THE AGENDA

No declarations of interest were received.

21/145 QUESTIONS FROM THE PUBLIC RELATING TO MATTERS ON THE AGENDA

- Liz Steele reported that she had recently taken part in the first quality walkabout to take place since the start of the pandemic. On behalf of the governors she thanked the team who had enabled this to happen and encouraged governors to take part in these when they were given the opportunity to do so.

  The walkabout had visited F8 and critical care where, despite the unit being extremely busy, she had been particularly impressed by the calm atmosphere.

  She had also been very impressed with the professional way in which structural remedial work was being undertaken by the estates team.

21/146 REVIEW OF AGENDA

The agenda was reviewed and there were no issues.

21/147 MINUTES OF MEETING HELD ON 30 JULY 2021

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

21/148 MATTERS ARISING ACTION SHEET

The ongoing actions were reviewed and the following noted:

Ref 1929; When clearer on national reset expectations (standards/targets) develop local metrics for IQPR to support local innovation and drive improvement. The Trust had been unsuccessful in recruiting to a fixed term appointment, therefore an interim had been recruited who would be starting imminently and this would be one of their key priorities.

Ref 1971; Improvement committee reports to the board to include update on progress of actions arising from FTSU self-assessment. This should be the involvement rather than improvement committee.

Ref 1979; Provide feedback to board on outcome of CCG review of Trust's provision/support for patients with learning disabilities. WSFT hosted a quality assurance visit from the CCG earlier this year where a table top review was undertaken together with discussion with teams from various specialties about managing patients with learning disabilities. Following on from this visit the Trust asked the CCG to come in and test services on a face to face basis. They visited a number of wards and teams and only raised one concern which was a lack of awareness of the term 'reasonable adjustment', although staff were able to articulate what they did to make life easier for patients. They also suggested that further work could be done with learning disability ward champions and the use of the reasonable adjustment tool, as well as improving literature for learning disability patients. However, on the whole feedback had been very positive and the Trust would work through the specific actions that had been raised.

Q Would these actions be incorporated into the Trust's formal improvement plan or would these be followed up at a lower level?

A These would be included in the improvement plan for patients with autism and learning disabilities. They would be revisited in three months to review progress.

The completed actions were reviewed and there were no issues.

21/149 PATIENT STORY

- An email was read out from the sister of a patient with learning disabilities sharing her experiences as his carer. She was very pleased that this story was being shared with the board.
- As well as expressing her thanks to everyone who had cared for her brother and for making his stay a positive experience overall, despite his serious medical problems, she was also very grateful for the support she received and the reasonable adjustments made for her as his carer.
- She was very appreciative of the work that staff had put into to ensuring that he would not return to his previous residential home, which was out of area, and would only be released into a residential setting local to Bury St Edmunds.
- In addition to being impressed with the hospital's procedures for managing Covid, she particularly highlighted the hospital passport system, twice weekly visits from the hospital chaplain, the encouragement given to her brother to visit the courtyard gardens and memory walk and the meals and choices available, which he had enjoyed.
- She made two suggestions for improving the stay in hospital for patients with learning disabilities; ensuring that medical conversations were as easy as possible to understand by using simple words and availability of television, which could be a good distraction.
- As well as her appreciation for the hospital staff she was also very grateful to members of the early intervention team who had identified the need for her brother to be admitted.
- This email showed the real compassion of staff and the fact that they made time for patients even though they were extremely busy coping with a significant number of challenges.
- The board recorded its appreciation to these staff, particularly on F3, for the care and kindness they were showing to patients.

21/150 CHIEF EXECUTIVE'S REPORT

- Craig Black said that this story embodied what that he was most proud of about the organisation and its staff.
- He highlighted the changes in personnel around the board table and referred to the absence of Stephen Dunn which was significant and left a big hole in the organisation and the team. He was particularly noted for always knowing everyone's name and the names and interests of their family.
- Prior this meeting he had been asked to detail what he considered to be his priorities for the next few months. He stressed that these were not only his priorities but were those of the board as a team. The over arching focus of the next few months would be around stability and settling people into their new roles in order to provide a platform from which a permanent Chief Executive build.
- The organisation would be facing some big challenges in the next few months including recent media attention around the RAAC planks.
- There was also a need to recognise the pressure that would be on staff even if additional funding was made available. Winter would be a big challenge, following a very busy summer both in the acute hospital, community services, mental health services and across the whole care system. The uncertainty as the organisation moved into winter was significant.

- There would be a difference in the way that the organisation was led with different people in different roles. A real focus on transparency was essential over the next few months as the organisation tried to manage the challenges and also focus on working together across the health and social care system, ie formal establishment of ICSs within the next six to nine months.
- This was the first public board meeting since the conclusion of the process to appoint a Chief Operating Officer to replace Helen Beck, who was retiring in the autumn. Nicola Cottington would be returning to WSFT in this role following a national recruitment process.

Q Would Craig be walking around the hospital and meeting people, as Stephen Dunn had done previously on a regular basis, ie weekly or fortnightly? This had been particularly appreciated by staff.

A He would do this as soon as possible.

DELIVER FOR TODAY

21/151 INSIGHT COMMITTEE REPORT

- The work of this committee was developing. Some of this linked with the work around producing dashboards and data at a divisional level, as the committee needed to see this detail to enable it to function as effectively as possible. The insight committee would review this detail and report to the board on any issues that it was considered it needed to be made aware of.
- It was explained that P codes were a factor of very long waiting lists and work was being undertaken to obtain information on the backlog of patients. The report in October should show an improvement as the process was now embedding
- The chair's key issues detailed what the committee aimed to achieve in terms of transparency and reporting. This linked with the organisational framework for governance, ie setting the scene as to how the board ensured accountability.
- The 3i committees had been established as assurance committees in addition to new and established governance committees. These committees would be doing a lot of the detailed work reviewing various sources of data to monitor performance across the trust
- The chair's key issues enabled the committees involved in the assurance process to give a clear report to the board on items discussed that needed to be escalated to the board, eg for approval. This would give the board an understanding of the assurances received and areas of concern raised that the management of the Trust was aware of and was dealing with, plus some of the positive assurance, eg audit reports. The aim was to ensure that issues were escalated to the board when necessary and to provide assurance that the Trust was operating effectively.

151.1 Finance and workforce report

- The Trust continued to break-even and it was anticipated that this would continue for August and September.
- However, early indications were that for the second part of the year funding arrangements may reduce by 3-3.5% under the assumption that issues around Covid would subside, but clearly this was difficult to predict.
- This reduction would significantly impact on the forecast; therefore it had been revised to show a possible deficit of £5m in the second half of the year due to the reduction in income. This was broadly in line with the original plan that had been submitted at the beginning of the year before Covid funding had been confirmed for

the first half of the year. Guidance for the second half of the year was expected to be issued shortly.

- As a result of the revised forecast measures had been reintroduced over the last few weeks to refocus on the financial position. These included the reintroduction of the vacancy approval plan and a focus on the cost improvement plan (CIP) which would be supported by a larger team than before Covid. The CIP during Covid was 1% but going forward this was likely to be significantly higher.
- Over the last few weeks a process had been put in place around business case approvals and a business case register was being introduced across the organisation. This was a developing process to ensure transparency and completeness of business cases at the point of approval, and to ensure benefits as presented were realised with appropriate post implementation review.
- It was currently difficult to predict activity through this coming winter but the finance team was trying to understand the run rate in line with forecast activity in order to forecast this year's financial position as accurately as possible, and the underlying position in readiness for the next financial year.
- The capital programme was currently overspent with a forecast overspend of £8m. Discussions were taking place with the regional office and the Trust was looking at any opportunities to reduce capital spend but most of this was pre-committed and was difficult to reduce.
- It was hoped to be able to provide high level information on the financial position for September at the board meeting on 15 October with a focus on the key issues.

Q Prior to Covid the department of health were saying that every trust should break-even. Was there likely to be any tolerance of projected deficits? They had also said that control totals would be managed at ICS level, was this the case, ie across the ICS?

A The financial directors across the system, including the CCG, meet every week and discussed their financial position and how they were managing their finances. This provided a control total across the ICS which was reviewed with the regional office to try and negotiate a realistic control total.

Q The balance sheet showed that cash could reduce to approximately £2m in March 2022; was this a cause for concern and was there anything that would mitigate this position if the Trust came close to it?

A The lower limit of cash that the Trust should always have was £1m. The Trust always had a degree of access to borrowing from the Treasury, if required, but it was hoped that this would not be needed; therefore, this not a great concern at the moment. Currently this was being driven by the capital overspend and the Trust might need to borrow in line with this if it could not be reduced.

Q If the Trust needed to borrow against the capital overspend would this be long term borrowing?

A Yes, this would be the case.

Q How much have the CIP pressures been shared with the organisation and what sort of reactions have there been?

A This had not yet been broadly shared with operational staff but it had been discussed as an executive team and was being highlighted to the board today. This would need to be carefully communicated across the organisation as staff were already feeling stressed and under pressure and would be asked to do more with less. This would be

a change from the last few months during which the Trust has been well funded and budget holders had been able to spend reasonably freely.

Some of the skill and test of leadership was to ensure that staff did not feel that efficiency took precedence over compassion. Divisional leaders were experienced and recognised that the additional funding would not continue and that tighter controls were likely to be introduced. However, currently the challenge was the uncertainty around what they would be required to do and how this would be funded.

Any CIP that was proposed was subject to a full quality impact assessment, which was a clinical, operational and efficiency assessment, as well as ensuring that the scheme does not impact disproportionally on particular groups of patients.

151.2 Operational report

- The was currently a real lack of clarity around what level of activity was considered to be good and what was expected. Similar to discussions about finance there appeared to be a shift in expectations in operations and performance but there had been no clarity.
- There was a major national drive to reduce long waiting lists, however this would need to be funded and resourced and meant that planning was very difficult both operationally and financially. It was important that the Trust was honest with staff about this.
- July was the busiest month on record for emergency department attendances and August had been even busier with a significant increase and very high attendances on some days. This was a national problem across the NHS but the Trust was having to manage this demand alongside the RAAC programme. Staff were tired and being asked to do more but the organisation was coping and caring for patients.
- At times there were long waits in the emergency department for beds for admitted patients but the team was working hard to manage this and the two extended areas were helping but not solving the issue.
- There had also been the unfortunate need to cancel cancer surgery on the day of admission. The teams went above and beyond to try to avoid doing this and arranged for these patients to be brought back in as quickly as possible, however this still resulted in distress to patients. Surgery was only cancelled if it was considered that it would be unsafe to continue and this had only happened on a couple of occasions.
- 'Patients who have exceeded their right to reside in the organisation' was new national terminology which replaced delayed transfer of care, delayed discharge etc. There was a new focus on why people were in hospital and if they had a right to reside there. Some of the challenges were around social care provision and work was going on to try to address this.
- Challenges in social care were unprecedented and over the last few months there had been a significant increase in the number of adults awaiting support, particularly relating to enabling them to return home and be supported in their home environment. This was mainly due to a workforce issue in the care industry, ie fatigue of staff and staff leaving which had resulted in a gap in care provision.
- There had also been an increase in demand due to the number of people requiring support in the community and an increase in acuity and the level of need. Providers had not been able to deliver the packages of care required.
- The integrated care system in Suffolk was working with the Suffolk Association of Independent Providers to try to meet the requirements of adults needing support to avoid them being admitted to hospital.

- A number of initiatives were being considered to address the challenges of the gap in the care market, including working with local communities and engaging with providers who had previously only worked with individuals on a private basis.
- West Suffolk alliance was working to enhance support for patients to go home as well as the enablement team offering to manage the safe transfer of care. It would continue to work to ensure that it was as prepared as it could be for the challenges of winter and a resilience plan for winter had been produced.
- It was important to recognise that as a result of the pandemic and people being required to isolate or shield for long periods they had not been able to be as physically active as in the past and this had resulted in long term consequences for some.
- At the time of writing this report Covid numbers in the hospital were static, however since last weekend this had increased to 15 and as of today was at 14, including two in critical care. Numbers in West Suffolk were lower than surrounding areas but this still had an effect on capacity. This would continue to be monitored and the Trust had a plan if there was a need to convert more capacity to care for Covid patients.
- The organisation was in the early stages of planning for winter and an update would be taken to the scrutiny committee next week. This would articulate the issues and challenges and work being undertaken to address these, however further work would still be required on the plan.
- The RAAC programme continued to be worked through and the Trust had hosted two visits from regional colleagues with a performance rather than estates focus. This had been very helpful in keeping them informed of the challenges and operational issues.
- The accelerator programme continued but was proving to be more challenging as the organisation moved into winter, as well as the Covid impact. A month ago trusts were being told that they needed to plant to deliver 100-120% of their previous elective activity; the regional team had now indicated that trusts would be asked to deliver 95% of this baseline elective activity through the winter period.
- Trusts had also been asked to submit capital schemes for additional capacity, that could be introduced from 1 April, in order to address some of the waiting list backlog. There had been no requirement to include any revenue costs to fund staffing etc. It was also unclear what funding there would be for activity above 95-100%; this was very challenging from both an operational and financial point of view
- Local media had reported that planning permission had been submitted for two theatres and a ward at Newmarket to provide a green elective site. It was stressed that this was very speculative and there was no guarantee that this would be funded.
- Annex A to this report included information on additional theatre capacity required at WSFT to return to pre-Covid levels, ie the waiting list position in February 2020. Orthopaedics was the biggest concern and provided evidence that there was demand for the Newmarket facility.

Q Was collaboration with ESNEFT working both ways across specialties?

A The two trusts were further forward than many in terms of provider collaboration and the operational teams had good working relationships. However, this was very complex and the biggest challenge was patient choice and people not wanting to have their treatment elsewhere. This had been escalated to the national team to request communication asking people to be prepared to go to wherever the waiting list was shortest.

Q How significant was the capacity available at the Nuffield and was this making a difference?

A This was significant in that everyone counted but it was not large volumes, ie two to three patients per week.

The Oaks business model included providing more NHS capacity. ESNEFT were working collaboratively with the Oaks and were supportive of WSFT accessing some of this capacity. However, patient choice was very significant and the Dr Dr platform was being used to contact patients with a short question and answer survey but ten patients were having to be contacted to identify at least one who was prepared to move.

Q Was there any way to bring more clinical input to bear to encourage patients to have their treatment elsewhere?

A For patients currently being listed conversations were taking place with specialists to advise them that they might have to go to another site. However, there was a real tension as it was very time consuming to have these conversations when consultants could be actually treating patients.

Q Could clinical helpline staff be utilised to help patients to make the decision to have their treatment at Ipswich or elsewhere?

A This was unlikely to be effective as the person who could persuade a patient was their consultant.

151.3 IQPR

- The board received and noted the content of this report which had been included for information. More detailed information would be provided to the insight committee.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

21/152 PUTTING YOU FIRST AWARD

- A Putting You First Award was received by the ward G8 staff team in August for arranging for a patient to celebrate her daughter's wedding via video link. They had given up their own time and made a real effort to make the day really special for her.
- The board congratulated and thanked the team for the compassion they had shown and for everything they had done to make this such a special occasion for this patient.

21/153 IMPROVEMENT COMMITTEE REPORT

- This committee had developed and was embedding it principles and work programme. The issues discussed at the meeting were included in this report.
- The committee continued to monitor the outstanding actions from the improvement programme which were previously monitored through the improvement board.
- The terms of reference for the committee had been approved at the meeting.
- It was noted that pathology, which had been on the risk register for a number of years, had been removed from the Board Assurance Framework (BAF). This was a significant achievement and a tribute to everyone who had been involved, however it was important not to lose focus on this and ensure that it continue to progress.

153.1 Maternity services quality and performance report

Karen Newbury and Justyna Skonieczny joined the meeting for this item.

- Sue Wilkinson referred to the recent article in the Bury Free Press which followed on from a whistleblowing letter written to the CQC. WSFT always welcomed staff raising concerns and took this very seriously and took action to fully understand and address their concerns.
- A verbal update was provided on the actions taken in response to this and a written update would be provided at the next board meeting.

ACTION: provide written update to board on response to concerns of midwives. **S Wilkinson**

- The freedom to speak up guardians had supported Sue Wilkinson and the HR business partner to hold a meeting for all midwifery staff so that there could be open and transparent conversations to explore the concerns raised in the letter and any additional concerns.
- Following on from this a meeting had taken place to review the concerns and actions taken. The themes were captured; some would take longer to address than others and were included in a long-term action plan.
- WSFT was not alone in facing some of the issues that had been raised, ie staffing levels and skill mix and the ability to support more junior colleagues in the workplace.
- There were also concerns about the shortage of staff in the community team and the continuity of care model. Some of these concerns could be supported and understood but there was a national drive to move towards the continuity of care model.
- A number of immediate actions had been taken and bank enhancement had been offered for people who wanted to work additional hours which had had a positive impact on the fill rate. The impact of these enhancements would continue to be monitored.
- Paul Molyneux would be undertaking a staff wellbeing survey within the maternity team and it was hoped that this would provide feedback that would help to understand everyone's views and how the Trust could help and support them.
- Richard Davies, Paul Molyneux and Sue Wilkinson had also been available and visible to staff on the unit to talk to so that they could try to understand their concerns.
- Karen Newbury had worked exhaustively with all staff to try and get the team to work together and support each other. The Trust would continue to work with the region and nursing and midwifery colleagues. It was also working through an eight-point plan from the regional and national office and would continue to do this.
- The board recognised how stretched the maternity team was and thanked Karen Newbury for all the work she had put into this.
- It was noted that it had only been a few people in the team who had gone to the press when they could have talked to someone in the HR department or the clinical director for women and children. There was also a need to focus on everyone else in the team who were demoralised and disappointed about what had happened as they had put so much work into improving the department.
- Acknowledging this, it was also important to recognise the motives behind writing this letter and that some people felt so strongly about the quality of care that the Trust was providing they decided to write a letter to the press and CQC.
- This suggested that, whatever the outcome, there was a real strength of opinion and focus on providing quality care within the organisation, which should be seen as a positive. However, the Trust needed to get better at giving people a way of raising

their concerns more quickly and efficiently rather than going through the press or CQC. Some of the issues in maternity could be addressed through better communication about the areas that everyone had been working hard on over the last few weeks.

- The mistake that leaders and organisations sometimes made when staff raised concerns was that they were too quick to judge the motives of the individuals who had raised this rather than looking at the content of what was being raised in and open and balanced way. However, there was also the need to consider how others felt about this; everyone's perspective in the team was important and should be valued, whether or not they raised concerns in this way.
- When Colchester hospital had received an inadequate CQC report and was put into special measures a lot of this had been due to a whistleblowing incident about cancer waiting times. The learning from this was the lack of speed of response from management to these concerns. Individuals had valid reasons for raising concerns and did not get any feedback from the management team that the issues were being taken seriously. This led them to believe that nothing was being done, therefore they went to the CQC. This highlighted the importance of process, culture and transparency.
- It was confirmed the Trust had maintained open and transparent conversations with the CQC and CCG about this issue and they were fully aware of the situation and actions and were assured that the appropriate steps were being taken to try and resolve this situation.
- Karen Newbury highlighted the key issues in the report for this month and explained that the appendices provided information that the board were required to have oversight of.
- As a result of recent issues the safety champion had undertaken three walkabouts this month across the unit.
- Some clinical data was still delayed due to e-care but a digital midwife had now been appointed and would be joining the Trust at the end of the month. A key part of her role would be to look at data cleansing and streamlining pathways on e-care.
- The quality dashboard showed a significant number of red indicators due to staffing and the very high number of births this month.
- Previously the number of births had reduced each month (approx. 180 births per month) but the acuity and number of inductions had increased which required more one to one care throughout the labour process.
- In July the number of births increased to 214, however with the high acuity and number staff absences due to Covid related issues the midwife to birth ratio was 1:33 which was a at the upper end of the tolerance level.
- One to one data for care in the labour suite for May and June was now available. This enabled individual cases to be looked at where this was not at 100%
- Grade 2 caesareans were now showing as green, as were fresh eyes and fresh ears.
- The board thanked the whole team and recognised the issues and challenges they were facing.

153.2 Infection prevention quality and performance report

- Covid activity continued to be monitored throughout the organisation. There was an ongoing focus on infection control measure and it was important to ensure that this continued.

- Flu jabs for staff would be run as part of the winter vaccination programme alongside Covid boosters which would take place in Quince House towards the end of the month. Priority would be given to patient facing staff and would depend on what was delivered to the organisation. Therefore, where possible, everyone was encouraged to have their flu vaccine or Covid booster through their GP.

154.3 Nurse staffing report

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

- Fill rates remained at over 90% across all shifts in July. However, the fill rate had decreased as the Trust moved into the school holidays.
- Fill rates would be more challenging in August as there had also been an increase in the number of people being required to isolate. This had impacted on a number of teams for short periods of time.
- In August government rules on isolation had changed and there was now a process to review clinical staff who were notified of contact to risk assess them coming back into the environment.
- Substantive numbers of nursing staff had not changed but vacancy rates had increased to 11.9% due to the increase in the budgeted establishment in a number of areas.
- Recruitment continued both locally and overseas and the HR team were engaging with an agency to try to attract overseas nurses. As the organisation moved into September a cohort of 22 newly qualified nurses would be joining the Trust. This was very positive and equated to 90% of student who had trained at WSFT which was a good reflection on the teams they had worked with.
- The aim was to produce a pipeline of future recruitment resources and once numbers had been established this information would be included in the report.
- The challenges faced in July had resulted in an increase in red flag incidents; this could be viewed as a positive as it showed that staff were reporting incidents. Currently no harm had been reported and there was good evidence available on what had occurred.

Q What did the future look like over for overseas nurses, recognising the problems as a result of Covid?

A The Trust was not seeing the numbers expected although a lot had been interviewed online. WSFT was working with an agency as it was not allowed to directly approach some countries, whereas the agency was able to, the majority of potential nurses were from Nigeria. Early indications from the HR team were that not as many as expected were showing an interest but it was still hoped to achieve a target of five to eight nurses per month.

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

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

BUILD A JOINED-UP FUTURE

21/155 FUTURE SYSTEM BOARD REPORT

- This report detailed the considerable of amount of work that continued on this project.
- The response to the engagement programme around the planning permission was highlighted with feedback from 700 people. The majority of this was expressed concern about access and traffic around the site and the ability to park on site.
- Work continued to further develop the clinical model and schedule of accommodation. However, a significant amount of work was still required and the current schedule of accommodation was not affordable or practical.

Q One of the major issues was the increase in demand and assumptions around demand. How was social care planning to meet this demand and develop to address the projected NHS demand?

A It was very important that social care did this in partnership and alongside the modelling. Therefore, they were working with the future system team to ensure that the programme of work was aligned. This could not be managed in isolation and the teams were working collaboratively to ensure that there was a joined up approach to responding to future demand and requirements.

GOVERNANCE

21/156 GOVERNANCE REPORT

- This report summarised the governance process for the appointment of an interim Chief Executive.
- It also included a summary of the recent audit committee meeting where the annual report of the audit committee for 2020/21 was approved.
- The revised NED responsibilities were attached to the report for information. It was noted that these were transitional and would change at some point next year following the appointment of a substantive NED.

21/157 ORGANISATIONAL FRAMEWORK FOR GOVERNANCE

- This document had been discussed with the executive team and NEDs. The aim of was to ensure accountability which was a key role of the board.
- The document showed how accountability was assured at WSFT and provided assurance to governors in their role in holding the NEDS to account for the performance of the board.
- This also showed how issues were escalated to the board and how the board directed the work of the rest of the organisation. It demonstrated how the organisational framework met the requirements of the regulator through the well led framework which was important for the committees when putting the agenda together.
- This was work in progress and was the foundation of how to make the structure work but there was still more work to be done.
- There would also be an evaluation of the board and governance effectiveness to understand what was working well and what needed to improve.

21/158 BOARD COMMITTEE TERMS OF REFERENCE

- The terms of reference had been to all the committees except for the remuneration and involvement committees.
- The board approved the terms of reference for the following committees, subject to review and approval of the remuneration and involvement committees of their respective terms of reference:
    - Audit Committee
    - Insight Committee
    - Improvement Committee
    - Senior Leadership Team
    - Involvement Committee
    - Remuneration Committee

ITEMS FOR INFORMATION

21/159 ANY OTHER BUSINESS

There was no further business.

21/160 DATE OF NEXT MEETING

Friday 15 October 2021, 9.15am

RESOLUTION TO MOVE TO CLOSED SESSION

21/161 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
1974	Open	28/05/21	Item 14.3	Provide further information to the board on the ward accreditation programme	Using a codesign methodology, the Ward accreditation steering group has been meeting weekly since May to scope the needs of the project, identify stakeholders and relevant workstreams. The steering group has now moved to monthly meetings and a smaller project group will take the actions identified forward in creating tools, process and pilot schedule. The project plan will be presented to the board in September. Project continues, update at October board. **Verbal update provided at today's meeting (15.10.21)**.	SW	~~30/07/2021~~ ~~03/09/2021~~ 15/10/2021	Amber	
1985	Open	30/7/21	Item 11	Provide update on metrics being developed to identify appropriate outcome measures for adult community services	**Update to be provided following completion of workshops (approx 3 months).**	HB	17/12/21	Green	
1986	Open	30/7/21	Item 11/ 12	Arrange joint board/CoG workshop on how social care works in west Suffolk , particulary relating to boundary issues. Consider how governors could be more involved in appropriate areas of the Trust.	Work programme for Council of Governors being developed. **Work programme has been produced and will be discussed at Council of Governors' meeting on 13 October, 2021.**	AA/SC	15/10/21	Green	

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

Board meeting - action points

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
1929	Open	26/2/21	Item 11	When clearer on national reset expectations (standards/targets) develop local metrics for IQPR to support local innovation and drive improvement. Set timeline for develop SPC charts at Trust, division and specialty level (previously action 1943)	IQPR pack being developed but the revision (taking out) and update (adding in) will take more time. This is also impacted by changes in roles and options being considered. Unfortunately we have again needed to second a key member of the team to support CRT for the RAAC works. We are actively looking for external support to backfill this gap. Matter on-going. Recruitment continues to find suitable support. Revised target to be provided following appointment of appropriate individual to focus on this. **Today's (15.10.21) integration and operation reports refer.**	HB	~~30/04/2021~~ tba	Complete	15/10/21
1944	Open	26/3/21	Item 12	Consider how to develop information on the quality of training provided in the 6-monthly education report.	**Future Education reports to reflect greater synopsis of Health Education England feedback, recommendations and organisational action plans.**	JMO	15/10/21	Complete	15/10/2021
1971	Open	28/5/21	Item 13	Involvement committee reports to the board to include update on progress of actions arising from FTSU self-assessment.	**To be reviewed at November's Involvement Committee with Board briefed thereafter.**	JO/AR	15/10/21	Complete	15/10/2021
1984	Open	30/7/21	Item 10.1	Provide update to board on alliance winter resilience plan.	**Update contained within today's (15.10.21) integration and operational reports.**	HB/CM	15/10/21	Complete	15/10/2021

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

8. Patient story (verbal)

To reflect on the experience shared with the Trust

For Report

Presented by Susan Wilkinson

9. Chief Executive’s report

To RECEIVE an introduction on current issues

For Report

Presented by Craig Black

Board of Directors – 15 October 2021

Agenda item:	9			
Presented by:	Craig Black, Interim Chief Executive Officer			
Prepared by:	James Goffin, Communications Manager Helen Davies, Head of Communications			
Date prepared:	11 October 2021			
Subject:	Chief Executive's Report			
Purpose:	X	For information		For approval

Executive summary:

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

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

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

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

Recommendation:
To receive the report for information

Chief Executive's Report

Dealing with unprecedented pressure

The Trust is experiencing huge amounts of pressure throughout our hospitals and in the community - levels we normally only experience in the winter.

While the increase in demand for services isn't just a local issue, we are still seeing record numbers of patients in our emergency departments as well as people waiting to receive their operations or procedures.

Our emergency department will always be there for anyone who needs it, but due to the high numbers of people we are seeing coming in, we are reminding members of the public to help us by thinking carefully about the best way to get non-urgent help with many options out there such as contacting NHS 111 or by visiting their local GP or pharmacy.

As we continue to recover from the effects of the pandemic, our teams are working around the clock to ensure that patients who need our care and support are seen as quickly as possible. We've introduced a raft of measures to help us increase our capacity, including:

- working across our ICS (Ipswich and Colchester) as well as local IS providers to ensure equity of waiting times and offer patients earlier appointments in other locations (such as ophthalmology at Newmedica in Ipswich).
- working with Abbeycroft Leisure to offer pre-surgery services aimed at improving people's general health and fitness to prepare them for surgery.
- adding further capacity by recommissioning a previously mothballed theatre.
- providing interim support via AHP Suffolk for additional therapy while waiting.
- looking to develop the Newmarket hospital site, subject to securing planning and funding.
- permanently establishing our 'keeping in touch' and clinical help lines to help loved ones stay in touch with patients in our care and freeing up clinician time to focus on patient care
- opening our new 'G10' ward to help us with our capacity as we deal with our urgent structural works across the hospital building.

Maternity whistleblowing

You will be aware of the media attention our maternity department received at the end of August as a result of inspectors and newspapers receiving an anonymous letter from midwives. The letter mentioned a number of issues, including low staff numbers, which left midwives overwhelmed and exhausted by their workload.

It's always very difficult to hear that members of staff are struggling and this is no different. We are working hard to address the issues raised so that staff can manage their workload and do not feel burnt out.

Recruitment is an issue in maternity throughout the NHS so we're working with colleagues regionally and internationally to help recruit quality staff into our maternity department as well as running a full training programme.

Whilst we work to address these issues, I am very grateful for the flexibility and dedication of our staff in ensuring that we provide a safe and caring service.

Update on the External Review

The external review, which was announced in February 2020 as a result of events arising from an anonymous letter that was sent to a relative of a deceased patient in October 2018, has yet to be published.

The report, which was commissioned by NHS Improvement and led by Christine Outram MBE, is completed but has not been seen by the Trust. We have been notified that a review process whereby individuals who have been subject to criticism in the report have the opportunity to comment before publication has begun.

We have been told that the final report will be published before the end of this year. As we have always said, we will welcome the recommendations and findings in the report and will use them to help us improve.

We will update colleagues as soon as we have more information on the date of publication.

Covid booster and flu vaccinations

All staff at our Trust are now able to book both their Covid-19 booster and flu vaccine through our online booking system. All directly-employed staff, including substantive and bank staff as well as students on placements, are able to book this easily through our bespoke booking system.

Unlike the initial Covid-19 vaccinations, we are not generally vaccinating other frontline and healthcare staff and all vaccinations will take place at a pop-up clinic at Quince House with appointments being available 6 days a week.

In most cases, staff can get both the booster and flu vaccination at the same time, but staff should wait at least six months since they had their second covid-19 vaccine dose. If staff decide to have their booster or flu jab at another location, they have been advised to let our Occupational Health know.

Looking after our staff

We have just finished our second ‘Love Yourself Week’ which was open to all members of our Trust to take part in. Organisations from across the county offered up their time and knowledge, encouraging staff to look after themselves so they can better look after patients. The week included drawing and photography classes run by Art Branches and a sleeping well session hosted by Suffolk Mind.

The autumnal themed week also included access to delicious warming food recipes, a chance to win tai chi sessions and opportunities to focus on mental wellbeing with the Trust’s staff psychology support team. The sessions have been made available to all Trust staff

through catch up recordings online. We look forward to the next week which is due to take place in March 2022.

The staff psychology team are always available to staff to provide extra emotional and mental wellbeing support for colleagues across the Trust. Emily Baker and her team are working harder than ever to provide individual and group sessions to staff who need support for their wellbeing. Their details are easily found on the intranet.

The offer of free sports membership at Abbeycroft gyms is still open for our staff and the uptake on this has been huge, with over 2,000 colleagues signing up, giving them free access to swimming, the gym and exercise classes at locations across Suffolk. This is a perfect opportunity for staff to take time for themselves to look after their mental and physical health.

Our chaplaincy and chaplains are on hand to offer emotional and spiritual support not just to our patients but our staff too and their support has been valuable throughout the pandemic. The chapel, located on the ground floor of the main hospital is open 24/7 and offers a place for reflection and peace for all faith groups.

Clinical Helpline wins national award

The Trust's clinical helpline is celebrating success at the recent National Patient Experience National Awards (PENNA) where they won the 'Support for Caregivers, Friends & Family' category. The Trust's clinical helpline was set up in April 2020 following the suspension of visiting at hospitals due to Covid-19 and takes calls from families and loved-ones requesting an update on patients who they're not able to see face-to-face.

The helpline, made up of around 70 staff with clinical backgrounds, has gone from strength to strength since its inception and to date has handled over 40,000 calls.

Having a loved-one in hospital can be a stressful experience. The helpline has been an important lifeline in keeping people connected with their loved ones whilst they're in the hospital. It also has the dual advantage of freeing up more time for clinicians to spend with their patients. It has been such a success that we are now establishing the helpline as a permanent service in the Trust.

Recruitment drive through healthcare academy

In September we held a series of free online events accessible to members of the public who were considering a career in the NHS. Our healthcare academy took place over three weekends and provided information and facts about the wide range of jobs available in the NHS – ranging from well-known health roles like nursing through to education and training.

The event was well attended and staff from different departments offered their own time to talk about how they enjoy their job and offer guidance to others who may consider a career in that specialism.

Events like this are very important in the current climate, we know recruitment is an issue in the NHS, and we are working hard to fill vacancies across the Trust.

Breathing second life into resuscitation kit

Medical kit that has helped train hundreds of NHS staff at our Trust was given the opportunity for a new lease of life in September.

The Trust's geriatrics and general internal medicine consultant physician Dr Joseph Yikona and resuscitation practitioner Kevin Brown worked with the University of Zambia's School of Medicine to provide the teaching school with resuscitation simulation equipment previously used at our site.

The equipment, which is considered surplus to requirement in the United Kingdom, can hugely benefit training and teaching in other parts of the world where resuscitation apparatus such as manikins can be very difficult to both find and fund. Thanks to both Joseph and Kevin for organising this very kind and powerful gesture and shows that WSFT's reach goes well beyond Suffolk.

10:00 DELIVER FOR TODAY

10. Insight Committee Report

To APPROVE the report

For Approval

Presented by Richard Davies

Board of Directors – 15 October 2021

Agenda item:	10			
Presented by:	Richard Davies, Non-Executive Director & Insight committee chair			
Prepared by:	Richard Davies, Non-Executive Director & Insight committee chair			
Date prepared:	6 September 2021			
Subject:	Insight Committee Sept 2021 – Chair's key issues			
Purpose:	X	For information		For approval

Executive summary:

The Insight Committee met on 6 September 2021. Below is the Chair's Key Issues document which will constitute the standard template for Insight Committee reports to Board.

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

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

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

Recommendation:

To approve the report

Chair's Key Issues

Part A

Originating Committee	Insight Committee	Date of Meeting	6 September 2021
Chaired by	Dr Richard Davies	Lead Executive Director	Helen Beck

Agenda Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref	Paper attached? ✓
4.1	**CQC Improvement Board Plan** • Good progress has been made on completing and embedding the majority of items within the plan following the CQC report • The few outstanding items are being actioned and monitored (and completed actions audited) through the new governance framework • The Insight Committee asked for assurance and clarity as to where ongoing responsibility lay for each item within the governance structure – and this will be reported to the next Insight Committee meeting	**Assurance**		
7	**Waiting times** • Waiting times for diagnostics, and for elective and non-elective care remain a challenge throughout the Trust – and this impacts on the work of all of the 3i committees • The Insight Committee discussed particularly the challenges in endoscopy, non-obstetric ultrasound and dermatology • Use of off-site endoscopy resources as well as work on-site is having a positive effect, and the situation for endoscopy is gradually improving. It is anticipated that this positive progress will be maintained • Capacity in non-obstetric ultrasound will be increased soon with the purchase of a new ultrasound machine for use at Newmarket hospital. It is anticipated that this will have a significant impact on ultrasound waiting times. Once the purchase is completed a report on the projected recovery timescale will be presented to the Insight Committee	**Assurance**		

7.1	**Dermatology** • The 2WW figures in dermatology remain well below target, although it is re-assuring that 28-day faster diagnosis data is much better (suggesting that although many patients are missing the 2WW target – the vast majority have a clear diagnosis within 28 days). • A new diagnostic pathway utilising AI software to screen potentially malignant skin lesions will be in place from October • This software is in use in a few other NHS organisations and is being championed by a local Consultant Dermatologist • The new pathway will be carefully evaluated over the next few months (in terms of both safety and effectiveness) but has the potential to substantially improve the position for speed of skin cancer diagnosis locally	**Assurance**		
6-9	**Subcommittee meetings** • All four Insight Subcommittees now have appropriate membership and terms of reference and all bar the Clinical Effectiveness Subcommittee have had at least one meeting • Reports to the Insight Committee continue to develop, utilising standard templates • The chair of the Patient Safety and Quality Governance Group was able to report that the meetings to date were felt to be effective and valuable	**Assurance**		
Date Completed and Forwarded to Trust Secretary		**6 September 2021**		

Part B

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

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

Board of Directors – 15 October 2021

Agenda item:	10			
Presented by:	Richard Davies, Non-Executive Director & Insight committee chair			
Prepared by:	Richard Davies, Non-Executive Director & Insight committee chair			
Date prepared:	4 October 2021			
Subject:	Insight Committee Oct 2021 – Chair's key issues			
Purpose:	X	For information		For approval

Executive summary:

The Insight Committee met on 4 October 2021. Below is the Chair's Key Issues document which will constitute the standard template for Insight Committee reports to Board.

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

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

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

Recommendation:

To approve the report

Chair's Key Issues

Part A

Originating Committee	Insight Committee	Date of Meeting	4 October 2021
Chaired by	Dr Richard Davies	Lead Executive Director	Helen Beck

Agenda Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref	Paper attached? ✓
	General comments • All of the Sub Groups have now met at least once • The consistency in approach to reporting into the Insight Committee from the Sub Groups was acknowledged and appreciated • This approach includes assurance as to the issues discussed by Sub Groups, actions being taken in relation to concerns identified and clarity as to how progress will be monitored • Delegation of responsibility to Sub Groups allows for flexibility and innovation (for example, discussion of linked patient safety issues within the Patient Safety and Quality Governance Group). This in turn leads to opportunities for shared learning and allows the Insight Committee to effectively fulfil its function as a Board Governance Committee	**Assurance**		
4.2	**Schedule of Operational Actions from CQC Improvement Board** • Incomplete outstanding actions from the CQC Improvement Board 'Must Dos' have a clearly defined 'Monitoring Forum' in one of the 3i committees. The Insight Committee requests assurance from Chairs of the other 3i committees that they are appropriately sighted on their outstanding items. • A similar process needs to be clarified for the 'Should Dos' and will be presented at the next committee meeting.	**Escalation**		
6	**Finance and Workforce Governance Group** • The Group's September meeting considered the Business Case Register, Divisional Finance Reports, CIP Programme Report and Workforce Divisional Scorecards	**Assurance**		

	• An emerging concern regarding parity across SNEE in relation to enhanced payments for staff was discussed and will be taken up by the HRD with SNEE colleagues			
7	**Patient Access Governance Group** • The 2WW figures remain a challenge. The Dermatology AI analytics software is now in place and there is a clear plan for recovery in Colorectal. It is anticipated that recovery in 2WW figures will commence from November. • A new 28 day Faster Diagnostic Standard will be reportable from Q3. Current Trust performance is close to the 75% target, with plans in place to improve further. • The 6 week standard for Diagnostic performance is not being met. Endoscopy figures continue to improve slowly. Non-obstetric U/S remains a challenge, however the new U/S machine has been ordered for use at Newmarket Hospital. • The new Urgent and Emergency Care Standards (which the Trust has been piloting) will be rolled out in shadow form from November 2021 and fully implemented from April 2022	**Assurance**		
8	**Patient Safety and Quality Governance Group** • The September meeting reviewed reports from the Nutrition Steering Group, Falls Group, Pressure Ulcer Prevention Group and IPC (Infection Prevention Committee). A number of emerging issues were discussed, with clear plans for management and monitoring • There has been a significant and welcome reduction in Hospital Acquired Pressure Ulcers	**Assurance**		
9	**Clinical Effectiveness Governance Group** • The Group has had its first meeting, approving the Terms of Reference and clarifying timelines for the baseline assessments in relation to National Clinical Audits	**Assurance**		
13	**Board Framework Assurance** • The workstream for review of items allocated to the Insight Committee from the Board Assurance Framework was presented and agreed	**Assurance**		

14	**CQC Insight Publication** • This publicly available publication brings together all of the information the CQC holds about the organisation and highlights areas of performance that are better or worse than national benchmarks. It helps form the basis for future CQC inspections • It was agreed that this publication (with some caveats in relation to the timeliness of some data) provides a useful indicator of areas of performance that need particular scrutiny, and that may not be subject to current specialist group review • It was agreed that the Insight Committee should have oversight of this information and ensure that items highlighted by this publication are appropriately allocated to a specific governance group.	**Assurance**		
Date Completed and Forwarded to Trust Secretary		**5 October 2021**		

Part B

Receiving Committee	Board of Directors	Date of Meeting	
Chaired by	Sheila Childerhouse	Lead Executive Director	Craig Black
Agenda Item	**Record of Consideration Given (Approved/ Response/ Action)**		
Date Completed and Forwarded to Chair of Originating Committee			

10.1. Finance and workforce report

To APPROVE the report

For Approval

Presented by Nick Macdonald

Board of Directors – 15 October 2021

Agenda item:	10.1			
Presented by:	Nick Macdonald, Executive Director of Resources (Interim)			
Prepared by:	Charlie Davies, Deputy Director of Finance (Interim)			
Date prepared:	16th October 2021			
Subject:	Finance and Workforce Board Report – September 2021			
Purpose:		For information	x	For approval

Executive summary:
The reported I&E for September is break-even (YTD break-even).

Due to COVID-19 we are receiving income for the period April to September 2021 in line with the period October 2020 to March 2021. We previously agreed a budget for 2021-22 to deliver a deficit of £10.5m, with a Cost Improvement Programme (CIP) of 1%. However, the funding arrangements for the first half of 21-22 have facilitated a break-even position for H1.

While financial allocations have been devolved to CCGs and are still being agreed, we are anticipating a reduction in our income of £1.7m in order to drive cost improvements. As a result, and due to possible unfunded COVID related costs and winter pressures we believe a forecast deficit of £5.0m for 2021-22 is now prudent.

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
September 2021 (Month 6)

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

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	£8.3m	on-plan
EBITDA margin YTD	5%	on-plan
Cash at bank	£12.3m	

Executive Summary

Due to the timing of the October Board, we are reporting the following:

- I & E position as at Month 6
- Balance Sheet as at Month 6

- The reported I&E for September is break-even (YTD break-even).
- Forecast a worst-case scenario deficit of £5.0m for 2021-22

Key Risks in 2021-22

- Costs and income associated with revised activity plan
- Costs associated with increased capacity pressures relating to COVID-19, RAAC planks and winter pressures
- Funding arrangements for 2021-22
- Delivery of CIP programme

SUMMARY INCOME AND EXPENDITURE ACCOUNT - September 2021	September 2021			Year to date		
	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)
	£m	£m	£m	£m	£m	£m
NHS Contract Income	26.1	25.7	(0.3)	144.2	142.6	(1.6)
Other Income	3.0	2.8	(0.2)	18.9	17.2	(1.7)
Total Income	**29.1**	**28.5**	**(0.5)**	**163.1**	**159.9**	**(3.2)**
Pay Costs	20.4	20.0	0.4	105.5	106.1	(0.6)
Non-pay Costs	7.4	7.2	0.3	50.2	45.4	4.8
Operating Expenditure	**27.8**	**27.2**	**0.6**	**155.7**	**151.5**	**4.1**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA excl STF	**1.2**	**1.3**	**0.1**	**7.4**	**8.3**	**0.9**
Depreciation	0.8	0.7	0.0	4.5	4.4	0.1
Finance costs	0.5	0.6	(0.1)	2.9	3.9	(1.0)
SURPLUS/(DEFICIT)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FINANCE AND WORKFORCE REPORT – September 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 – September 2021

Income and Expenditure Summary as at September 2021

The reported I&E for September 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, due to the funding arrangements for the first half of 21-22 a break-even position was achieved for H1.

Planning guidance has now been received for H2 and financial allocations have been devolved to CCGs. These are still being agreed, and once done will inform H2 plans and will drive our 21/22 outturn. However, we are anticipating a reduction in our income of £1.7m in order to drive cost improvements. As a result, and due to possible unfunded COVID related costs and winter pressures we believe a forecast deficit of £5.0m for 2021-22 is now prudent.

Elective Recovery Fund (ERF)

The targets for H1 achievement of ERF were based on the Trust performing a level of 19/20 activity. This increased incrementally to 95% of 19/20 activity. For H2 achievement, there has been a slight change of focus, with achievement of ERF based on the Trust performing against 19/20 RTT activity. While we are still working to understand the full impact of this for the Trust, at present we anticipate earning around £5m and forecast similar costs in order to deliver this activity.

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	7	0	⇔	Green
EBITDA %	0.0%	0.0%	0.0%	⇔	Green
Clinical Income YTD	(113,197)	(111,211)	(1,985)	↓	Amber
Non-Clinical Income YTD	(49,863)	(48,615)	(1,248)	↓	Amber
Pay YTD	105,473	106,104	(631)	↑	Amber
Non-Pay YTD	57,592	53,731	3,861	↑	Green

Page 3

Cost Improvement Programme (CIP) 2021-22

The CIP programme for 2021-22 is £3.1m (100%). In the year to August we achieved £1,651k (54.0%) against a plan of £1,674k (54.8%), which is a shortfall of £23k. It is anticipated that M6 delivery will be in line with M5 achievement.

We anticipate that expected reduction of our income in H2 by £1.7m will increase the CIP requirement by an equal amount. We are also expecting a further increase in CIP in 22/23. As such our early planning assumptions include an additional 3% CIP in 22/23.

FINANCE AND WORKFORCE REPORT – September 2021

Trends and Analysis

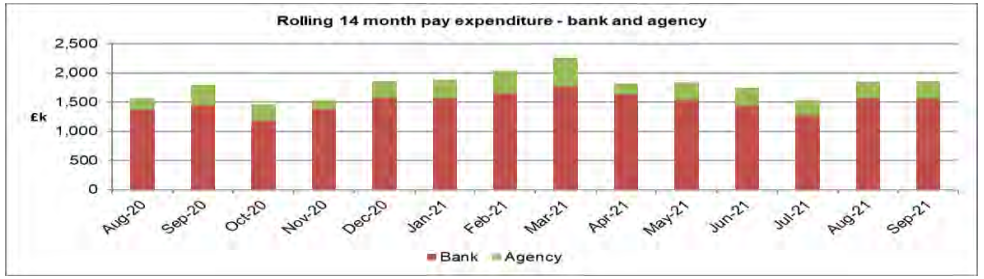
Workforce

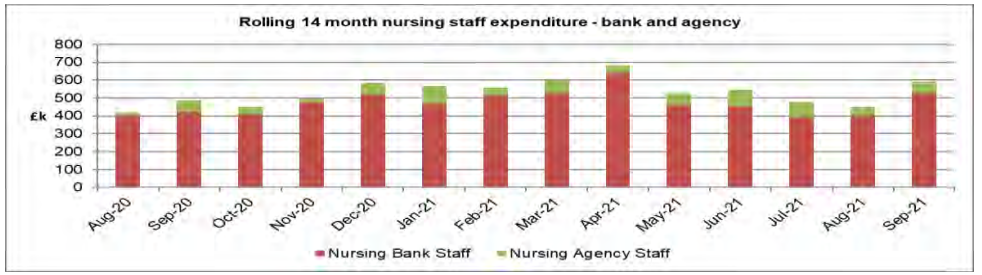
During September the Trust spent £0.4m less than budget on Pay costs (£0.6m overspent YTD).

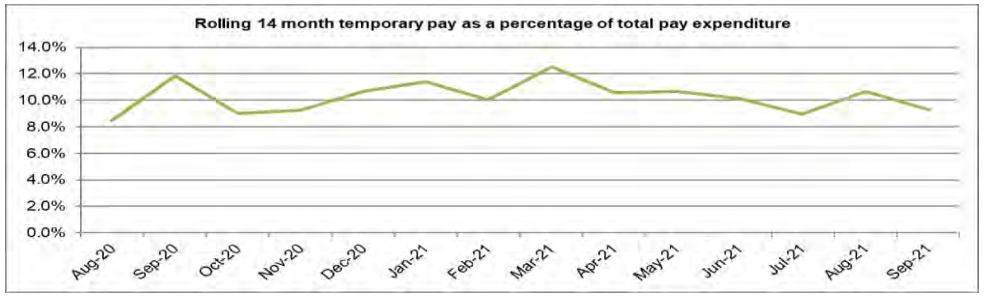
Monthly Expenditure (£)				
As at September 2021	Sep-21	Aug-21	Sep-20	YTD
	£000's	£000's	£000's	£000's
Budgeted Costs in-month	20,409	17,459	15,657	105,473
Substantive Staff	18,173	15,478	13,333	95,457
Medical Agency Staff	163	128	200	740
Medical Locum Staff	240	357	369	1,683
Additional Medical Sessions	299	338	236	1,635
Nursing Agency Staff	63	48	69	398
Nursing Bank Staff	526	400	418	2,869
Other Agency Staff	79	112	81	522
Other Bank Staff	229	181	237	1,327
Overtime	147	122	82	714
On Call	115	167	102	759
Total Temporary Expenditure	1,861	1,854	1,794	10,647
Total Expenditure on Pay	20,034	17,331	15,128	106,104
Variance (F/(A))	375	128	530	(631)
Temp. Staff Costs as % of Total Pay	9.3%	10.7%	11.9%	10.0%
memo: Total Agency Spend in-month	305	289	350	1,661

Monthly WTE				
As at September 2021	Sep-21	Aug-21	Sep-20	YTD
	£000's	£000's	£000's	£000's
Budgeted WTE in-month	4,459.2	4,414.8	4,071.2	28,891.3
Substantive Staff	4,047.7	4,051.9	3,745.4	24,291.3
Medical Agency Staff	6.2	7.1	13.3	38.4
Medical Locum Staff	27.2	30.0	28.0	161.6
Additional Medical Sessions	6.8	5.1	6.3	33.3
Nursing Agency Staff	9.5	7.7	16.8	57.7
Nursing Bank Staff	126.4	116.3	123.5	776.7
Other Agency Staff	15.9	12.6	10.1	92.2
Other Bank Staff	78.7	68.6	98.1	507.9
Overtime	34.1	29.3	23.1	169.8
On Call	8.7	8.2	6.8	46.4
Total Temporary WTE	313.4	284.8	326.0	1,883.9
Total WTE	4,361.1	4,336.7	4,071.4	26,175.2
Variance (F/(A))	98.1	78.1	(0.1)	2,716.1
Temp. Staff WTE as % of Total WTE	7.2%	6.6%	8.0%	7.2%
memo: Total Agency WTE in-month	31.6	27.4	40.2	188.2

Pay Costs







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	(7,420)	(7,257)	(163)	(44,119)	(43,092)	(1,027)
Other Income	(293)	(265)	(27)	(1,758)	(1,585)	(173)
Total Income	**(7,713)**	**(7,523)**	**(190)**	**(45,877)**	**(44,677)**	**(1,200)**
Pay Costs	5,479	5,515	(36)	27,637	29,117	(1,480)
Non-pay Costs	1,755	1,849	(94)	9,910	10,444	(533)
Operating Expenditure	**7,234**	**7,364**	**(131)**	**37,547**	**39,560**	**(2,013)**
SURPLUS / (DEFICIT)	**479**	**158**	**(321)**	**8,330**	**5,117**	**(3,213)**
SURGERY						
NHS Contract Income	(5,410)	(4,720)	(689)	(31,414)	(29,249)	(2,165)
Other Income	(199)	(174)	(25)	(1,194)	(1,129)	(66)
Total Income	**(5,609)**	**(4,894)**	**(714)**	**(32,608)**	**(30,377)**	**(2,231)**
Pay Costs	4,257	4,236	21	22,173	22,004	169
Non-pay Costs	1,414	1,360	55	7,637	7,395	242
Operating Expenditure	**5,671**	**5,596**	**75**	**29,810**	**29,399**	**411**
SURPLUS / (DEFICIT)	**(62)**	**(702)**	**(639)**	**2,798**	**978**	**(1,819)**
WOMENS AND CHILDRENS						
NHS Contract Income	(2,023)	(1,919)	(104)	(11,869)	(11,329)	(539)
Other Income	(67)	(75)	8	(402)	(422)	20
Total Income	**(2,090)**	**(1,994)**	**(96)**	**(12,270)**	**(11,752)**	**(519)**
Pay Costs	1,794	1,737	57	9,236	9,123	113
Non-pay Costs	166	210	(44)	1,015	1,291	(276)
Operating Expenditure	**1,960**	**1,947**	**13**	**10,251**	**10,414**	**(163)**
SURPLUS / (DEFICIT)	**130**	**48**	**(82)**	**2,019**	**1,337**	**(682)**
CLINICAL SUPPORT						
NHS Contract Income	(637)	(570)	(67)	(3,651)	(3,174)	(477)
Other Income	(157)	(136)	(21)	(942)	(889)	(54)
Total Income	**(794)**	**(706)**	**(87)**	**(4,593)**	**(4,062)**	**(530)**
Pay Costs	2,561	2,563	(3)	12,813	12,977	(164)
Non-pay Costs	1,009	1,482	(473)	6,058	6,956	(898)
Operating Expenditure	**3,570**	**4,046**	**(476)**	**18,871**	**19,934**	**(1,063)**
SURPLUS / (DEFICIT)	**(2,776)**	**(3,340)**	**(563)**	**(14,278)**	**(15,871)**	**(1,593)**
COMMUNITY SERVICES						
NHS Contract Income	(2,677)	(2,643)	(35)	(16,064)	(16,019)	(45)
Other Income	(1,119)	(1,103)	(16)	(6,712)	(6,655)	(57)
Total Income	**(3,796)**	**(3,745)**	**(51)**	**(22,776)**	**(22,674)**	**(102)**
Pay Costs	3,302	3,365	(63)	16,703	17,053	(350)
Non-pay Costs	1,203	1,089	114	7,135	7,155	(20)
Operating Expenditure	**4,505**	**4,454**	**51**	**23,839**	**24,208**	**(370)**
SURPLUS / (DEFICIT)	**(709)**	**(709)**	**0**	**(1,063)**	**(1,534)**	**(472)**
ESTATES AND FACILITIES						
NHS Contract Income	0	0	0	0	0	0
Other Income	(446)	(319)	(127)	(2,679)	(1,586)	(1,092)
Total Income	**(446)**	**(319)**	**(127)**	**(2,679)**	**(1,586)**	**(1,092)**
Pay Costs	1,192	1,283	(91)	5,927	6,398	(471)
Non-pay Costs	655	796	(141)	3,929	3,756	173
Operating Expenditure	**1,847**	**2,079**	**(232)**	**9,856**	**10,155**	**(299)**
SURPLUS / (DEFICIT)	**(1,401)**	**(1,760)**	**(359)**	**(7,177)**	**(8,568)**	**(1,391)**
CORPORATE						
NHS Contract Income	(7,877)	(8,623)	746	(30,853)	(33,403)	2,550
Other Income	(742)	(704)	(37)	(11,355)	(11,201)	(154)
Total Income	**(8,619)**	**(9,327)**	**709**	**(42,209)**	**(44,604)**	**2,396**
Pay Costs	1,823	1,334	490	10,984	9,432	1,552
Non-pay Costs	1,204	352	852	13,884	8,201	5,683
Capital Charges and Financing Costs	1,252	1,338	(86)	7,969	8,429	(459)
Operating Expenditure	**4,279**	**1,685**	**2,594**	**32,837**	**17,633**	**15,205**
SURPLUS / (DEFICIT)	**4,339**	**7,642**	**3,303**	**9,371**	**26,972**	**17,600**
TOTAL						
NHS Contract Income	(26,044)	(25,732)	(312)	(137,969)	(136,266)	(1,703)
Other Income	(3,023)	(2,777)	(245)	(25,042)	(23,467)	(1,576)
Total Income	**(29,067)**	**(28,509)**	**(557)**	**(163,011)**	**(159,733)**	**(3,278)**
Pay Costs	20,409	20,034	375	105,473	106,104	(631)
Non-pay Costs	7,405	7,137	269	49,569	45,199	4,370
Capital Charges and Financing Costs	1,252	1,338	(86)	7,969	8,429	(459)
Operating Expenditure	**29,066**	**28,509**	**557**	**163,011**	**159,731**	**3,280**
SURPLUS / (DEFICIT)	**0**	**0**	**0**	**0**	**2**	**2**

FINANCE AND WORKFORCE REPORT – September 2021

Statement of Financial Position at 30 September 2021

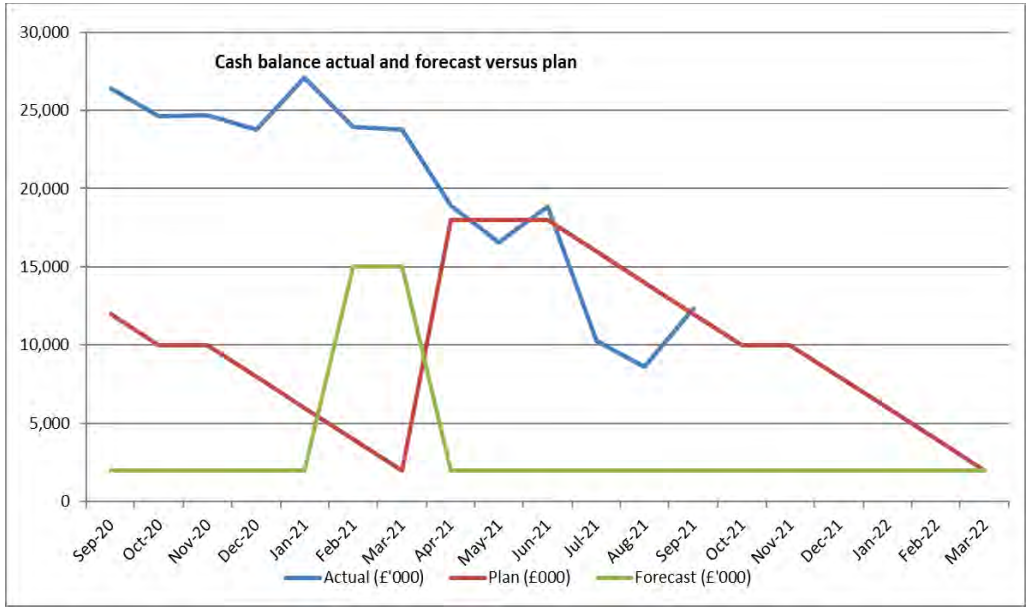
STATEMENT OF FINANCIAL POSITION

	As at 1 April 2021	Plan 31 March 2022	Plan YTD 30 September 2021	Actual at 30 September 2021	Variance YTD 30 September 2021
	£000	£000	£000	£000	£000
Intangible assets	52,198	54,398	53,198	62,368	9,170
Property, plant and equipment	137,103	168,603	150,603	148,771	(1,832)
Trade and other receivables	6,341	6,341	6,341	6,341	0
Total non-current assets	**195,642**	**229,342**	**210,142**	**217,480**	**7,338**
Inventories	3,481	3,481	3,481	3,588	107
Trade and other receivables	19,362	19,362	19,362	14,888	(4,474)
Cash and cash equivalents	23,788	2,006	12,006	12,316	310
Total current assets	**46,631**	**24,849**	**34,849**	**30,792**	**(4,057)**
Trade and other payables	(52,522)	(37,779)	(44,379)	(46,616)	(2,237)
Borrowing repayable within 1 year	(6,439)	(5,500)	(5,500)	(5,574)	(74)
Current Provisions	(46)	(46)	(46)	(46)	0
Other liabilities	(1,357)	(3,357)	(3,357)	(2,327)	1,030
Total current liabilities	**(60,364)**	**(46,682)**	**(53,282)**	**(54,563)**	**(1,281)**
Total assets less current liabilities	**181,909**	**207,509**	**191,709**	**193,709**	**2,000**
Borrowings	(47,719)	(43,319)	(45,519)	(47,519)	(2,000)
Provisions	(852)	(852)	(852)	(852)	0
Total non-current liabilities	**(48,571)**	**(44,171)**	**(46,371)**	**(48,371)**	**(2,000)**
Total assets employed	**133,338**	**163,338**	**145,338**	**145,338**	**0**
Financed by					
Public dividend capital	158,650	188,650	170,650	170,650	0
Revaluation reserve	8,743	8,743	8,743	8,743	0
Income and expenditure reserve	(34,055)	(34,055)	(34,055)	(34,055)	0
Total taxpayers' and others' equity	**133,338**	**163,338**	**145,338**	**145,338**	**0**

The balance sheet continues to remain stable and is largely in line with expectations against the plan. 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.

Cash Balance Forecast for the year

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



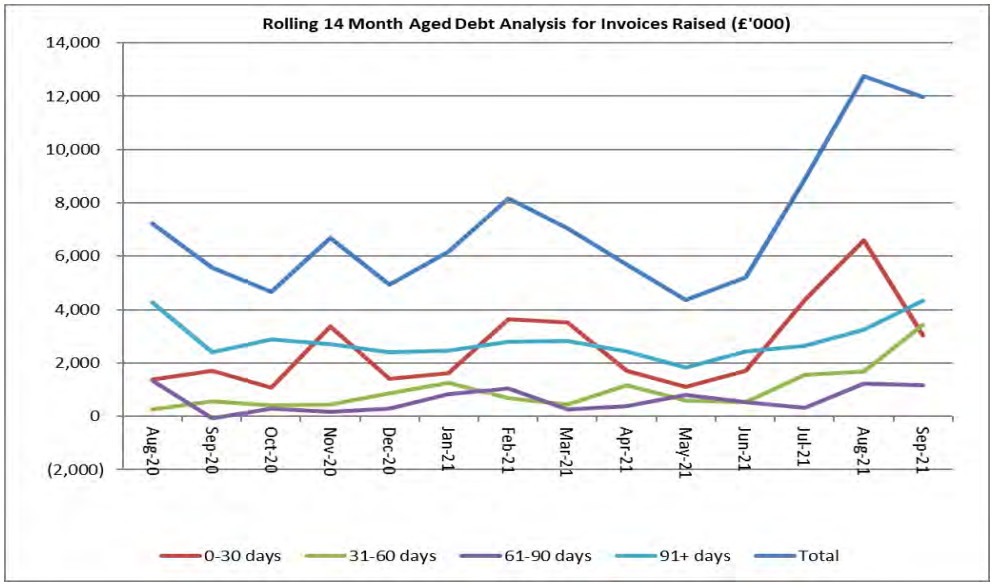
The Trust's cash position is currently being rigorously monitored during 2021/22 as the Trust will no longer be receiving any income in advance as it was in 2020/21. We also need to ensure that the timing of the capital payments is line with capital cash funding due to be received. The cash position has remained stable in September and is in line with the plan.

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 – September 2021

Debt Management

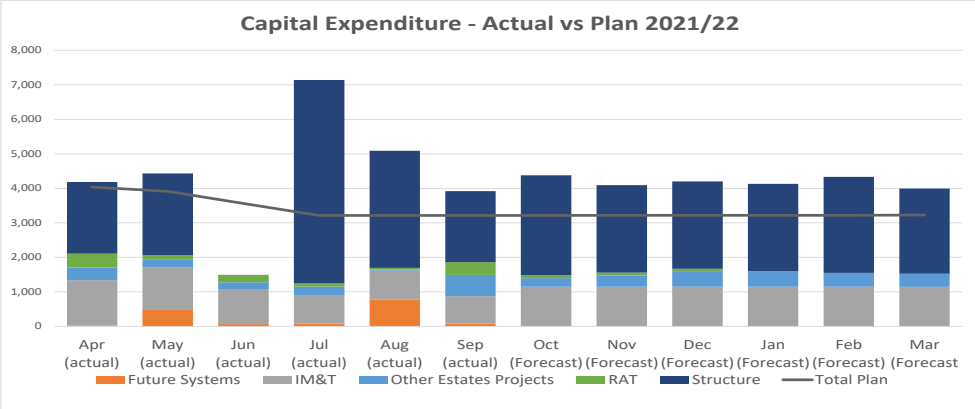
The graph below shows the level of invoiced debt based on age of debt.



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, with a slight decrease since the previous month. The majority of the debts outstanding are historic debts, although these are reducing. Over 87% of these outstanding debts relate to NHS Organisations, with 33% of these NHS debts being greater than 90 days old. We are actively trying to agree a position with the remaining corresponding NHS Organisations for these historic debtor balances and a significant amount of work has been completed in this area to help reduce these historic balances.

Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Actual £'000	Aug Actual £'000	Sep Actual £'000	Oct Forecast £'000	Nov Forecast £'000	Dec Forecast £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	Total 2021-22 £'000
Future Systems	24	498	66	85	781	83	0	0	0	0	0	0	1,537
IM&T	1,316	1,219	1,016	825	835	796	1,148	1,148	1,148	1,148	1,148	1,144	12,891
Other Estates Projects	368	229	194	246	34	612	248	323	433	453	403	382	3,925
RAT	403	120	203	90	44	370	90	90	90	0	0	0	1,500
Structure	2,073	2,368	16	5,892	3,397	2,058	2,893	2,531	2,531	2,530	2,780	2,469	31,538
Total / Forecast	**4,184**	**4,434**	**1,495**	**7,138**	**5,091**	**3,919**	**4,379**	**4,092**	**4,202**	**4,131**	**4,331**	**3,995**	**51,391**
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 funded through PDC.

The prime focus of the Capital Programme is work to ensure the structure of the current hospital site is safe and can continue to be used until the new hospital is built. Within this project there are a number of schemes such as RAAC planks, roof work, electrical and water infrastructure. The year to date figures agree to the separate return submitted to NHSI. The other main focus of the programme is the continuation of the Ecare programme. The original plan submitted did not reflect the full plan for Ecare and at the moment this forecast to overspend the existing budget. This issue has been discussed with NHSI with the view to additional funding to support the ongoing expenditure to develop the system. Other funding sources for this overspend are also being pursued. The table and graph reflect this forecast overspend to the end of the year.

10.2. Operational report

To APPROVE a report

For Approval

Presented by Helen Beck

Trust Board – 15 October 2021

Agenda item:	10.2			
Presented by:	Helen Beck, Executive Chief Operating Officer			
Prepared by:	Alex Baldwin, Deputy Chief Operating Officer			
Date prepared:	08 October 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;

1. an update on current operational pressures,
2. impact of RAAC remedial work,
3. a summary of the winter plans,
4. overview of recent planning guidance.

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:	Winter planning meeting, CRT
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 continues to face sustained operational pressure although the totality of acute activity reduced through September.

ED attendances fell to 7500 (from 7852 in July, 7752 in June) and daily attendances have reduced from the peaks seen in early July and August. The number of patients waiting over 12 hrs in the department has risen significantly to 155 (86 in July, 30 in June, 23 in May). Delayed admissions continue to be a factor, with the average time for admission 390 minutes in September. This continues to reflect internal bed pressures.

Availability of social care capacity continues to be the biggest contributory factor – at the time of writing **47** patients are awaiting ongoing care in the community. This is reflected in our stranded patient numbers which are at record levels (**198** +7 days, **104** +14 days, **64** +21 days).

Covid levels have increased over the past month but remain manageable – **14** at the time of writing and we have not yet exceeded our surge Covid capacity. Detailed modelling of future demand remains patchy but we are starting to consider our management plans as the disease moves in to an endemic phase. Maintaining sufficient capacity is a key planning assumption of our winter preparedness activity.

The ongoing workforce challenges, in addition to the above, make for a difficult operational picture. Our teams continue to function well in trying circumstances but many can be described as working in survival mode with little residual resilience or bandwidth.

This picture is reflected across the ICS and nationwide. System support continues to be an area of focus and we are working with our acute, community and social care partners to deliver the short-term improvements we need to see.

RAAC bearing extension and operational impact

Work continues to progress with wave 4 now well underway. NNU, F1, F4 and theatre all have work under way presently. NNU failsafe is scheduled to complete by 29 October with the service returning home from F2 at the start of November. F1 bearing extension will be completed by the middle of the month with the Paediatric service returning on 18 and 19 October. F4 bearing extension will be completed by 22 October.

Adaptation work will commence on G10 on 20 October with occupation by the medical service scheduled for 08 November. F2 failsafe will commence on 02 November and is expected to be concluded by Christmas. F10 failsafe will commence on 28 October and is scheduled to be completed by 01 February. Similarly, F9 failsafe will commence after Christmas.

Unfortunately, the planned F7 bearing extension work was delayed as a result of operational pressures and the need to convert to a temporary medically optimised ward. A revised start date of 08 November has been agreed which should see works completed before Christmas.

As you can see this is a complex and rapidly moving plan but one which is being managed ably by the core resilience and estates teams.

Winter planning

Seasonal planning is progressing well and a detailed plan has been formed. There are a series of outputs and actions which will define the degree to which we have sufficient capacity for winter 21/22. The plan has, as in previous years, been based on detailed demand modelling. In summary;

- During the peak period (February) demand will be **618** beds. We will have **633** available, a nominal surplus of **15**.
- Modelling assumes 92% occupancy in line with best practice. It assumes we deliver 95% of pre-pandemic elective activity and 100% of non-elective activity.
- Covid contingency has been set at 5% which is equivalent to **24** beds. Current occupancy is approximately 4%.
- The model assumes that up to 2 wards are available for the RAAC decant programme throughout winter 21/22.
- In addition to the **603** beds nominally available to the trust an additional **45** block booked community beds are included in the model.

A full breakdown of the model is available in table 1 below.

Table 1: 2021/22 winter bed model (11/10/21)

Mitigated demand and capacity									
	POD	Group	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Notes
Bed Demand	Emergency - General and Acute	General and Acute Beds	507	489	500	544	552	536	
	Elective inpatients	General and Acute Beds	5	23	36	36	36	36	
	Non Covid patients	General and Acute Beds	511	512	536	580	588	571	
	Covid	General and Acute Beds	26	26	27	29	29	29	Assumes 5% covid demand.
	Total Demand	General and Acute Beds	537	537	563	609	618	600	
Bed Capacity	Baseline	General and Acute Beds	411	419	458	484	484	484	Core G&A beds inc. critical care
	Baseline	Escalation	76	61	61	61	87	87	Escalations beds
	Additional	Surge	17	17	17	17	17	17	Surge beds
	Additional	Winter block beds	17	45	45	45	45	17	Ashmore, Catchpole, St Peters, Brandon, Melford, Stowlangtoft
	Additional	LOS reduction	0	0	0	0	0	0	Zeroed
	Additional		0	0	0	0	0	0	
	Additional		0	0	0	0	0	0	
	Social Distancing Impact	General and Acute Beds	0	0	0	0	0	0	
	Baseline Capacity	General and Acute Beds	521	542	581	607	633	605	
	Baseline Bed Surplus / Gap		-16	5	18	-2	15	5	
	Sufficent / Insufficient beds for NEL+Covid		INSUFFICENT	SUFFICENT	SUFFICENT	INSUFFICENT	SUFFICENT	SUFFICENT	
		Assumptions	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	
		NEL demand	100%	100%	100%	100%	100%	100%	Assumes 100% pre covid by May 21
		EL (IP) throughput	60%	60%	95%	95%	95%	95%	Assumes 60% until Dec 21.
		Social distancing workaround	0%	0%	0%	0%	0%	0%	
		LOS reduction	0%	0%	0%	0%	0%	0%	

The modelling is complex, more so as a result of the ward decant programme which means that not all beds are available for use at once and the available number changes from month to month. It should also be noted that the model assumes that all available beds are used, so a surplus of 15 still requires use of escalation and surge capacity with the associated pressures on capacity and staff that this brings.

As normal there will be peaks and troughs in demand with the two greatest peaks falling at the end of December and the end as March as we have experience in previous years. Outstanding key actions include converting Rosemary Ward at Newmarket Hospital into a 33 bedded inpatient unit supporting medically optimised patients. It is anticipated that this will have been completed by 1 November. At the time of writing all additional nursing vacancies required in support for this move have been identified.

An additional 45 block booked beds have been procured to re-provide the reablement beds that are currently at Newmarket. Further community actions are set out in the Integration paper.

The overall summary of this position is that it is very challenging and caution should be applied before taking assurance from the numbers. The winter “season” will be very challenging indeed we can expect to see a continuation of the current challenges until well in to the spring next year.

2021/22 priorities and operational planning guidance

On 30 September NHS England and Improvement published the planning guidance for the second half of the year (H2). Broadly mirroring the priorities established for the year published in March it sets out the expectations for the next 6 months.

The full guidance can be found here: C1400-2122-priorites-and-operational-planning-guidance-oct21-march21.pdf (england.nhs.uk)

The key focus remains on the six key priorities previously identified in addition to the tackling of health inequalities – indeed boards are asked to include reporting by deprivation and ethnicity in all future performance reports.

Funding is provided in the form of £1.5b (£1b revenue, £500m capital) to support continued recovery of elective activity and cancer services.

Perhaps the biggest change for acute providers is the transition to measuring completed pathways rather than treatments, as has been the case to date. This can provide a perverse incentive for organisations to prioritise high volume, low complexity services where a greater proportion of contacts result in completed pathways at the expense of low volume, high complexity services where many of our longest waits can be found. We will not adopt this approach at the trust, instead we will monitor both completed pathways and treatments to ensure we strike the right balance between waiting list maintenance and reducing the longest waits.

A summary of key objectives for each priority is summarised below.

A. Supporting the health and wellbeing of staff and taking action on recruitment and retention.
    - Systems are asked to continue to deliver on the pillars of the People Plan.
    - Increasing workforce availability and putting in place new and more productive ways of working and transformation opportunities.

B. Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19.
    - Systems are asked to ensure specific provision is available for children aged 12 to 15.

C. Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services.
    - Maximise elective activity and eliminate waits over 104 weeks by March 2022 except where patients choose to wait longer (P5 and P6 patients).
    - Hold or reduce the number of patients waiting over 52 weeks.
    - Stabilise waiting lists around the levels seen at the end of September 2021.
    - Maintain ring-fenced elective capacity of HVLC procedures, adopting “hub” models where appropriate.
    - Engage in the clinical validation and prioritisation programme.
    - Work collaboratively to optimise referral and avoid unnecessary outpatient attendances.
    - Increase advice and guidance (minimum of 12 A&G requests per 100 outpatients first attendances by March 2022).
    - Ensure patient initiated follow-up (PIFU) is in place for five major outpatient specialties with 1.5% of outpatient’s attendances discharged via PIFU by December 21 and 2% by March 22.
    - Increase virtual attendance to 25% of overall outpatient activity.

- Continue to ensure health inequalities are considered within elective recovery plans and progress is tracked via board level performance reports.
- Restore full operation of all cancer services. This includes maximising all capacity and use of IS facilities.
    i. Objective to return the number of people waiting longer than 62 days to February 2020 levels by March 2022.
    ii. Meet the faster diagnostic standard by Q3 ensuring at least 75% of patients have cancer ruled out or diagnosed within 28 days of referral for diagnostic testing.
- Deliver improvements in maternity care, including responding to recommendations of the Ockenden review,

D. Expanding primary care capacity to improve access, local health outcomes and address health inequalities.

E. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (EDs), improve timely admission to hospital for ED patients and reduce length of stay.
    - Specifically embedding actions set out in the UEC action plan to support services with particular focus on reducing the number and duration of ambulance handover delays, eliminating 12 hour waits in ED and ensuring safe and timely discharge of those patients without clinical criteria to reside in an acute hospital.

F. Working collaboratively across systems to deliver on these priorities.

As a provider we are asked to develop initial plans for submission by 14 October. This will focus largely on our elective recovery and capacity plans for the second half of the year, and will include narrative on 104 and 52 week waits, management of the waiting list size, recovery of the 62-day cancer standard, UEC and Covid pressure management, elective care maintenance, workforce and health inequalities. In addition, we expect to set out risks to delivery.

We have also provided a shortlist of investments for the Targeted Investment Fund (TIF) that can be delivered in year.

Achievement of all the asks will be a tall order. In the case of our elective programme and specifically 104 and 52 week waits it will be challenging to eradiated (104w) and reduce (52w) until we have a full complement of elective theatres. Accordingly, we may expect to see a rising waiting list but this can be mitigated via shared mutual support with ESNEFT and other system partners (such as the IS). We have robust plans to recover our 62-day cancer performance and can see positive signs in terms of our faster diagnostic performance. We also have appropriate winter and Covid plans.

So, whilst the ask may be challenging and our operational context complex we will engage all of our collective knowledge and experience to get as close to these priorities as possible. And where we are not able to we will have clear plans for when we will recover to achievement.

Lastly our final plans covering the second half of the year, alongside system plans, are due for submission by 16 November.

Recommendation

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

Appendix1: SNEE weekly activity and accelerator report

WSFT

Specialty	Total
Base week (w/e)	26 September 2021
Comparison week (w/e)	03 October 2021
Trust/SNEE	WSFT
All/DTA incompletes	All

Week ending	Wait time (92%ile)	Wait list	>18 wks	>52 wks	>78 wks	>98 wks	>104 wks	%<18wks
26 September 2021	56 weeks	24387	8382	2271	1217	220	99	65.6%
03 October 2021	56 weeks	24358	8427	2239	1149	228	115	65.4%
Change	0	-29	45	-32	-68	8	16	-0.2%

Clock stops	<=18w	>18w	Total	Crude clearance time*
This week	698	216	914	27 weeks
Last 4 weeks	679	207	886	28 weeks

ESNEFT

Specialty	Total
Base week (w/e)	26 September 2021
Comparison week (w/e)	03 October 2021
Trust/SNEE	ESNEFT
All/DTA incompletes	All

Week ending	Wait time (92%ile)	Wait list	>18 wks	>52 wks	>78 wks	>98 wks	>104 wks	%<18wks
26 September 2021	40 weeks	61782	19396	1540	324	35	24	68.6%
03 October 2021	39 weeks	61550	19559	1459	293	37	25	68.2%
Change	-1	-232	163	-81	-31	2	1	-0.4%

Clock stops	<=18w	>18w	Total	Crude clearance time*
This week	2000	874	2874	22 weeks
Last 4 weeks	2037	835	2872	22 weeks

*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 03/October 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 JULY are 5 July - 1 August average and AUGUST are 2 August - 4 September.								
Key headlines:								
First outpatients:		JULY		88.2%	AUGUST		88.0%	
Overall	87%	was	90%	Target:	85%	(from July)		
WSFT	80%	was	81%					
ESNEFT	88%	was	93%					
Follow up outpatients:		JULY		95.8%	AUGUST		92.4%	
Overall	87%	was	92%	Target:	85%	(from July)		
WSFT	87%	was	93%					
ESNEFT	88%	was	92%					
Inpatient electives:		JULY		87.5%	AUGUST		83.3%	
Overall	88%	was	83%	Target:	85%	(from July)		
WSFT	48%	was	44%					
ESNEFT	101%	was	94%					
Daycases:		JULY		97.8%	AUGUST		91.2%	
Overall	94%	was	94%	Target:	85%	(from July)		
WSFT	74%	was	76%					
ESNEFT	101%	was	100%					
MRI:		JULY		94.9%	AUGUST		96.4%	
Overall	99%	was	101%	Target:	85%	(from July)		
WSFT	87%	was	87%					
ESNEFT	102%	was	105%					
CT:		JULY		106.1%	AUGUST		111.3%	
Overall	108%	was	110%	Target:	85%	(from July)		
WSFT	107%	was	119%					
ESNEFT	108%	was	108%					
Endoscopy:		JULY		104.6%	AUGUST		95.4%	
Overall	75%	was	80%	Target:	85%	(from July)		
WSFT	36%	was	49%					
ESNEFT	98%	was	97%					
n.b. data from Weeks 24-26 as there is a lag in the reporting								

10.3. IQPR

To NOTE the report

For Report

Presented by Helen Beck and Susan Wilkinson

Trust Public Board - 15 October 2021

Agenda Item:	10.3			
Presented By:	Helen Beck & Sue Wilkinson			
Prepared By:	Information Team			
Date Prepared:	Jul-21			
Subject:	Performance Report - July 2021 data			
Purpose:	**X**	**For Information**		**For Approval**

Executive Summary:

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

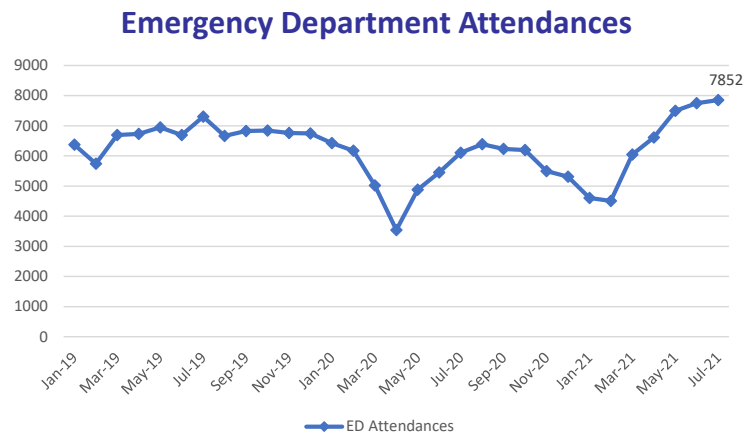
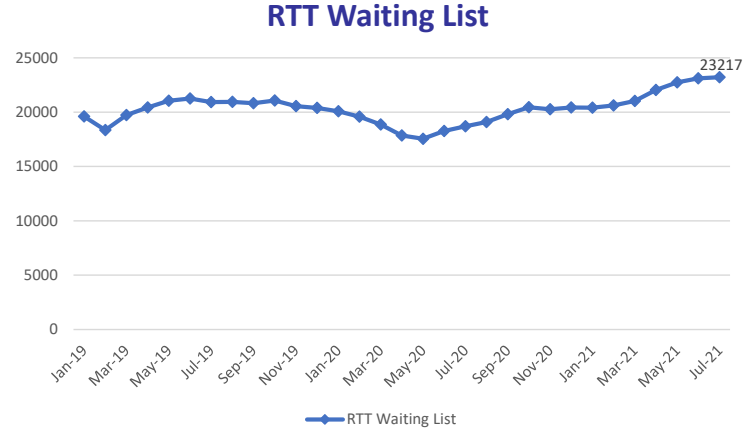
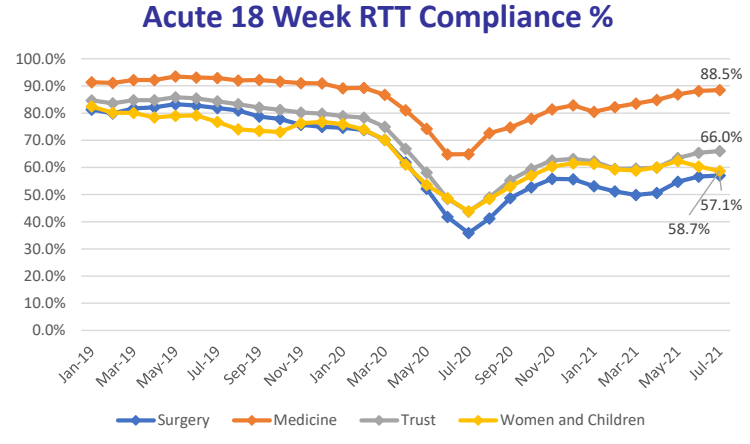
Trust Priorities [Please indicate Trust priorities relevant to the subject of the report]	**Delivery for Today**	**Invest in Quality, Staff and Clinical Leadership**	**Build a Joined-up Future**
	X		

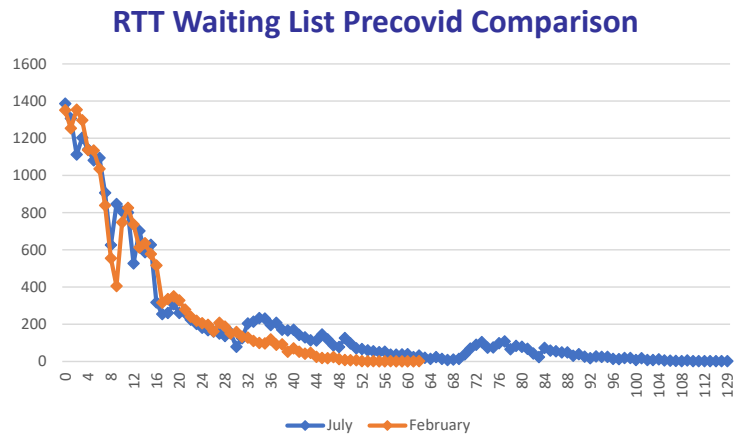
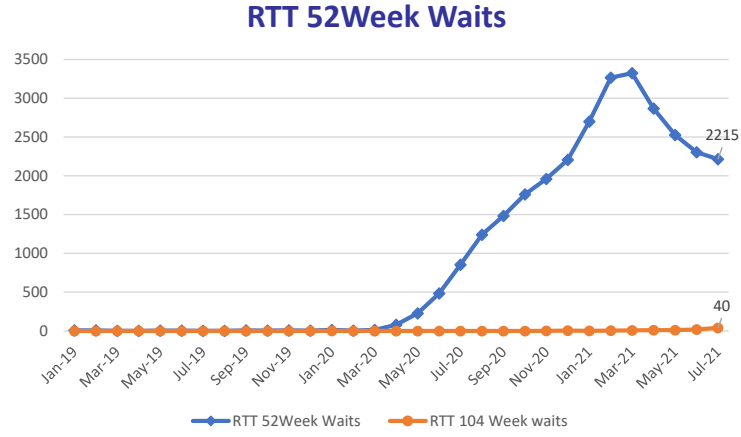
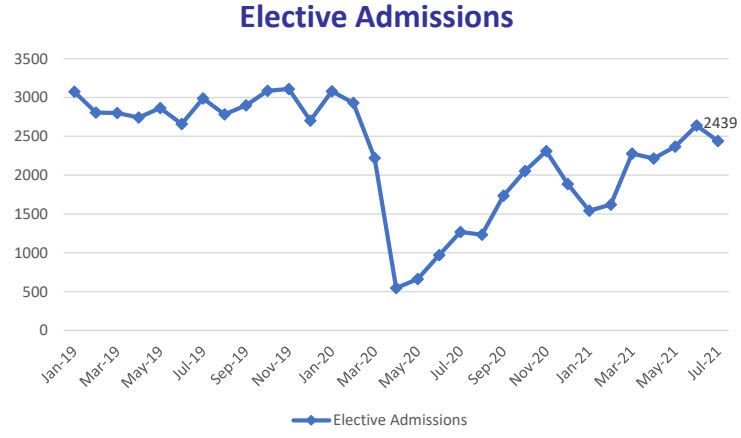
Trust Ambitions [Please indicate ambitions relevant to the subject of the report]	Deliver personal care	Deliver safe care	Deliver joined-up care	Support a healthy start	Support a healthy life	Support ageing well	Support all our staff
		X	**X**				**X**

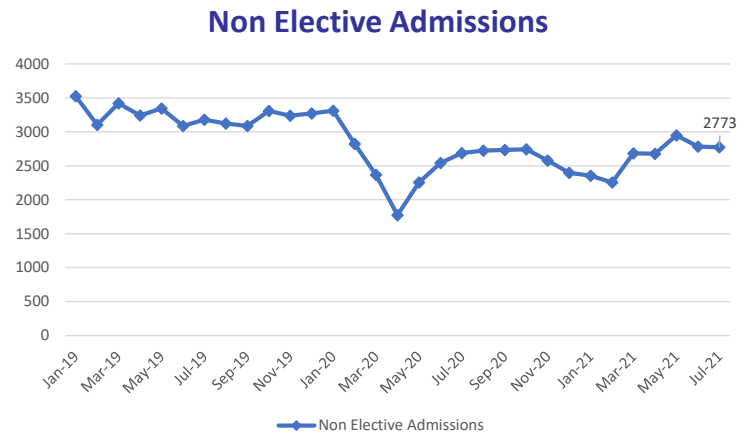
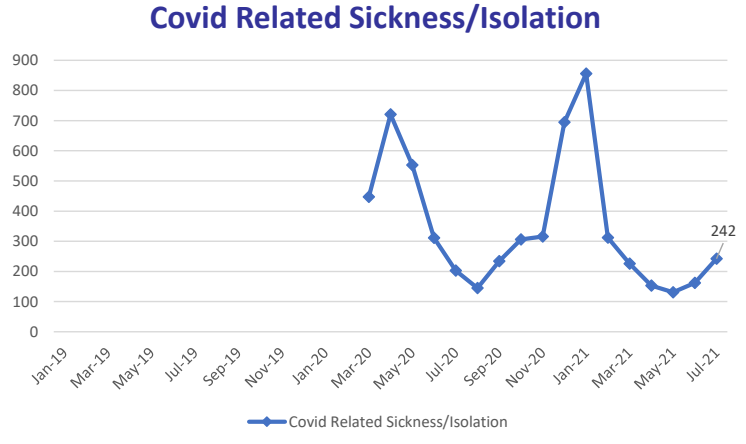
Previously Considered by:	Insight committee - September 2021
Risk and Assurance:	
Legislation, Regulatory, Equality, Diversity and Dignity Implications	

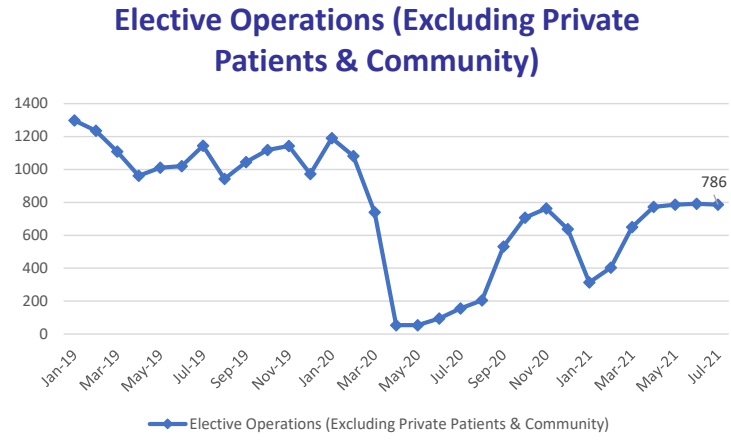
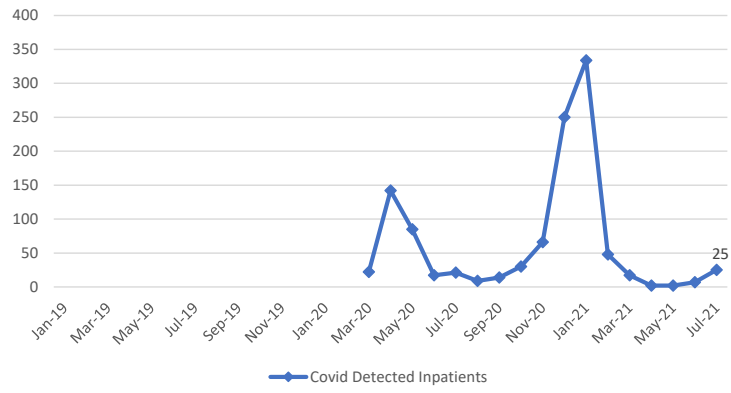
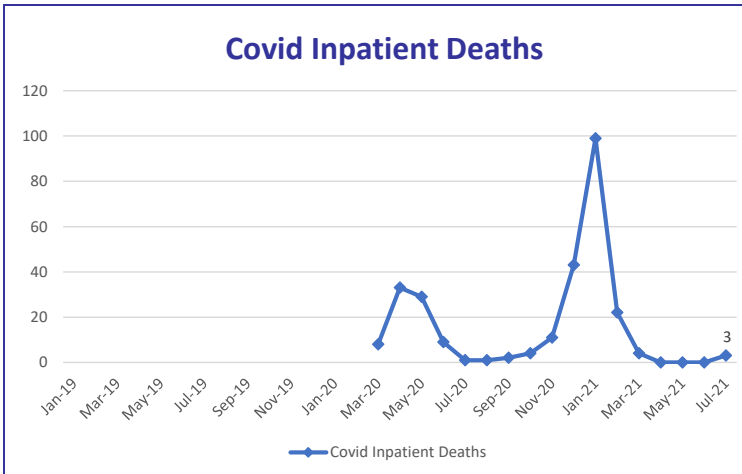
Recommendation:

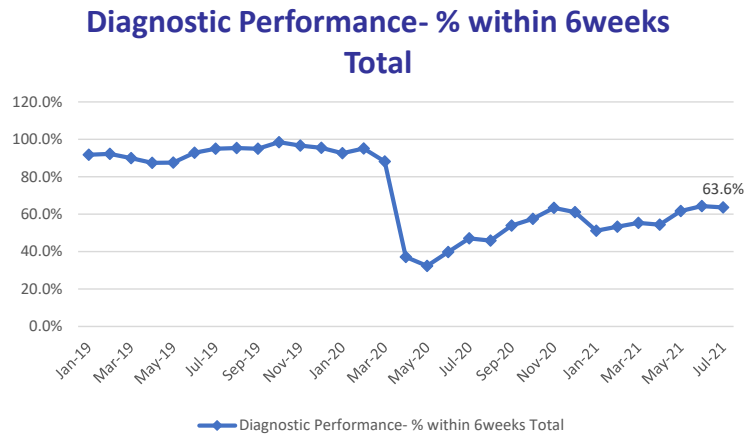
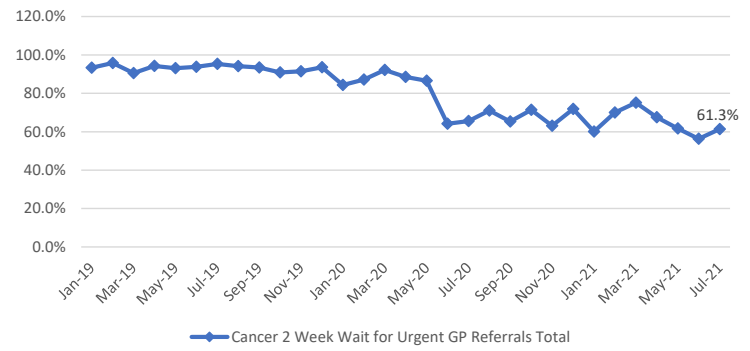
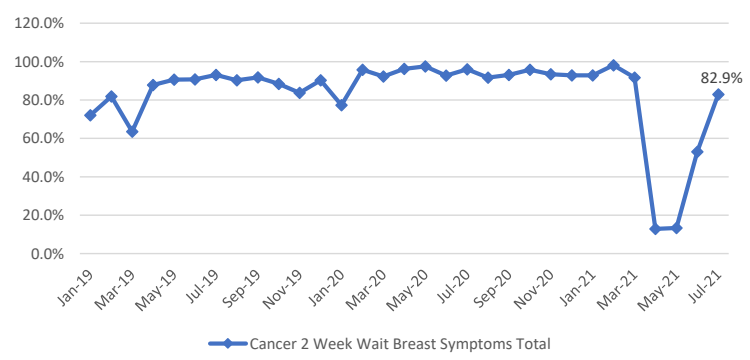
That Board note the report.

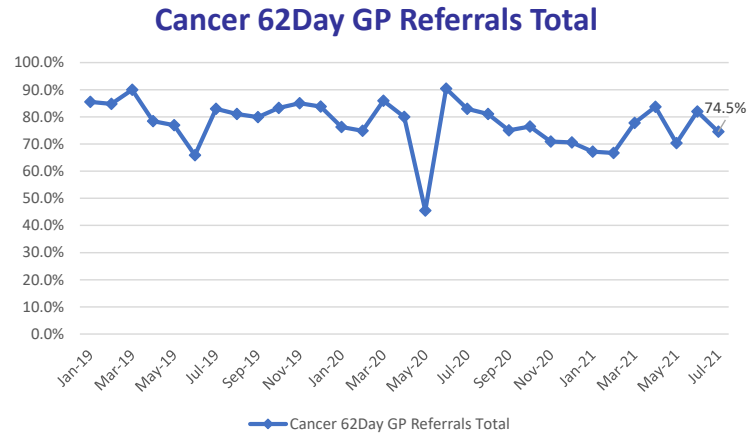
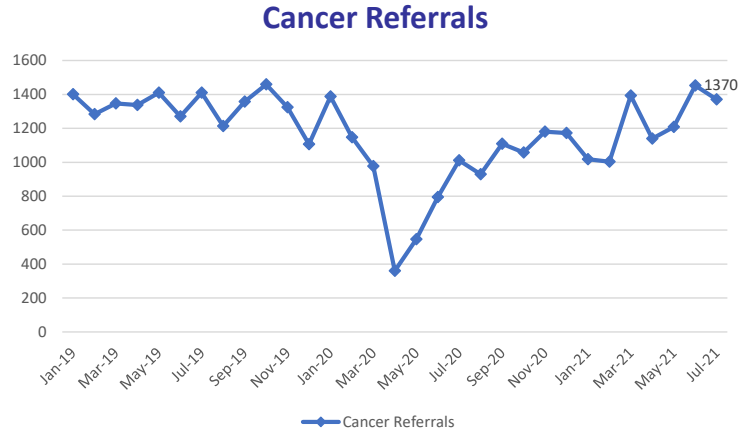
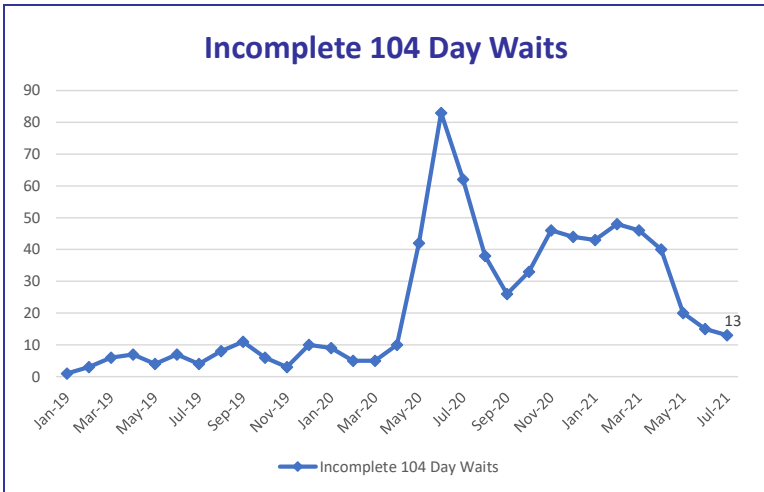
Board Report KPIs	Narratives
	There were 7752 attendances in June 2021 and 7852 in July 2021 - an increase of 100 attendances. Attendances continue to rise but at a slightly lower rate than the previous month. In the month of July, the main increases in attendances fell in the admitted category for both trauma and orthopaedics and medicine. Psychiatric attendances also saw a further increase.
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 risen again in July, although by a slightly smaller amount. Referrals are up in many areas and as seen in previous months the amount of patients we are able to treat electively remains an issue.
A count of the patients on the waiting list for treatment.	
	Slight improvement in the trust overall position now at 66% from 65.4% in June. Medicine continues to make positive steps to recovery, with compliance now at over 92% in Dermatology, Neurology, Rheumatology and Geriatric Medicine. Women and Children compliance has dropped, mostly due to the capacity constraints within Urogynaecology and the inability to treat these long waiting patients.
% of patients on incomplete RTT pathways	

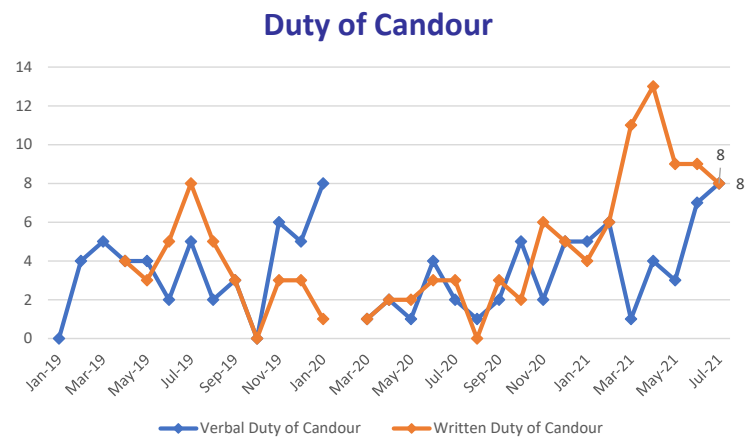
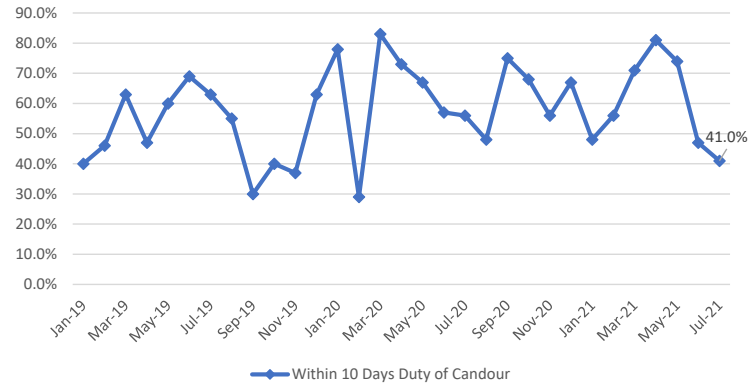
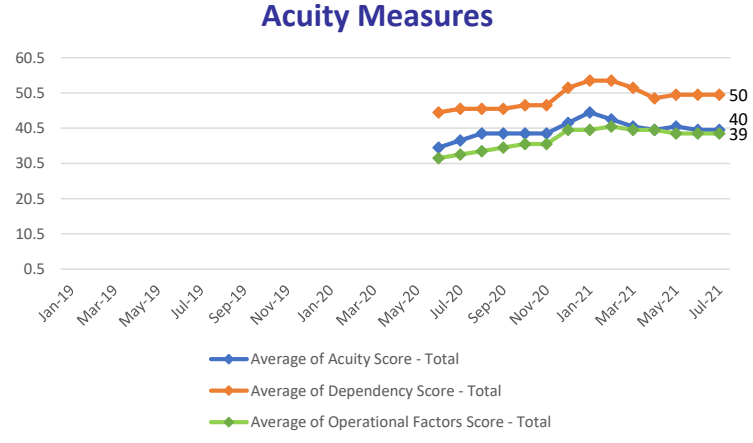
Board Report KPIs	Narratives
	As in previous months the tail extends further with the longest waits in Orthopaedics.
A year on year comparison of the number of patients waiting for treatment.	
	The number of patients over 52 weeks continues to reduce, which is positive however the amount of patients waiting over 78, 98 and 104 weeks is increasing week on week. 40 patients are over 104 weeks as at the end of July, of which 26 were in Orthopaedics.
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 are down in July as a direct impact of the theatre RAAC works.
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.	

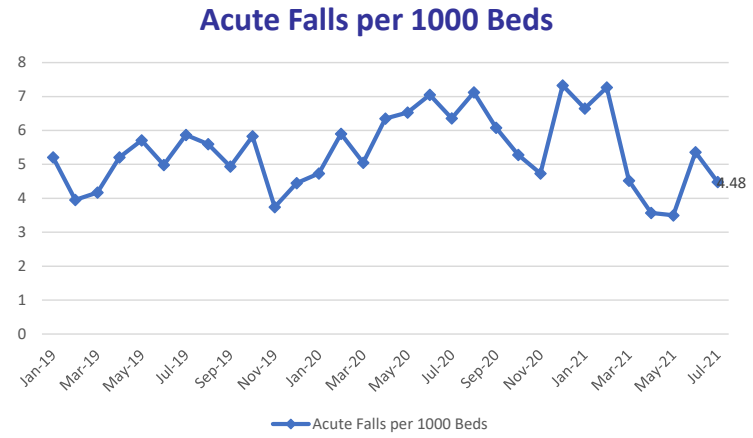
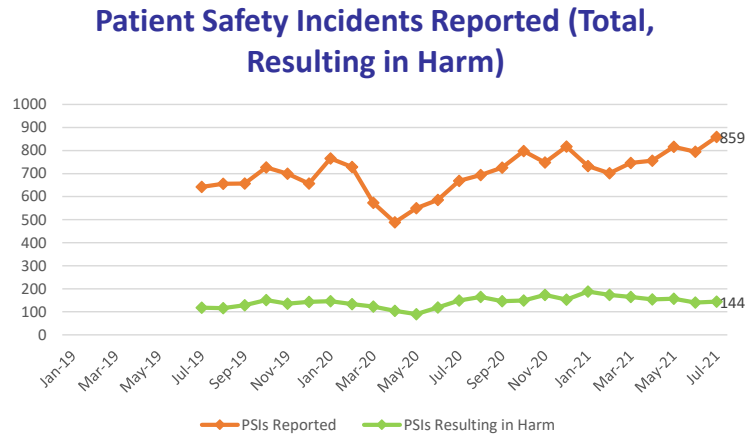
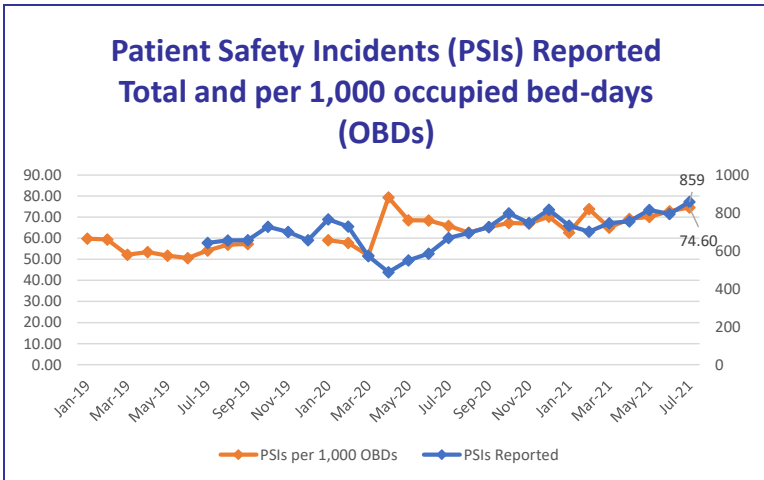
Board Report KPIs	Narratives
	There were 2784 non elective admissions via ED in June 2021 with July 2021 showing a very slight decrease with 2773 admissions. The main reduction was in surgical and obs and gynae admissions. In comparing the attendance graph to the admission graph it can be seen that although attendances were up admissions were down.
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 July 2021 was 3.9%, a slight increase on June 2021 figues of 3.8%; a continuing upward trend for the last two months.
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 July 2021 there were 242 episodes recorded which is an increase on June 2021 which recorded 162 episodes of COVD-19 related sickness; a continuing upward trend for the last two months.
A count of our staff who have been off sick with a Covid related symptoms or to isolate. This is a local metric to monitor the impact of Covid on our workforce.	

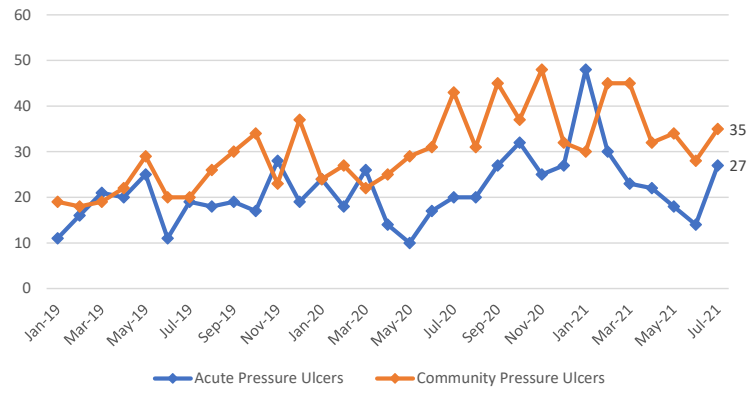
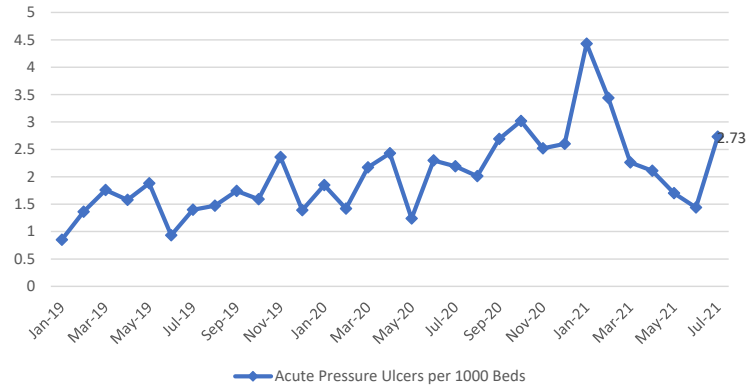
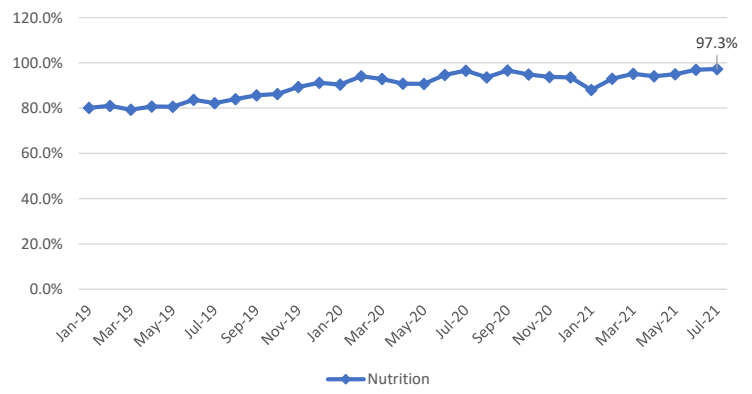
Board Report KPIs	Narratives
	Elective operations have maintained the same level for 4 months now and will not be possible to increase further until all theatres are back up and running. The gap is mitigated in part from outsourced activity.
This is a count of the number of operations that were carried out. This is a local measure to monitor our productivity and recovery from Covid.	
	There were 25 individual patients admitted during July, who had their first diagnosis of Covid-19. In July the highest number of Covid positive inpatients residing in the trust on any one day was 11.
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 3 patients who died within 28 days of a positive Covid result in July. The total is now 269. 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.	

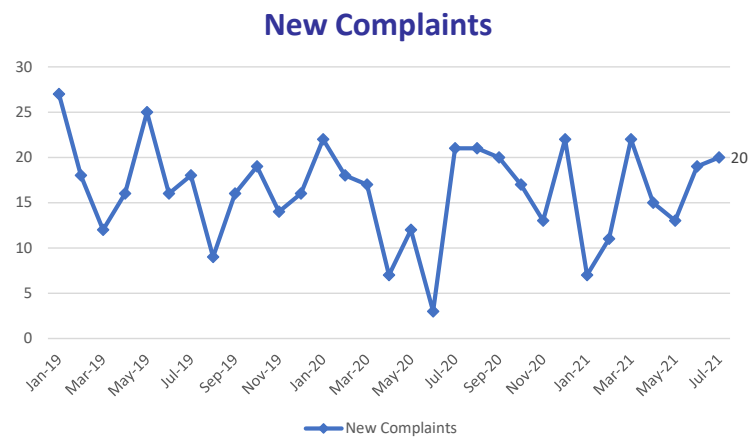
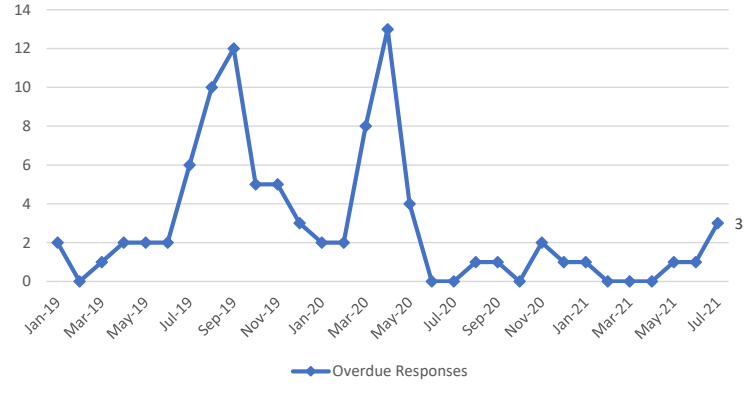
Board Report KPIs	Narratives
	Marginal improvement on diagnostic performance. Capacity constraint continues in all endoscopy areas and ultrasound. There are plans in place for endoscopy activity with using additional capacity in Inhealth in Ipswich for surveillance overdue and routine long waits. Some options are being drawn up in terms of ultrasound.
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.	
	Improvement in two week wait standard in July from June. Breast has seen full recovery to 93% for July but Skin has dropped down to 18%. Plans are in place for Skin recovery with an AI tool which will be in place from October 2021. Upper and Lower GI continue to improve.
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.	
	Positive recovery for 2WW breast symptomatic patients, although not yet in a position to fully recover this position.
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.	

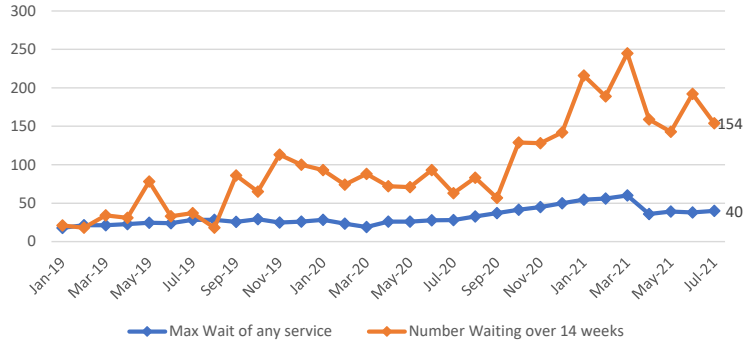
Board Report KPIs	Narratives
	Drop in July performance for 62 day performance as expected, partly due to the lack of theatre resource and delays in diagnostics within Colorectal and Urology particularly.
To measure compliance with the national standards for access to cancer treatment. This metric measures 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.	
	Cancer referrals slightly dropped in July from June. June was a particularly high month with referrals into Skin particularly increased from what we would usually expect.
A count of the number of patients referred to the hospital with suspected cancer, requiring investigation. This metric shows the activity by month for cancer services, which informs the national metric which measures the number of these patients that were seen within 2 weeks (further in the performance pack).	
	Continued reduction of patients waiting 104 days on a cancer pathway
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
 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	Duty of Candour was discussed at the (3i) Improvement committee in July which agreed that a formal task & finish group, chaired by a senior medical leader should be set up to progress all aspects of Duty of Candour. Dr Moody (CD for Specialist Medicine) has agreed to be the chair with a first meeting scheduled for September. Conversations have taken place in the Medical staffing committee around Duty of Candour awareness and training requirements and a 'survey monkey' is planned led by Dr Jeynes as MSC chair. A planning meeting in August, to agree scope and wider membership, proposed a revisit of the (originally drafted in 2019) DoC 'driver diagram' on Life QI
 The percentage of cases reported in that month where verbal duty of candour was completed within the nationally required 10 working day timeframe.	
 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.	There has been continued levelling of the acuity and dependency metrics in July, but this is 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. This is particularly reflective in the admitting wards, though the community beds remain at a steady state. 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.

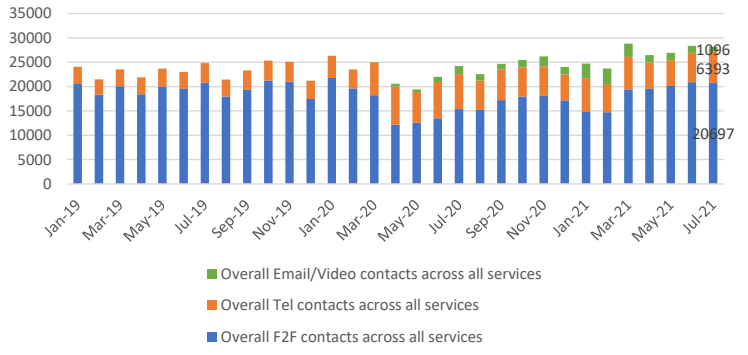
Board Report KPIs	Narratives
	This is now reported in Staffing paper.
A measure of the number of falls in the acute hospital measured per 1000 bed days. Community falls are excluded from this metric.	
	The number of patient safety incidents reported in July rose compared to recent months however the number of incidents resulting in harm remained at the lower level reported in June.
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 July as a consequence of increased reporting but remained broadly within the range of the previous 12 months.
The number of patient safety incidents reported as a percentage of occupied bed days to measure reporting rates	

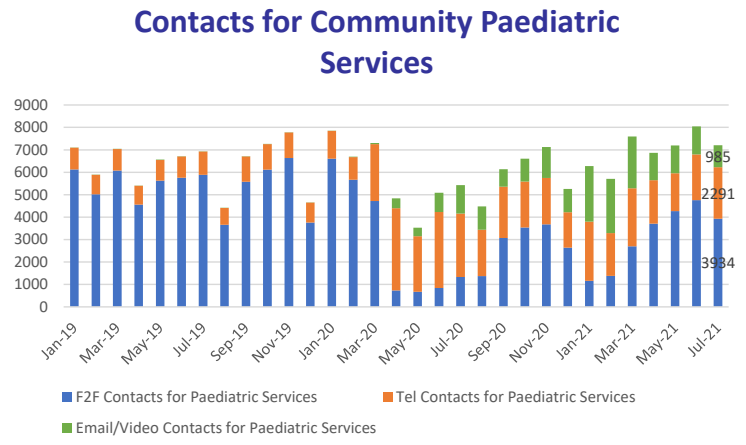
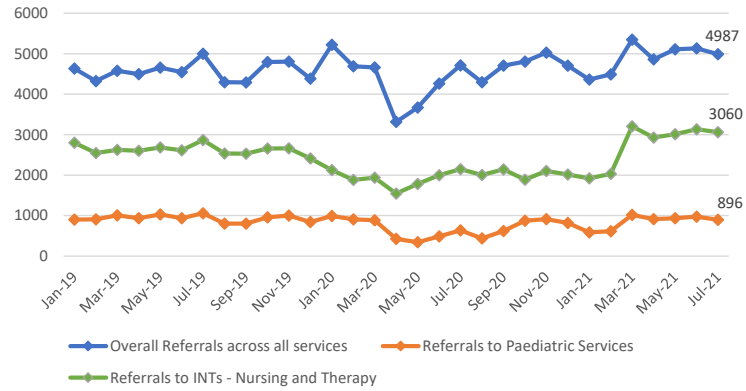
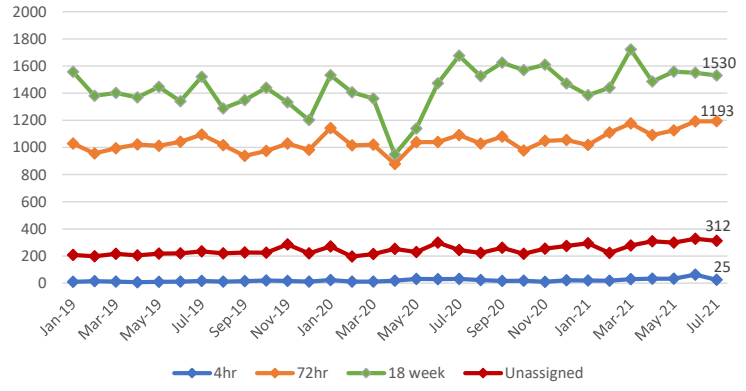
Board Report KPIs	Narratives
Pressure Ulcers  A count of the number of recorded new pressure ulcers across the Trust. This metric will include those recorded in the acute hospital and community settings	This is now reported in Staffing paper.
Acute Pressure Ulcers per 1000 Beds  A measure of the number 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.

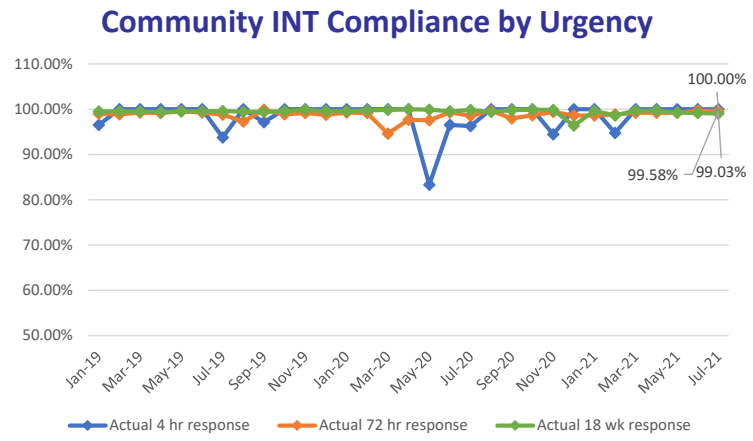
Board Report KPIs	Narratives
	20 formal complaints received in June which is our highest month recorded since February 2021. We have seen an increase in women and children's divisional complaints (5) specifically patient care and treatment antenatally, during labour and postnatally. We have also seen an increase in complaints relating to Gynae around patient care, staff behaviours (lack of empathy and communication) with ladies who have miscarried. We understand there are huge staffing pressures, especially in these areas which is reflected in the increase in complaints and PALS cases. We are looking at ways we can support the patient experience within these departments. A continued trend we have been seeing is in regards to communication across all divisions.
New formal complaints received and accepted, this counts both West Suffolk Hospital and Community	
	19 complaints closed in July which was a high amount given the amount of annual leave.
Formal complaints signed off by the CEO, this counts both West Suffolk Hospital and Community	
	A slight delay with some letters being signed at the Trust office and an increase in annual leave due to the summer has caused a delay with some responses. All complainants had been kept up to date with progress.
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 increased to 3 in July. At the end of July these services were: Paed SLT, Wheelchairs and Environmental. The maximum wait for each of these services are: Paed SLT - 36 weeks (increased from 33) Wheelchairs - 40 weeks (increased from 38 weeks) and Environmental - 18 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 vaciancies 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 July was 90.32% with the lowest individual service being Wheelchairs at 87.55%.
Services covered: Adult SLT, Heart Failure, Neurology Service, Parkinson's Nursing, Wheelchairs, Pead OT, Pead Physio and Pead SLT. RTT nationally is for consultant led services but the community services are required to report on compliance to 18 week Referral to Treatment locally to our CCG. Target is 95% of referrals are given a first definitive treatment within 18weeks	

Contacts for ALL Community Services (Adults and Paediatrics) 	The total activity for community services has returned to pre-COVID levels and exceeded the values although the ratio of face to face and other means of contact (telephone, video and email) have altered. March, April, May, June and July have been exceptionally above the levels of either March, April, May, June and July 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 as a whole has increased for the last 3 months
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 the same months in April, May, June and July 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 July.
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)	

Trust Public Board - 15 October 2021

Agenda Item:	10.3			
Presented By:	Helen Beck & Sue Wlkinson			
Prepared By:	Information Team			
Date Prepared:	Sept-21			
Subject:	Performance Report - August 2021 data			
Purpose:	**X**	**For Information**		**For Approval**

Executive Summary:

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

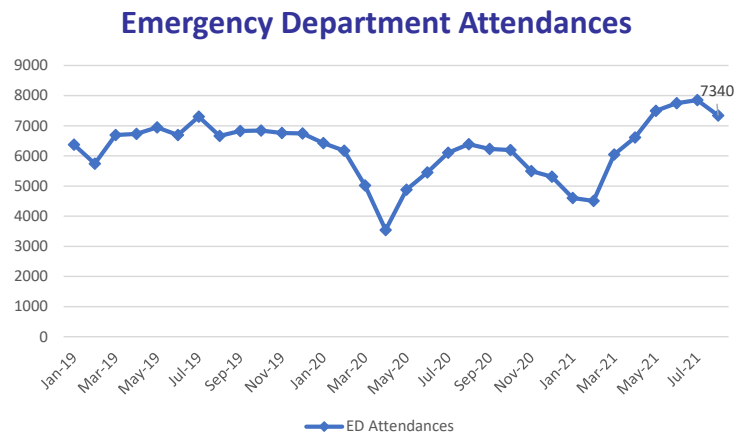
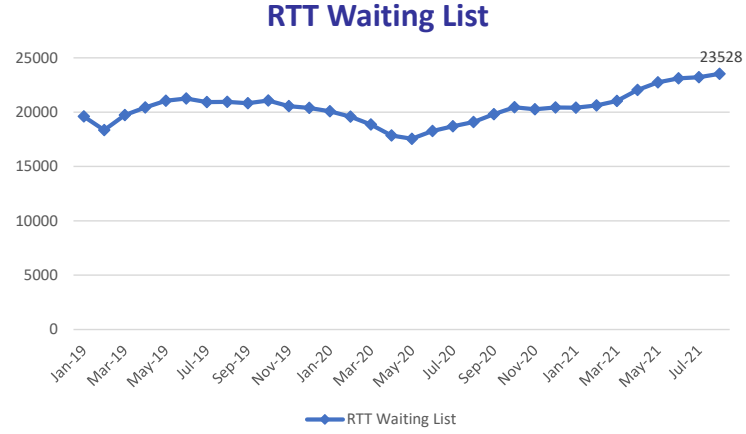
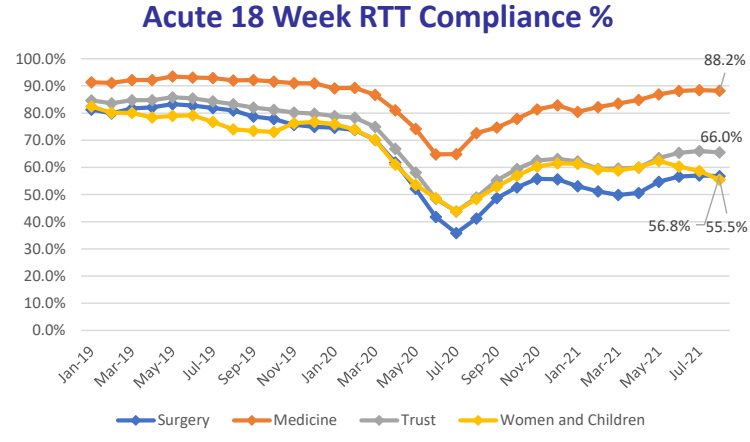
Trust Priorities [Please indicate Trust priorities relevant to the subject of the report]	**Delivery for Today**	**Invest in Quality, Staff and Clinical Leadership**	**Build a Joined-up Future**
	X		

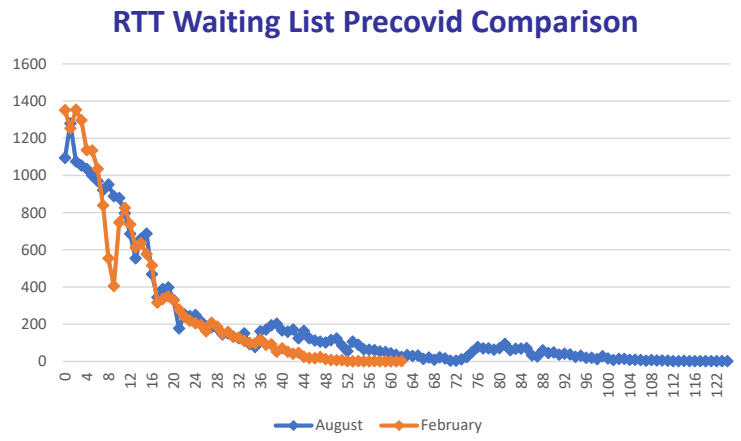
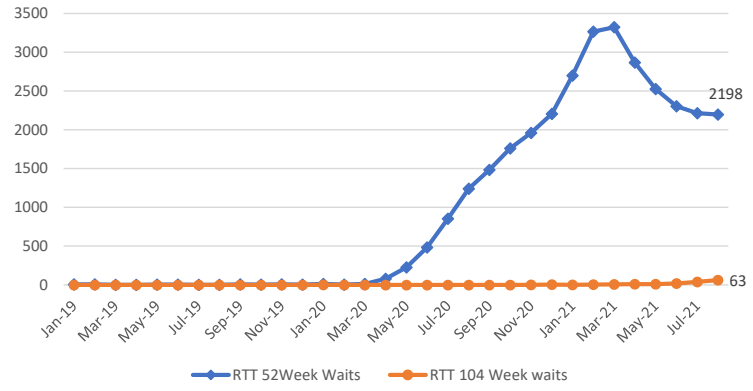
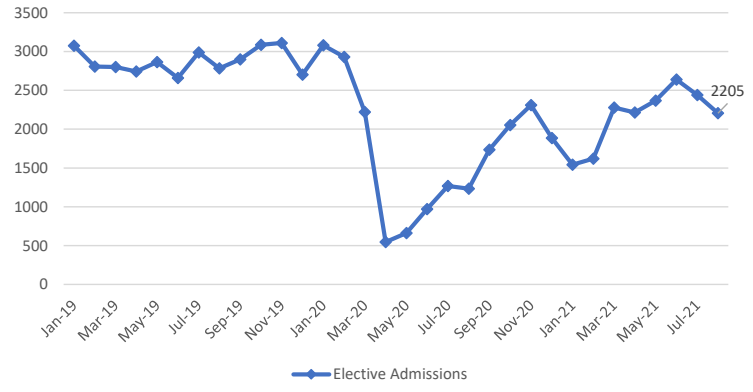
Trust Ambitions [Please indicate ambitions relevant to the subject of the report]	Deliver personal care	Deliver safe care	Deliver joined-up care	Support a healthy start	Support a healthy life	Support ageing well	Support all our staff
		X	**X**				**X**

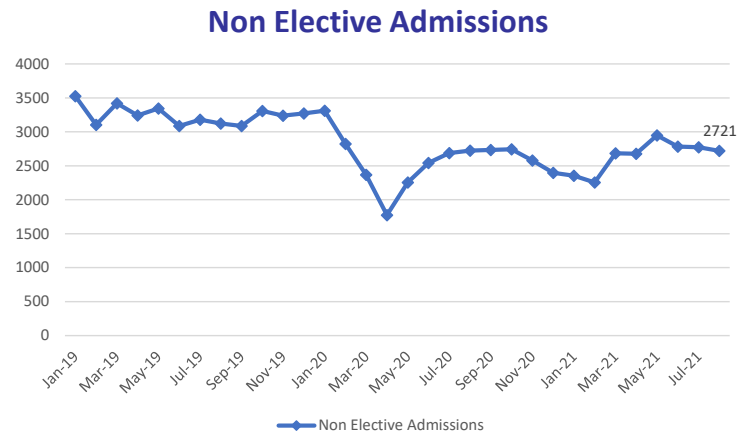
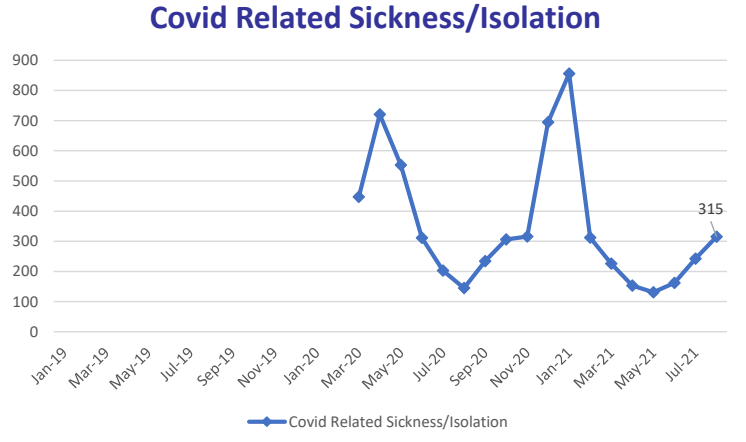
Previously Considered by:	Insight committee - October 2021
Risk and Assurance:	
Legislation, Regulatory, Equality, Diversity and Dignity Implications	

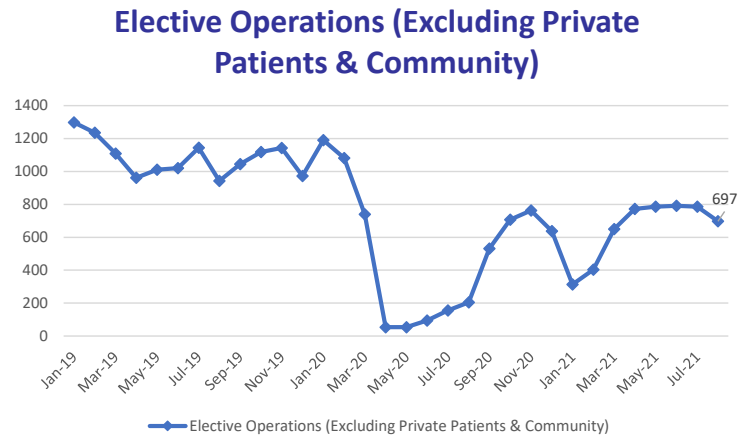
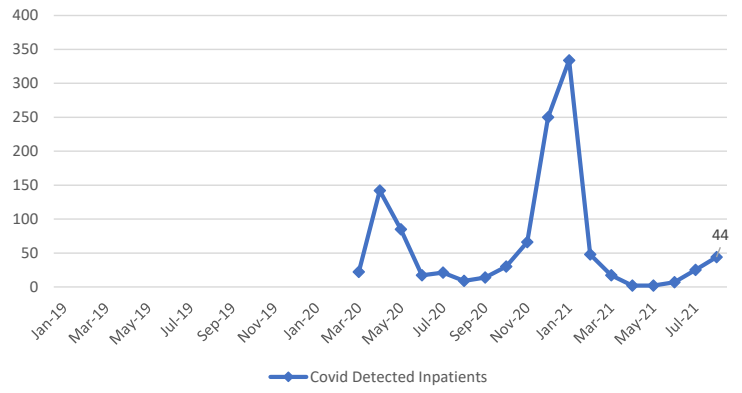
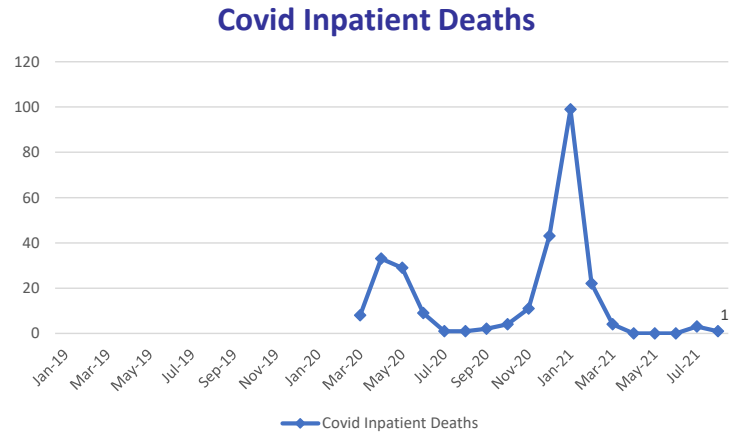
Recommendation:

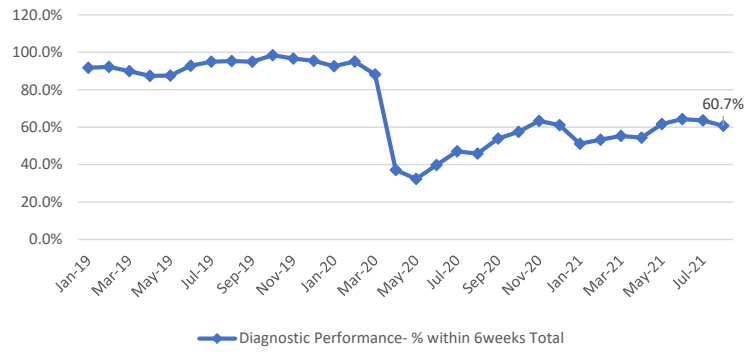
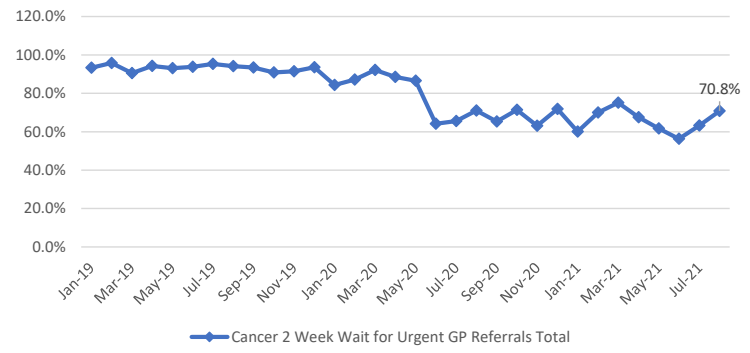
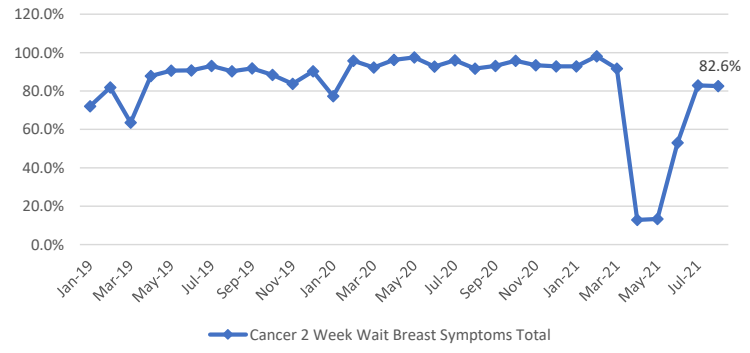
That Board note the report.

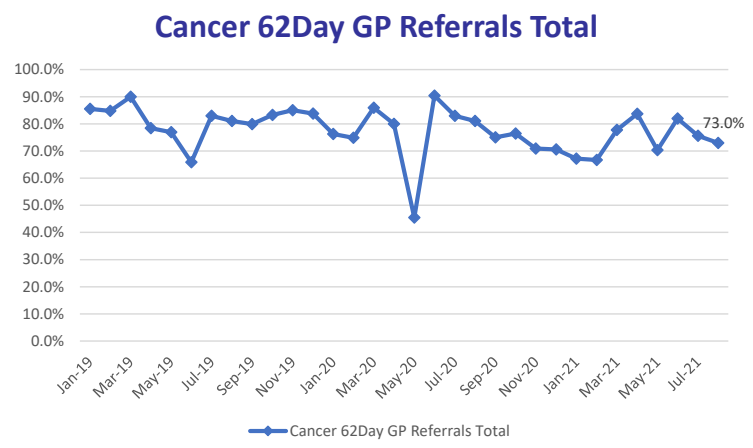
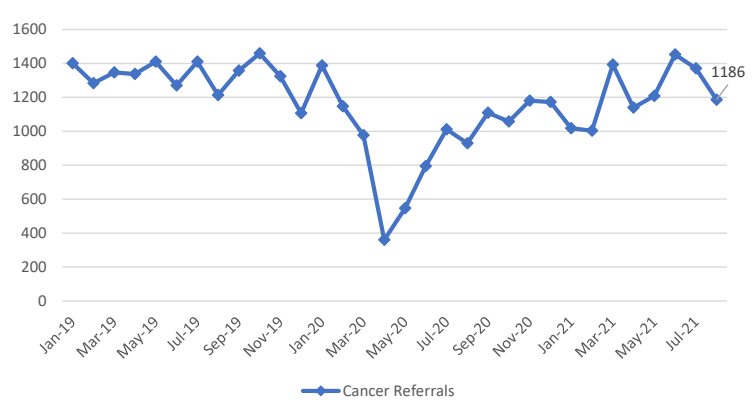
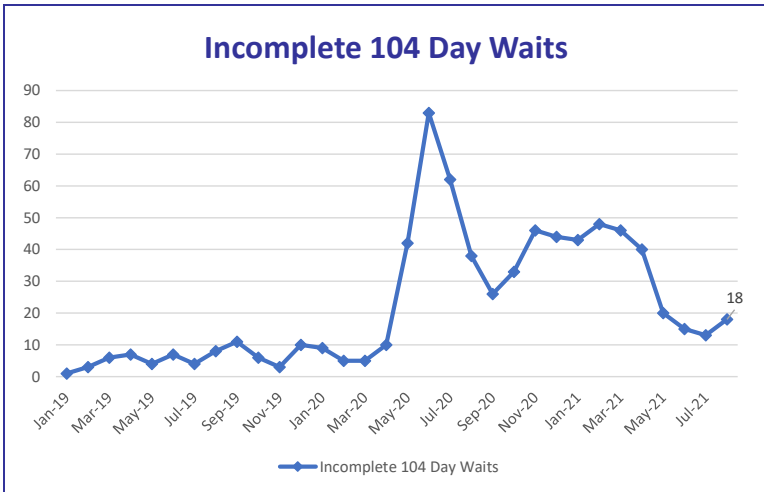
Board Report KPIs	Narratives
	Overall attendances have dropped slightly from 7852 in July to 7340 in August, this represents a 6.5% decrease in overall attendances. This decrease is seen within the non-admitted stream with a 7.5% decrease. There has been increases in all specialities for admitted patients during August, which has been reflected within the trust's current capacity and the increase in 12 hour LOS within ED during August at 107 versus 86 in July.
A count of the arrivals at the Emergency Department. This metric has no national target but is key to understanding demand for non elective services.	
	The total waiting list continues to rise as expected with referrals rising and reduced capacity to treat patients. The increase is steadier than it was with an addition of 200 patients this month.
A count of the patients on the waiting list for treatment.	
	As we have seen in previous months medicine continues to improve their position, now up to over 88%. Surgery has managed to sustain their position at 57% compliance, with the biggest constraint being the availability of main theatre capacity. Women's and Children's performance continues to drop, whilst paediatrics is making good progress, Gynaecology performance continues to decrease, mostly due to the capacity constraints with the Uro-Gynaecology sub-speciality.
% of patients on incomplete RTT pathways	

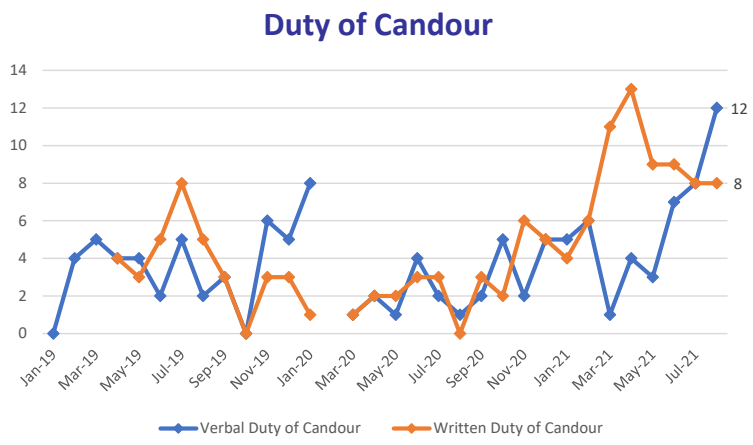
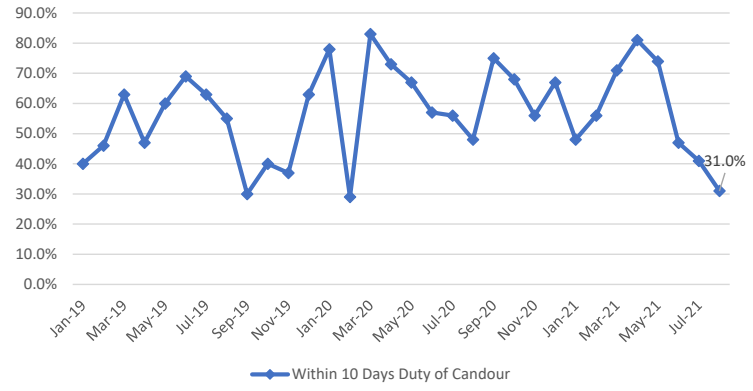
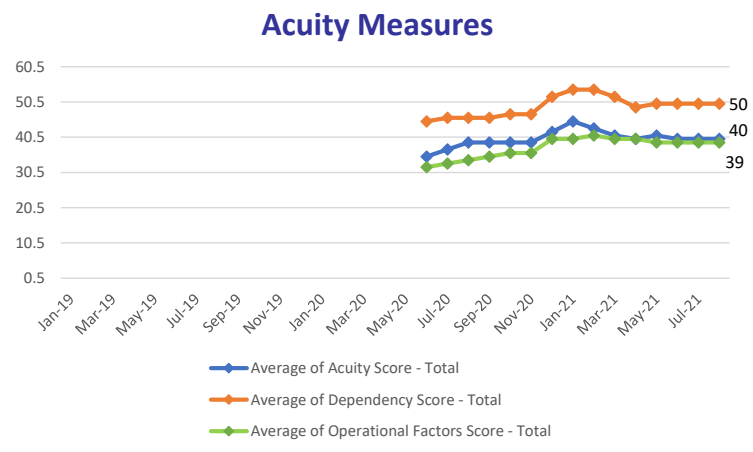
Board Report KPIs	Narratives
	The overall tail continues to increase and the patients waiting over 78 weeks is still increasing, again this is mostly within Surgical specialities and Gynaecology due to the limited main theatre access. The front end of the waiting list is now back up to that of pre-Covid, which shows the referral numbers increasing.
A year on year comparison of the number of patients waiting for treatment.	
	The 52 week wait position does continue to improve and we are making progress in those long wait pathways that do not require inpatient surgery. However, that decrease is slowing down. The amount of patients that are waiting over 104 weeks is increasing, with the bulk of these being within Orthopaedics. Overall the longer waits over 78 and 98 weeks continue to increase, with the patients 52-78 weeks slowly decrease.
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 have reduced in August in line with the summer holidays and the theatre work programme. One week in August there was a reduction from 2 to 1 elective main theatre due to the RAAC works.
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.	

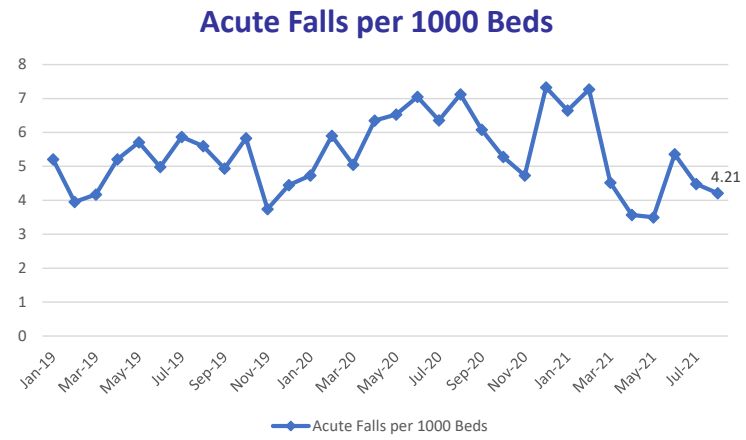
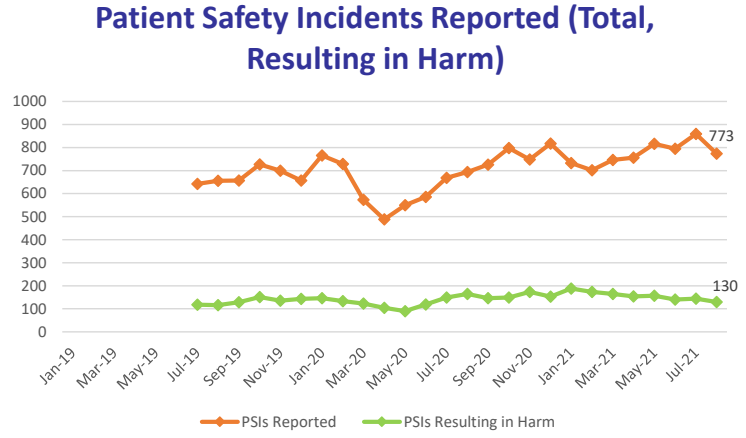
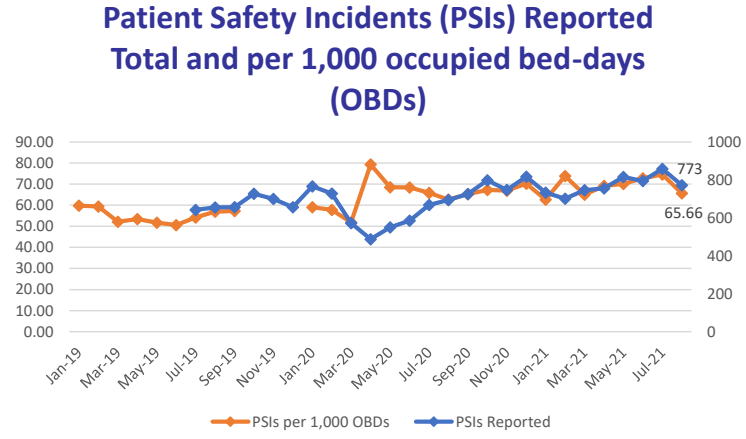
Board Report KPIs	Narratives
	Within August there has been a slight decrease of 1.9% in non elective admissions from July data. This is reflected in the decrease of AAU admissions during August. Admissions via ED have however increased in all adult specialities.
A count of the number of patients who 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 August 2021 was 4%, a slight increase on July 2021 figures of 3.9%. This increase was expected as we experience a continuing upward trend over the last three months.
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 August 2021 there were 315 episodes recorded which is an increase on July 2021 which recorded 242 episodes of COVID-19 related sickness; a continuing upward trend now for the last three months.
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.	

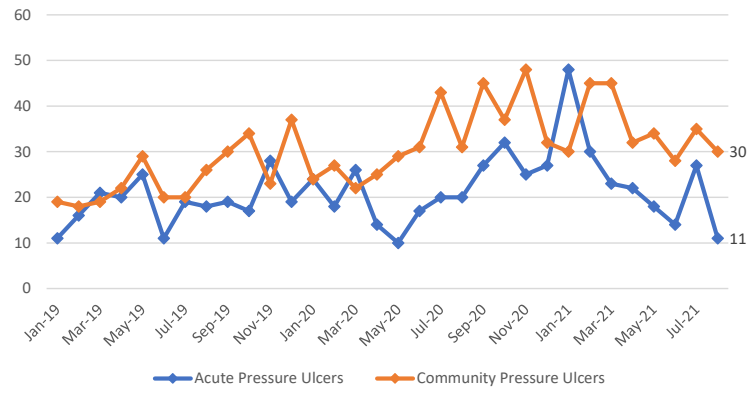
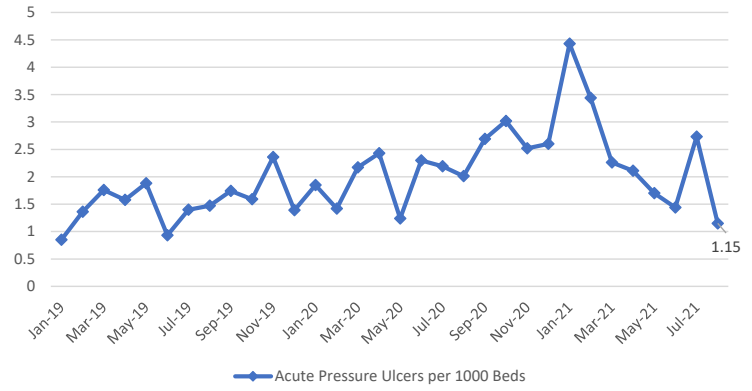
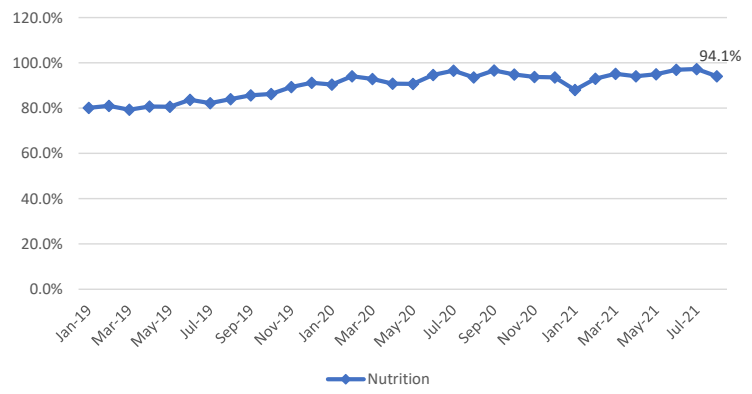
Board Report KPIs	Narratives
	During August there was one week where we only had one elective theatre within the Main theatre complex. In addition, there was some dropped lists within the day surgery unit due to well deserved consultant leave.
This is a count of the number of operations that were carried out. This is a local measure to monitor our productivity and recovery from Covid.	
	There were 44 individual patients admitted during August, who had their first diagnosis of Covid-19. In August the highest number of Covid positive inpatients residing in the trust on any one day was 13.
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 was 1 patients who died within 28 days of a positive Covid result in August. The total is now 270. 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.	

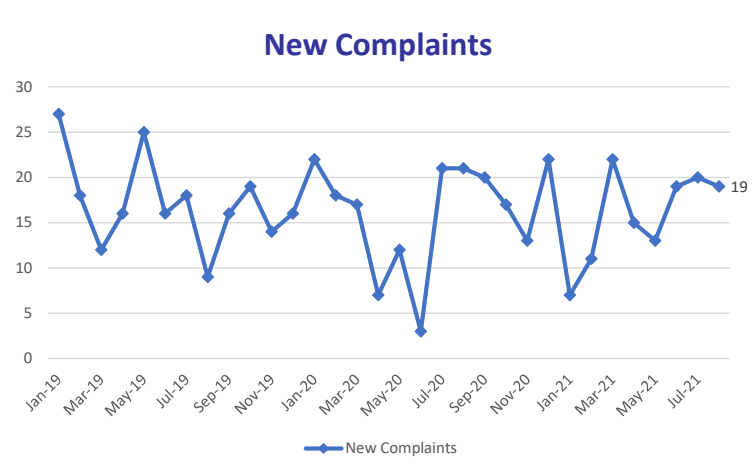
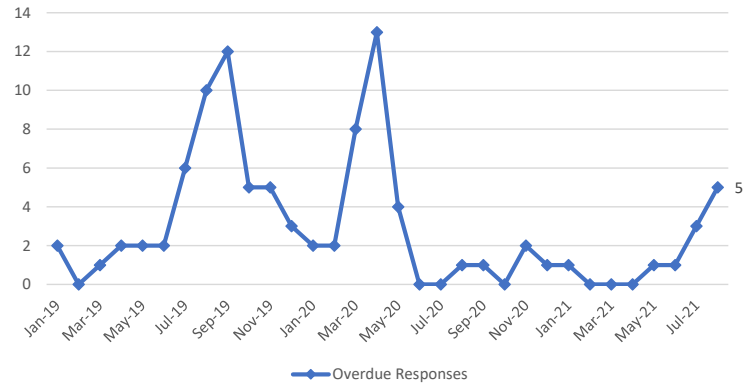
Board Report KPIs	Narratives
Diagnostic Performance- % within 6weeks Total 	A further drop in diagnostic performance in August. MRI and CT continue to perform at 100%. ECHO's had been performing at 100% but this performance has dropped in the last 2 months to 81% in August. This is mostly due to the demand rising and capacity still reduced due to current restrictions as well as staff shortages. Endoscopy services continue to improve slightly each month, with additional capacity coming on line & their overall waiting list reducing.
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 	Improved performance to 70% for August, this is still below the 93% standard. There are some specific constraints within Skin, which had performance of around 30%, Upper and Lower GI (which has improved but not to standard) and Breast. For Skin, an AI solution is commencing 4th October and we expect full recovery by November. Improvements continue for Upper and Lower GI. Breast had fully recovered in July, and was still at 90% for August but there are capacity challenges in September with some additional referrals.
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 symptomatic performance has been sustained at 82% for August. All patients are reviewed and triaged/prioritised.
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.	

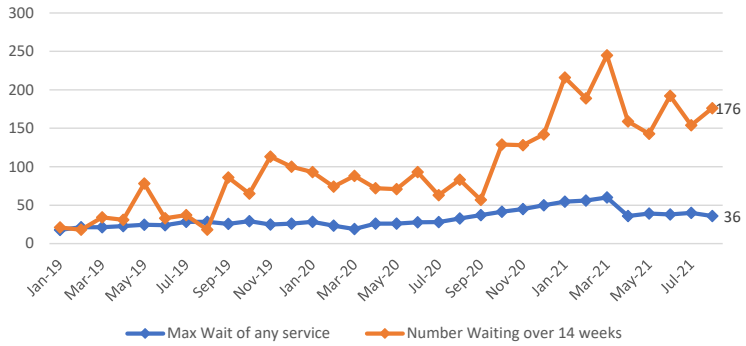
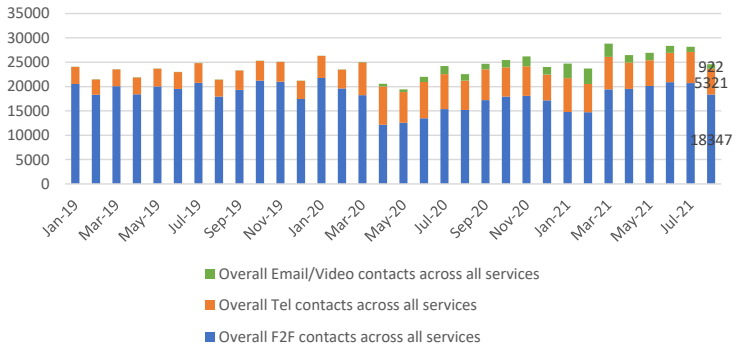
Board Report KPIs	Narratives
	As predicted our August performance for 62 days has reduced to 73%, largely due to the reduction in main theatre capacity which has reduced the flexibility.
To measure compliance with the national standards for access to cancer treatment. This metric measures the percentage 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.	
	August referral numbers did drop down from July, in line with our normal referral trends.
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).	
	Patients over 104 days had increased for the end of August, there is still a big focus on this and for the most part the long waits are due to multiple patient complexities and tertiary centre referrals.
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.	

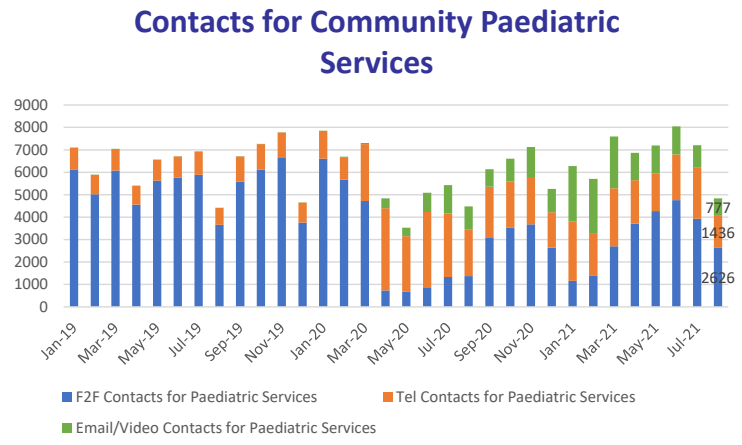
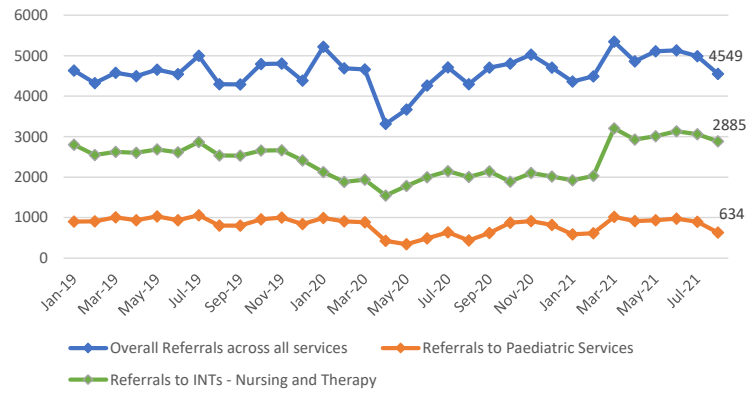
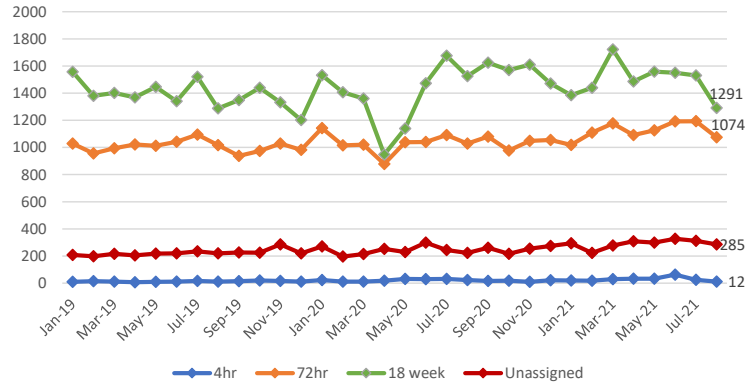
Board Report KPIs	Narratives
	The Duty of Candour task & finish group has not yet met, this is being arranged. The Duty of Candour improvement plan, led by the Head of Patient Safety & Quality, is being monitored through the new Patient Safety & Quality governance group. The Duty of Candour policy is scheduled for update and review in December and this will include review of the IQPR measures to ensure they are appropriate and reflect national mandates (e.g. the 10 working days target).
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 August. On review of the metrics, there are several areas who continue to experience higher than average acuity and / or dependency which correlates with the anecdotal pressures the wards and departments are continuing to experience. This is particularly reflective in the admitting wards, though the community beds remain at a steady state. 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. Nurse staffing has been under increased pressure during August due to vacancy, isolation and sickness, however this is not reflected in these measures.
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.	

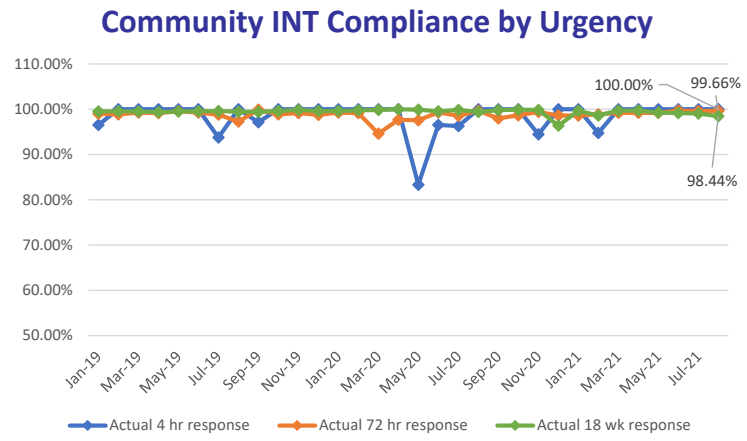
Board Report KPIs	Narratives
	This is now reported in Staffing paper.
A measure of the number of falls in the acute hospital measured per 1000 bed days. Community falls are excluded from this metric.	
	The number of patient safety incidents reported in total, as a % of occupied bed days and resulting in harm all dropped in August. More information on incident reporting can be found in this month's board learning report.
A count of the number of patient safety incidents reported in total and those resulting in harm	
	The number of patient safety incidents reported in total, as a % of occupied bed days and resulting in harm all dropped in August. More information on incident reporting can be found in this month's board learning report.
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
	19 formal complaints received in August which is now an average monthly figure received and relates to similar volumes pre-Covid. We continue to see an increase in women and children's divisional complaints (8) specifically patient care and treatment antenatally, during labour and postnatally. We have also seen an increase in complaints relating to Gynae around patient care, staff behaviours (lack of empathy and communication) with ladies who have miscarried. We understand there are huge staffing pressures, especially in these areas which is reflected in the increase in complaints and PALS cases. We have collated feedback from recent social media posts in relation to maternity both positive and constructive with the aim that we will put the positive comments onto a storyboard to try and boost morale and work with the head of midwifery to review and analyse the negative feedback. Due to the pressures seen within maternity wards, we have relaxed the timeframes for a response in order for clinical staff and management staff to focus working clinically which has been well received by the staff.
New formal complaints received and accepted, this counts both West Suffolk Hospital and Community	
	17 complaints closed in August. We have seen a high amount of sickness and annual leave over the summer holidays which has caused some delays in responses.
Formal complaints signed off by the CEO, this counts both West Suffolk Hospital and Community	
	Operational issues resulted in a small number of responses being sent to complainants beyond their timeframe, however contact was made with all and apologies offered. Changes in process will prevent this from reoccurring.
Any complaints which were sent outside of the given timeframe and no extension was agreed, this counts both West Suffolk Hospital and Community	

Board Report KPIs	Narratives
Community Non Consultant Led 18week Max Wait  Services covered: Adult SLT, Heart Failure, Neurology Service, Parkinson's Nursing, Wheelchairs, Paediatric Occupational Therapy, Paediatric Physio and Paediatric Speech and Language Therapy, There are no patients waiting over 52weeks for treatment from referral, so community look at number of patients waiting over 14 weeks. Historically, 14 weeks was agreed on as an internal measure because it gives an approx. number of patients who would breach the 18 week target at the end of the next month.	The number of services with patients waiting over 18 weeks has increased to 3 in August. At the end of August these services were: Paed SLT, Wheelchairs and Environmental. The maximum wait for each of these services are: Paed SLT - 31 weeks (decreased from 36) Wheelchairs - 36 weeks (decreased from 40 weeks) and Environmental - 23 weeks (increased from 19 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. Environmental has 1 patient waiting longer than 18 weeks due to service capacity issues.
Community Non Consultant Led 18week Compliance  Services covered: Adult SLT, Heart Failure, Neurology Service, Parkinson's Nursing, Wheelchairs, Pead OT, Pead Physio and Pead SLT. RTT nationally is for consultant led services but the community services are required to report on compliance to 18 week Referral to Treatment locally to our CCG. Target is 95% of referrals are given a first definitive treatment within 18weeks	The aggregated % of patients treated within 18 weeks for all community services in August was 92.11% with the lowest individual service being Wheelchairs at 85.71%. `
Contacts for ALL Community Services (Adults and Paediatrics)  Activity is counted as a face to face/telephone/email/video contact with a patient/carer/parent which is clinically relevant. This means activity that a clinician carries out which is writing reports, liaising with other healthcare professionals is NOT counted as activity. This is in line with acute systems where there is an assumption that clinicians will carry out related activities that result from contact with a patient.	The total activity for community services has returned to pre-COVID levels and exceeded the values although the ratio of face to face and other means of contact (telephone, video and email) have altered. March, April, May, June, July and August have been exceptionally above the levels of either March, April, May, June, July and August in the last 2 years of 2020 and 2019.

Board Report KPIs	Narratives
	The Paediatric services have moved a high proportion of their activity to telephone and email/video contacts but they are still unable to carry out any group work due to social distancing requirements. There are also shortages in clinic availability in certain locations. The wearing of masks and social distancing means Speech and Language therapy is particularly hard to do. The services are reviewing all possible options. Activity as a whole has increased for the last 3 months.
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 the same months in April, May, June, July and August 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 August.
Referrals into the Integrated Neighbourhood Teams have urgencies of Red (within 4 hours), Amber within 72hrs) and Green (within 18 weeks). These contractual urgencies are locally agreed pan Suffolk with the CCG and there is a 98% response target for Red, Amber and Green response times have a 95% threshold (These are local contractual targets)	

Comfort Break - 10 minutes

10:30 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

11. Improvement Committee Report

To APPROVE the report

For Approval

Presented by Jude Chin

Board of Directors – 15 October 2021

Agenda item:	11			
Presented by:	Jude Chin, Non-Executive Director & Improvement committee chair			
Prepared by:	Jude Chin, Non-Executive Director & Improvement committee chair			
Date prepared:	11 October 2021			
Subject:	Improvement Committee September 2021 – Chair's key issues			
Purpose:	X	For information		For approval

Executive summary:

The Improvement Committee met on 13 September 2021. Below is the Chair's Key Issues document which will constitute the standard template for Improvement Committee reports to Board.

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

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

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

Recommendation:

To approve the report

Chair's Key Issues – Improvement Committee

Part A

Originating committee	Improvement Committee	**Date of meeting**	Monday 13 September 2021
Chaired by	Jude Chin	**Lead Executive Director**	Sue Wilkinson

Agenda Item	**Details of Issue**	**For: Approval/ Escalation/Assurance**	**BAF/ Risk Register ref**	**Paper attached? ✓**
4.1.1	**Pressure ulcers**: A metric was needed for a level of assurance and clarification regarding flow of information to Insight/Improvement committees.	Assurance		
4.1.2	**Deteriorating patients out of hours**: It was acknowledged that deteriorating patients was not being adequately addressed. A proposal for additional resources to address the OoH escalation issues needed clear evidence to support the proposals and provide the results needed. Confirmation was needed regarding the approval process for the business case.	Assurance		
4.2.1	**Clinical audit/effectiveness**: Understanding was needed regarding how the process worked, monitoring and reporting however the work was moving forward and the appointment of a medical AD would help emphasise its importance.	Assurance		
4.2.2	**Duty of candour**: Work was in progress and the quality of DoCs was improving. Quantitative/quality work was on going for extra assurance. Clarification was needed regarding the reporting pathways.	Assurance		
4.2.3	**Community pain assessment**: Sandra Webb to detail a plan for community staff regarding documenting conversations with patients: it was believed this was happing but the process of recording electronically was still an issue.	Assurance		
4.3.1	**Never events**: Numbers had increased but there were no major themes, mitigating actions were in place and learning was shared. To move to bi-annual reporting to the committee unless there were concerns to escalate.	Assurance		
4.4	**Reporting structure/flow of information**: The reporting framework to be revisited for clarification and how it links to the other committees and governance groups.	Assurance		
5.1	**CQC assessment framework**: This was changing; consideration was needed regarding a self/peer/external assessment process and clarification	Assurance		

	needed as to where this should be reported/monitored within the new governance structure.			
Date completed and forwarded to Trust Secretary		Monday 20 September 2021		

Part B

Receiving Committee	**Board of Directors**	**Date of Meeting**	**3 September 2021**
Chaired by	**Sheila Childerhouse**	**Lead Executive Director**	**Craig Black**
Agenda Item	**Record of Consideration Given (Approved/ Response/ Action)**		
Date Completed and Forwarded to Chair of Originating Committee			

11.1. Maternity services quality & performance report

To APPROVE the report

For Approval

Presented by Susan Wilkinson and Karen Newbury

Trust Open Board– 15 October 2021

Agenda item:	11.1			
Presented by:	Sue Wilkinson, Executive Chief Nurse/ Paul Molyneux, Interim Medical Director & Executive MatNeo Safety Champion/ Karen Newbury, Head of Midwifery			
Prepared by:	Karen Newbury – Head of Midwifery Justyna Skonieczny- Deputy Head of Midwifery			
Date prepared:	September 2021			
Subject:	Maternity Quality & Safety performance Report			
Purpose:	x	For information		For approval

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

This report contains:
- eCare
- Maternity improvement plan
- Safety champion feedback from walkabout
- National Staff Satisfaction Survey Results
- Service user feedback
- National best practice publications
- Reporting and learning from incidents
- Maternity Clinical and Quality dashboard (Annex A)
- Continuity of Carer Trajectory
- NHSE Summer 21 Workforce Concerns Action Plan Plan (Annex B)
- 8 Point Maternal and Neonatal Service Action Plan (Annex C)
- ATAIN (Annex D)

<u>eCare</u>
Data collection is an improving picture and issues due to workflow and user input are slowly being resolved. The eCare and Information team continue to work closely with maternity team to address this. In the meantime, there is approximately a 2-month delay in providing the same level of reporting until all of these issues have been resolved. The Digital Midwife started on Monday 27th September 2021 and is currently undertaking her induction programme.

<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 captured the actions needing completion from the Ockenden and Maternity Incentive Scheme evidence submissions- and this will continue for the next few months. A schedule for reports to be written and presented each month has been developed for CNST year 4.

<u>Safety Champion Walkabout feedback</u>
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 30/9/2021 across NNU. Issues raised:

- Lack of ability to chain O2 cylinders
- Insufficient storage area/ power sockets
- Hight temperature in the drug room

It was acknowledged that the NNU has been relocated to a different area for the period of 2 months while some safety checks are being undertaken in their usual area and the issues raised are being addressed.

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

National Staff Satisfaction Survey Results

The National Staff Satisfaction Survey results were published in March 2021. On the back of the results, key elements of the survey were used to form a targeted questionnaire to band 5 & 6 midwives in April 2021, however survey returns were low in number. The division is keen to develop further action points by listening to staff in more detail and have led focus groups run by a manager from a different department. Staff engagement from maternity has been minimal. The division alongside their HR Business partner and Board Safety Champion continues to develop different methods to engage with staff to ensure support and that there is every opportunity for staff to be listened to in a productive way. Further to the whistleblowing within the maternity services, there has been a link to a very short survey sent to all midwifery staff to gain further understanding of what support is required to move forward with a closing date on the 1st October. Feedback from this will support and further inform our action plan, plan dissemination is planned for the week commencing 1st November 2021.

Service User feedback via F&FT and maternity Facebook page

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It's a quick and anonymous way to give views after receiving NHS care or treatment.

In August, the maternity service received 53 FFT returns, with the average score of 98.5 %.

National best practice publications

The publication of the new Caesarean birth NICE guidance has been discussed and a GAP analysis has been completed with the action plan in place to address areas for improvement.

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 and we are awaiting feedback.

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'). This is part of the ongoing collaboration with the Trust team.

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 August and 1 in September that required transferring for cooling that has been accepted by HSIB for investigation.

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 July 2021. From this month onwards, red rated data will be

represented in line with the national NHSI model of SPC charts.

The **Quality Dashboard** is also included. This gives assurance that the maternity service has a robust monitoring and auditing programme relating to quality and safety. Annex A highlights the red rated domains for August 2021 and improvement from previous red rated domains.

Indicators	Narrative
Appraisal completion	Reflects staffing issues at present, however high on line-managers/ Matrons' agenda to complete and improving trajectory with midwifery and obstetric team
Training compliance	Reflects staffing issues at present, however ongoing monitoring and compliance checks in place.
Daily checks	This is high on line-managers/ Matrons' agenda to complete and improving up on, discussed on a daily Safety Huddle to monitoring compliance.
Labour Suite coordinator supernumerary status and	In August 82% compliance was achieved. This was one of the lowest numbers reported this year and resulted from an increased staffing absence due to Covid 19, staffing shortages as well increase acuity over the summer period. The escalation policy was activated as required but there was a time delay from on-call staff being called to them physically being present on the unit resulted in some of the Red flags.
Midwife to birth ratio	Midwife to Birth ratio was 1:30 in August, this is higher than national average of 1:28 or Birthrate Plus recommendation of 1:27.7. There were some shortages in shifts due to Covid absences and staffing shortages that is reflected in the midwife to birth ratio, many were last minute which resulted in the shifts not being filled. Despite the increase in midwife to birth ratio 100% of 1:1 care provision has been achieved in August.

Continuity of Carer Trajectory roll out plan

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

NHSE Summer 21 Workforce Concerns Action Plan (Annex B)

Following an increased pressure with midwifery shortages NHSE developed an action plan for all Maternity Services to complete. There are 15 areas set out in this paper which include response to divert and escalation process for Maternity Service and this has been completed for Maternity Service at WSFT

8 Point Maternal and Neonatal Service Action Plan (Annex C)

In conjunction with regions, the national team have developed an eight-point plan with immediate and medium-term actions to ensure the safe care of pregnant women who have tested positive for COVID-19, and the management of current pressures on maternity and neonatal services. There are eight areas set out in this paper which include response to Covid-19 positive pregnant women; workforce; & vaccination. Key issues have been identified and responses outlined at a local, system/regional and national level.

ATAIN Programme (Annex D)

ATAIN (an acronym for 'avoiding term admissions into neonatal units') is a programme of work to reduce harm leading to avoidable admission to a neonatal unit for infants born at term, ie ≥ 37+0 weeks gestation. The programme focuses on 4 key clinical areas which make up the majority of admissions to neonatal units, however it is expected that shared learning from local reviews will identify other reasons for admission.

The ATAIN programme uses tools developed by NHS improvement for the 4 areas under focus:

• Respiratory conditions
• Hypoglycaemia
• Jaundice
• Asphyxia (perinatal hypoxia – ischaemia)

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

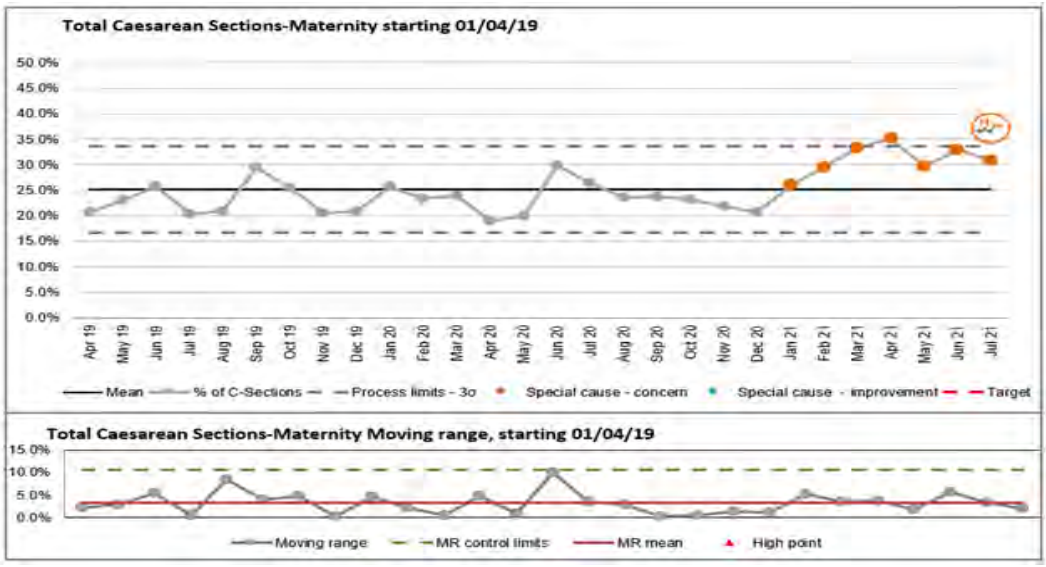
Trust ambitions	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	x	x	x	x	x		

Previously considered by:	
Risk and assurance:	
Legislation, regulatory, equality, diversity and dignity implications	
Recommendation: Receive for information	

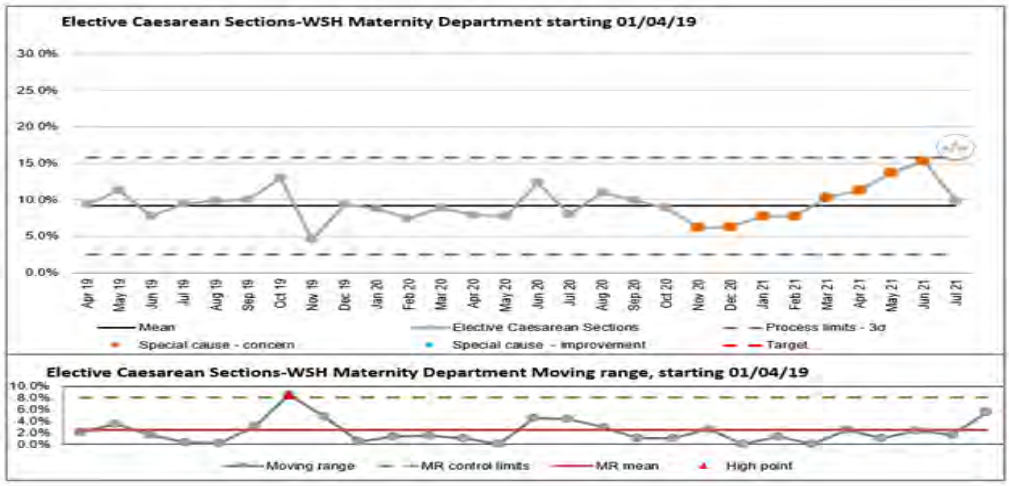
Annex A Clinical Dashboard

SPC charts

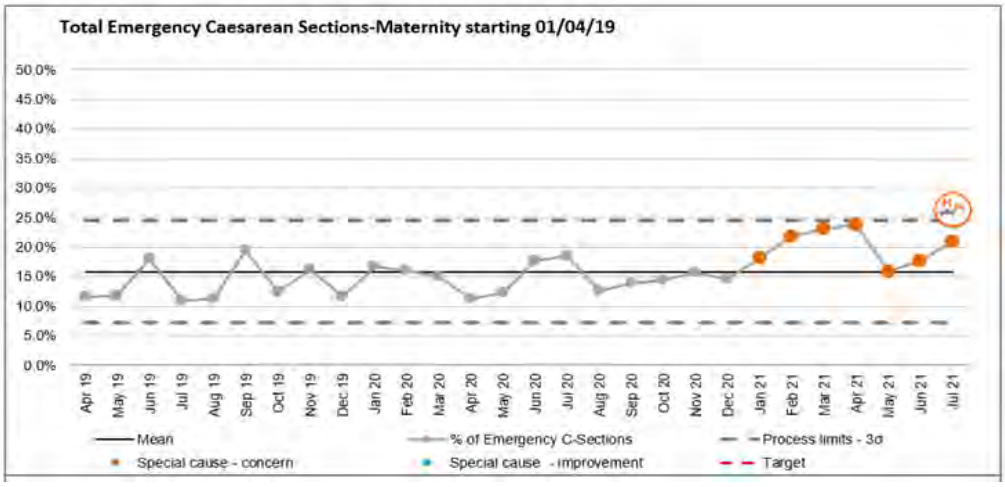
Total LSCS:



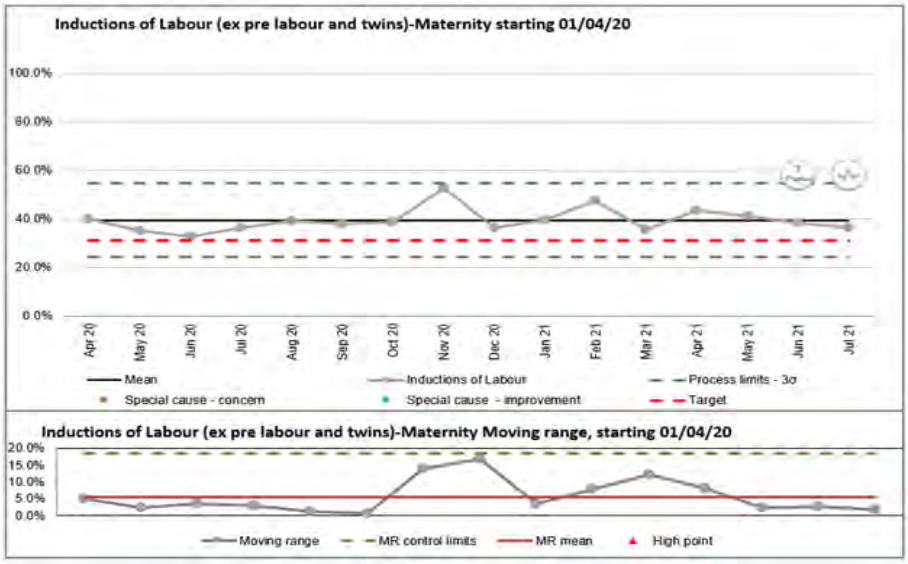
Elective LSCS:



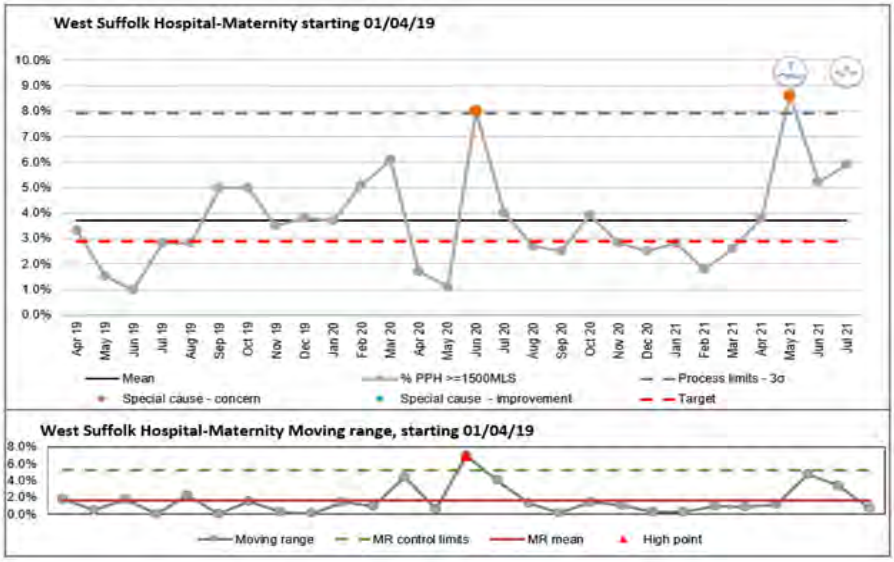
Emergency LSCS:



IOL:


Inductions of Labour (ex pre labour and twins)-Maternity starting 01/04/20
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Mean
Inductions of Labour
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
Inductions of Labour (ex pre labour and twins)-Maternity Moving range, starting 01/04/20
20.0%
15.0%
10.0%
5.0%
0.0%
Moving range
MR control limits
MR mean
High point

PPH:


West Suffolk Hospital-Maternity starting 01/04/19
10.0%
9.0%
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
Apr 19
May 19
Jun 19
Jul 19
Aug 19
Sep 19
Oct 19
Nov 19
Dec 19
Jan 20
Feb 20
Mar 20
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Mean
% PPH >=1500MLS
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
West Suffolk Hospital-Maternity Moving range, starting 01/04/19
8.0%
6.0%
4.0%
2.0%
0.0%
Moving range
MR control limits
MR mean
High point

Quality Dashboard

West Suffolk NHSFT	MIDWIFERY SERVICE: QUALITY DASHBOARD						
QUALITY TOPIC							
STAFF SUPPORT & DEVELOPMENT							
Appraisal completion	Standard	March	April	May	June	July	August
Midwives Hospital % in date	90%	80%	96%	91%	81%	68%	73%
Midwives Community & ANC % in date	90%	98%	99%	97%	98%	97.7%	96%
Support Staff Hospital % in date	90%	81%	90%	88%	84%	86%	79%
Support Staff Community & ANC % in date	90%	100%	89%	94%	93%	100%	100%
Medical Staff (Consultant) % in date	90%		82%	89%	94%	66%	66%
Mandatory Training Overview	Standard	March	April	May	June	July	August
Midwives: % compliance for all training	90%	95.5%	97.7%	98.7%	98.7%	98.5%	98.8%
Midwives: % compliance with PROMPT training	90%	96.0%	100.0%	100.0%	99.3%	97.7%	98.5%
Midwives: % compliance with GAP training	90%	87.0%	86.0%	78.0%	77.8%	81.7%	91.3%
Midwives: % compliance with Safeguarding Children training	90%	98.0%	99.0%	100.0%	100.0%	98.0%	99.0%
Midwives: % compliance with All Fetal Monitoring training	90%	78.1%	86.3%	56.3%	68.6%	89.6%	94.1%
ANC Midwives: % compliance with All Fetal Monitoring training	90%	100.0%	100.0%	85.7%	83.3%	50.0%	85.7%
Obstetric Medical Staff: compliance with PROMPT training	90%	89.7%	90.6%	90.3%	89.3%	96.4%	95.7%
Obstetric medical staff: % compliance with GAP training	90%	80.0%	83.0%	80.0%	91.7%	96.0%	95.8%
Obstetric Medical Staff: compliance with Safeguarding Children training	90%	85.0%	90.0%	92.0%	96.0%	96.0%	93.0%
Obstetric Medical Staff: % compliance with All Fetal Monitoring training	90%	90.9%	82.6%	91.7%	95.8%	83.3%	79.2%
EQUIPMENT SAFETY							
Checking of Emergency Equipment	Standard	March	April	May	June	July	August
Labour Suite: Adult Trolley	100%	97%	93%	100%	97%	94%	100%
Labour Suite: Resuscitaires		99%	97%	96%	95%	81%	81%
Ward F11: Adult Trolley		97%	97%	94%	100%	94%	97%
Ward F11: Resuscitaire		97%	97%	100%	97%	97%	97%
MLBU: Resuscitaires	100%	97%	100%	90%	99%	87%	87%
Community: Emergency Bags		94%	94%	97%	94%	94%	88%
MONTHLY QUALITY & SAFETY AUDITS:							
	Standard	March	April	May	June	July	August
Supernumerary Status of LS Coordinator	100%	94%	93%	96%	96%	81%	82%
1-1 Care in Labour	100%			99.50%	98.90%	No Data	100%
MW: Birth Ratio	1:28			1:28		1:33	1:30
No. Red Flags reported		1		1	4	17	18
Epidural response <30 min	90%	88%	Data per 1/4	Data per 1/4	96%	Data per 1/4	Data per 1/4
LSCS decision to delivery time met							
Grade I LSCS	95%	100.0%	100.0%	100.0%	100.0%	100%	80.0%
Grade 2 LSCS	80%	64.0%	74.0%	64.0%	64.0%	85.70%	57.8%
Governance							
Oututstanding Datix (last day of the month)		2	2	2	7	13	12
Out of date guidelines		2	2	2	4	6	
Number of serious incidents		1	1	0	1	1	0

Annex B- NHSE Summer 21 Workforce Concerns Action Plan

Annex C- 8 Point Maternal and Neonatal Service Action Plan

Annex D- ATAIN Programme

NHS
West Suffolk
NHS Foundation Trust

KEY (Change status)
1 Recommendation agreed but not yet actioned
2 Action in progress
3 Recommendation fully implemented
4 Other (please provide supporting information)

ACTION PLAN

Title:	*Divert / Escalation and Staffing Action Plan*	**DATE:**	*July 2021*
Action Plan Lead	*Name: Justyna Skonieczny*		

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

Recommendation	**Actions required** *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Comments/action status / as at date** *(Provide examples of action in progress, changes in practices, problems encountered in facilitating change, reasons why recommendation has not been actioned etc)*	**Change stage** (see Key)
1. Ratified NHSEI Regional divert policy	Recently ratified to launch and follow when divert necessary			Completed	3

2. Escalation Policy including Site Operations Team	Work collaboratively with site team to define role responsibilities local (i.e. who contacts EEAST) and ensure this is within the internal escalation policy	August 2021	Bleep Holder Band 7	Escalation Policy in place last up-dated in April 2021. Bleep Holder to instigated the escalation policy when required with the support from Matron/ Manager on call Bleep Holder attends daily Trust Safety Huddle When available the Trust will provide a Register Nurse/ Support staff to support postnatal ward	3
3. Offer enhanced payment to bank staff and staff with other roles to support such as additional RGNs HCSW and Nursery Nurses, specialist Registrars, neonatal nurses	DOM/HOM to implement with HR and executive agreement	July/ August 2021	HOM	Discussion took place regarding the provision of enhanced payment at Divisional and Trust level and this has been agreed with 2 weekly reviews Additional bank shift for RN available however no interest has been expressed	3
4. Implement a maternity bed manager	Identify a bed manager	Already in place	Bleep Holder Band 7	This is part of the Bleep Holder role	3

5. Specialist Midwifery support	Rostered in to support the service across July/Aug to add to clinical support	Ongoing	Bleep Holder Band 7	Part of the Escalation Policy that is follow when triggered points met	3
6. SLT review all meetings to holding essential only	Send out communication to all staff			Reviewed on a daily basis	3
7. Clinical review elective work/IOL and if possible transfer to another unit/trust within LMNS or outside of LMNS.	Embed as operational internal MDT daily discussions in safety huddles and system wide LMNS huddles as required	ongoing	Bleep Holder	Escalation policy in place and daily reviews including Safety Huddle, Consultant leading on decisions making about care plans in the event of high acuity Daily Staffing Tracker completed and being submitted to Region	3
8. Review staffing to unit template in response to acuity changes review staffing internally, call in midwives from community and as a last call COC teams	Embed as operational MDT daily discussions in safety huddles	ongoing	Bleep Holder/ Matrons/ Deputy HOM/ HOM	Birthrate Plus acuity tool in place 519 book used to record the daily activity Datix system with red flags reporting in place Safety Huddle every 24 hrs Escalation policy in place Bleep holders/Managers	3

				meeting twice weekly to review the staffing with senior team	
9. Suspend Home Birth service/closure of MLU	To write to confirm process for closure with staff			Reviewed on a daily basis depending on staffing situation and acuity	3
10. Matrons Hours	To work different pattern of hours to support the resilience in the service	ongoing	HOM	Matrons, Deputy HOM, HoM working flexible depending on service needs. Maternity Manager on call available 24 hours 7 days a week to provide senior support as required	3
11. Increase Agency staff	Contact the agency to recruit a long line agency midwife	July/August 2021	HOM	Agency staff requested however no interests expressed.	3
12. Utilise midwives for midwifery duties	Review any non-midwifery roles use of midwives in these areas: Recovery Scrubbing HDU Running TC			Recovery - initially unable to support Maternity as staff re-deployed to other clinical areas and due to the risk of separation of mother and baby main recovery areas not used Scrubbing- Midwives are not trained to undertake this role. HDU- not available TC- run by NNU staff with oversight of postnatal ward	3

				Business plan approved for additional support and administrative staff	
13. Review of staff isolation due to Test & trace App and PHE guidance	Identify staff who are isolating due to Test & trace App and review immunisation status for covid.	ongoing	Chief Nurse	New Trust policy in place- Risk assessment put in place that is being reviewed by Tactical Team twice daily to look at bringing safely staff back to work that had been in contact with person who was Covid +	3
14. Complete the regional daily sit rep	Currently weekly	ongoing	HOM/Deputy HOM	Sitrep for Maternity continues to be weekly	3
15. Complete regional digital emergency bed service	Daily Heatmap in place.	August 30 2021	Midwifery Manager on-call	Complete	3

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MATERNAL AND NEONATAL SERVICE ACTION PLAN

Title:	*Maternal and Neonatal service action plan*	**DATE:**	*August 2021*
Action Plan Lead			

Recommendation	***Where are we now?***	***Gaps identified ?***	***Action required***	***Action holder/ Action by date***
1. Care of pregnant women who test positive for COVID-19				
Local response				
1.Continue to follow infection prevention and control (IPC) guidance and undertake a full risk assessment to ensure safe delivery of care for all women and families.	- Infection Control guideline in place last up-dated July 2021 - The Management of Covid-19 in Maternity including IPC last up-dated December 2021 - Risk Assessment in place - Mandatory use of PPE in the Trust	None	None	N/A
2. Allow partners access to all maternity services.	Visiting as per pre-Covid 19 changes	None	None	N/A
3. MDT review of critically ill women with COVID-19, continue to follow local guidance on the timing of transfer to intensive care unit (ICU) and delivery making sure the right baby in right place are born	- Links with other departments required to care for Covid 19 women well established - Maternal Medicine meeting on 2 weekly bases -Guidelines in place sign off by the MDT	None	None	N/A
4. Continue repatriation of baby as soon as clinically safe to do so when appropriate cot capacity, safe staffing and transport are available.	- Recommendation met, no changes to the current practice required	None	None	N/A
5. Medical directors are asked to ensure that care meets the standards set out in the guidance of the Royal College of Obstetricians	- Links with other departments required to care for Covid 19 women well established - Guidelines in place sign off by the MDT	None	None	N/A

and Gynaecologists (RCOG) and Royal College of Midwives (RCM), including early senior involvement of the maternal medicine team for any pregnant or postpartum woman admitted with COVID-19.				
National response				
1.Collaboration with RCOG/RCM to update COVID-19 guidance, including the management of pregnant women with COVID-19 who are not admitted and the role of maternity services in giving advice and ensuring follow-up. General principles include: – encouraging attendance for usual pregnancy concerns or any worsening of symptoms – emphasis on an MDT approach – awareness and management of potential and sudden deterioration.	GAP analysis for MBRRACE completed	None	None	N/A
2.The Safety Improvement Programmes have produced safety information which includes advice for pregnant women and their families who have tested positive for COVID-19, are self-isolating or recovering from COVID-19. We are working to include a link to this information in the test and trace text confirming a positive test result.	National response required	None	None	National Team
2. COVID-19 vaccination for pregnant women				
Local response				
1.Proactively encourage pregnant women to get vaccinated against COVID-19	- Social media used to proactively encourage women - Take 5 used to share this with staff	None	Continue to encourage All women to have a vaccine	All staff
2. Ensure availability of up-to-date information on vaccination in pregnancy, including information on the safety of the woman and baby.	- Leaflets are provided prior to booking and at every antenatal app, and documented on e-care - Poster displayed in some clinical areas - Social media have been used to share the information	None	N/A	N/A

3. Provision of vaccination clinics within antenatal clinics and engagement of the most vulnerable populations about vaccination to encourage uptake	- Works are being undertaken with the Trust vaccination lead to support the provision of the vaccination clinic in ANC. - leaflets in top 5 languages.	Awaiting feedback from Pharmacy regarding commencement date	Nil at present	Tracey Oats
4.Vaccination programme and primary care to cascade key messages from the letter of 30 July from the Chief Midwifery Officer and National Clinical Director for Women's Health and Maternity to: – vaccination settings as a reminder that pregnant women should receive the vaccination if they choose. – primary care to have proactive discussions with women and partners about vaccination as part of routine preconceptual care.	-Social media used to share the information -Leaflets provided to all women - Posters displayed in some clinical areas	None	N/A	N/A
5. Increase the involvement of maternity voices partnerships (MVPs) and other networks in the cascade of information on vaccination in pregnancy, and ensure concerns raised by women and their families are addressed-	- Maternity Service at WSFT has a well-established relationship with MVP, - Regular bi-monthly meeting taking place to up-date on current situation - MVP sharing the information on their MVP website,	None	N/A	N/A
6. Provide information at every contact with pregnant women, including to children's centres.	- Leaflets are being provided at every appointment with the community midwife during antenatal/ postnatal period. This discussion is documented in Maternity E-care system	None	N/A	N/A
7. Local engagement with pharmacy colleagues encouraging them to take the opportunity to have proactive discussions on vaccination when pre/antenatal women are purchasing pregnancy tests/folic acid.	Actioned own by CCG	None	CCG to respond	CCG

8. Health visitors should use the 28-week health check to provide information and support women on vaccine choice.	Actioned own by CCG	None	CCG to respond	CCG
9. Health visitors use their five universal health reviews (particularly newborn visits) to support mother and infant health and wellbeing, and use this as an opportunity to support women in their vaccine choice.	Actioned own by CCG	None	CCG to respond	CCG
Regional response				
1.Regions to engage directors of public health regarding proactive promotion of vaccines to pregnant women.	Regional response	None	Regional response	Regional response
National Response				
Letter of 30 July from the Chief Midwifery Officer and National Clinical Director for Women's Health and Maternity asking maternity services to: – advise women on vaccination in pregnancy at every antenatal contact – ensure that recommended Public Health England (PHE) and RCOG leaflets are given to every pregnant woman and that these leaflets and other materials (posters) are available in maternity settings – encourage vaccination uptake among maternity staff (see below).	 Complete Complete Encouragement given	None	N/A	N/A
Lead midwives for education/council of deans to contact education providers with a request for student midwives and O&G trainees to receive information and advice to ensure they can support pregnant women when on placement.	National Response	None	National Response	National Response
Work with PHE and other national stakeholders as appropriate to produce additional maternity-specific materials on	National Response	None	National Response	National Response

vaccination in pregnancy, including a poster and promotional videos for use in antenatal settings.				
Share details of pilot sites where vaccination clinics have been set up within antenatal clinics.	National Response	None	National Response	National Response
3. COVID-19 vaccination – to increase uptake among the maternity workforce				
Local response				
1. Every provider to ensure a supportive conversation has taken place with any member of the maternity team who has not had a vaccine.	Information shared with all maternity team advising the Covid vaccination	TBC		
National Response				
1. Letter of 30 July from the Chief Midwifery Officer and National Clinical Director for Women's Health and Maternity to encourage uptake of vaccine among professionals.	National Response	None	National Response	National Response
2. Chief Midwifery Officer and National Clinical Director for Women and Maternal Health to host a webinar on the vaccination of maternity staff.	National Response	None	National Response	National Response
3. Continue to work with PHE, RCOG and RCM as appropriate to support activity and ensure the availability of information and materials to further encourage uptake.	National Response	None	National Response	National Response
4. Workforce – maternity multidisciplinary team				
Local response				
1. Staff who are well, in self-isolation or shielding should be supported to undertake virtual appointments to release	-Community MW's undertakes virtual appt when able to do so.	None	Ongoing discussion with staff effected to	Bleep Holders/

other midwifery and obstetric staff to provide care that requires physical presence	- New guidelines has been approved by the Trust and twice daily meetings to review the risk assessment submitted are undertaken for staff who have been advised to self-isolate.		make sure the process is being followed	Managers/ Matrons
2. Ensure local processes are in place, as per guidance, to ensure essential frontline staff can return to work following a negative PCR if they have been asked to isolate due to potential contact with COVID-19	Risk assessment in place reviewed by the Tactical Team to bring staff back to work	None	Ongoing discussion with staff effected to make sure the process is being followed	Bleep Holders/ Managers/ Matrons
3. Consider potential opportunities for additional support for student midwives, newly qualified midwives and trainees and the opportunity for retired midwives to return to practice	-Newly qualify midwives offered to start as Band 3 while awaiting NMC registration, -HOM to write to all staff that have retired to ask for assistance	None	Awaiting response from staff complete	Karen Newbury
4. Avoid the redeployment of obstetricians, obstetric anaesthetists and other medical members of the MDT	No staff have been re-deployed within the Trust	None	N/A	N/A
Regional response				
1.Support the collection of real-time essential data to understand and evidence capacity issues to manage a regional/system response.	Daily heat map- Staffing Tracker being submitted to the Regional Team	None	N/A	Regional response
2.Ensure a co-ordinated response to escalation and collaboration across the region including mutual aid where appropriate.	Regional Response	None	N/A	Regional response
National response				
1.Clinical guidance Delivering midwifery intrapartum care where local COVID-19 escalation protocols are required to be enacted published in Wave 1 to be reviewed, updated and reissued.	National Response	None	N/A	National Response

2. Work with the NMC to explore the possibility of accelerating the time between completing qualification and achieving full registration.	National Response	None	N/A	National Response
3. Funding of supernumerary Band 7 midwife for the remainder of 2021/22 for every maternity unit in England to support with recruitment, retention and pastoral care.	National Response	None	N/A	National Response
4. Additional funding for 1,200 additional midwives and the equivalent of 100 more whole time equivalent (WTE) obstetric consultant posts across England to be in place from September 2021.	National Response	None	N/A	National Response
5. Review and accelerate programmes of work with royal colleges that support recruitment and retention.	National Response	None	N/A	National Response
5. Maternity Transformation Programme workstreams and other national initiatives/reporting/assurance				
1. Trusts to consider the potential for additional governance, data and administrative support for maternity services	Administrative support business case approved, additional posts out to advert.	None at present	N/A	Karen Newbury
National response				
1.Review planned requests of trusts/systems and non-essential reporting to ensure a focus on safety throughout the period of escalation.	National response	None	N/A	National response
2.Where requests cannot be avoided, these will be reviewed to ensure they are not overly burdensome and that they make best use of existing processes and resources.	National response	None	N/A	National response

3.Through the Stakeholder Council, liaise with partner organisations – including Care Quality Commission, Health Education England, Healthcare Safety Investigation Branch, NHS Resolution and PHE – regarding the significant pressures on maternity services and ask for support in reducing the burden on services at this time.	National response	None	N/A	National response
6. Charities – support from non-NHS organisations				
National response				
1.Engage with and work alongside our key stakeholders, including charities and support groups, to share and amplify key messages to women, their families and members of the public, with a particular focus on areas of social deprivation and vulnerable/high-risk groups.	National response	None	National response	National response
2.Support the Pregnancy and Baby Charities Network (PBCN) to revise the scope of support that they can offer to women and families, as well as maternity services during periods of heightened escalation during the pandemic.	National response	None	National response	National response
3.We will ensure regular and formal contact with MVPs, to ensure consistent communication to service users, and to boost the support and encouragement they provide to staff.	National response	None	National response	National response
7. Working with other services				
Local Response				
1.Work collaboratively with ambulances trusts to ensure routine escalation policies are enacted when required.	Process already in place	None	N/A	N/A

2.Local services and regional colleagues to consider contingency plans to maintain homebirth services	Service continues as normal as long as staffing situations allows- this is being reviewed on an at least daily basis	None	N/A	N/A
3.Reinforce importance of maintaining maternity theatre provision, staff and obstetric anaesthetists and ensure redeployment to other areas does not occur, supported by the RCM/RCOG	Service continues as normal	None	N/A	N/A
4.Paediatric critical care surge plans have been developed in every region led by the paediatric critical care operational delivery networks (ODNs). Continue to engage the neonatal ODNs in RSV surge planning to ensure access to neonatal critical care is maintained and not compromised	Service continues as normal	None	N/A	N/A
8. Communication				
Regional response				
1.Regional communications teams to reinvigorate their local vaccination messaging and activity targeted at pregnant women. For example, ensure new case studies are profiled, reinforce advice on vaccination using regional and local spokespeople to highlight the importance of vaccination for pregnant women.	Complete via LMNS	None	N/A	LMNS
National responses				
The national campaigns team to explore the feasibility of a national maternity vaccination campaign.	Await actions	None	N/A	National response
The vaccine communications team will review current messaging and materials with a view to strengthening messaging for pregnant women, i.e. vaccination is recommended during pregnancy.	Complete	None	N/A	National response

The vaccine communications team will plan communications targeting partners in recognition that the decision to have the vaccination may be made collectively rather than solely as an individual.	Await actions	None	N/A	National response
The nursing communications team will work with vaccine communications team to identify new case studies and will seek to secure national media coverage to raise further awareness and encourage uptake.	Await actions	None	N/A	National response

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ATAIN Programme

Avoiding Term Admissions to the Neonatal Unit

Progress Report
Quarter 2
APRIL - JUNE 2021

JULY 2021

Sarah Paxman - Clinical Risk Midwife
Dr Ian Evans - Neonatal Safety Champion
Karen Ranson - Ward Manager NNU

Background to project

ATAIN (an acronym for 'avoiding term admissions into neonatal units') is a programme of work to reduce harm leading to avoidable admission to a neonatal unit for infants born at term, ie ≥ 37+0 weeks gestation.

The programme focuses on 4 key clinical areas which make up the majority of admissions to neonatal units, however it is expected that shared learning from local reviews will identify other reasons for admission.

The ATAIN programme uses tools developed by NHS improvement for the 4 areas under focus:

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

The local definition of an admission is a baby who is on the neonatal unit for more than 4 hours.

Local reviews

For all unplanned admissions to the neonatal unit for medical care at term, a joint clinical review by maternity and neonatal services takes place each month to identify learning points to improve care provision, and considers the impact that transitional care service has on reducing admissions and identifies avoidable harm. Learning is identified and included on a rolling action plan. The review group includes:

- Neonatal ward manager / neonatal practice development nurse
- Clinical risk manager / clinical risk midwife
- Consultant paediatrician
- Consultant obstetrician (either attends the meeting or reviews records outside of the ATAIN meeting)

Process for review

The neonatal and midwifery team review the maternal and neonatal records prior to the ATAIN meeting using the approved NHS improvement tools. Cases identified which require in depth obstetric review are discussed with a consultant obstetrician to determine if different care in labour may have reduced the risk for the baby.

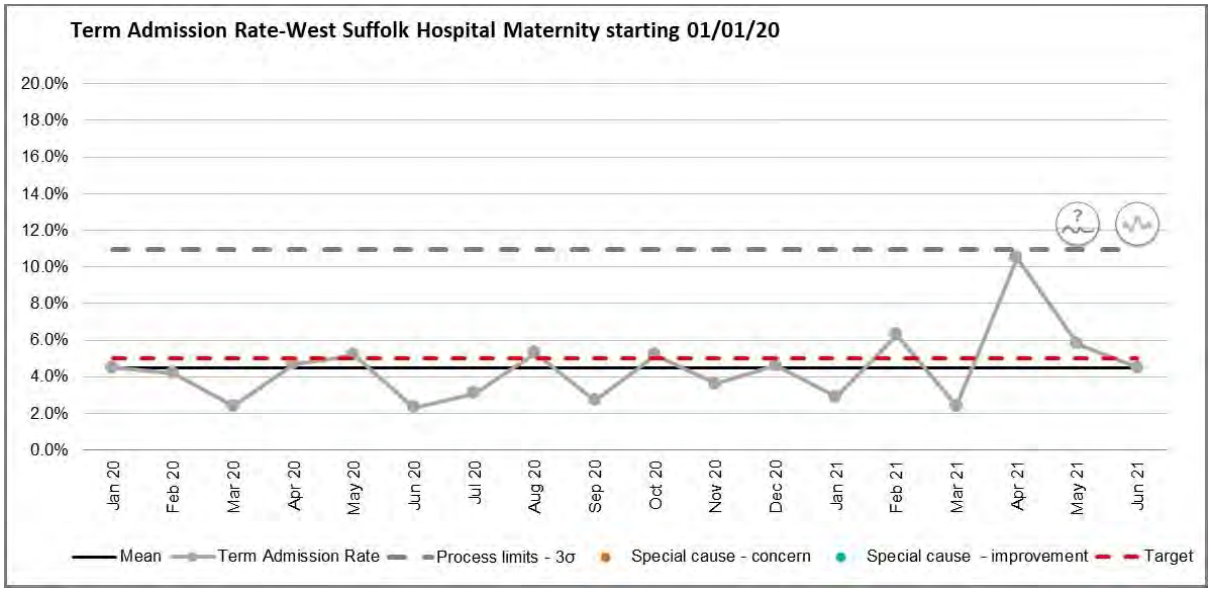
Findings

Term admission rates vary month on month. During the past quarter there has been an increase above the national average. Cases were reviewed carefully to identify any themes or areas for improvement. No obvious themes in terms of reason for admission could be identified, and there have been no changes to the criteria for Transitional Care which could explain the increased rate.

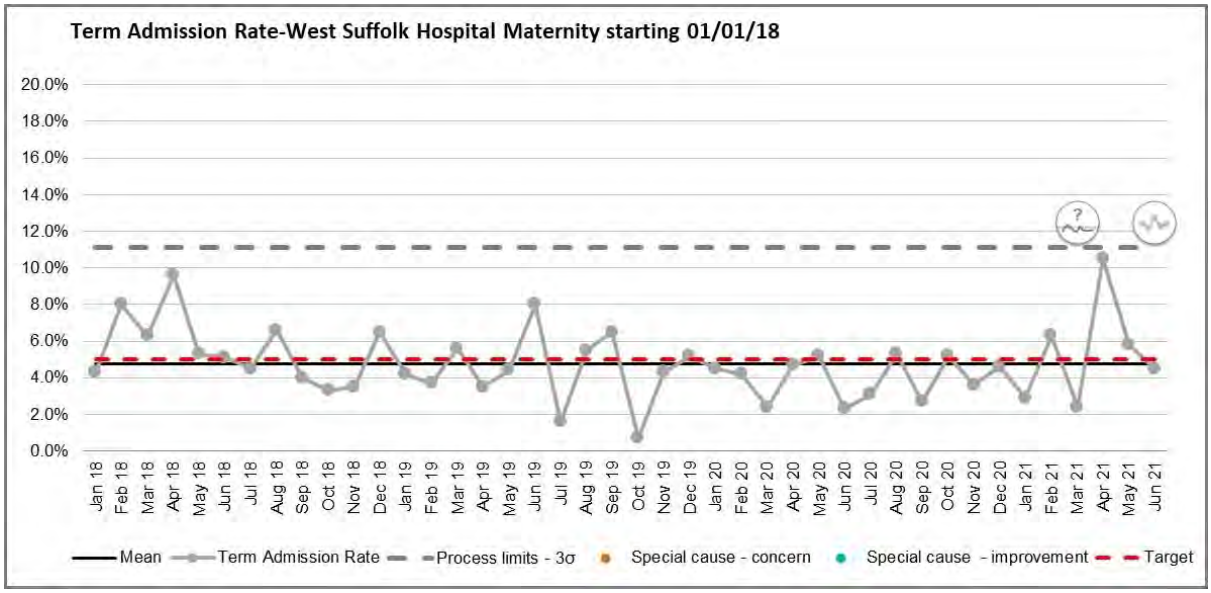
During May 2021 it was identified that there was a trend of low admission temperatures in babies who required admission to the NNU. This has been explored and learning has been shared to address the issue of cool room temperatures on the Labour Suite and in the obstetric theatre as a result of using air conditioning during spells of hot weather.

This alone does not explain the increased rate, but is continuing to be addressed and monitored.

Progress

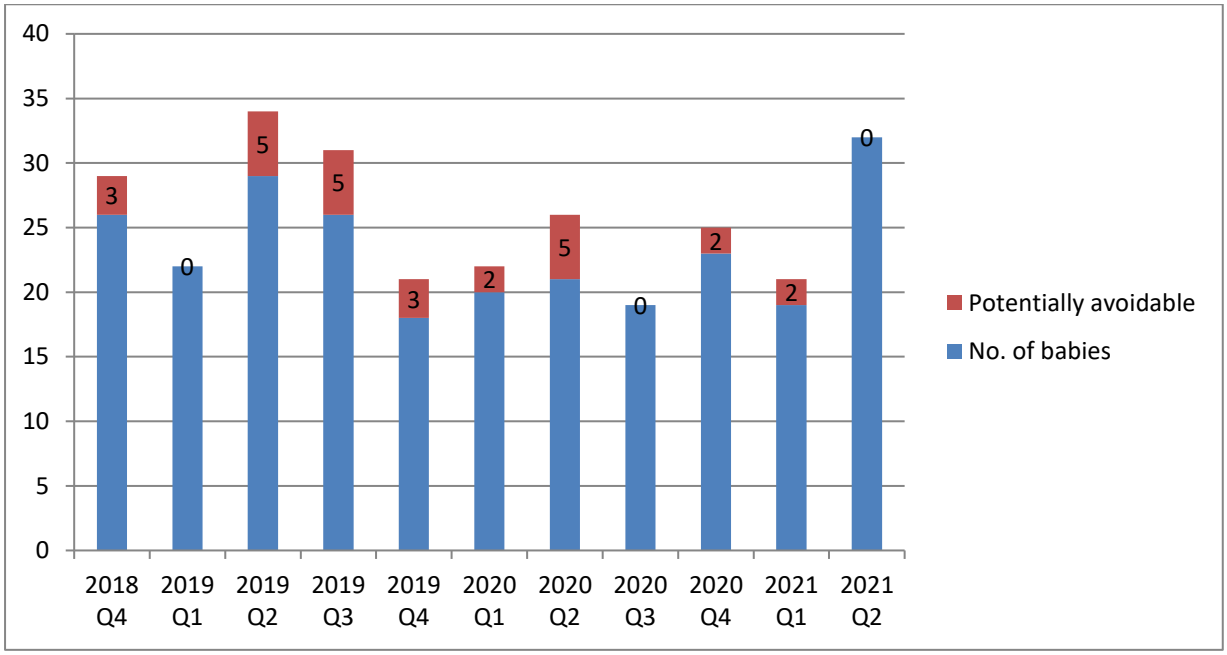


Overall progress since programme began



Potentially avoidable term admissions

In the past quarter, none of the admissions were classified as avoidable, in terms of our current guidelines and criteria for TC.



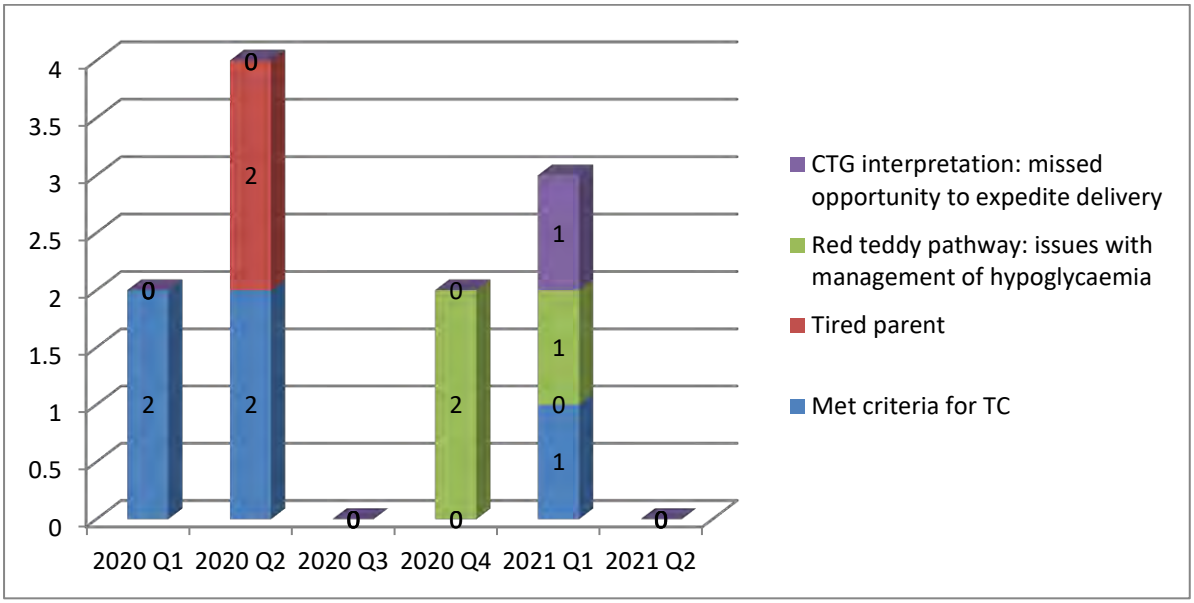
However, three cases were deemed to have been potentially avoidable *if* improvements were made to the way that the Transitional Care bay located on ward F11 is run. Currently, this bay is not able to staffed by neonatal unit staff. Instead, nurses and nursery nurses visit the ward when observations are due, etc.

More babies would be able to remain by their mothers' side if TC had a member of neonatal unit staff present at all times for observation (three cases this month involved periods of >4 hours observation on NNU with grunting, but the babies did not require respiratory support). As TC currently works, with no member of the NNU team present consistently, it is not considered to be safe enough to transfer babies to TC until their respiratory symptoms are fully resolved.

Improving the TC service would require investment in more neonatal unit staff. Something that has been requested by the NNU Manager. If a member of staff was able to be present consistently to care for babies in TC, the criteria for TC could be reviewed and expanded. This would be a positive step to reduce unnecessary separation of mothers and babies.

Until the staffing arrangements are changed, babies who require close observation will continue to be admitted to the NNU, as this is considered to be the safest option in terms of clinical care and treatment, despite the harm caused through separation.

This table shows the reasons previously identified as being the cause of potentially avoidable admissions.



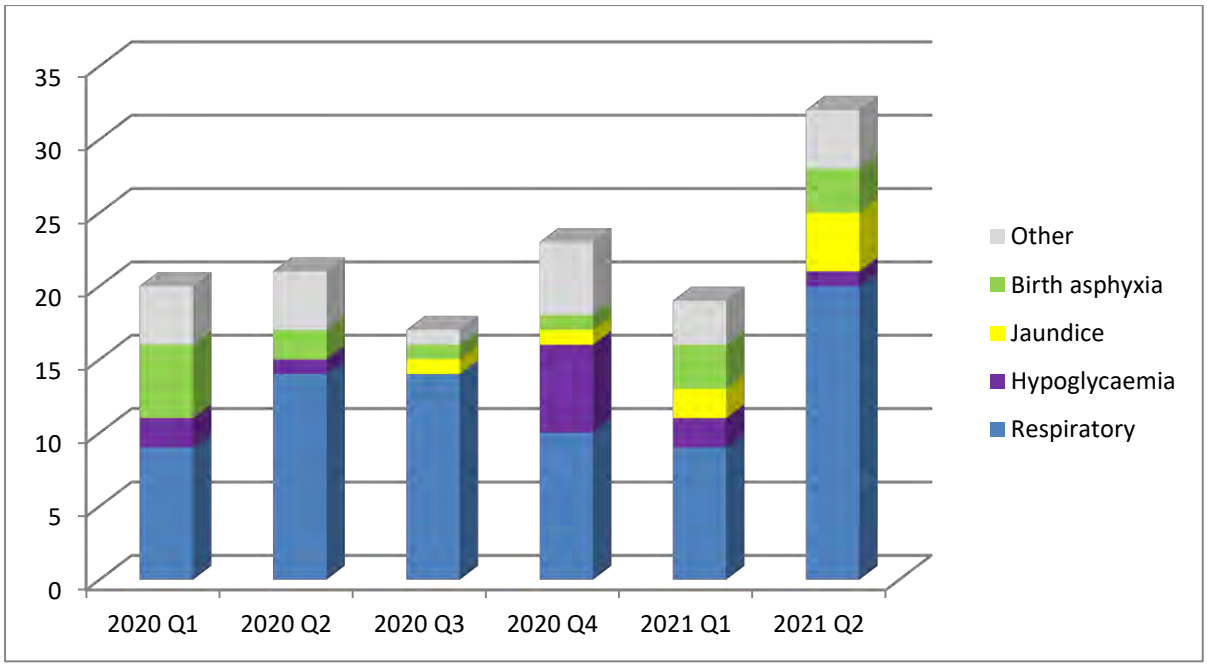
The group uses cases that have been defined as potentially avoidable to guide learning and improvement actions in order to reduce unnecessary separation of mothers of babies.

Learning is also often picked up and actioned even when it would not have reduced separation, but has the potential to improve care in other areas.

Please refer to the rolling action plan for details of work undertaken. In summary, there has been no recurrence of avoidable admissions in the areas previously identified (as shown in the table above). There was a particular drive to improve education and awareness of the correct management of neonatal hypoglycaemia, and this is evidence that learning has taken place.

Progress and learning with the four key reasons for admission

Data collection during quarter 2 in 2021 demonstrates that respiratory issues (needing respiratory support in some form) continue to be the primary reason for the admission of term babies into the Neonatal Unit.



The table helps to demonstrate that the apparent sharp increase of admissions associated with hypoglycaemia in quarter four, 2020 has reduced.

There is an apparent increase in the number of admissions associated with jaundice. During this quarter, there was also a serious incident relating to a baby who was readmitted with severe jaundice which sadly led to permanent hearing loss.

On investigation, opportunities were missed to identify and treat the jaundice sooner. This incident has been subject to a patient safety incident investigation (PSII). A system improvement plan has been developed to support maternity and neonatal staff to better risk assess for jaundice, identify high serum bilirubin levels when blood samples are processed using the blood gas analysis machine, and generally improve awareness and understanding of the potential for serious harm when there is early-onset jaundice.

Progress with the system improvement plan for jaundice will be recorded on the Datix system, ref. WSH-IR-69668.

11.2. Midwifery whistleblowing response and action plan

To RECEIVE the report

For Report

Presented by Susan Wilkinson and Karen Newbury

Trust Open Board– 15 October 2021

Agenda item:	11.2			
Presented by:	Sue Wilkinson, Executive Chief Nurse Paul Molyneux, Interim Medical Director & Executive MatNeo Safety Champion Karen Newbury, Head of Midwifery			
Prepared by:	Karen Newbury – Head of Midwifery			
Date prepared:	September 2021			
Subject:	Maternity whistleblowing response			
Purpose:	x	For information		For approval

Executive summary:

This report provides an overview of the actions taken following a recent whistleblowing in maternity.

This report contains:

- Background of midwifery whistleblowing letter to CQC
- Midwifery Whistleblowing Action plan (Annex A)
- Feedback shared with staff following Freedom to Speak up meeting (Annex B)

Background: In June 2021 a letter was written anonymously to the CQC on the back on the published CQC report from a recent inspection of maternity. The CEO and Chief Nurse were also sent an anonymous copy of this letter. On 3rd August 2021 the local press received an anonymous letter which was a version of the letter sent to the CEO & CQC in June.

Main points of the letter were reported as follows;

- Shifts are consistently short staffed
- Staff are working under extreme pressures which has left them fed up, exhausted and burnt out.
- Concerns regarding skill mix.
- There is a reliance on community midwives who are unfamiliar with working in the hospital environment.
- Due to nationwide staffing problems, expectations of what is considered acceptable staffing levels have been lowered so much it is consistently unsafe and unacceptable.
- Staff being overwhelmed by the unmanageable and relentless workload, and as a result are giving substandard care which is demoralising and heart-breaking.
- No acknowledgement of the letter had been received from the CQC or CEO and Chief Nurse.

Midwifery Whistleblowing Action plan: (Annex A)

Many of the actions had already been undertaken prior to the whistleblowing letter been sent and although the majority of the 18 actions have been completed the processes in place will hopefully aid more effective communication with all staff and guide them of where and how to raise concerns in the future.

Feedback Shared with staff following Freedom to Speak up Meeting (Annex B)

In response to the Whistleblowing letter the Trust arranged for midwifery staff to meet with Freedom to speak up Guardian via a Teams meeting. The meeting had over 30 attendees. No midwifery managers attended purposely to encourage transparent dialogue with the guardian. The Chief Nurse was invited to give feedback on the response of the Trust. Areas of concerns were identified and a follow up meeting was held with the midwifery management team in attendance to feedback what was in place to address their concerns. (Annex B). The Freedom to Speak up Guardians continue to have contact with midwifery staff on an individual basis.

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

Recommendation:

Receive for information

Midwifery Whistleblowing Letter Action Plan – September 2021

Actions	Details of actions	Further Actions	Responsibility	Timescale
Freedom to speak up guardian engagement events	Two events have been undertaken with good engagement from midwifery staff. 18.08.21: Meeting to address concerns raised with CQC (prior to press release) to thank people for raising concerns, to inform of routes to raise concerns and to give the opportunity to air any additional concerns. 09.09.21: Meeting to inform of actions planned following concerns raised "How Should I speak Up?" document produced and (if agreed) to be posted on staff Facebook page. Speak up and Listen Up training promoted via document above Attendance to Focus Groups with Mai Buckley (NHSE/I) Maternity Improvement Representatives from Maternity staff invited to join FTSU Champions network	FTSU presentation shared on staff face book page to inform of routes to speak up FTSUG details shared and promoted as a route to speaking up Decision to be made by senior leads and manager to post document on Facebook page	Sue Wilkinson, Amanda Bennett Sue Wilkinson, Amanda Bennett Amanda Bennett / service leads & Managers	Completed Completed Completed
Support women's anxieties via social media and Maternity Voice Partnership (MVP)	In conjunction with the communications team, assurance given regarding safety in maternity at WSFT.	Feedback monitored and actioned as required.	Communications team, Patient experience Team, HOM, Deputy	Complete and ongoing

Midwifery Whistleblowing Letter Action Plan – September 2021

Actions	Details of actions	Further Actions	Responsibility	Timescale
			HOM, Midwifery Matrons.	
Human Resources led focus groups	Prior to whistleblowing all midwifery staff invited to focus groups to listen to staff concerns, recommendations for improvement, unfortunately with low engagement.	Staff survey sent to all staff, shared via 'Take 5' (see below)	HR Business Partners	Complete
Support meeting with all midwifery staff & to reunite team	Immediately after the story was published in the paper, support offered to all midwifery staff who had been negatively affected by the article.	Open door policy for all staff as required Engagement of the Staff Support Team to support staff (see below)	HOM, Deputy HOM, Matrons Staff Support Team	Complete and on-going
Communicate updates via Take 5 and Staff Facebook page	At FTSU engagement events midwifery staff identified preferred methods of communication	All updates to staff via staff Facebook page and Take 5	HOM, Deputy HOM, Matrons	Complete and ongoing
PMA (Professional Midwifery Advocate) service/support to staff	PMA's available Mon-Fri to offer support to all staff groups.	Concerns, anxieties and emotional distress caused by public posts on public Maternity Facebook Page. Meeting with communications team and PMA service	Communications team & PMA service	Complete and ongoing

Midwifery Whistleblowing Letter Action Plan – September 2021

Actions	Details of actions	Further Actions	Responsibility	Timescale
		undertaken to discuss lessons learnt and ways forward.		
Staff Support Team to offers structured support to all staff in maternity	Meetings with Staff Support Team undertaken. Actions and next steps agreed	Well-being team to work with team leads to support them to implement pre and post shift huddles, to attend handover to provide support and proactive in-reach work and to undertake small group sessions for those staff that wish to participate.	Staff Support Team	To commence by beginning of October 2021
Staff incentive comparable with other units in the region	Financial incentives offered to midwifery staff for working additional shifts. Agreed and implemented.	On-going monitoring of fill-rates of shifts.	HOM	Ongoing
International recruitment	Regional approach to international recruitment, recruits and funding applied for.	Nil at present	HOM/ Deputy HOM	Complete

Midwifery Whistleblowing Letter Action Plan – September 2021

Actions	Details of actions	Further Actions	Responsibility	Timescale
Recruitment	Rolling advert via NHS jobs. Business case for additional support staff (care assistants and ward clerks) approved.	Adverts for all jobs live, awaiting closing dates and ongoing recruitment process. Due to National Midwifery staffing crisis Registered Nurses to be introduced to postnatal ward – advert live at present.	HOM/Deputy HOM/ Matrons/Midwifery Managers	End October 2021
Support for increased number of Student midwives and Preceptor midwives	Health Education England (HEE) have increased the number of midwifery students at WSFT, to support students HEE have funded a Lead Clinical Practice Facilitator who is in post. To support the increased number of preceptorship midwives and new staff the Trust has supported an increase in Practice Development Midwives from 0.8 wte to 1.8 wte.	All personal in post.	HOM	Complete
Specialist midwives, managers, matron, deputy	All specialist midwives work one rostered clinical shift per 4-week period and all non-	Nil	Specialist midwives,	Complete and ongoing

Midwifery Whistleblowing Letter Action Plan – September 2021

Actions	Details of actions	Further Actions	Responsibility	Timescale
HOM, HOM working clinically to support unit	rostered midwives cover breaks and work clinically in times of escalation.		managers, matron, deputy HOM, HOM	
Safety Champion Walkabouts/ virtual walkabouts	Safety Champion to undertake monthly walkabouts to speak to all maternity staff regarding any safety issues. These have increased since the whistleblowing. Non-executive Safety Champion undertook Virtual 'walkabout' with good engagement from community-based midwifery staff.	To share concerns raised and actions undertaken via 'Risky Business' (Maternity Monthly Quality & Safety update)	Safety Champions	Completed and on-going. Safety Champion item in 'Risky Business' by End October 2021
Monthly Unit meeting via Teams	Monthly meeting for all staff that work in maternity to cascade information up and down. Meeting via Teams with good attendance from all midwifery teams.	Minutes and action plan to be shared on Staff Facebook page.	HOM	Complete and ongoing
Meeting with Union reps to discuss further support, avenues to 'speak up'	Meeting occurred with RCM and Unison Reps, to discuss whistleblowing and how to support staff to speak up in future through correct channels.	Unions to promote services and to signpost staff through correct channels to raise concerns.	Individual Unions	Complete and ongoing
Staff survey to all midwifery staff	Link to a very short survey sent to all midwifery staff to gain further understanding of what support is required to move forward.	Feedback and action plan dissemination planned for the week commencing 1st November 2021.	HR/Medical Director	Beginning of November 2021

Midwifery Whistleblowing Letter Action Plan – September 2021

Actions	Details of actions	Further Actions	Responsibility	Timescale
	Survey open and closes 1st October.			
Share information regarding the midwifery whistleblowing letter and actions taken with wider trust staff vis Staff Briefing and Consultant meetings	Maternity whistleblowing letter and actions taken discussed at Trust Staff Briefing 14/09/2021 & Trust MSC 08/09/21	Future whistleblowing with be acknowledged by the Trust transparently and shared with staff in a timely manner.	Chief Nurse	Complete
LMNS/CCG/NHSE/CQC updated regarding midwifery whistleblowing letter and actions taken.	Actions discussed	Completed action plan to be shared with external organisations as required/applicable	Chief Nurse/HOM	End October 2021

Annex B

Concern	Action
How to Speak Up at WSFT	Please watch this short presentation: https://heeoe.cloud.panopto.eu/Panopto/Pages/Viewer.aspx?id=3919eb87-0fd5-47ee-978d-ad3300886bb8
We are exhausted and don't get breaks	• During the day breaks are agreed with whoever is in charge or, at other times, through 519. • We are looking at how this can be better supported over the weekends and nights. • Specialist staff and managers work clinically at least weekly if not daily covering breaks or so staff can attend essential training and in times of high acuity • Staffing issues are raised daily to the tactical team and region via a Maternity Heatmap tracker. Also escalated to Safety Champions, the Executive Board, the Trust Board, CCG, LMNS, regional and the national teams, NHS England.
We are short staffed. How can we do things differently and use other staff to relieve the pressure on midwives?	• We have appointed a digital midwife to have more in unit support with E-care. • Currently advertising for a band 3 rota administrator to ensure Healthroster is kept up to date • Full time cleaner / stocker in the labour ward will be discussed with lead housekeeper • Business Plan has been successful which means that we can recruit: • Additional Maternity Support Workers so that there is a full-time equivalent in the four community teams • Increase the number of Care Assistance on F11 including nursery nurses • Increase the number of ward clerks to enable 24hour 7 days a week cover on the labour suite and additional cover on F11 • Maternity Care Assistant in MDAU to cover weekends • Current advert out for MCA's for inpatient areas
Can we get volunteers back on the wards	• Currently it is still unsafe, as soon as we are able we will support their return. • Infant feeding co-ordinator is working with the LMNS to secure some breastfeeding volunteers for the ward. • National guidance with Covid will dictate timescales on their return.

Annex B

MDAU staffing levels is unsafe	• MDAU lead is due to start at end of sept, part of this role will include working clinically and as mentioned previously care assistants 7 days a week.
How can you ensure the safe working of community staff?	Enhancements on late and night shifts have been implemented in the short term, while new midwives are in their induction period, to reduce the need of calling Continuity of Carer and Community Midwives in for escalation. If this has not answered the question please email with further details to Karen Bassingthwaighte.
How can we adequately support our Newly qualified staff and students?	• Practice Development Team are allocated as mentors for Preceptors. • Each NQM is also allocated a preceptor and they should aim to meet with them monthly to assess progress • 2 x band 7's on each shift. • We have increased our PDM team last year to support the increase number of newly qualified midwives/preceptors • We have increased our clinical practice facilitator team to support the increase in students
Continuity of Care	• This is a nationally driven initiative. • A meeting will be arranged for the regional Continuity Leads to come and speak to our colleagues here at West Suffolk. • We will evaluate our current continuity of carer ways of working and work from feedback. • The Trust have agreed to fund additional midwives to enable us to move forward with Continuity of Carer but only when safe numbers of midwives are in post.
How can we best communicate with everyone?	• Agreed by all that the Maternity Facebook Group and Take 5 are the best methods of communication for the whole team.
What is the Trust doing to retain current staff?	• We implemented an additional staff incentive payment for out of hours work (as above) • We have introduced Professional Midwifery Advocate Service. • We have asked the bank office to look into weekly pay – which they are doing. • We have also increased our benefits (temporarily) to include free tea and coffee, free car-parking and free gym membership. • We have also implemented and increased the number of colleagues in our staff support psychological team.

	• We provided opportunities for feedback though our staff survey for midwives, staff focus group and HR clinics.
What is the Trust doing to recruit new staff	• Continued recruitment campaign, band 6, 7, registered nurses and new post for rota admin all advertised on NHS jobs. • Further 4 newly qualified, MDAU lead, clinical effectiveness & quality assurance midwife, and 1 band 6 all due to start by end of September/early October & all external candidates. • We are also part of the overseas midwifery recruitment project – no set timeframe yet. • Currently we have 6.4 wte vacancies however when the above are in post this will be reduced to just under 2wte vacancies.
How can we ensure we work in a safe environment?	• We have increased our governance team to support the increase in scrutiny for maternity • We have an additional Band 7 24 hours a day to provide additional senior cover across the Department. • We have escalated the staffing shortages to the Trust Board, CCG, LMNS, Regional and National Teams. • We continue to achieve 100% for 1:1 care in labour
How can we support LS coordinators?	• Opportunities to share Quality Improvement and ideas through various forums and meeting such as Labour Suite Forum, Unit Meeting. • Support from Matrons, HOM, ward manager, PMA service, staff support team
Morale is very low	• We acknowledge this and can offer support, for example, in the following ways: • The PMA (professional Midwifery Advocates) are available to support any staff member as required. When not working clinically they visit the clinical areas to ask staff regarding their wellbeing any support required and contact the community to offer the same support • The wellbeing service is here for all staff. • A wellbeing survey is being released next week to identify what you think would make further improvements. • Please do not forget your colleagues and managers for support.
How can staff speak up and be heard?	• The management team are committed to making improvements and welcome your thoughts and opinions. • The Exec safety Champion undertakes monthly ‘safety champion walkabouts’ in all areas so that staff can raise concerns.

	• The non-exec safety champion undertook a 'virtual' safety champion walkabout that was well attended by the community staff. • The monthly unit meeting is for ALL to attend. • The Freedom to Speak Up Guardians are available to speak to. • If a member your union. • PMA's • Staff psychological support team. • HR
We feel that Risk Team, constantly tell us what we are doing wrong but do not acknowledge how hard it is. What can be done to improve this "blame culture"?	• We are embracing an open culture where we actively encourage colleagues to speak up through the channels available. Looking as a learning opportunity rather than blame or punitive. • Any culture change takes time to embed.

11.3. Infection prevention and control assurance framework

To APPROVE the report

For Approval

Presented by Susan Wilkinson

Board of Directors – 15 October 2021

Item	11.3			
Presented by:	Sue Wilkinson Exec Chief nurse			
Prepared by:	Rebecca Gibson – Head of Compliance & Effectiveness			
Date prepared:	September 2021			
Subject:	NHSE ICT assurance framework			
Purpose:	x	For information		For approval

Executive summary:

This report provides a monthly update on the progress to achieve compliance with the NHSE ICT COVID-19 board assurance framework*.

This month's report contains

- Dashboard
- Swabbing audit (see Appendix 1)

The NHSE IPC BAF is being transferred to a record on the Datix risk register with a working title of "*Prevention of Nosocomial Covid and staff work-related Covid infections*". This will enable an oversight of the trust's controls through the risk management process and this report will become more focussed on a dashboard to support measures of assurance of the controls.

The Integrated 'learning from Covid' is being prepared by the Public Health team and is scheduled to be presented to the Board in December. The findings, recommendations and actions in place will also feed into the new risk register entry.

**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)	Aug 21	0	0	→
Staff work-related C19 cases reported to RIDDOR	Aug 21	0	0	0
Incidents relating to C19 management	Aug 21	19	22	22 →
Admissions swabs within 24 hours of DTA	Aug 21	98%	97%	98%↑
Inpatient swabs	See Appendix 1			
C19 clusters / outbreaks	Aug 21	0	0	0 →
Staff sickness / absence due to C19	Aug 21	131	242	315↑

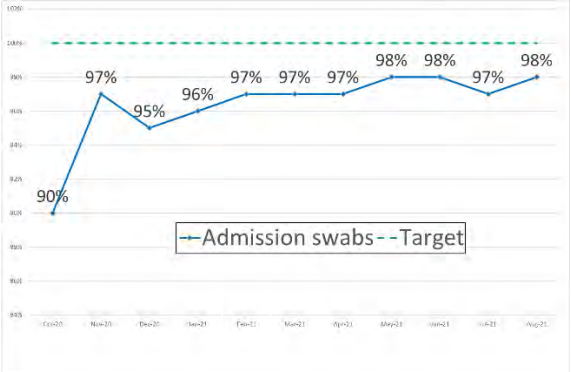
Associated charts / tables / narrative

C-19 admission swabs

The total number of patients swabbed in August remained similar to previous months with compliance of 97% of patients having a swab taken within 24 hours of the DTA in August and 98% in total. 32 patients (2.1%) did not have a record of having a swab taken in this episode.

NB: The data no longer includes the Paediatric ward.

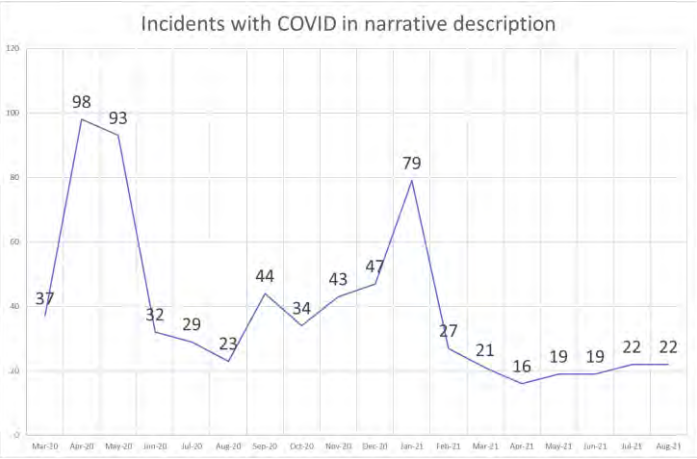
Paediatrics are now using the Lumira rapid point of care testing for all their patients in order to allocate patients to the correct bay whilst on G10 and experiencing the predicted paediatric surge. This means that the vast majority of our patients no longer require a PCR test sending immediately on admission especially as we are also swabbing for RSV and this then depletes the nostrils of cells in order to be able to accurately also test for a PCR result



Inpatient swabs audit

The Clinical audit team are now undertaking a more detailed swabbing audit. See Appendix 1 for details.

The information team have developed a daily report that lists all “un-swabbed” inpatients and a flow-chart for the use of this to proactively manage timely swabbing is currently being designed.



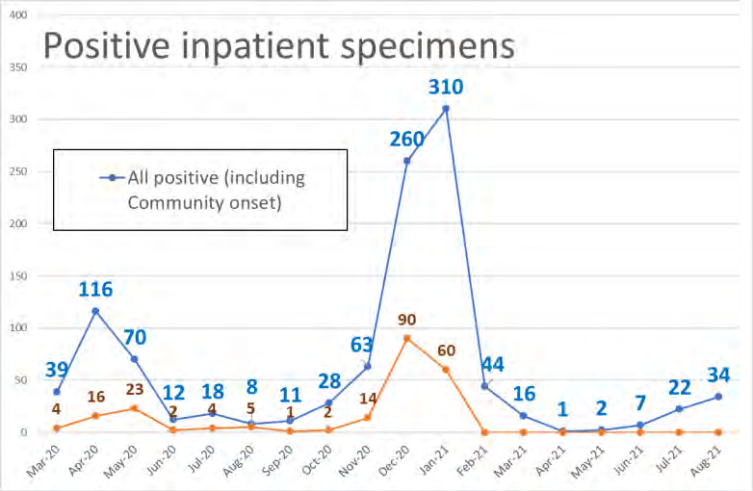
The number of **incidents relating to C-19** recorded in August remained similar to recent months.

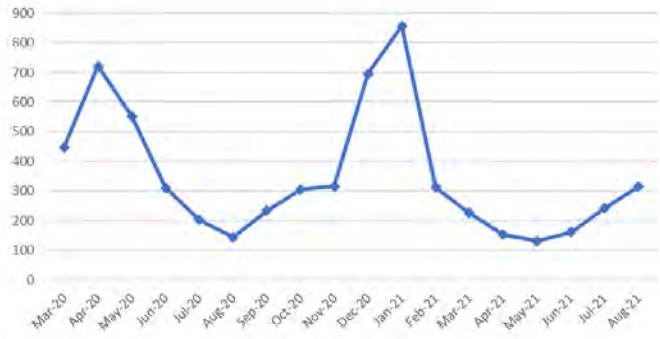
21/22 reported incidents were green and there was one amber relating to a patient admitted to a bay with an inconclusive result who subsequently tested positive requiring the full bay of patients having to self-isolate.

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 August. The number of community onset continued to rise in August matching the national picture but still remains well below the peak of last December-January.





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 August 2021 there were 315 episodes recorded, an increase from July (242 episodes) a continuing upward trend now for the last three months.

We selected a sample of 16 patients on Medical ward G4 and 12 patients on Surgical ward F3. Data was collected with the following inclusion criteria "All patients with a LOS (length of stay) between 4 to 10 days, inclusive" and exclusion criteria "Patients that tested positive less than 90 days before the audit's date". The data collection took part on 01/10/2021.

G4	F3
Day 1 compliance – 13 out of 16 patients had the swabs done on the day. The non-compliant ones: • one patient was a GP referral to AAU and arrive at 22:58h with the swab being done at early hours next day, 00:10h; • one patient was repatriated from Addenbrookes and had no admission swab done; • one patient had the admission swab done before the decision to admit being made. Day 3 compliance – six patients did not have the swab timely done. Two of which did not have the swab done at all (one of which the repatriated from Addenbrookes); the other five patients all had the swabs on the following day (three had the reminder triggered after 8pm) Day 5 to 7 compliance – only one patient had not had the swab done; the repatriated from Addenbrookes and two other patients had a swab after the 5-7 day timeframe. There is a clear decrease in compliance from day 1 to day 3 swabbing and a specific concern about the repatriated patient (*who is being followed up with the matron outside of these audit parameters*)*	Day 1 compliance – 100%, all 12 patients had the swab done on admission Day 3 compliance – 4 out of 12 did not have the day 3 swab done timely, all swabs were performed on the following day – with only one swab reminder triggered after 8pm Day 5 to 7 compliance – only one patient did not have this swab done within timeframe (done on day 9 of admission)

**post-audit note – this patient subsequently did have a swab which was negative*

The audit preliminary findings have been shared with the G4 and F3 Matron and the full audit will be discussed at a future NMCC with a view to developing improvements. This will focus initially on the use of the new 'flagging' report developed by the Information team to proactively manage timely swabbing.

	Day 1 (decision to admit)	LOS (from time of audit)	Lateral Flow Test (Day 1 - ED presentation)	Admission swab (Day 1 - Samba Test)	Retested 3 days post admission (PCR)	Retested 5 to 7 days post admission (PCR)	Comments
Ward G4	27/09/2021 11:17:12h	4.1 days	27/09/2021 09:06h	27/09/2021 10:53h	29/09/2021 15:23h	N/A	
	27/09/2021 04:10:44h	4.4 days	27/09/2021 05:19h	27/09/2021 07:10h	29/09/2021 09:08h	01/10/2021 13:45h	
	27/09/2021 02:29:11h	4.5 days	27/09/2021 01:33h	27/09/2021 01:33h	29/09/2021 18:09h	30/09/2021 23:54h	
	27/09/2021 02:18:11h	4.5 days	26/09/2021 22:57h	26/09/2021 22:33h	Not done	01/10/2021 07:38h	day 5 flagged 30th 22:23h and done 01st 07:38h
	26/09/2021 22:34:19h	4.6 days	27/09/2021 00:28h	26/09/2021 19:37h	29/09/2021 16:49h	30/09/2021 20:36h	day 3 flagged 28th at 20:30h, done 29th 16:49h
	26/09/2021 16:11:36h	4.8 days	26/09/2021 18:29h	26/09/2021 18:29h	28/09/2021 17:27h	30/09/2021 16:49h	
	25/09/2021 22:58:00h	5.5 days	Not done - GP referral to AAU	26/09/2021 00:15h	28/09/2021 12:06h	02/10/2021 07:38h	Day 1 done on day 2, day 3 flagged 27th 23:30 and done 28th 12:06h
	26/09/2021 03:30:08h	5.5 days	25/09/2021 23:38h	26/09/2021 02:08h	28/09/2021 12:15h	30/09/2021 10:02h	
	26/09/2021 00:31:32h	5.6 days	25/09/2021 22:27h	25/09/2021 23:56h	28/09/2021 10:00h	30/09/2021 00:02h	Day 3 flagged on 27th 21:55h and done 28th 10:00h
	25/09/2021 15:34:37h	5.9 days	25/09/2021 16:21h	25/09/2021 16:23h	27/09/2021 18:33h	30/09/2021 10:10h	
	24/09/2021 04:37:00h	7.3 days	24/09/2021 06:48h	24/09/2021 07:00h	26/09/2021 04:20h	28/09/2021 05:05h	Day 1 Samba replaced by PCR due to ITU admission
	23/09/2021 19:31:00h	7.7 days	23/09/2021 18:19h	23/09/2021 18:19h	26/09/2021 06:43h	28/09/2021 07:12h	day 3 flagged on 25th 17:50h, done 26th 06:43h
	22/09/2021 14:53:03h	8.9 days	22/09/2021 14:48h	22/09/2021 14:48h	25/09/2021 16:42h	26/09/2021 16:45h	day 3 flagged on 24th 14:40h, done 25th 16:42h
	22/09/2021 04:34:00h	9.5 days	Not done	Not done	Not done	Not done	Repatriation from CUH, no swabs were found on eCare/Ice by 02/10. Patient noted as non-compliant
	21/09/2021 12:32:22h	10 days	21/09/2021 16:50h	21/09/2021 15:19h	23/09/2021 14:17h	27/09/2021 09:56h	
	21/09/2021 06:23:53h	10.3 days	21/09/2021 03:38h	21/09/2021 06:52h	23/09/2021 14:47h	26/09/2021 16:09h	
Ward F3	27/09/2021 13:01:31h	4.1 days	27/09/2021 17:42h	27/09/2021 16:12h	29/09/2021 16:12h	01/10/2021 12;23h	
	26/09/2021 19:00:25h	5.0 days	26/09/2021 17:48h	26/09/2021 17:48h	28/09/2021 17:20h	30/09/2021 15:59h	
	26/09/2021 08:14:36h	5.4 days	26/09/2021 06:23h	26/09/2021 06:24h	28/09/2021 09:40h	Not done yet	Audit was on Day 6 so still within timeframe therefore not 'a fail'
	26/09/2021 01:29:24h	5.6 days	26/09/2021 01:20h	26/09/2021 01:23h	28/09/2021 14:20h	30/09/2021 12:00h	
	26/09/2021 00:04:00h	5.8 days	25/09/2021 22:18h	26/09/2021 19:13h	28/09/2021 10:00h	30/09/2021 15:00h	day 3 flagged 27th at 20:13h but done 28th 10am
	25/09/2021 14:55:08h	6.0 days	Not done	25/09/2021 18:39h	28/09/2021 14:22h	30/09/2021 14:01h	day 3 flagged 27th at 13:09h but done 28th 14:22h
	24/09/2021 19:21:44h	6.8 days	24/09/2021 19:00h	24/09/2021 19:01h	27/09/2021 00:00h	29/09/2021 13:27h	day 3 flagged 26th 18:22h but done 27th 00:00h
	24/09/2021 12:09:00h	7.4 days	24/09/2021 04:18h	24/09/2021 04:18h	26/09/2021 17:34h	28/09/2021 10:07h	
	23/09/2021 17:56:03h	7.9 days	Not done	23/09/2021 20:41h	25/09/2021 16:46h	28/09/2021 09:42h	
	23/09/2021 15:32:24h	8.2 days	23/09/2021 11:09h	23/09/2021 13:24h	25/09/2021 13:22h	01/10/2021 18:24h	day 5 flagged 27th, done on day 9
	22/09/2021 18:03:12h	9.0 days	22/09/2021 15:03h	22/09/2021 14:57h	24/09/2021 16:37h	27/09/2021 16:32h	
	20/09/2021 19:45:42h	10.9 days	20/09/2021 18:48h	20/09/2021 20:05h	23/09/2021 14:17h	25/09/2021 18:50h	day 3 flagged on 22th 18:09h, done 23rd 14:17h

11.4. Nursing staffing report

To APPROVE the report

For Approval

Presented by Susan Wilkinson

Trust Board – 15 October 2021

Agenda item:	11.4			
Presented by:	Susan Wilkinson, Executive Chief Nurse			
Prepared by:	Daniel Spooner Deputy Chief Nurse			
Date prepared:	September 2021			
Subject:	Quality and Workforce Report & Dashboard – Nursing August 2021			
Purpose:	X	For information		For approval

Executive summary:

This paper reports on safe staffing fill rates and mitigations for inpatient areas for August 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

- RN fill rates in the day under 90%
- Staff isolation rates have continued after increasing last month
- Sickness rates increased in both RN and NA groups
- The vacancy percentage for RN/RM within inpatient areas Have reduced marginally from 11.9% to 11.5%.
- Anticipated recruitment of 90% of student cohort qualifying in September 2021

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

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

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

Recommendation:

This paper is to provide overview of August'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 August 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 August 2021 within the data submission deadline. Table 1 shows the summary of overall fill rate percentages for these months and for comparison the previous four months.

	Day		Night	
	Registered	Care Staff	Registered	Care staff
Average Fill rate for March 21	98%	87%	95%	99%
Average Fill rate for April 21	93%	96%	97%	110%
Average Fill rate for May 21	96%	96%	98%	108%
Average Fill rate for June 21	94%	95%	95%	109%
Average Fill rate for July 21	93%	93%	95%	107%
Average Fill rate for August 21	89%	91%	91%	104%

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

Highlights

- Reduction in fill rates across all periods, most noticeably in RN day shifts
- Surgical areas seeing low fill rates across all wards
- Overfill in Paediatrics due to continuation of winter staffing and planning for RSV surge

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 both RNs and NAs has increased in August, and total sickness is over 5% for the first time since January 2021 at the height of the pandemic

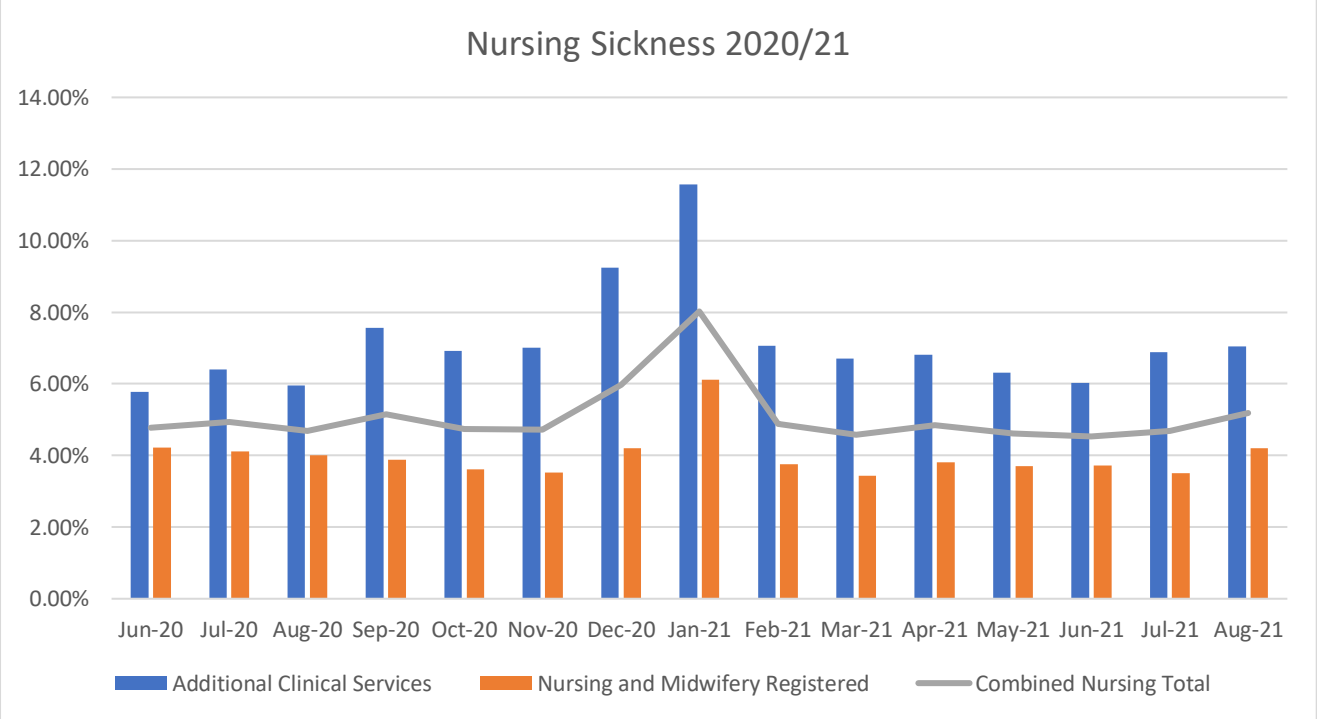


Chart 2.

	Jan 21	Feb 21	Mar 21	April 21	May 21	Jun-21	July-21	Aug-21
Unregistered staff (support workers)	11.56%	7.07%	6.71%	6.81%	6.32%	6.03%	6.88%	7.05%
Registered Nurse/Midwives	6.11%	3.75%	3.43%	3.81%	3.70%	3.72%	3.51%	4.20%
Combined Registered/Unregistered	**8.02%**	**4.89%**	**4.57%**	**4.85%**	**4.62%**	**4.53%**	**4.69%**	**5.19%**

Table 2b

Challenges to providing safe staffing have also been exacerbated by staff that are required to self-isolate, either due to exposure to Covid 19, or due to a member of their household being symptomatic. This is captured separately to sickness and is demonstrated below (chart 3). The anticipated rise in isolating staff has continued this month, following an increase in July, further compounding staffing challenges. This is illustrated in chart 3.

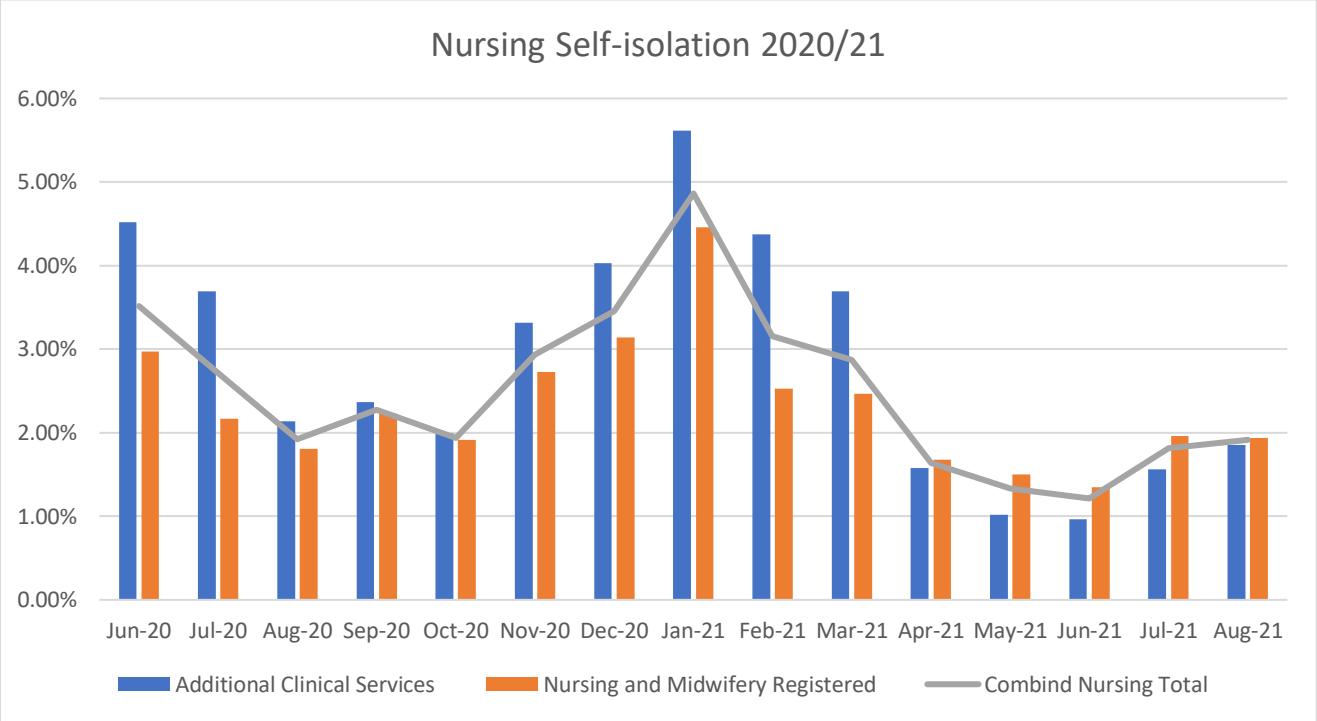


Chart 3

5. Patient Flow and Escalation

Good patient flow is central to patient experience, clinical safety and reducing the pressure on staff. It is also essential to the delivery of national emergency care access standards (NHSI 2017). Ward closures and moves can add additional staffing challenges and opportunities. In recent months ward relocations and structural repair have challenged flow and staffing.

6. Recruitment and Retention

Vacancies: Registered nursing (RN/RM):

- WTE vacancies for inpatient areas is 78.5 WTE a slight improvement from last month
- The vacancy percentage for RN/RM within inpatient areas Have reduced marginally from 11.9% to 11.5%. Total substantive numbers remain relatively static (Table 4).
- Overall vacancy percentage for RNs (inpatient and all other areas) is 9.7%, an increase of 0.4% from previous month.

	Ward RNs	Sum of Actual Period 12 (March)	Sum of Actuals Period 1 (April)	Sum of Actuals Period 2 (May)	Sum of Actuals Period 3 (June)	Sum of Actuals Period 4 (July)	Sum of Actuals Period 4 (Aug)	WTE VACANCY at period 5
RN/RM Substantive	Ward	611.7	612.7	609.4	603.1	602.0	605.9	78.5
	CV19 Costs	1.4	1.3	1.1	0.0	0.0	0.0	0.0
Total: RN Substantive		**613.1**	**614**	**610.5**	**603.1**	**602.0**	**605.9**	**78.5**

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

The chart below demonstrates the total RN establishment for the organisation (wards and non-wards). While we have seen an increase in vacancy rate this financial year due to the increased establishment in many areas, the total number of substantive RNs is not a declining trend (chart 4a). This is demonstrating a sustained improvement since the starting point of April 2020

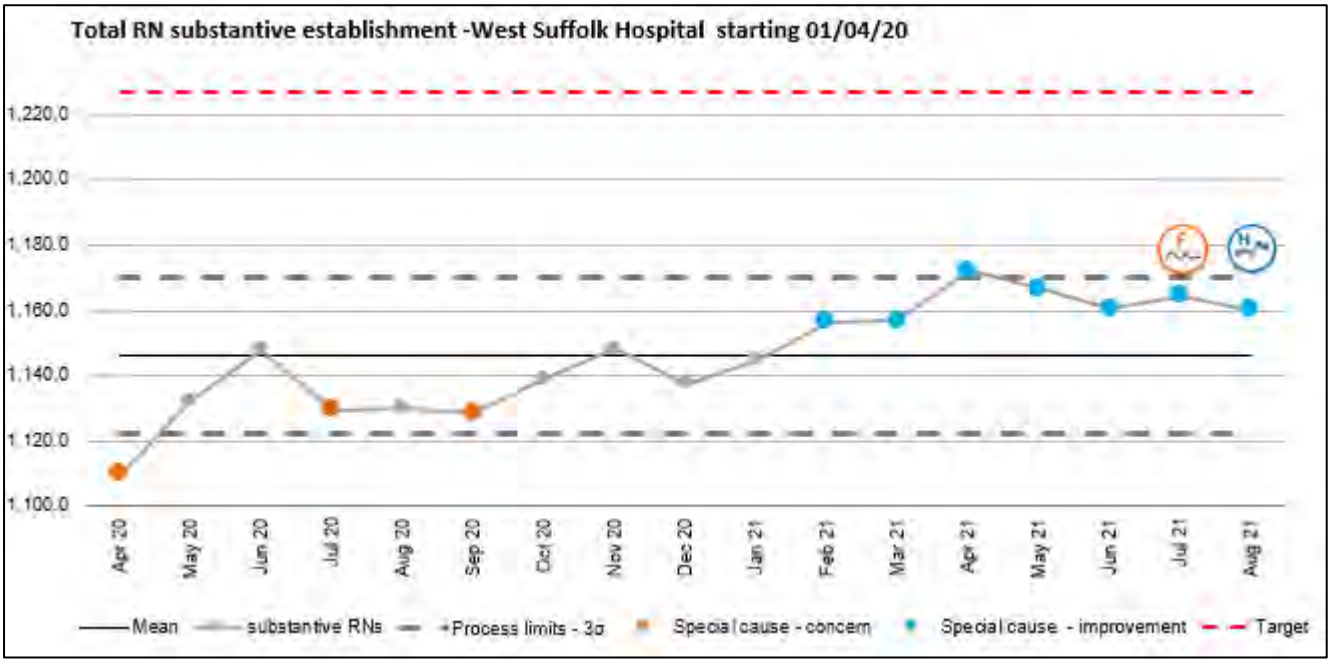


Chart 4a: SPC data adapted from finance ledger

Vacancies NAs (midwifery and Nursing combined):

- This month total NA vacancies has decreased from 6.5% to 6.3%
- Inpatient NA vacancies has increased to 3.8% to 4.2% with a WTE vacancy of 16.9 (table 5)

	Ward Nursing	Sum of Budget Period 12 (Mar)	Sum of Budget Period 1 (April)	Sum of Budget Period 2 (May)	Sum of Budget Period 3 (June)	Sum of Budget Period 4 (July)	Sum of Budget Period 4 (August)	WTE VACANCY at period 4
Nursing Unregistered Substantive	Ward	393.8	391.3	393.4	395.3	389.3	386.7	16.9
	CV19 Costs	19.5	10.8	4.3	0.0	0.0	0.0	0.0
Total: NA Substantive		**413.2**	**402.1**	**397.6**	**395.3**	**389.3**	**386.7**	**16.9**

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

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

- F6 remains a concern given their high vacancy rate, however this has improved in month. Active recruitment has occurred following a risk summit and once all appointments start in the coming months, they will retain a 3.5WTE vacancy.
- G8 also has high vacancy rate following uplift in April the clinical teams are engaging with HR to produce rotational posts in order to attract more staff
- Midwifery services continues to have a high vacancy rate. The HOM is collaborating with regional and national teams to respond to 8-point plan to address this regional and national concern.

7. New Starters and Turnover

International Nurse Recruitment:

Five international nurses arrived in August as planned. The HR team have successfully engaged with a recruitment agency to maintain international recruitment flow.

New starters

	March	April	May	June	July	August
Registered Nurses	30	18	13	9	12	17
Non-Registered	28	17	11	17	16	19

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

- In August 2021 seventeen RNs completed induction; of these; eight were for acute services, six for pure bank, one for community services and two midwives joined this cohort
- In August 2021, nineteen NAs completed induction; of these twelve NAs are for the acute Trust, seven for bank services

At the time of writing the new qualified nurses have commenced in the trust and are currently undergoing supernumery time. Their impact on vacancies will not be seen until September data is published. As anticipated 90% of students that trained at WSH have stayed in the organisation on qualifying.

Turnover

On a retrospective review of the last rolling 6 months, turnover for RNs has slightly increased from 5.92% to 6.9% but remains well below the trust ambition of <10%. NA turnover has also increased from 10.79% to 11.69%

Turn Over 01/09/2020 - 31/08/2021								
Staff Group	Average Headcount	Avg FTE	Starters Headcount	Starters FTE	Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
Nursing and Midwifery Registered	1,270.50	1,093.64	105.00	80.76	97.00	75.44	7.63%	6.90%
Additional Clinical Services	559.00	469.24	171	148.77	61	54.83	10.91%	11.69%

Table 7.

8. Quality Indicators

Falls

The number of falls reported in August was reduced compared to July. Within August the majority of the falls resulted in no harm however there were 8 with minor harm, 1 with moderate harm ED, one major harm F4 (on F14) and one catastrophic on Acute Assessment Unit.

Learning from the incidents involving harm has resulted in a policy on bed rails to be written and is currently being circulated to the senior nursing team for consultation. Education and training will also be provided to staff on the use of bed rails and ensuring all staff are aware of the risks associated with bed rails.

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.

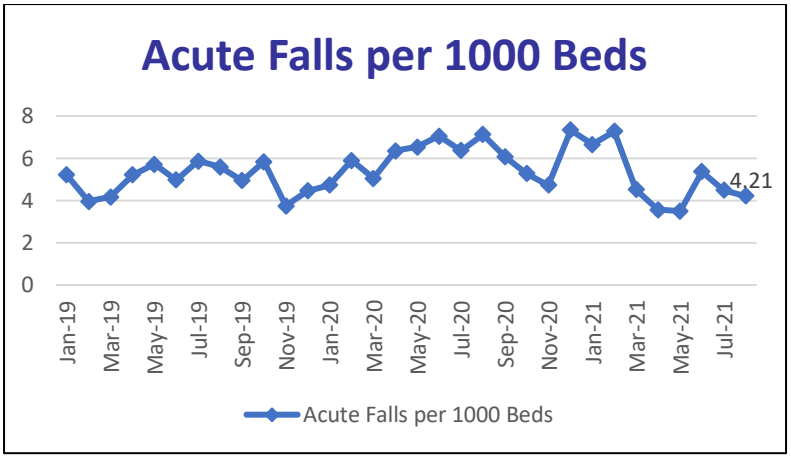


Chart 8

Pressure Ulcers

In August pressure ulcer incidence reduced following a small increase last month. Considering the challenges to staffing seen this month this is positive (chart 9A). There is no significant area of concern, pressure ulcers reported or over both surgical and medical department none of which showing any concerning trend.

The Tissue viability team have now introduced a revised simplified skin and wound assessment template on e-care, to complement this tissue viability has changed the way it is documenting its intervention, signposting staff towards this new template in order to create a greater compliance with the use of this assessment process. Tissue viability will be promoting this new template throughout September. The pressure reduction QI project on the renal ward which has been delayed due to staffing challenges.

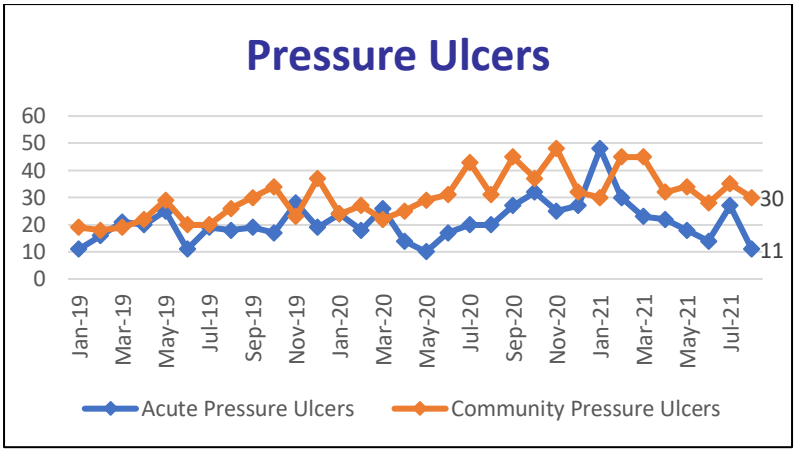


Chart 9a

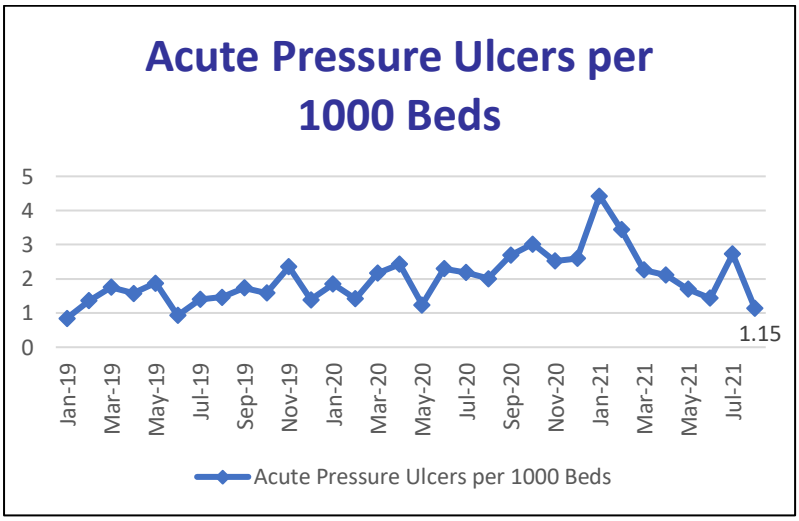


Chart 9b

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 78 calls a day to assist relatives who are unable to attend the wards to receive updates of the care of our patients.

	Compliments	Complaints
December 2020	44	22
January 2021	11	7
February 2021	17	11
March 2021	13	22
April 2021	26	15
May 2021	25	13
June 2021	31	19
July 2021	23	20
August 2021	17	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 August there were 33 Datixs recorded for nurse staffing that resulted in a Red Flag event (see table 11.). No harm is recorded for these incidents. This is a reduction on the previous month, but above the average number seen this year

Red Flag	Feb 21	Mar 21	Apr 21	May 21	June 21	July 21	Aug 21
Registered nursing shortfall of more than 8 hours or >25% of planned nursing hours	0	3	2	3	4	23	12
>30-minute delay in providing pain relief	1	0	0	1	0	4	7
Delay or omission of intention rounding	4	9	2	1	5	12	12
<2 RNs on a shift	1	1	3	5	1	1	2
Vital signs not recorded as indicated on care plan	0	1	1	2	1	0	0
Unplanned omissions in providing patient medication	0	1	0	0	0	1	0
Total	6	15	8	12	11	49	33

Table 11.

11. Maternity Services

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

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

Red Flag events

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

- There were eighteen red flag events in August demonstrated in chart 12 below. No harm was recorded as in impact of these incidences

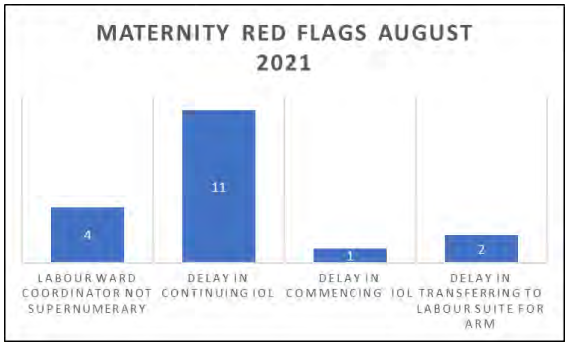


Chart 12.

Midwife to Birth ratio

Midwife to Birth ratio was 1:30 in August, this is higher than national average of 1:28 or Birthrate Plus recommendation of 1:27.7. Despite the increase in midwife to birth ratio 100% of 1:1 care provision has been achieved in August.

Supernumerary status of the labour suite co-ordinator

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

- In July 82% 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.

Appendix 1. Fill rates and CHPPD. August 2021 (adapted from unify submission)

NHS West Suffolk NHS Foundation Trust

	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	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	964	1015	1756	1553.5	1012	943	1380	1268	105%	88%	93%	92%	452	4.3	6.2	10.6
Glastonbury Cour	714.25	718.5	1067.5	1014.5	713	715	542.5	532	101%	95%	100%	98%	384	3.7	4.0	7.8
AAU	2139	2106.5	2469	1786	1777.5	1729.5	1426	1523	98%	72%	97%	107%	761	5.0	4.3	9.4
Cardiac Centre	2869	2432.5	1342	1169	1782.5	1533	713	655	85%	87%	86%	92%	632	6.3	2.9	9.2
G9	1426	1416	1426	1289.5	1426	1271	1069.5	1260.5	99%	90%	89%	118%	752	3.6	3.4	7.0
F12	552	669.5	355.5	352	713	586	356.5	284	121%	99%	82%	80%	240	5.2	2.7	7.9
F7	1786.5	1576	1758.75	1512.0833	1425	1292	1770.5	1504	88%	86%	91%	85%	683	4.2	4.4	8.6
F9	1777.5	1268.25	1782.5	2010.5	1067	931.25	1426	1589.5	71%	113%	87%	111%	744	3.0	4.8	7.8
G1	1414	1092.3333	356.5	296.5	713	690	356.5	308	77%	83%	97%	86%	392	4.2	1.4	5.6
G3	1782.5	1425.1667	1778.5	1618.25	1069.5	1058	1069.5	1408	80%	91%	99%	132%	864	2.9	3.5	6.4
G4	1778	1630.25	1817	1750.75	1069.5	990.1666667	1422	1468	92%	96%	93%	103%	896	2.9	3.6	6.5
G8	2485.41667	1977.9167	1847	1646.4167	1782.5	1418.833333	1069.5	1163	80%	89%	80%	109%	615	5.5	4.6	10.1
F8	1426	1440.5	2136	1660.6667	1058	942.5	1426	1329.5	101%	78%	89%	93%	723	3.3	4.1	7.4
Critical Care	2760	2539.25	341	827	2670	2451	0	380	92%	243%	92%	N/A	388	12.9	3.1	16.0
F3	1782.5	1486.7	2123	1811.6	1069.5	1058	1414.5	1413	83%	85%	99%	100%	732	3.5	4.4	7.9
F4	655.5	553	444	340.5	655.5	586.5	460	368	84%	77%	89%	80%	633	1.8	1.1	2.9
F5	1782.5	1347	1426	1328	1069.5	923	1068.5	979.5	76%	93%	86%	92%	698	3.3	3.3	6.6
F6	2017.5	1584.3333	1635.5	1465.5	1414.5	1090.5	701.5	756	79%	90%	77%	108%	942	2.8	2.4	5.2
Neonatal Unit	1116	1193	372	207.5	1116	1020	364	186	107%	56%	91%	51%	116	19.1	3.4	22.5
F1	1226.25	1332	713	766.5	1069.5	1311	0	228.75	109%	108%	123%	100%	115	23.0	8.7	31.6
F14	874	869.25	438	467.5	847.5	705.5	138	300	99%	107%	83%	100%	106	14.9	7.2	22.1
Total	33,328.42	29,672.95	27,384.75	24,873.77	25,520.50	23,245.75	18,174.00	18,903.75	**89%**	**91%**	**91%**	**104%**	**11868**	**4.2**	**3.5**	**7.6**

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

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

Ward/Department	Register Nurses/Midwives				Ward/Department	NA/MCA			
	Actual establishmet	Budgetted establishment	Vacancy rate (WTE)	Vacancy percentage %		Actual Establishment	Budgeted Establishment	Vacancy rate (WTE)	Percentage Vacancy %
AAU	30.0	30.1	0.1	0.4	AAU	24.1	28.3	4.3	15.0
Accident & Emergency	65.2	77.3	12.1	15.7	Accident & Emergency	29.1	34.5	6.3	0.2
Cardiac Centre	37.9	40.7	2.8	6.9	Cardiac Centre	15.7	15.7	0.1	0.4
Glastonbury Court	12.1	11.7	-0.4	-3.6	Glastonbury Court	11.7	12.6	0.9	7.5
Critical Care Services	42.7	43.0	0.3	0.7	Critical Care Services	6.8	1.9	-4.9	-261.7
Day Surgery Wards	12.2	11.0	-1.2	-11.1	Day Surgery Wards	3.9	3.9	0.0	0.0
Gynae Ward (On F14)	12.3	14.1	1.8	12.9	Gynae Ward (On F14)	2.0	2.0	0.0	0.0
Neonatal Unit	18.9	20.6	1.7	8.2	Neonatal Unit	4.0	4.3	0.2	5.8
Rosemary ward	13.5	16.6	3.1	18.6	Rosemary ward	22.2	25.8	3.5	13.7
Recovery Unit	18.6	25.4	6.9	27.0	Recovery Unit	0.9	0.9	0.0	1.2
Ward F1 Paediatrics	22.8	22.3	-0.4	-2.0	Ward F1 Paediatrics	6.7	6.7	0.0	0.4
Ward F12	8.6	11.9	3.3	27.8	Ward F12	4.9	5.9	0.9	15.9
Ward F3	20.7	22.2	1.5	6.7	Ward F3	22.3	25.8	3.6	13.8
Ward F4	13.6	13.6	0.0	0.2	Ward F4	11.4	14.6	3.3	22.4
Ward F5	19.3	22.2	2.9	12.9	Ward F5	18.2	18.1	-0.1	-0.6
Ward F6	18.8	26.6	7.8	29.2	Ward F6	16.4	17.4	1.0	5.6
Ward F7 Short Stay	22.7	24.9	2.2	8.9	Ward F7 Short Stay	20.6	25.8	5.1	19.9
Ward F9	17.7	21.8	4.0	18.5	Ward F9	30.6	23.2	-7.4	-31.8
Ward G1 Hardwick Unit	26.7	30.6	3.9	12.8	Ward G1 Hardwick Unit	9.6	10.5	1.0	9.3
Ward G3	20.3	22.1	1.8	8.0	Ward G3	25.0	23.0	-2.1	-8.9
Ward G4	19.5	22.1	2.6	11.8	Ward G4	21.4	22.8	1.4	6.2
Ward G8	25.4	32.7	7.3	22.2	Ward G8	20.7	20.6	-0.1	-0.4
Renal Ward - F8	18.7	19.5	0.8	4.3	Renal Ward - F8	23.3	25.8	2.4	9.5
Respiratory Ward - G9	22.9	23.7	0.8	3.2	Respiratory Ward - G9	20.8	18.0	-2.8	-15.5
Total	539.8	605.6	65.8	10.9	Total	374.3	388.9	14.6	3.7
Hospital Midwifery	48.7	59.6	10.9	18.2	Hospital Midwifery	14.6	15.6	1.0	6.2
Continuity of Carer Midwifery	14.5	18.3	3.8	20.9	Continuity of Carer Midwifery	0.0	0.0	0.0	0.0
Community Midwifery	17.2	19.1	2.0	10.4	Community Midwifery	3.8	3.8	0.0	-0.5
Total	80.4	97.0	16.7	17.2	Total	18.4	19.4	1.0	4.9

*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 August 2020

HAPU

August 2021	Cat 2 (Minor)	Cat 3	Unstageable	Total
F4 - ward	1	0	0	1
F5 - ward	1	0	0	1
F6 - ward	1	1	0	2
G4 - ward	1	0	0	1
G8 - ward	1	0	0	1
Gastroenterology Ward	1	0	0	1
Renal Ward	1	0	0	1
Respiratory Ward	1	0	0	1
Rosemary Ward	1	0	0	1
F7	1	0	1	2
Total	10	1	1	12

Falls

August 2021	None	Negligible	Minor	Moderate	Major	Catastrophic	Total
Eye Treatment Centre - First Floor	0	0	1	0	0	0	1
Eye Treatment Centre - Theatres	0	0	1	0	0	0	1
Eye Treatment Centre - Ward	1	0	0	0	0	0	1
F14 (Gynae - EPAU)	1	0	0	0	0	0	1
F3 - ward	1	0	0	0	0	0	1
Respiratory Ward	1	0	0	0	0	0	1
Speech and Language Therapy	0	0	1	0	0	0	1
Acute Assessment unit (AAU)	1	0	0	0	0	0	1
Rapid Access and Treatment (RAT)	0	0	0	1	0	0	1
Major Assessment Area (MAA)	0	0	0	0	0	1	1
Cardiac Centre - Ward	2	0	0	0	0	0	2
F4 - ward	1	0	0	0	1	0	2
Renal Ward	1	0	1	0	0	0	2
F12 Isolation Ward	3	0	0	0	0	0	3
F6 - ward	3	0	0	0	0	0	3
G1 - ward	3	0	0	0	0	0	3
F5 - ward	3	1	0	0	0	0	4
Gastroenterology Ward	1	2	1	0	0	0	4
Rosemary Ward	2	2	0	0	0	0	4
G4 - ward	3	0	2	0	0	0	5
G8 - ward	5	0	0	0	0	0	5
Glastonbury Court	3	1	1	0	0	0	5
G3 - Endocrine and General Medicine	7	0	0	0	0	0	7
F7	9	1	0	0	0	0	10
Total	51	7	8	1	1	1	69

Appendix 4: Red Flag Events

Maternity Services

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

Acute Inpatient Services

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

11.5. Quality and Learning Report

To APPROVE the report

For Approval

Presented by Susan Wilkinson

Trust Open Board – 15 October 2021

Agenda item:	11.5			
Presented by:	Sue Wilkinson – Executive Chief Nurse			
Prepared by:	Rebecca Gibson – Head of Compliance & Effectiveness			
Date prepared:	September 2021			
Subject:	Patient Safety & Quality learning report			
Purpose:	X	For information		For approval

Executive summary:

This report provides a summary of key learning points, trend analysis and opportunities for improvement that have arisen from in the quarter ending 31/06/21. It includes the following sections: Learning themes from investigations in the quarter, Q1 (20/21) incident analysis, learning from deaths, staff concerns and learning disabilities quality assurance.

Future reports will have a new format to match an increased frequency of publication as follows:

Core (every report)
– Outcome of investigation / reports (PSIIs and PSRs) issued since last report
– Quality & Safety dashboard (*being developed – this will include key KPIs and quality measures*)
– Learning from other sources: patient and public feedback, LfD, claims, patient safety audits, staff concerns, etc.
– National patient safety updates

Theme (different each report and not all of the below each time)
– Focus on one (or more) subject(s) within the PSIRP (local patient safety incident response plan)
– Quarterly incident analysis
– HSIB national reports
– External Quality assurance (e.g. CCG visits / CQC inspection / other regulatory or professional body) (aspects being discussed in meeting with the CCG in October)
– Greatix / Learning from excellence (*aspirational future content possible for later in 2022*)

The Risk management update (Mitigated red risks / learning from RIDDOR) section previously reported here will now be included in the Corporate Risk Governance group report to Insight instead.

Please note items of quality, safety & learning can also be found in the separate board papers (Maternity, staffing, People plan & OD, Covid) as well as in the 3i's committee reports

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

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

1. Learning themes from investigations in the quarter

Please note: The newly convened Action oversight group (AOG) will be responsible for overseeing the follow-up of all the safety recommendations listed below, either as standalone or via the specialist groups reporting frameworks in the new 3i committee structure.

1.1 PSII (patient safety incident investigations) completed in Q1/Q2 (to date) approved via Patient safety quality assurance panel (PSQAP)

There were no PSII reports approved in Q1 and one in Q2.

Incident details	Learning
WSH-IR-70904 Misconnection of an epidural line to peripheral cannula *Initially reported as a Never Event but subsequently downgraded as per the national exclusion criteria*	This investigation was undertaken with the full involvement of the patient whose experience is documented in the report and who gave time to input and feedback their thoughts on the report content. Three immediate safety actions taken post incident: • Addition of a label to the epidural giving set and epidural line by attaching 2 labels, one each side of the epidural filter • Ensuring epidural filter is always visible at the front of the patient and not hidden behind • Updating epidural e-Care record to include extra checks to confirm that the correct connection has occurred and has 2 witnesses The main findings from the investigation were as follows: • Trust had assessed compliance with National Patient Safety Alert “Resources to support safe transition from the Luer connector to NRFit for intrathecal and epidural procedures and delivery of regional blocks” published Aug17. The evidence to support implementation included that NRFit intrathecal sets had been safely and successfully implemented in theatres with local plans for implementation of the NRFit epidural sets in January 2018. • A risk assessment had been undertaken and added to the risk register and there was evidence that the risk was monitored on a regular basis through the Corporate Risk Committee. • The investigation found that external factors, including a delay in the commercial availability of NRFit epidural sets being available, were contributory to the delay in implementing NRFit epidural sets and were outside the control of the hospital. • No training or competency issues were identified as potential contributory factors. • There was overall good evidence of teamworking and communication between the team members. • There were no specific environmental or patient factors identified that may have contributed to the event. Seven safety recommendations were developed and are being taken forward within the maternity and anaesthetics teams. These focussed on equipment procurement, clinical guidelines, record keeping, team communication pathways and exploring opportunities within eCare. The full report will be provided within the Closed board pack in the December meeting in line with the new process

1.2 PSR (patient safety reviews) completed in Q1/Q2 (to date) approved via Patient safety quality assurance panel (PSQAP)

There were six PSII reports approved in Q1 / Q2.

Incident details	Learning
WSH-IR-66816 Burn injury (from hot drink) in the ED and subsequent ongoing care	A patient with partial sightedness (which was not flagged on eCare) was left unsupervised with hot tea in an insulated cup which was spilled and led to a burn. Whilst initial management following the burn appeared to be appropriate, a lack of wound record (photography) and referral for review by specialist burns unit may have contributed to wound deterioration. Limitations due to the COVID pandemic led to remote community review of burn rather than a face to face and staffing shortages in the tissue viability (TVN) service (also COVID related) meant ward care of burn (following an admission) lacked TVN oversight and was inconsistent in record keeping. Three safety recommendations were developed and are being taken forward by the Emergency department, the TVN service and the eCare team. Investigation findings were shared with patient and their family as part of a complaint response.
WSH-IR-68633 Mucosal tear during an endoscopic procedure requiring transfer to tertiary unit for ongoing care	During a procedure, bleeding and a small mucosal tear was observed on the screen. There was a prompt transfer to surgical ward for advanced care and an urgent CT scan was arranged to confirm the level of damage. CT confirmed the presence of an oesophageal perforation and the patient was transferred to Addenbrooke's hospital for on-going care later the same evening. The patient was able to be discharged home seven days later. Upon inspection of the device a frayed wire was discovered during the decontamination process and the Imaging Services Manager rapidly arranged replacement items which prevented disruption to patient services. Eight immediate safety actions were taken post incident for patient care and equipment management and the patient received an immediate explanation and apology. Three safety recommendations were developed and are being taken forward by the Endoscopy and EBME including the re-establishment of the Medical Device User Group to enable effective distribution of information, share alerts and discussion of issues with current equipment in use. The report has been shared with the patient with a follow up call scheduled to answer any queries they might have.
WSH-IR-68703 Mepitel (dressing) embedded in surgical wound	A patient with a topical negative pressure device (VAC) for wound healing was under the care of the practice nurse for ongoing dressings with some remote advice given by tissue viability (similarly to the first case above, the TVN service provision was affected by COVID) . Wound was still problematic and not fully healed and re-excision of the wound discovered a small piece of Mepitel had become embedded in the wound and the wound had healed over it. Three safety recommendations were developed and are being taken forward by the pressure ulcer prevention group relating to clinical pathways and documentation. The incident was highlighted through a claim and the report will be shared with the patient and their family as part of the claim response.

Incident details	Learning
WSH-IR-68839 Vascular/wrong site surgery	A patient was incorrectly booked for (and surgery for) a Left Long Saphenous Vein radiofrequency ablation surgery rather than Left Short Saphenous Vein radiofrequency ablation. It was noted that this didn't meet the definition of a Never Event (wrong site surgery) as it had the exclusion criterion "*due to incorrect laboratory reports/results or* ***incorrect referral letters***" Immediate safety actions were put into place to escalate the issues relating to image availability for US scan escalated to the appropriate IT Team Four safety recommendations relating to the Vascular service were developed and are being taken forward by the local team. A fifth recommendation concerning image availability and reporting set-up sits with the wider IT team to resolve what, if any actions are required. Opportunities to share the report with the patient's family are being explored
WSH-IR-69033 Drug induced nephrotoxicity due to prolonged Gentamicin use	An ICU patient received post-surgical antibiotic regime with gentamicin and vancomycin that continued for a total of 24 days, contributing to AKI stage 1 that progressed to stage 2, with an eGFR decline from their pre-admission baseline of around 90 to its lowest point at 23. Three main considerations were highlighted as suitable for quality improvement projects: staff training; allergy status / appropriate documentation of allergy history; and transition of prescribing gentamicin and vancomycin on e-Care rather than paper charts. The oversight of this will be through the antimicrobial group, drugs & therapeutics committee and the eCare medicines team. The patient has been contacted and offered a copy of the report which he has accepted and a follow up phone call is planned.
WSH-IR-69177 Delay in diagnosis/Fall	There was a failure to handover outstanding diagnostics (CT scan) of a patient who presented following a possible fall but was admitted with a probable diagnosis of sepsis (and treated accordingly) and the CT findings of head and pelvis were not identified until the next day. Four safety recommendations were identified relating to eCare scan reporting, staff training and refresher on NEWS and sepsis and a package of measures relating to LD patients (of which this patient was one) a number of which are already in place. Opportunities to share the report with the patient's family are being explored.

1.3 Q1 (2020/21) incident analysis
(Undertaken using an Insight / Involvement / Improvement framework)

The Patient safety team have undertaken a detailed thematic analysis of incidents for the period April to June 2021. This will be repeated in future quarters and will form an important part of the development of future year's PSIRP and the wider safety improvement plan.

The full report will be shared with divisions and the themed chapters with the relevant specialist committees / subject leads. This narrative below provides a high level overview summary only.

A total of 2931 incidents were reviewed and the report categorised these by location, by severity/harm, by incident type, and (for the top five categories only) by sub-category.

- pressure ulcers – note this includes the reporting of community acquired / present on admission to service PUs.
- clinical care and treatment
- medication
- slips, trips & falls
- discharge, transfer and follow up

A sixth 'top category' of safeguarding was made up almost entirely of record keeping for safeguarding referrals to Customer First and application of DoLS so is not examined in detail here.

For these five the report also identifies the over-arching themes and current improvements (underway prior to sharing of this analysis). The themes are as follows (bullet points only – more detail in main report):

Type	Themes	
Pressure ulcers	Equipment: Patient compliance with planned care	Pre-emptive care as a patient's overall condition deteriorates
Clinical care & treatment	Transfers Cancelled/delayed procedures Monitoring and following up (including test results)	Covid swabbing timeframes DNAR: Readmissions/returns Accidental damage to patient's skin
Medication	Controlled Drugs Critical medicines Duplicate doses given Insulin IV fluids	Opioids Discharge medication General checks/documentation/human error: Contrast/extravasation incidents
Falls	Unwitnessed falls Patient's condition Falls during toileting Equipment availability Falls on transfers	Supported/assisted falls Patient's clothing/footwear Visibility of patients Environment/flooring Slips from bed and chair
Discharge, transfer and follow up	Delayed transport Community nursing/midwives not informed of discharged patients Delayed discharge letters to GP	Ward beds not available for patients in recovery and critical care Inappropriate transfer of patients to discharge waiting area

Several different groups / teams will be involved in the management of these subjects and the report documents a series of current improvements underway and will feed into the Improvement committee.

The patient safety & quality team will be ensuring that these themes are recognised locally and incorporated into the specialist improvement plans (if not already). Where a theme (or indeed an incident type) does not have a natural 'owner' these will be taken forward through the new safety & quality governance group as part of the new 3i's committee framework.

2. Patient safety incident response framework (PSIRF)

A six-month Executive review of the PSIRP was undertaken in the summer; this is a brief summary of the findings and conclusions of the review:

- Method of deciding the top risks was robust and would be enhanced in 2022/21 through more detailed quarterly thematic review of incidents (see section 1.3 of this report for Q1).
- Additional review methods working well:
  - Patient safety review (PSR) has been used by a range of staff within the divisions
  - Hot debrief + After action review used in Falls now being rolled out to pressure ulcers.
  - Patient safety audit used in pressure ulcers and, more recently, for 'near miss' wrong site surgery incidents
  - Completion of risk assessment (on Datix) where an incident (or near miss) highlights an ongoing patient safety concern

There is now a plan for 2022/23 PSIRP to be developed in early 2022 with stakeholder involvement as before and using the learning from Q1, Q2 (and possibly Q3) thematic review of incidents.

The PSIRF leads (LW / RG) are presenting 'the PSIRF journey + Falls' at national forums including Patient safety specialists and our local PSI Investigators (MP / OF) are participating in the national trial of Systems Engineering Initiative for Patient Safety (SEIPS) at the personal request of the national team.

3. Learning from Deaths (LfD)

The LfD bulletins are available to all staff on the intranet

http://staff.wsha.local/Intranet/Documents/E-M/LeadershipandQualityImprovementFaculty/Sharedlearningbulletin.aspx

Table 1: LfD data Q4 (19/20) – Q3 (20/21)

	Deaths	Deaths with an SJR* completed	SJRs classified as Poor / Very poor care	Deaths judged as >50% preventable**
Apr-Jun	254	99 (161 for SJR)	12	0
Jul-Sep	188	40 (102 for SJR)	7	2
Oct-Dec	286	44 (133 for SJR)	12	0
Jan-Mar	346	61 (197 for SJR)	8	0
Apr-Jun	202	27 (69 for SJR)	5	0***

** SJR - Structured Judgement Review*

***National reporting requirement (judgement based on a multidisciplinary review of SI final report at the LfD group)*

**** PSIRF has altered the way preventability is determined and numbers are now provided by the patient safety team*

In July the LfD team recruited six new reviewers, (two of these are on bank contracts) five of whom are already in post with the final reviewers starting in October. Training is ongoing and as such existing experienced reviewers completed less reviews through August and September as their time has been spent training and supporting the new team members. The recruitment will enable a timelier completion rate for the scheduled SJRs and wider participation in the developing LfD QI programme in the coming months.

The LfD improvement plan is developed with initial subjects highlighted for inclusion are:

- Aspiration pneumonia (with Dr Gillian Unwin – Consultant Microbiologist)
- End of life care (with End of Life group, trial of tool to improve recognition of end of life)
- Weekend handover (Dr Paul Molyneux lead)
- Human factors project (with orthopaedic colleagues)

Priorities for 2021/22 include

- Increase staff awareness of the LfD process
- Shared learning events

- Provide data from learning from deaths for all ward areas to present at local governance forums annually
- Learning from deaths platform on the intranet
- Collaborative working to progress quality improvement projects (as above)

Shared learning event September 2021, attended by 8 colleagues from the medical, nursing and AHP teams (numbers limited due to CoViD restrictions for face to face meetings).

- Positive evaluation and feedback – notably multi professional learning and hearing from families
- Case based discussions on end of life care and medically optimised for discharge (MOFD)
- Ward to Board: Staff identified Blue ribbon initiative as helpful in reducing bed moves, halted during the pandemic. Escalated to End of Life group and chief nurse; agreed to reinstate across the organisation.

Monthly shared learning events planned with increased capacity, and a proposal for a mix of face to face and virtual events.

4. HSIB reports

4.1 National HSIB reports issued in Q1 2021/22

A proposal for the management of these reports was agreed at the June Insight committee meeting as part of the wider improvement plan for clinical audit & effectiveness. A pilot to test the proposal is in progress and future report will have a section on the national and local learning from these national best practice documents.

For information HSIB publications (non-Maternity) issued in Q1/Q2:

Issued	Title
APR-21	Wrong site surgery – wrong tooth extraction
APR-21	Outpatient appointments intended but not booked after inpatient stays
JUN-21	Wrong site surgery – wrong patient: invasive procedures in outpatient settings
JUN-21	Oxygen issues during the COVID-19 pandemic
AUG-21	Timely detection and treatment of spinal nerve compression (cauda equina syndrome) in patients with back pain

4.2 Issued in Q1/Q2 (to date) 2021/22 which relate to the care of a WSFT patient

The table overleaf provides details of HSIB Maternity reports issued which relate to the care of a WSFT patient. This provides a high-level summary of the learning, local review of content and any actions arising from these reports.

A structured action plan from each HSIB report received is developed, submitted to the CCG for assurance and monitored locally within the wider Maternity improvement plan and the HSIB reports in full are provided to the Board within the closed Board incident report.

- WSH-IR 65391 - Four safety actions - Final report receipt May 2021
- WSH-IR 66949 - Five positive findings - Final report receipt Aug 2021

Local ref.	Key learning points	Safety actions identified following review of HSIB report and recommendations
WSH-IR 65391	**Clinical** Assessment (oversight) The Trust to ensure all mothers receive a holistic risk assessment on admission to determine ongoing plans for labour and birth and for obstetric led women that would include a face to face obstetric review	This review has been completed, and as a result changes have been made to the on-call arrangements for the obstetric team. This enables the doctor on call to focus on cases on the Labour Suite, without being distracted by calls for the gynaecology service or MDAU. There is now a robust admission risk assessment in in place. This is mandatory for all women admitted in labour and available on eCare
	Fetal Monitoring The Trust should support staff in adhering to local policy and encourage appropriate early escalation when the quality of the CTG monitoring does not enable a systematic assessment or provide assurance of fetal wellbeing. This should include supporting staff to apply an FSE when there is difficulty obtaining an accurate recording of the baby's heart rate.	All Labour Suite Co-ordinators have undertaken CTG Masterclass training since this incident occurred. The maternity service has made the decision to change to intrapartum CTG interpretation guidance based on the 'Physiological Approach'. A separate action plan is in place to monitor the progress with this work. In the interim, a new 'care review' system has been implemented for use by senior midwives alongside the 'fresh eyes' system. The system prompts the people interpreting the CTG to consider additional factors such as cyclicity, and importantly, prompts escalation if the CTG cannot be interpreted due to loss of contact and consideration of applying an FSE. Since this incident occurred, the maternity service has begun using Cerner e-care. 'Fetalinks' is an electronic system which enables to MDT to view the CTG from outside the room. Multiple pairs of 'fresh eyes' maximises the opportunity to consider all aspects of the CTG, and to detect persistent loss of contact / action it without delay
	Escalation (categorisation of instrumental delivery urgency) The Trust should introduce a system of categorisation of urgency for trial of instrumental deliveries, with clear timescales for the decision to delivery interval to ensure a shared understanding between the MDT of the timeframes required.	The new system of categorisation of instrumental delivery will commence in October 2021. This has been a long collaborative process involving a large MDT. The theatre WHO checklist has been amended and the emergency bleep cascade has had an urgent Instrumental delivery category added. The guideline is going through the ratification process and upon completion Instrumental deliveries will be categorised in the same way as caesarean sections.
	Clinical Assessment (risk assessment) The Trust to ensure that a robust system is in place for a regular face to face senior obstetric review of all high risk mothers on the delivery suite to ensure there is an agreed management plan and an ability to adapt care with an increasing risk profile.	Morning and evening ward rounds, led by the consultant and attended by the MDT are now firmly embedded. Compliance has been subject to audit, demonstrating consistent high compliance. These now recognised as a valuable tool in care planning and oversight.
WSH-IR 66949	- Antenatal care was in line with national guidance (NICE, 2008). SFH measurements were completed and followed the expected growth trajectory. - The Mother had RFM at 35+5 weeks, this was managed in line with guidance and did not change the clinical pathway. - After contacting the unit at 39+6 weeks with contractions and no fetal movements the Mother was reviewed, appropriately transferred to obstetric care and a CTG was promptly commenced. - When the Mother was reviewed, with ongoing CTG concerns, a holistic assessment was not possible. The plan to revisit 30 minutes later was reasonable based on the information available to the clinicians at the time. - Staff proactively prepared the Mother in case a CS became necessary. This meant that when the Baby's heart rate suddenly could not be located, a category 1 CS was performed promptly and within the recommended decision to delivery interval of 30 minutes (RCOG, 2011).	Report and highlighted positive findings shared with those involved

Local ref.	Key learning points	Safety actions identified following review of HSIB report and recommendations
	An USS at 36 weeks indicated the Baby's growth was on the 50th centile, umbilical artery doppler measurements were not performed. Omission of the doppler meant that a full USS assessment of the Baby was not performed, on this occasion it is unlikely to have altered the care pathway.	This was not routine practice at the time of this incident, current practice would now include doppler measurements.
	The Baby was delivered stillborn by CS. The interval from arrival in the unit to delivery by CS was 70 minutes, the sudden demise of the Baby was not predictable based on the preceding CTG monitoring.	No action required
	Neonatal resuscitation was in line with national guidance, and it was reasonable to cease efforts after 28 minutes without a heart rate and deteriorating blood gas results.	No action required
	PME indicated the Baby was on the 9th centile and the placenta was on the 3rd centile with a fetal placental ratio of 97%. There was evidence of acute hypoxia and placental examination indicated a fetal inflammatory response and chorioamnionitis indicating ascending infection. The findings of an SGA Baby with a high fetal/ placental ratio, and additional infection was likely to have influenced the Baby's ability to cope with the additional stress of contractions.	No action required
	Tripartite Meeting with HSIB family, HSIB, Lead Consultant, Head of Midwifery, Bereavement Midwife and Governance Matron: During the tripartite meeting the family further shared some of the communication between themselves and the Consultants and Midwives they met during their care. They talked openly and frankly about positive encounters, but also reflected on some communication that they found difficult and upsetting. This centred around 2 aspects of care: the first being the communication following admission when there were anxieties regarding the fetal monitoring. The family felt that at the time the midwife did not share those anxieties with them. We apologised for this and as a tripartite decided to: 1.Include discussion regarding communication with parents when situations are escalating to PROMPT MDT training 2.Reflect with midwives and use the families experience in the bereavement element of mandatory training The second aspect was, the communication regarding the PM, they felt overwhelmed at the information given and were distressed by the consultant's approach to this. We apologised and agreed on the following actions 1. The individual involved will undertake a reflective discussion with a colleague 2. All Senior obstetricians and juniors have been encouraged to undertake the robust post mortem training available and online, many have already completed this. 3. The Bereavement midwife attends the obstetric education session to discuss and share women's reflections on the care and communication at the time of their loss.	

6. Quality assurance (QA)

During COVID the previous formal Tuesday morning walkabouts ceased due to the pandemic requirement to reduce visitation to ward areas. Multi professional QA visits involving external partners provide a level of assurance to support improvement plans at divisional or subject level. Most recently this covered the care for patients with a learning disability via a QA 'round table event' in Dec20 and a site visit in May 2021. More details are reported in section 9.

A plan to reintroduce a more focused patient experience quality assurance programme is in place including NEDs / Governors using the '15 steps' tool to guide the visits to the wards and a meeting took place in October between the WSFT and the CCG quality and safety leads to consider the wider clinical external assurance timetable for 2022 with 'falls and frailty' identified as the first theme/subject.

7. Raising concerns

WSFT has a number of options for staff to raise their concerns internally including opportunities to do this anonymously. Formal pathways include talking to line managers, member of the human resources department, trade union representative and the 'Freedom to Speak Up' Guardians as well as an Intranet reporting form. Concerns raised through all the above methods are captured on a trust database held on a secure drive active since January 2020. More information is available via the FTSUG reports to Trust Board.

Staff concerns raised 1st May 2021 to 31st August 2021 n = 30	
Route for raising concern	
Freedom to Speak Up Guardian	18
Senior Independent Director	0
Chief Executive	12
Anonymous phone line	0
Other e.g. NED other than SID	0
Concerns including element of patient safety/quality	9
Concerns including element of bullying and/or harassment	4
Detriment experienced i.e. staff experience detriment as a result of raising concern	2
Concerns raised anonymously	4

Staff group raising concerns		**Division of staff member raising concern**	
Not disclosed	2	Not disclosed	6
AHP	4	Medical	3
Medical	2	Surgical	3
Registered nursing and midwifery	8	Integrated services	4
HCA	1	Clinical support services	3
Administrative and clerical	7	Women and children	2
Maintenance and ancillary	3	Corporate	4
Manager	0	Estates and facilities	3
Senior leader	0	Bank/locum	2
Professional and technical	0		
Corporate services	3		
Other	0		

The FTSU Guardians report a theme of dissatisfaction with the Datix process. Although the Datix system provides a way to "Speak Up" to share concerns and report incidents, some people report feeling discouraged from using it as they are not always clear how or if their incident has been followed up and feedback is not always received.

The FTSU guardians are meeting with leads in the Patient safety & quality team to explore options including a collaborative article for the Green sheet possibly a flow chart which explains the journey an incident may go on through Datix, and then some examples and learning as well as the common reasons (non-system based) that feedback is less than ideal to prompt better (system based) feedback.

8. Learning from patient and public feedback:

Specific learning from complaints and concerns related to COVID is being incorporated into the '*Integrated learning from Covid'* report being prepared by the Public Health team.

Eight complaints received in Q4 were deemed to be upheld at the time of producing this report. Actions from these are set out in the table below. The complaints team are reviewing ways of ensuring that actions are implemented. Whilst a review of the actions tab on Datix will be completed, an interim process of sending out action plans to staff with the final response to complete.

Whilst action plans are being returned (in some cases with evidence) documenting that the actions and learning have been completed, the complaints team do not currently carry out spot checks. When workload allows, we will be conducting spot checks for actions (such as reminders for staff) to ensure the learning has been understood with staff across the Trust.

Ref.	Issues identified	Actions and learning
1872	Patient did contract Covid-19 during admission and there was poor communication with patient's relatives.	• Further staff have been recruited to ward F7 which should help to improve communication with the ward. • The ED now uses lateral flow tests on patients as part of triage for rapid assessment of where best placed to reduce risk of transmission.
1885	Wrong information relayed to patient's brother contacting clinical helpline	• Refresher training for helpdesk staff to ensure confidence in how to perform search functions on eCare to ascertain whether a patient has been admitted to the hospital.
1891	Patient's necklace was lost during admission.	• Patients' family members given information on how to claim compensation for lost item. • PALs will be working with colleagues across the trust to set up a focus group on reducing lost property
1889	Patient's items were lost in hospital	
1858	Delay in patient receiving analgesia and medication	• Although the ward was very busy, staff have been reminded to check on patients and follow up with pain relief if pain score indicates a requirement
1866	Oversights about the processing of the patient's samples which led to a delay in his treatment	• The delay in availability of urgent results to Macmillan unit will be discussed at the biochemistry team meeting to highlight the impact this had on patient care. • Implement a procedure for all urgent samples to be placed in red racks for processing and checked as they are removed from the analyser to ensure that the sample has processed correctly. • An audit on samples referred to Ipswich hospital will be conducted. There will also be discussions about any delays to turnaround times with colleagues at ESNEFT. • An additional portable device to maintain samples at 37 degrees c will be purchased. • All phlebotomy staff will be reminded of the requirement to keep samples from patients with cryoglobulins warm and reminded of the correct procedure to be used.
1888	Staff relayed information to a family member against NOK's wishes. There was clear documentation on patient's record that information should not be provided to this person.	• Complaint has been shared with all ward staff to highlight the impact that error in communication caused. • Ward staff reminded to ensure that entries leading up to and after a patient's death should be read prior to providing any information to anyone who contacts the ward.

Ref.	Issues identified	Actions and learning
1852	Delay in patient's injury being diagnosed, also personal and oral hygiene care was inadequate.	• Ward manager has reminded her team to ensure that head to toe assessments are carried out on patients to avoid the risk of injuries being missed. • Staff champions for patients with any level of learning disability will be appointed to ensure that referrals are made to the learning disability liaison nurse and to ensure that there is clear communication and documentation about where the patient lives and is cared for. • Ward manager undertakes spot checks for all staff to ensure they understand their patients' personal and mouth hygiene needs. • Staff have been reminded that patients' personal hygiene needs should be checked daily and where possible skin integrity should also be checked daily. • Further training on mouth care and personal hygiene care will be given to staff on the ward. • Therapy team have reflected on patient's treatment and have been reminded of the importance of being considerate of communication needs of patients with a learning disability.

9. Quality Assurance - Learning disabilities QAV visit – WSCCG / LeDER

This report focuses on the feedback and learning from the Learning disabilities (LD) table top review and quality assurance visit conducted by a team from the West Suffolk CCG and learning from national and local LeDeR reviews.

In December 2020 a table top review of the service provision for individuals with a learning disability who attended West Suffolk Foundation Trust was conducted by WSCCG. This was a comprehensive review of services and care pathways, both elective and non- elective for those individuals with a diagnosis of learning disability and autism. The review focused on patient and carer experience, staff training and awareness, application of reasonable adjustments and appropriate use of the Mental Capacity Act 2005 (MCA), best interest decision making and Deprivation of Liberty Safeguards (DoLS).

From the table top review, some areas of focus for improvement were identified jointly with the Learning Disability Liaison Nurse and Adult Safeguarding Lead, including:

- Engagement with users to gain feedback and improve service provision
- Improving awareness of the use of Hospital Passports and reasonable adjustments
- Improving Mental capacity assessments

However, it was also recognised that there was limited resource to achieve these recommendations without further support in the team. At the time of the review there was 0.5 WTE of a Learning Disability Liaison Nurse, who had a dual role as the Adult Safeguarding Nurse, supported by the Head of Nursing for Surgery, who also has the responsibility as Adult Safeguarding Lead. Despite this, there was positive feedback and recognition for the improvements and work that had been achieved within the previous 12 months, recognising that services and individualised support for patients with a learning disability and autism had been maintained during the Covid -19 pandemic. There was praise for the electronic flag and alerting systems utilised and that processes were put in place to ensure easy read materials were available, as well as, individualised pathways for planned patients.

In May 2021, a further review was conducted by the team from the WSCCG. This took the format of a Quality Assurance Visit to WSFT. The visit was conducted by the Patient Safety & Clinical Effectiveness Lead, Clinical Quality Leads, Learning Disabilities Quality Improvement Lead Nurse Specialist, and Deputy Designated Clinical Officer – SEND, in conjunction with the Adult Safeguarding Lead, the Learning Disability Liaison Band 7 Nurse and newly appointed Learning Disability Band 6 Nurse for WSFT. The QAV focused on adult and paediatric elective and emergency pathways and included reviews of the Emergency Department (ED) adult and paediatric settings,

the Acute Assessment Unit (AAU), Pre- assessment Unit (PAU), Ward F3, Ward G5, Day Surgery Unit (DSU) and Rainbow Ward (F1). There were also visits to the Psychiatric Liaison Service and PALS to gain full insight into the multiple pathways and interactions that individuals with a Learning Disability may encounter and experience. During the visit, the team had the opportunity to speak to staff and service users, as well as observe practice and review documentation and protocols.

Overall, there was positive feedback and praise for the service provision for individuals with a learning disability and autism. Processes felt safe, effective, caring, responsive and well led and the needs of individuals were recognised and catered for. The team were complimentary of the welcome they had received by the various teams in the Trust and recognised the work that had been achieved to improve patient pathways for this group. In general, there was assurance that teams were aware of the use of communication tools, hospital passports and observed the provision of reasonable adjustments and appropriate use of the MCA and DoLS. In summary there was:

- Good awareness of reasonable adjustments in specialist areas
- Appropriate use of hospital passports
- A welcoming and friendly feel
- Positive use of Flag system
- Recognition of individual needs in patient pathways and services

The visit was followed by a report of the table top review and QAV. This was a comprehensive account of the findings, most of which had been verbalised during the encounter and there were recommendations for further development and improvement. These were:

- Improved provision of information in easy read format
- Seek engagement from service users
- Improve knowledge of reasonable adjustments in all settings
- Engage Ward champions/ ambassadors
- Improve use of Hospital passport in the paediatric settings
- Review and standardise training and education
- Explore Makaton training for teams, specifically in the paediatric setting
- Review coding and recording of LD, Autism, etc.

It was reassuring to the team that many of these areas of improvement had already been acknowledged and plans have been put in place to support quality improvement. The recruitment and introduction of a full time Learning Disability Nurse to support the existing personal has been a positive and welcome addition to the team. This has enabled improvements to be driven and raised awareness of the complex needs of these individuals and how they can be supported. In the first three months in post, she has raised awareness of the role and support available, focussed on improving the Flag alert and coding systems, reviewed the training packages and provision and focussed on raising awareness of HELPS:

- H-Hospital Communication Book
- E-Electronic Alert
- L-Learning Disability Liaison Nurse or Equivalent
- P-Patient Passport
- S-Support for Family Carers

This is key and fundamental to improving the communication and support for individuals with a learning disability and autism. A focussed improvement plan is being developed to capture all the recommendations to enable progress and monitoring of the service and quality improvements.

In addition to these reviews, there is continued learning and engagement with the LeDeR reviews, both locally and nationally. This provides the organisation with data, feedback and recommendations for improvements in care and service provision for those with a learning disability or autism. The Learning Disabilities Mortality Review (LeDeR) Programme is a national programme aimed at making improvements to the lives of people with learning disabilities. The LeDeR programme supports local areas in England to review the deaths of people with learning disabilities (aged four years and over) using a standardised review process. The programme collates and shares anonymised information about the lives and deaths of people with learning disabilities so that common themes, learning points and recommendations can be identified and taken forward into

policy and practice improvements.

From the Annual review, published in April 2021, there were 42 deaths reported in Suffolk in the previous 12 months, an increase of 50% from the previous year. It was acknowledged that this was not due to Covid-19, but the main cause of death relates to aspiration pneumonia, with sepsis a close second. Sadly, 62% of these deaths occur in a hospital setting and it is recognised that pathways to facilitate an individual with a learning disability to die at home are poor or non-existent. This is an area of focus both locally and nationally, along with:

- Use of reasonable adjustments
- Promoting accurate Mental capacity assessments
- Promoting the use of advocates
- Early detection of sepsis

From the period of 1st April 2020 to 31st March 2021, there were 11 deaths of individuals with a learning disability who were inpatients in WSFT. The majority of these deaths relate to pneumonia, aspiration pneumonia or sepsis. There are still some outstanding reviews, however, from those which have taken place, key learning for the organisation has been surrounding:

- Improving pain management
- Promoting the use of Hospital Passports
- Promoting the use of reasonable adjustments regarding visiting
- Consideration of reasonable adjustments with discharge planning and CAB placement
- Promoting the use of advocates
- Improving communication with families and carers
- Improving communication regarding treatment limitations
- Promoting best interest decision making processes and recording

Many of these recommendations tie in with the recommendations from the assurance visit and are being captured in the improvement plan, and specifically, the work being achieved in promoting HELPS. There have already been positive improvements and examples of how learning has taken place to improve the care and experience of others during their admission, hospital stay and discharge, ensuring a holistic and person-centred approach to care and service provision. In addition to this, the team are working collaboratively with other practitioners within the Integrated Care System (ICS) to improve the discharge planning processes for those with a learning disability and autism and standardise and promote hospital passports within Suffolk and North East Essex.

12. Involvement Committee Report

To APPROVE the report

For Approval

Presented by Alan Rose

Board of Directors – 15 October 2021

Agenda item:	12			
Presented by:	Alan Rose, Non-Executive Director & Involvement committee chair			
Prepared by:	Alan Rose, Non-Executive Director & Involvement committee chair			
Date prepared:	11 October 2021			
Subject:	Involvement Committee September 2021 – Chair's key issues			
Purpose:	X	For information		For approval

Executive summary:

The Involvement Committee met on 20 September 2021. Below is the Chair's Key Issues document which will constitute the standard template for Involvement Committee reports to Board.

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

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

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

Recommendation:

To approve the report

Chair's Key Issues – Involvement Committee

Part A

Originating Committee	Involvement Committee	Date of Meeting	20 September 2021
Chaired by	Alan Rose	Lead Executive Director	Jeremy Over

Agenda Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref	Paper attached? ✓
	The Committee has identified a need to **embed involvement in any change management process** that the Trust develops and notes that an involvement toolkit will be developed to support this.	Assurance	N/A	
	The Committee notes that a staff and stakeholder engagement forum will be created to support the **implementation of the People Plan** and, in particular, to ensure staff involvement in its delivery and evaluation.	Assurance	N/A	
	In the discussion of its Terms of Reference, the Committee proposes to include a **governor as a regular attendee**, to report on governor engagement and also to ensure that governors get early insight into other Trust engagement initiatives involving staff, patients and other partner organisations.	Approval	N/A	
	Learning from the maternity whistleblowing incident identified a number of actions that the Trust needs to take forward, including the need for a quicker response and engaging more widely should similar situations arise again. Processes will be reviewed in the light of this learning.	Assurance	N/A	
	In the light of the actions taken by the Trust to strengthen its controls in this area and the imminent introduction of new legislation related to integrated care systems, the Committee recommends the **de-escalation of the BAF risk "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"	Approval	BAF Risk Ref 9	
Date Completed and Forwarded to Trust Secretary				

Part B

Receiving Committee	Board of Directors	Date of Meeting	15 October 2021
Chaired by	Sheila Childerhouse	Lead Executive Director	Craig Black

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

12.1. People & OD highlight report (attached)

To APPROVE the report

For Approval

Presented by Jeremy Over

Board of Directors – Friday 15 October 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:	06 October 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
- Freedom to Speak Up guardians' quarterly report
- Equality, Diversity & Inclusion annual report
- Quarterly staff survey results
- Appraisal and mandatory training quarterly report
- Long COVID update
- Education and training six monthly report
- Healthcare worker flu vaccination best practice management checklist
- 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
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 – September 2021 awards

Liz White, Speech and Language Therapy (SALT) team
Nominated by Liza Asti, SALT professional lead

Liz was travelling back from a home visit when she spotted someone collapsed at the wheel of his car – she stopped and alongside two more passers-by got him out of the car and commenced CPR until the ambulance arrived.

She took a risk in stopping as the car was in a difficult spot with many cars continuing to drive by. Her actions clearly reflect our West Suffolk values.

Pete Southam, staff support psychology service
Nominated by Sally Williams

I would like to nominate my fellow colleague Pete Southam. Pete goes above and beyond his managerial/general duties every day that he is at work, often putting himself last!

His kind and caring nature is second to none and he has helped me personally (beyond the role of a manager) over the last year. Personal circumstances have made it difficult for me to cope and Pete has gone above and beyond, using his own time to ensure that I have sourced and received the relevant support I need to make my circumstances easier.

He always finds time for others, even if it isn't there!

I have never had a manager that is so approachable and emotionally available to every member of their team, and the unique thing about Pete… he doesn't know he is even doing it most of the time!

Freedom to Speak Up Guardians quarterly report

Our Freedom to Speak Up Guardians, Amanda Bennett and James Barrett, quarterly report is attached as **appendix 1**. This reflects their learning, influence and experience over the past quarter. They will be in attendance to present and discuss the report at our meeting on 15th October.

Equality, Diversity & Inclusion Annual Report

The annual trust equality, diversity and inclusion report is attached for board members' approval as **appendix 2.**

This report provides an update on progress with our Inclusion Strategy and provides assurance that the Trust is meeting the requirements of the NHS Standard Contract, NHS Constitution and CQC as well as equalities legislation, including our Public Sector Equality Duty (PSED).

Key developments since the last report to the Board in September 2020 include:

- Sunflower Scheme – launched in May 2021. To support our colleagues with a hidden disability the lanyard or bin badge is a subtle but visible way to help identify that the wearer may require some extra help, time, or assistance.
- New equality and diversity mandatory e-learning package – improved and more comprehensive training launched June 2021. Our E-learning for healthcare package covers all areas of equality, diversity and inclusion and gives practical examples of scenarios to support staff.
- Developing our staff networks by funding a staff network chair training day. Learning will be shared through all networks.
- Introduction of disability leave for staff with disabilities in February 2021. This special leave is for those who need to take time away from work for disability related reasons.
- Extension of 'not every disability is visible' signage on lavatory doors in the Trust.
- Good practice on reasonable adjustments in the selection process added to our Recruitment and Selection policy to help ensure we give every candidate the opportunity to fully present their abilities and best self to the panel.

In the summer of 2021 we invited all staff, staff networks and staff side colleagues to contribute to identifying priority areas for action over the next 12 months. We also took account of the results of our 2021 Workforce Race Equality Standard (WRES) and, Workforce Disability Equality Standard (WDES) assessments, as well as 2020 Gender Pay Gap report and NHS staff survey results.

The following four priorities have been identified:

- Inclusive recruitment – to review our recruitment and selection training for all staff who sit on a recruitment panel. Ensuring we include information on unconscious bias.

- Disability awareness and reasonable adjustments - to raise the profile of the challenges faced at work of those with a disability and how reasonable adjustments ensure colleagues are able to fulfil their potential. Targeting both new starters within the recruitment process and existing colleagues.

- Cultural awareness - to encourage staff to broaden their understanding of the lived experiences of others and celebrate all cultures represented at WSFT, including those recruited overseas.

- Staff networks - to develop and nurture the staff networks to provide support to staff and guidance to the trust.

Action to progress these priorities has been built into our EDI action plan.

Appraisal and mandatory training quarterly report

Mandatory training
The Trust target of an overall mandatory training compliance of at least 90% has been met since April 2021. In September 2021 overall compliance stood at 90% but the overall picture has deteriorated slightly as will be seen from **appendix 3**.

Estates and Facilities division compliance has increased by 3% to 92%. However, the Corporate, Surgical and Medicine directorates have all fallen to just below 90%. The overall deterioration in compliance may be due to a combination of factors including junior doctors' changeover in August resulting in a significant number of new colleagues with mandatory training requirements (medical staff compliance fell by 5% July to September). Annual leave in the summer, relatively high sickness absence, the need for staff to self-isolate, the impact of building works and service pressures have also impacted on the availability of staff to undertake mandatory training. Social distancing in the Education Centre continues to reduce face-to-face training capacity and e-learning continues to be provided where this is an appropriate alternative.

Appraisal
The overall trust appraisal compliance rate was 78.92% at the end of August; a reduction of 1.76% since the last report to the Board and below the target compliance rate of 90%. Divisions continue to work against their agreed action plans and trajectories to reach compliance. Only the Estates and Facilities division (93.21%) is at/above 90%. Both the Corporate Services Division (+5.25%) and Clinical Support Division (+2.55%) made significant increases in compliance over July figures. Details are provided at **appendix 3**.

HR Business Partners continue to work with their divisions to support completion of appraisals but report significant challenges. For example, in the surgical division, the impact of building works on staffing within surgical wards and theatres has further impacted the difficulties in getting back on top of appraisals. This has been compounded by high level of work pressure linked to the recovery programme, increasing levels of staff sickness absence, increased employee turnover and vacancies, and colleagues taking annual leave.

Action to support the completion of appraisals includes managers being encouraged and supported to consider whether they can disseminate further 'appraiser' responsibility, which could provide development opportunities as well as ensuring staff receive an appraisal. The HR team are supporting with appraisal training.

Long COVID update

At the end of September 2021, we were aware of 13 colleagues on long term sickness absence due to long COVID (i.e. people who have new or ongoing symptoms four weeks or more after the start of acute COVID-19). This is only a slight increase since the last update to the board in July when 10 colleagues were absent for this reason. The length of time absent ranged from 40 to 434 days. Of those staff absent, 12 had been absent for more than 100 days which may suggest a decline in new cases. It is important to note that not all colleagues experiencing long COVID are on sick leave as some are able to stay in work despite their symptoms.

The long COVID support group established by the Staff Support Psychology team has met for six of its planned 10 group sessions via MS Teams. The group is made up of eight staff members and attendees have reported finding it very helpful. The topics covered are generated by the group and this has covered a range of challenges being faced. They have also had a guest speaker in Suzahn Wilson from the Suffolk and North East Essex Long COVID Service. Feedback from Dan Curran, one of the psychologists running the group, is that the principle benefit of the group is probably the validation members feel from knowing there are others experiencing similar things. A comprehensive evaluation of the group will take place once it has finished at the end of November. The team will then will review and plan to set up another group to meet a growing wait list.

Education and training six monthly report

This report demonstrates how education and training is contributing to the three priorities of the Trust's proposed Strategic Framework 'Our patients, our hospital, our future, together' and can be found at **appendix 4**.

Quarterly staff survey results

A shorter, quarterly staff survey has been implemented across the NHS this year, the first iteration of this having taken place in July. The purpose of this will be to more frequently track staff engagement (using the nine questions from the Engagement theme in the NHS Staff Survey), in line with the commitment in the People Plan 2020/21. This will replace the staff Friends and Family Test.

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

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

Response rate
The survey was undertaken over a two-week period in July 2021. We received 1298 responses from a census of 5528 eligible staff, giving a response rate of 23%. This is on par with the national average for this first quarterly survey.

Headline results
The headline results are summarised below and indicate a slightly worsened position compared with the results from the annual survey in 2020 (undertaken nine months ago between October-November 2020):

- The overall staff engagement score has reduced from 7.2 to 7.0 out of 10.0.
- The most notable reduction in scores when looking at the individual questions is the extent to which staff agree with the statement *"care of patients is my organisation's top priority"*, reducing from 7.7 to 7.0.
- Reductions were less marked for the other two 'advocacy' questions (recommend as place to work and recommend as place to receive care) – a reduction of 0.2 for both questions
- Out of the three components that make up 'engagement', 'motivation' was the one that overall saw the biggest drop, a reduction of 0.4 / 10.0.

Thus far we have not received the results broken down by any form of demographics or sub-organisational level, or comparison to other similar trusts.

What next?
There are likely to be a number of different factors underpinning this, although perhaps it is not surprising given the range and complexity of the operational, estate and capacity challenges we face as an organisation and the ways in which these impact on colleagues at an individual and team level. On the back of launching our new five-year trust strategy, including the refresh of our organisational FIRST values, we will be setting out the next iteration of our People Plan to bring together all of our development work to continue to improve our culture and support and develop our staff and teams.

Healthcare worker 'flu vaccination best practice management checklist

As in previous years, the Department of Health and Social Care and Public Health England require all NHS Trusts to complete a self-assessment against a best practice checklist which has been developed based on five key components of developing an effective 'flu vaccination programme. DHSC and PHE require Trusts to publish the completed checklist in public board papers at the start of the 'flu season. This is provided as **appendix 5**.

A robust plan is in place to promote and provide vaccination against both the 'flu and Covid-19 to all WSFT staff. The WSFT winter vaccination programme started on 29th September 2021 and both the 'flu vaccine and the Covid-19 booster vaccine is being offered to all trust staff. 1579 'flu vaccinations and 1877 COVID boosters were booked between 29th September and 9th October. Uptake is being monitored closely and our plans will be adapted as needed to ensure staff are given every opportunity to have a vaccination.

Recent Consultant Appointments

Post: Consultant Anaesthetist with an interest in critical care medicine
Interview: 26 August 2021
Appointee: Dr Claire Malcolm
Start date: 4 January 2022

Current post: ST7/stage 3 Intensive Care Medicine, West Suffolk NHS FT
May 2021 – Sept 2021

Previous Position:
Feb 2020 – May 2021
Acting consultant; Norfolk and Norwich University Hospitals NHS FT

Post: Consultant Anaesthetist
Interview: 17 September 2021
Appointee: Dr Ramasamy Radhika
Start date: TBC

Current post: Consultant Anaesthetist, Darlington Memorial Hospital and Bishop Auckland Hospital, June 2010 to current

Previous Position:
Nov 2009 to April 2010
Locum consultant; Nottingham University Hospitals and Norwich University Hospitals NHS FT

APPENDIX 1 – People and OD report

Freedom to Speak Up: Guardians' Report November 2021

Introduction

Since November 2020, two Guardians, James Barrett and Amanda Bennett have been employed at WSFT. The number of concerns raised with the guardians remains steady with 15 and 18 cases in the last two quarters.

In the National Guardian's Office Freedom to Speak Up Index 2021 (https://nationalguardian.org.uk/2021/05/27/freedom-to-speak-up-index-2021/) the West Suffolk NHS Foundation Trust was identified as the Trust which had the third highest overall decrease in its FTSU Index Score between 2019 and 2020. Whilst this reflects the known results from the 2020 NHS Staff Survey, it reminds us all that FTSU and culture are linked and that supporting a "Just Culture" is a priority for us all.

James and Amanda continue to promote Freedom to Speak Up and are in the process of training approximately 40 Freedom to Speak Up Champions to support their work.

Data

Data Submitted to NGO for Q1 2021/2022

Number of cases brought to FTSUGs / Champions per quarter	14
Numbers of cases brought by professional level	
Worker	10
Manager	3
Senior leader	0
Not disclosed	1

Numbers of cases brought by professional group

Allied Health Professionals	0
Medical and Dental	2
Registered Nurses and Midwives	3
Nursing Assistants or Healthcare Assistants	1

Corporate Services	1
Administration, Clerical & Maintenance/Ancillary	4
Not Known	1
Other	2
Of which there is an element of	
Number of cases raised anonymously	1
Number of cases with an element of patient safety/quality	2
Number of cases with an element of bullying or harassment	5
Number of cases where disadvantageous and/or demeaning treatment as a result of speaking up (often referred to as 'detriment') is indicated	1
Number of cases with an element of worker safety	0
Response to the feedback question, 'Given your experience, would you speak up again?	
Total number of responses	1
The number of these that responded 'Yes'	1
The number of these that responded 'No'	0
The number of these that responded 'Maybe'	0
The number of these that responded 'I don't know'	0

Common themes from feedback

- Support for those suffering with Long Covid
- Poor working relationship with line manager
- Poor working relationship with colleagues

Summary of learning points

- Information regarding support for Long Covid circulated by communications team

Data Submitted to NGO for Q2 2021/2022

Number of cases brought to FTSUGs / Champions per quarter	18

Numbers of cases brought by professional level	
Worker	14
Manager	1
Senior leader	1
Not disclosed	2
Numbers of cases brought by professional group	
Allied Health Professionals	2
Medical and Dental	1
Registered Nurses and Midwives	7
Nursing Assistants or Healthcare Assistants	3
Administration, Clerical & Maintenance/Ancillary	1
Not Known	3
Other	1
Of which there is an element of	
Number of cases raised anonymously	6
Number of cases with an element of patient safety/quality	12
Number of cases with an element of bullying or harassment	6
Number of cases where disadvantageous and/or demeaning treatment as a result of speaking up (often referred to as 'detriment') is indicated	1
Number of cases with an element of worker safety	6
Response to the feedback question, 'Given your experience, would you speak up again?	
Total number of responses	0
The number of these that responded 'Yes'	0

The number of these that responded 'No'	0
The number of these that responded 'Maybe'	0
The number of these that responded 'I don't know'	0

Common themes from feedback

- Difficulties with line manager – both clinical and non-clinical skills
- Policy and procedure felt unsafe, or by its lack of implementation
- Staffing levels, or inappropriate staff mix leading to unsafe working
- Lack of communication
- Bullying/incivility

Summary of learning points

- Importance of feeding back in a timely manner
- Communication methods best determined at local level

The Guardians are working to improve the culture of speaking up throughout the WSFT. Our actions are categorised under 8 key workstreams:

Workers throughout the organisation have the capability, knowledge, and skills they need to speak up themselves and to support others to speak up.

What's going well:

- Rolling programme of training given to overseas nurses, HCA's and Foundation year doctors
- NGO e-learning programme ("Speak Up" and "Listen Up") to made part of Mandatory training either through induction training or as a "one-off" update (date to be confirmed)
- Continuing to promote Speaking Up, Listening Up and Following Up at team meetings, Nursing and Midwifery Clinical Council and Medical Staff Committee meetings
- Continuing to offer drop in sessions to teams
- Continue to distribute posters around Hospital and community sites

Even better if:

- As COVID restrictions relax to introduce more "face to face" presentations and meetings to promote FTSU

Speaking up policies and processes are effective and constantly improved

What's going well:

- Guardians both members of the policy working group ensuring FTSU represented on policy updates.

Even better if:

- Assist Board in production of clear FTSU strategy
- To update FTSU Policy document following year in post and bring into line with other Trust Documents

Senior leaders are role models of effective speaking up

What's going well:

- Quarterly meetings in place with CEO, Chair of Board and Senior independent director
- Excellent support from Chief and Deputy Chief Nurses

Even better if:

- National Guardian's Office e-learning recommended to all senior leaders when available (to be published later this year)
- FTSU pledge to be established for Board and wards

All workers are encouraged to speak up

What's going well:

- Continuing number of concerns raised to the Guardians (15-18 concerns per quarter)
- Development of the FTSU Champions network to support staff in speaking up and to signpost to most appropriate service

Even better if:

- Concerns around perceived negative consequences of speaking up (detriment) must be challenged
- "Learning Bulletin" developed to complete feedback loop and show that speaking up leads to change and improvement

Individuals are supported when they speak up

What's going well:

- Individuals report feeling supported by the Guardians when raising concerns
- Development of Freedom to Speak Up Champion role – please see attached appendix for the FTSU Champion pledge
- Started training FTSU Champions (First session 20 September, next sessions 6 October and 2 November)
- Freedom to Speak Up Champions launch in October which is "Speak Up Month"

Even better if:

- Continue to expand Champion network to support areas/groups not currently covered

Barriers to speaking up are identified and tackled

What's going well:

- Good relationships with HR Business Partners and working together to analyse staff survey results
- Links with Union representatives and their views gathered to identify barriers to

speaking up
- FTSU Guardians were informed when Board members resigned and have spoken to NHSE and I Regional Director and ICS Chair to identify actions for the board
    - To check that FTSU was referenced in Annual Report
    - To confirm that FTSU Guardians present at Board Meetings
- FTSU Guardians were informed when the Maternity concerns were raised to CQC and later prior to the letter being published in the local press. Amanda Bennett attended a meeting via Teams to which all maternity staff were invited. James Barrett met with NHSE and I Maternity Improvement Lead, Mai Buckley. The Guardians are still involved in the ongoing work in this area.

Even better if:
- Listening up training undertaken by all managers
- Speaking up rewarded and embraced within teams
- Integration of FTSU within the Just and Learning culture, so that speaking up is "business as usual"

Information provided by speaking up is used to learn and improve

What's going well:
- Working with Patient Safety colleagues, particularly with regard to the Datix recording and feedback processes
- Individual improvements have been witnessed by the FTSU Guardians following raising concerns
    - Staff who initially raised concerns via FTSU, have become FTSU Champions
- Following concerns raised about redeployment of ward staff at short notice, a "rapid response nursing pool" has been launched to support areas with a shortfall of staff

Even better if:
- "Stories" to encourage Speaking Up to be communicated via Green Sheet in October "Speak Up" Month
- Developing FTSU Teams Channel to help communication within the FTSU Guardians and Champions

Freedom to speak up is consistent throughout the health and care system, and ever improving

What's going well:
- Members of East of England FTSU Guardian Network and have attended quarterly meetings

Even better if:
- Encourage Board Members to read NGO publication The National Guardian Office's Freedom to Speak Up Strategic Framework (https://nationalguardian.org.uk/2021/07/22/our-strategic-framework-for-freedom-to-speak-up/)

APPENDIX 2 – People and OD report

Annual equality, diversity and inclusion report 2021

Purpose of this report

- To update the Trust Board on progress being made towards the development of a culture of inclusion, as a service provider and an employer

- To provide Trust Board members with assurance about the steps taken to meet the Trust's commitment to comply with the 2010 Equality Act, our Public Sector Equality Duty (PSED), equality, diversity and inclusion requirements of the NHS standard contract, NHS Constitution and CQC criteria.

Introduction - WSFT inclusion strategy

WSFT is developing and promoting an inclusive culture. This means we embrace all people irrespective of, for example, race, religion or belief, sex, gender identity or expression, sexual orientation, age, marital status, pregnancy, maternity or disability.

Our aim is to ensure WSFT is a place where everyone is confident and comfortable being their authentic and whole self, whether as a member of staff, volunteer, patient, service user or visitor. We strive to give equal access and opportunities to all and to get rid of discrimination and intolerance as an employer and as a service provider.

An inclusive culture supports our commitment to the provision of high quality, safe care for all members of the communities we serve and our ambition to support all our staff as set out in our strategic framework 'Our patients, our hospital, our future, together'.

Equality, diversity and inclusion objectives and action

The following nine inclusion objectives were agreed by the Board in September 2019 to further progress our Inclusion Strategy. These objectives were developed following a process of consultation with staff, patient representatives and the wider community, as well as a review of our performance against NHS standards and legal requirements.

For patients, service users and carers

- Improve the experience and care of patients and service users experiencing mental distress those with learning disabilities and neurodiversity
- Improve the experience and care of people who are lesbian, gay, bisexual, trans and all other sexualities and gender identities

For staff

- Promote and support inclusive leadership at all levels of the trust
- Ensure recruitment and selection processes are bias free and inclusive
- Facilitate the voices of all staff, providing forums for individuals to come together, to share ideas, raise awareness of challenges, provide support to each other and feedback to the trust on issues of equality, diversity and inclusion
- To take action to support the mental health wellbeing of all staff

For patients, service users, carers and staff

- Promote a culture of inclusion in delivery of care to all patients and staff
- Improve information and data collected, in respect of protected characteristics in order to understand what action may be required
- Tackle bullying and harassment of and by staff and support staff to respectfully and successfully challenge problem behaviours

In the summer of 2021 we invited all staff, staff networks and staff side colleagues to contribute to identifying priority areas for action over the next 12 months. We have also taken account of the results of our 2021 Workforce Race Equality Standard assessment (see **Appendix 2** for report), Workforce Disability Equality Standard assessment (see **Appendix 3** for report), Gender Pay Gap report and NHS staff survey results.

Within these objectives the following 4 priorities have been identified for the next 12 months:

- **Inclusive Recruitment** - Review our recruitment and selection training for all staff who sit on a recruitment panel. Ensuring we include information on unconscious bias.

- **Disability Awareness and reasonable adjustments** - Raise the profile of the challenges faced at work of those with a disability and how reasonable adjustments ensure colleagues are able to fulfil their potential. Targeting both new starters within the recruitment process and existing colleagues.

- **Cultural Awareness** - Encourage staff to broaden their understanding of the lived experiences of others and celebrate all cultures represented at WSFT, including those recruited overseas.

- **Staff Networks** - Develop and nurture the staff networks to provide support to staff and guidance to the trust.

Our draft equality, diversity and inclusion plan sets out an action plan for the coming year. See **Appendix 1.**

Governance of equality, diversity and inclusion

Development and implementation of our inclusion strategy is overseen by the Equality, Diversity and Inclusion Steering Group and an update is provided to the Patient Experience Committee for patient issues. Staff issues are escalated to the Involvement Committee as required. A report is made to the Trust Board annually. The LGB&T+, Staff Disability and BAME staff networks are invited to contribute to the organisational inclusion agenda and decision making through representation on the Equality, Diversity and Inclusion Steering Group.

Key developments since the 2020 annual report include:

- Sunflower Scheme – launched in May 2021. To support our colleagues with a hidden disability the lanyard or bin badge is a subtle but visible item to help identify that the wearer may require some extra help, time, or assistance.
- Speaking Up Champions – launched in September 2021. A new role which works alongside the Speaking up Guardians to encourages staff to speak up, support and

signpost colleagues to health & wellbeing and support services and to raise awareness.
- New Equality & Diversity e-learning package – improved and more comprehensive training launched June 2021. The E-learning for healthcare package covers all areas of Equality, diversity and Inclusion and gives practical examples of scenarios to support staff.
- Developing our staff networks by funding a staff network chair training day where learning can be shared through all networks.
- Introduction of disability leave for staff with disabilities in February 2021 who need to take time away from work for disability related reasons.
- Extension of 'not every disability is visible' signage on lavatory doors in the Trust.
- Good practice on reasonable adjustments in the selection process added to our Recruitment and Selection policy to support giving every candidate the opportunity to fully present their abilities and best self to the panel.

Standards and external assurance

Equality Delivery System 2 (EDS2)

Implementation of the EDS2 is a requirement on both NHS commissioners and NHS providers. At the heart of the EDS2 is a set of 18 outcomes grouped into 4 goals. These focus on the issues of most concern to patients, carers, communities, NHS staff and Boards of Directors.

The four goals are:

- Better health outcomes
- Improved patient access and experience
- A representative and supported workforce
- Inclusive leadership

The WSFT EDS2 was reviewed, in consultation with staff, patient representatives and the wider community June to August 2019. This is an electronic document and a copy can be found on the Trust website in the corporate information, information we publish section. Our EDS2 will be reviewed from August 2022.

Workforce Race Equality Standard (WRES)

The Workforce Race Equality Standard (WRES) is included in the NHS standard contract and its main purpose is:

- To help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators.
- Produce action plans to close the gaps in workplace experience between white and Black, Asian and Minority Ethnic (BAME) staff and
- To improve BAME representation at the Board level of the organisation.

A report showing WSFT performance against the WRES indicators is attached along with our proposed actions in relation to the feedback received. **Appendix 2**.

Workforce Disability Equality Standard (WDES)
The Workforce Disability Standard (WDES) was included in the NHS standard contract from April 2019 and its main purpose is to improve the experiences of disabled staff in the NHS.
It comprises 10 metrics covering representation of disabled staff in the workforce and on the Trust Board, how the organisation facilitates the voices of disabled staff to be heard, comparison of the experience of disabled versus non-disabled staff around harassment bullying and abuse; opportunities for career progression or promotion, satisfaction with how individual's work is valued by the Trust; engagement and pressure from managers to attend work despite not feeling well enough to perform their duties. Disabled staff are also asked about the provision of reasonable adjustments.

Full details of the Trust's performance against the WDES indicators are provided along with our proposed actions in relation to the feedback in **Appendix 3**.

Gender Pay Gap (GPG) reporting

All employers with 250 or more employees are required by law to publish their gender pay gap each year on their own and the Government's website.

The figures reported show West Suffolk NHS Foundation Trust's gender pay gap in two ways – as median and mean average hourly rates. Average hourly rates:

	Average hourly rate (mean) % pay gap	**Median hourly rate % pay gap**
31.3.17	24.2%	8.1%
31.3.18	23.5%	6.0%
31.3.19	22.8%	5.3%
31.3.20	22.7%	4.8%

In 2019/20 the average hourly rate of pay for women remained lower than that of men but the trend towards narrowing the gap continued.

As in previous years the gender pay gap is caused by the trust employing proportionately more men in more skilled, senior, higher paying jobs than we have women; in particular amongst senior management roles and medical staff. Detailed analysis of the data by pay band highlights that female pay is higher than male pay in 7 out of the 15 pay bands/groups including Bands 8d and 9. The average hourly rates of men are still higher than those of women at executive level and amongst medical staff.

What bonuses are paid to staff?

New guidance was issued nationally on what constitutes bonus pay for the reporting year ending 31.3.19. Bonus pay is any remuneration that is in the form of money, vouchers, securities or options and relates to profit sharing, productivity, performance, incentive or commission. The following payments are now included in the calculation of bonus pay:

- Clinical excellence awards (CEA) and discretionary points awarded to senior medical staff (NB: until 2019 these were the only payments counted as bonus pay).
- Welcome payments. These are incentives paid in the form of one or two lump sums to staff appointed to areas where recruitment is difficult e.g. pharmacy and staff nurses.

- Recruitment and retention premium. These are on-going increases to base salary for staff appointed to areas where recruitment is difficult e.g. estates trades and craftspeople, pharmacy, clinical coding, sonographers.
- Commitment awards e.g. bonus paid to nursing assistants on completion of their Care Certificate
- Recommend a friend payment i.e. payments made to existing staff who recommend WSFT as a place to work to a friend who joins and remains with the Trust
- Long service awards paid on retirement to staff with over 25 years' service at WSFT

2018 bonus gender pay gap data is not, therefore, directly comparable with 2019 and 2020 data.

Bonus pay	2018		2019		2020	
	Female	Male	Female	Male	Female	Male
% staff receiving bonus pay	1.09%	5.14%	5.99%	10.97%	6.39%	9.71%
Mean average bonus pay	£7563	£9857	£2634	£5088	£2553	£6163
Mean average bonus GPG	23.27%		48.23%		58.58%	
Median average bonus pay	£6032	£6032	£1500	£3000	£1500	£3406
Median average bonus GPG	0%		50%		56%	

What causes this gap?

Proportionately more men than women receive the highest level of the highest paying bonuses (i.e. Clinical Excellence Awards (CEA) made to consultant medical staff). 54% of the 85 men receiving bonus payments were consultant medical staff in receipt of CEA, whilst only 18% of the 234 women receiving bonus payments were consultant medical staff in receipt of CEA.

Therefore, the inclusion since 2019 reporting of a large number of additional, lower, awards in addition to CEA, has exacerbated this situation. The impact has been to drive down both the mean and median bonus disproportionately for women and increased the bonus GPG. A copy of the full report published in April 2021 can be found on the Trust website.

National NHS Staff Survey 2020: Equality, diversity and inclusion theme

In addition to information from the NHS staff survey referenced in sections on WRES and WDES above, overall trust performance in the equality, diversity and inclusion theme placed WSFT as matching the national average for similar trusts and close to the best in the country.
Trust performance in the equality, diversity and inclusion theme has remained equal to or above the national average for the past five surveys.

	2016	2017	2018	2019	2020
Best	9.4	9.4	9.6	9.4	9.5
WSFT	9.3	9.2	9.3	9.3	9.1
Average	9.2	9.1	9.1	9.0	9.1
Worst	8.2	8.1	8.1	8.3	8.1

West Suffolk NHSFT equality and diversity profile 31 March 2021

The Trust workforce appears more diverse than immediate local areas, and less diverse than the whole of England with the exception of Asian groups. Ethnic groups account for approximately 13% of total workforce and 9% of total staff survey of respondents.

Whilst the White British group makes up around 80% of the workforce, this is not reflected across all staff groups:

- Estates & Facilities, Admin & Clerical, AHP and ACS staff groups have a greater proportion of white groups overall (>60%)
- Nursing is slightly more diverse than the above, with 70% of staff in White groups and 21% in Minority groups.
- Medical & Dental has an almost equal distribution of white and minority groups.

80% of the Trust's workforce is female, with the majority in nursing, administrative and healthcare support posts. Male staff members represent 20% of the workforce with a more even distribution in the medical & dental roles (Female 50.8%, Male 49.2%)

Female staff members work almost equally part-time and full-time, whilst almost 90% of male staff members work full-time. Overall, 59% of Trust staff work full-time, with 41% working part-time.

Staff members between the ages of 40-60 account for 48% of the workforce, with over 60% of staff having been with the trust between 1-10 years. A quarter of staff members have been with the Trust for more than 10 years.

- Approximately 47% of the workforce falls within the 36 – 55 age group.
- There are 375 employees over 60, 12 of these are over the age of 71.
- 84% of staff have a current length of service between 1-15 years.

3.6% of staff have declared a disability, 48.6% have said they do not have a disability and the status of the remaining 47.9% of staff is unknown.

There has been a slight increase (2%) in staff members choosing to disclose their sexual orientation.

- 0.76% bisexual
- 1.05% gay or lesbian
- 75.77 % heterosexual
- 22.34% not disclosed

- 0.04% other sexual orientation not listed
- 0.04% undecided

Trust staff have a diverse range of faiths and religions. For example, 49.1% report their religion as Christianity, 0.89% Buddhism, 1.35% Hinduism, 1.33% Islam, 14.93% Atheism and 15.73% chose not to disclose their faith or religion.

Performance Management

2020/21
As part of the Trust's processes for equality monitoring the Workforce and Communications Directorate record all formal investigations for disciplinary, capability, grievance, bullying, harassment and recruitment complaints. The factors being monitored are age, ethnicity, gender and disability to identify any trends that may indicate discrimination.

In 2020/2021 the Trust conducted a total of (22) formal investigations split into the categories listed in the table below.

	2020/21	2019/20	2018/19
Disciplinary	8	27	37
Capability	5	7	2
Grievance	9	13	8
Bullying and harassment	0	5	1
TOTAL	22	52	48

Our analysis shows that 19 of the cases listed above involved people of White British or White European/White other ethnicity. One member of staff was Filipino, one was Portuguese and one was Polish. None of the employees involved has a disability and the age range of staff was from 20 years old to 70 years old.

Disciplinary Cases 8
Male = 3
Female = 5
Disability = 0
Dismissed = 1 - female, White British
Resigned before hearing = 0
On hold due to Covid-19 = 0
Ethnicity = White British = 7, Portuguese = 1
Age range = 20 years old to 56 years old

Capability Cases 5
Male = 0
Female = 5
Disability = 0
Dismissed = 0
Resigned before hearing = 0
On hold due to Covid-19 = 1
Ethnicity = White British = 4 Filipino = 1
Age range = 26 years old to 55 years old

Grievance Cases 9
Male = 2
Female = 7
Disability = 0
Dismissed = 0
Resigned before hearing = 0
On hold due to Covid-19 = 0
Ethnicity: White British = 8, Polish = 1
Age range = 25 years old – 70 years old

Bullying & Harassment 0
Male =0
Female = 0
Disability = 0
Dismissed = 0
Resigned before hearing = 0
On hold due to Covid-19 = 0
Ethnicity: N/A
Age range = N/A

Based on the information above for 2020/21 there are no areas of concern within our performance management data in relation to colleagues with protected characteristics.

Update on 2019/2020 performance management report

Following a review of the 2019/20 performance management data (included in the 2020 Annual Equality Diversity and Inclusion Report) it was identified that staff from the Philippines were disproportionately represented in HR cases. 15% of cases involved staff from the Philippines whilst they represent only 3% of our workforce. As a result, a full review of previous disciplinary, grievance, capability and bullying and harassment cases, involving Filipino colleagues, including outcomes was undertaken with the following conclusions.

- Overall recruitment, selection and induction processes were very good and Filipino nurses joining the Trust were well supported. There was some evidence from the review of investigations of staff who would have benefitted from a greater level of continued support when they were new, particularly when working in very busy environments. Additionally, there was some evidence that a reluctance to raise issues or ‘make a fuss’ or alert managers to things the individual was struggling with, may have resulted in processes going forwards might otherwise have been resolved earlier.

- There was a general theme, not restricted to Filipino colleagues, of situations that may have been resolved informally becoming a formal investigation. The work the trust is undertaking to develop a just and learning culture is expected to address this – particularly the pre-investigation review process that is now in place. This means no performance management concerns will be investigated formally until a review has been carried out to understand if matters can be resolved informally.

- It was recognised that there is a need for Filipino colleagues who feel unable to raise concerns to be able to get the help of others to advocate for them.

The following actions were agreed and taken:

1. Continued support after induction to be discussed with the Non-Medical Clinical Education Lead.
2. Ensure Filipino colleagues are aware of the advocacy and support available via the BAME staff committee.
3. The review's outcomes to be shared with the Trust Equality, Diversity and Inclusion Steering Group.

Appendix 1

Draft Inclusion Action Plan October 2021 to October 2022

Objective	Action	Lead	Comments
Where actions are relevant to improving WSFT performance against the Workforce Race Equality Standard (WRES) or Workforce Disability Equality Standard (WDES), Gender Pay Gap (GPG) reporting or NHS People Plan this is indicated against the objective. All of the actions in this plan help us achieve our Public Sector Equality Duty.			
For patients, service users and carers			
1. Improve the experience and care of people who are lesbian, gay, bisexual, trans and all other sexualities and gender identities	Continue to participate in the NHS Rainbow Badge Scheme to promote a message of inclusion to LGB&T+ patients, service users, and carers	LGB&T+ network	WSFT joined scheme in June 2019 and over 500 staff have signed the pledge
For staff			
2. Ensure that the recruitment and selection processes are bias free and inclusive	Inclusive recruitment: Recruitment & Selection training to be reviewed to ensure in incorporates information around unconscious bias *WDES & WRES*	Wellbeing & Inclusion Manager and Recruitment Team	To be implemented by April 2022

3. Facilitate the voices of all staff, providing forums for individuals to come together, to share ideas, raise awareness of challenges, provide support to each other	Staff networks: Develop and nurture the staff networks to provide support to staff and guidance to the trust: Support the development and work of the Trust Staff Disability Network. *WDES* Support the development and work of the Trust BAME, LGB&T+ and Menopause networks *WRES* International Medical Support Group *WRES* Review the governance arrangements of Trust staff networks with members to ensure they are able to contribute to and inform decision-making processes in the Trust *NHS People Plan*	 Wellbeing & Inclusion Manager Wellbeing & Inclusion Manager Medical Staffing Manager and Consultant in Obstetrics and Gynaecology Executive Director of Workforce and Communications	 A relaunch is planned for Autumn 2021 to support membership and encourage regular meetings and an elected chair. Induction Guidelines for International Medical Graduates has been distributed to corporate managers in June for action from August 2021 onwards. Engagement exercise underway with staff networks. Deadline December 2021
4. To take action to support the mental health wellbeing of all staff	Provide access to resources, training and awareness raising for managers and staff to support mental health wellbeing *WDES & WRES*	Consultant Clinical Psychologist and Staff Support Psychology Service,	The Staff Support Psychology service provide regular support training sessions to managers on a variety of topics. Programme Autumn/Winter 2021/22 A post within the Staff Support Psychology service has been funded by My Wish Charity for one year to support those from a minority background.

For patients, service users, carers and staff			
5. Promote a culture of inclusion in the delivery of care to all patients and staff	Ensure every level of the workforce leaderships is representative of the overall BAME workforce *NHS People Plan, WRES*	Deputy Director of Workforce (Learning and OD)	Monitor WSFT progress against the 'Model Employer: increasing black and minority ethnic representation at senior levels across the NHS' goals and identify action to achieve them.
	Identify opportunities to increase diversity of executive and non-executive Trust Board membership *GPG, WDES & WRES*	Trust Board Chair	
	Cultural awareness: Encourage staff to broaden their understanding of the lived experiences of others and celebrate all cultures represented at WSFT, including those recruited overseas. *WDES & WRES*	Wellbeing & Inclusion Manager	Programme set up and started by 31 December 2021 to run until Dec 2022
	Raise the profile of the challenges faced at work of those with a disability and how reasonable adjustments ensure colleagues are able to fulfil their potential. Targeting both new starters within the recruitment process and existing colleagues. *WDES & WRES*	Wellbeing & Inclusion Manager	Programme set up and started by 31 December 2021 to run until Dec 2022

6. Tackle bullying and harassment of and by staff and support staff to respectfully and successfully challenge problem behaviours.	Recruit, train and support a wide cohort of Speaking Up Champions who can offer advice and support from their own lived experience and knowledge *WDES & WRES*	Freedom to Speak Up Guardians	Champions recruited from a range of staff to represent all staff groups, especially those who find it more challenging to speak up. First Champions recruited and training running September, October, November 2021

Appendix 2

Workforce Race Equality Standard Report 2021

Name and title of board lead for WRES:	Jeremy Over, Executive Director of Workforce and Communications
Name, title and contact details of lead manager for compiling this report:	Rebecca Rutterford, Wellbeing & Inclusion Manager rebecca.rutterford@wsh.nhs.uk
Name of commissioner this report has been sent to:	Giles Turner, Human Resources Business Partner, West Suffolk CCG
This report was signed off by the Trust Board on:	15 October 2021
Total Number of staff at 31.3.21 (permanent, fixed term and bank staff):	5855 (5271 - 2020)
Proportion of BME staff employed within the trust at 31.3.21:	12.9% (12.8% 2020)
Period this data refers to:	31 March 2021
Workforce Race Equality Standard Indicators	
Relative likelihood of staff being appointed from shortlisting across all posts	2019 = shortlisted white candidates 1.43 times more likely to be appointed than BME candidates 2020 = shortlisted white candidates 0.90 times more likely to be appointed than BME candidates (i.e. BME candidates **more likely** to be appointed than white candidates) **2021** = shortlisted white candidates 1.30 times more likely to be appointed than BME candidates **NB**: There was a significant number of overseas BME candidates who were offered the job but choose not to accept due to applying for multiple vacancies.
Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator is based on data from a two-year rolling average of the current year and the previous year	2019 = BME staff less likely than white staff to enter the formal disciplinary process (0.62) 2020 = BME staff less likely than white staff to enter the formal disciplinary process (0.15) **2021**= BME staff less likely than white staff to enter the formal disciplinary process (0.88)

<table>
<tr><td></td><td colspan="5">NB: the numbers involved are small. The numbers of BME staff entering the formal disciplinary process were: 2019 – 3, 2020 – 1, 2021 -1</td></tr>
<tr><td>Relative likelihood of staff accessing non-mandatory training and CPD</td><td colspan="5">2019 = White staff less likely to access non-mandatory training and CPD compared to BME staff (0.57)

2020 = White staff less likely to access non-mandatory training and CPD compared to BME staff (0.91)

2021 = White staff less likely to access non-mandatory training and CPD compared to BME staff (0.69)</td></tr>
<tr><td rowspan="3">National NHS Staff Survey 2020 Indicator
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months</td><td></td><td>2017</td><td>2018</td><td>2019</td><td>2020</td></tr>
<tr><td>White</td><td>26.5</td><td>26.7</td><td>25.1</td><td>25.2</td></tr>
<tr><td>BME</td><td>41.9</td><td>20.5</td><td>27.9</td><td>29.6</td></tr>
<tr><td rowspan="3">National NHS Staff Survey 2020 Indicator
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months</td><td></td><td>2017</td><td>2018</td><td>2019</td><td>2020</td></tr>
<tr><td>White</td><td>18.5</td><td>22.9</td><td>21.5</td><td>24.4</td></tr>
<tr><td>BME</td><td>29.5</td><td>34.1</td><td>21.9</td><td>28.2</td></tr>
<tr><td rowspan="3">National NHS Staff Survey 2020 Indicator
Percentage believing that the trust provides equal opportunities for career progression or promotion</td><td></td><td>2017</td><td>2018</td><td>2019</td><td>2020</td></tr>
<tr><td>White</td><td>88.8</td><td>90.0</td><td>89.6</td><td>87.9</td></tr>
<tr><td>BME</td><td>81.8</td><td>78.6</td><td>84.9</td><td>76.4</td></tr>
<tr><td rowspan="3">National NHS Staff Survey 2020 Indicator
Percentage staff personally experienced discrimination at work for manager/team leader or other colleague</td><td></td><td>2017</td><td>2018</td><td>2019</td><td>2020</td></tr>
<tr><td>White</td><td>5.5</td><td>6.6</td><td>5.7</td><td>5.9</td></tr>
<tr><td>BME</td><td>15.9</td><td>11.4</td><td>11.9</td><td>13.1</td></tr>
<tr><td rowspan="3">Percentage difference between the organisations' board voting membership and its overall workforce</td><td colspan="2">2019</td><td colspan="2">2020</td><td>2021</td></tr>
<tr><td colspan="2">White +16.6%</td><td colspan="2">White +11.00%</td><td>White +12.3%</td></tr>
<tr><td colspan="2">BME -10.9%</td><td colspan="2">BME -12.8%</td><td>BME -12.9%</td></tr>
<tr><td colspan="5">The Trust board voting membership on 31.3.21 was 100% white. Recruitment consultants are instructed to actively seek candidates from all possible sources from within the constituency to provide a diverse range of candidates for all board appointments.</td></tr>
</table>

Proposed Actions for 2021		Completion date
Inclusive Recruitment	Review our recruitment and selection training for all staff who sit on a recruitment panel. Ensuring we include information on unconscious bias.	Implementation by April 2022
Cultural Awareness	Encourage staff to broaden their understanding of the lived experiences of others and celebrate all cultures represented at WSFT, including those recruited overseas.	Programme set up and started by 31.12.21 to run until Dec 2022
Staff Networks	Develop and nurture the staff networks to provide support to staff and guidance to the trust.	Ongoing

Appendix 3

Workforce Disability Equality Standard Report 2021

Name and title of board lead for WRES:	Jeremy Over, Executive Director of Workforce and Communications	
Name, title and contact details of lead manager for compiling this report:	Rebecca Rutterford, Wellbeing & Inclusion Manager Rebecca.rutterford@wsh.nhs.uk	
Name of commissioner this report has been sent to:	Giles Turner, Human Resources Business Partner, West Suffolk CCG	
This report was signed off by the Trust Board on:	15 October 2021	
Total Number of staff at 31.3.21 (permanent, fixed term and bank staff):	5855 (5271 - 2020)	
Proportion of disabled staff employed within the trust at 31.3.21:	3.6% (3% - 2020)	
Period this data refers to:	31 March 2021	
Workforce Disability Equality Standard Indicators		
Relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.	2019	1.03 non-disabled staff are slightly more likely to be appointed than disabled staff from shortlist.
	2020	1.46 non-disabled staff are more likely to be appointed than disabled staff from shortlist
	2021	1.40 non-disabled staff are more likely to be appointed than disabled staff from shortlist.
Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.	2019	0.0 no disabled staff entered the formal capability procedure
	2020	0.32 disabled staff are less likely to enter the formal capability process than non-disabled staff.
	2021	0 no disabled staff entered the formal capability process
National NHS Staff Survey 2020 Indicator Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	**Disabled**	
	2019	30.7%
	2020	30.7%
	Non-Disabled	
	2019	24.4%
	2020	25.4%
National NHS Staff Survey 2020 Indicator Percentage of staff experiencing harassment, bullying or abuse from	**Disabled**	
	2019	16.8%
	2020	17.9%
	Non-Disabled	

managers in the last 12 months	2019	9%
	2020	10.1%
National NHS Staff Survey 2020 Indicator Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	**Disabled**	
	2019	23.5%
	2020	26.9%
	Non-Disabled	
	2019	15.8%
	2020	19.1%
National NHS Staff Survey 2020 indicator Percentage of disabled staff compared to non-disabled staff saying that last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	**Disabled**	
	2019	44%
	2020	56.4%
	Non-Disabled	
	2019	45.5%
	2020	43.3%
National NHS Staff Survey 2020 Indicator Percentage believing that the trust provides equal opportunities for career progression or promotion	**Disabled**	
	2019	84.3%
	2020	86.6%
	Non-Disabled	
	2019	90%
	2020	86.7%
National NHS Staff Survey 2020 Indicator Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	**Disabled**	
	2019	25.1%
	2020	26.3%
	Non-Disabled	
	2019	17.7%
	2020	18.8%
National NHS Staff Survey 2020 Indicator Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	**Disabled**	
	2019	51.8%
	2020	44.7%
	Non-Disabled	
	2019	59.7%
	2020	52.4%
National NHS Staff Survey 2020 Indicator Percentage of disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work	80.6% (82.1% 2019)	
National NHS Staff Survey 2020 Indicator The staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score of the organisation	**Disabled**	WSFT 7.1 (7.2 – 2019)
		National Average 6.7 (6.7 in 2019)
	Non-Disabled	WSFT 7.3 (7.6 - 2019)
		National Average 7.1 (7.1 in 2019)
	Overall staff Trust score 7.2	

Has your Trust taken action to facilitate the voices of disabled staff in your organisation to be heard?	Yes – staff disability network
Percentage difference between the organisation's Board voting membership and its organisation's overall workforce	No board members with a declared disability

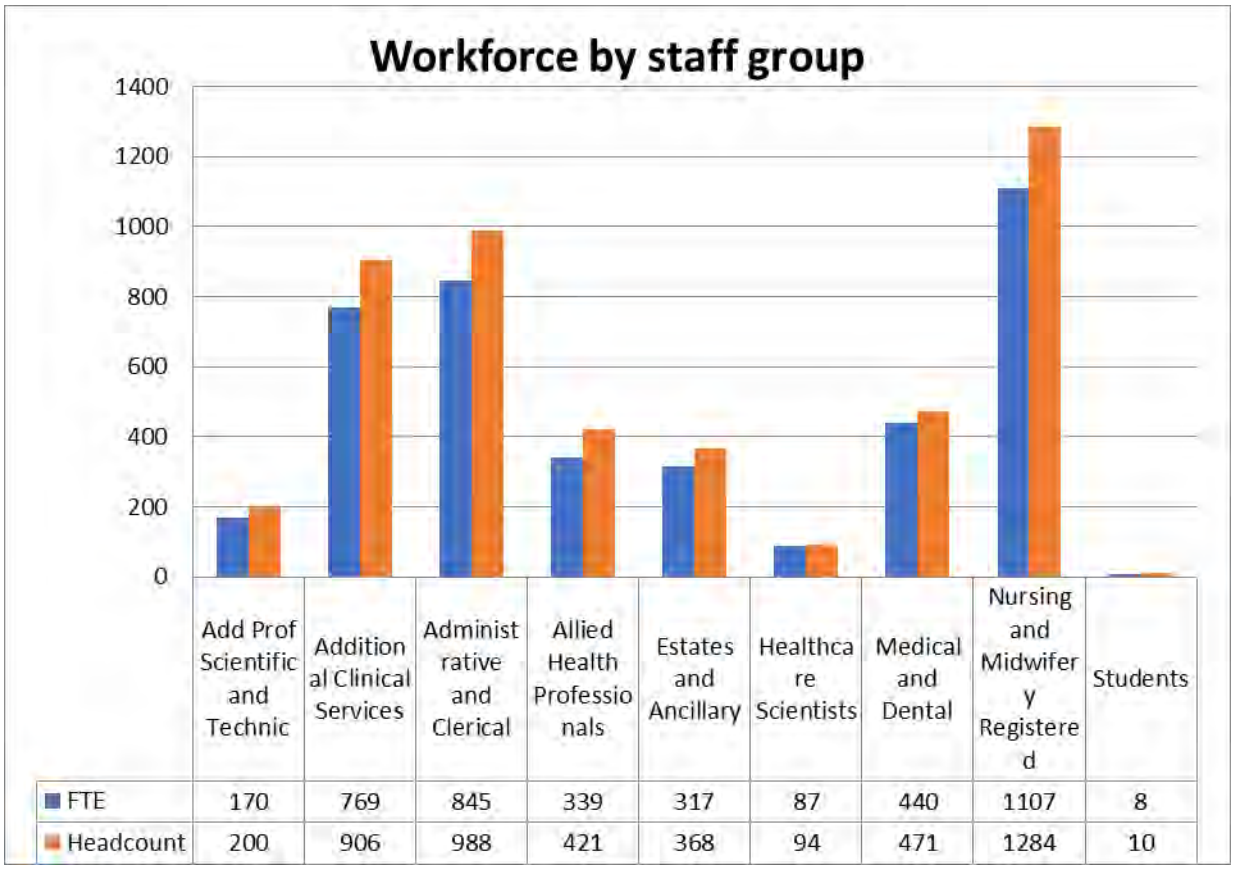
Proposed Actions for 2021		**Completion date**
Inclusive Recruitment	Review our recruitment and selection training for all staff who sit on a recruitment panel. Ensuring we include information on unconscious bias.	Implementation by April 2022
Disability Awareness and Reasonable Adjustments	Raise the profile of the challenges faced at work of those with a disability and how reasonable adjustments ensure colleagues are able to fulfil their potential. Targeting both new starters within the recruitment process and existing colleagues.	Programme set up and started by 31.12.21 to run until Dec 2022
Staff Networks	Develop and nurture the staff networks to provide support to staff and guidance to the trust.	Ongoing

Appendix 4

WSFT equality and diversity profile 31 March 2021

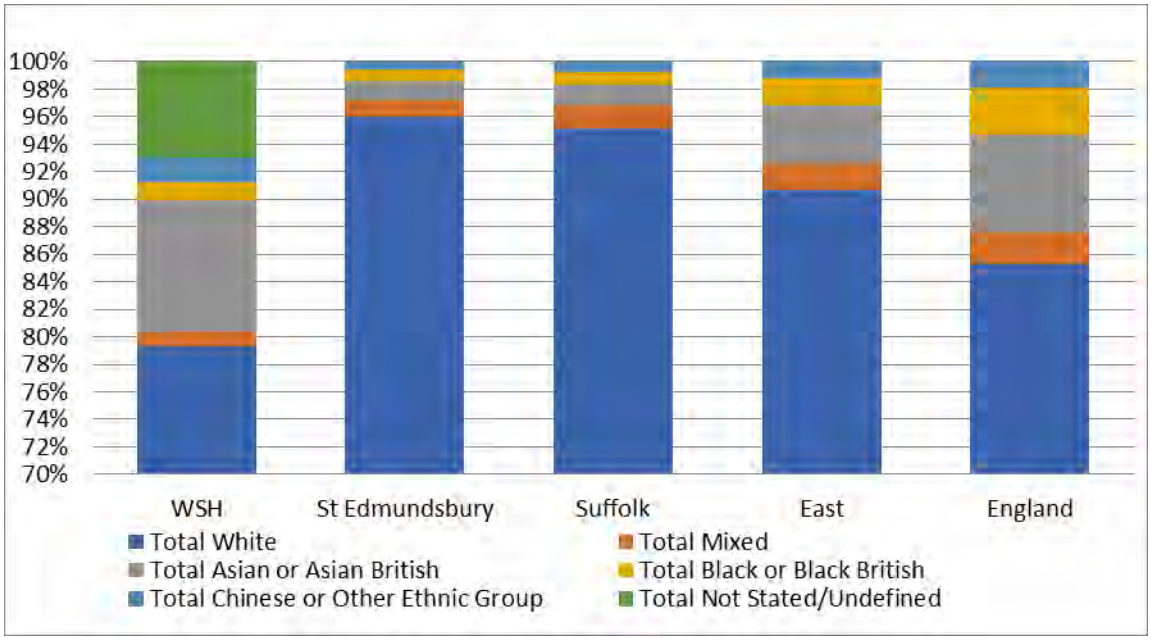
Workforce by staff group

The Trust's total headcount as of 31 March 2021 was approximately 4742. Registered nurses and midwives continue to be the largest single staff group, accounting for almost 30% of total staff in the Trust, followed closely by administrative and clerical and additional clinical services.



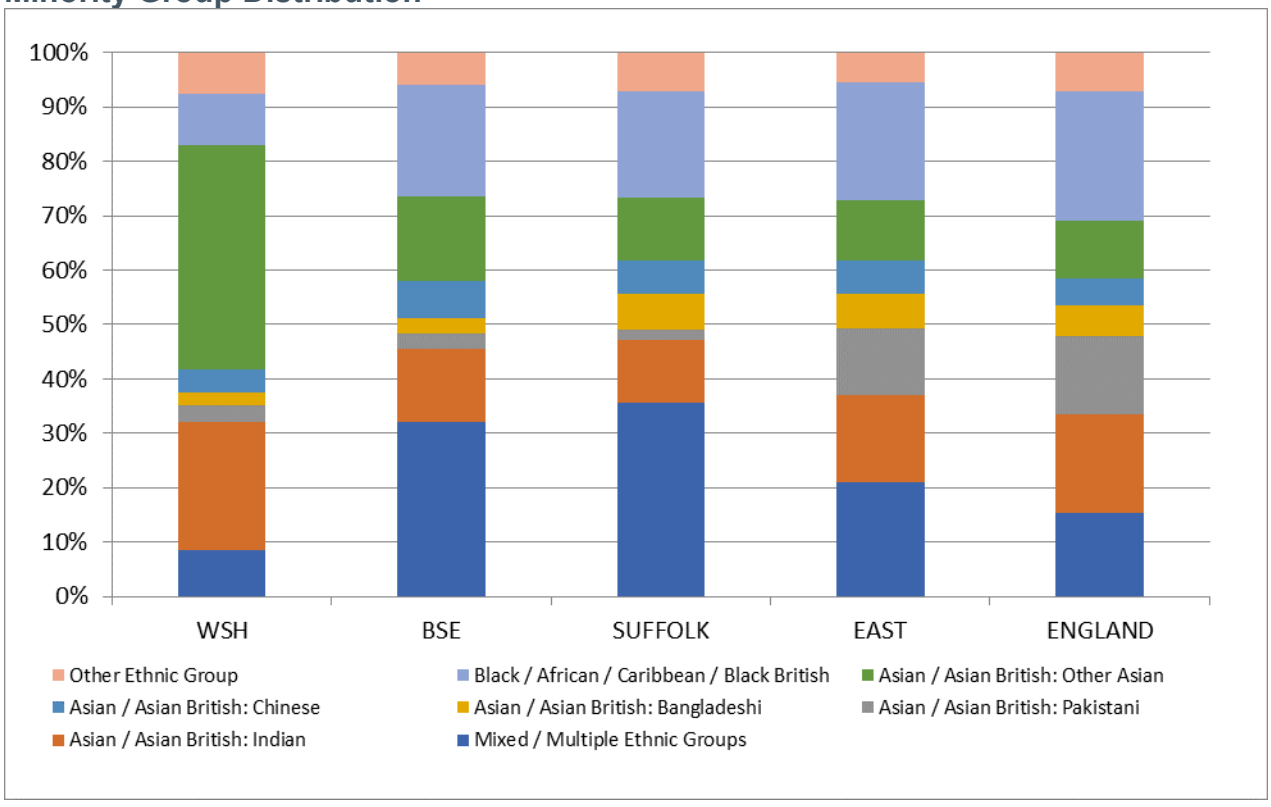
	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	Students
FTE	170	769	845	339	317	87	440	1107	8
Headcount	200	906	988	421	368	94	471	1284	10

Population ethnicity



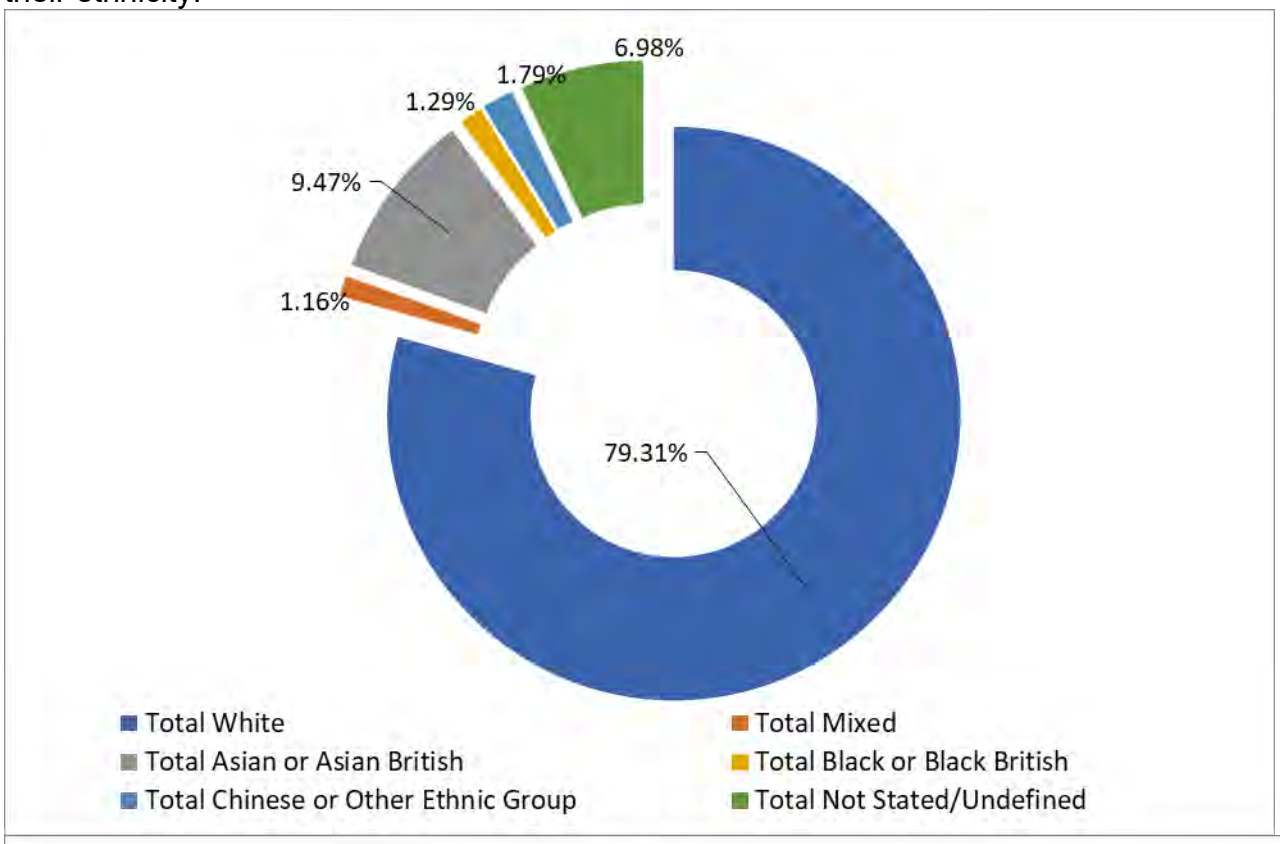
The chart above compares the overall ethnic profiles for the Trust, Bury St Edmunds, Suffolk, East of England and England as a whole. The Trust appears more diverse than the immediate local areas, however slightly less diverse when compared with England as a whole, with the exception of the Asian groups.

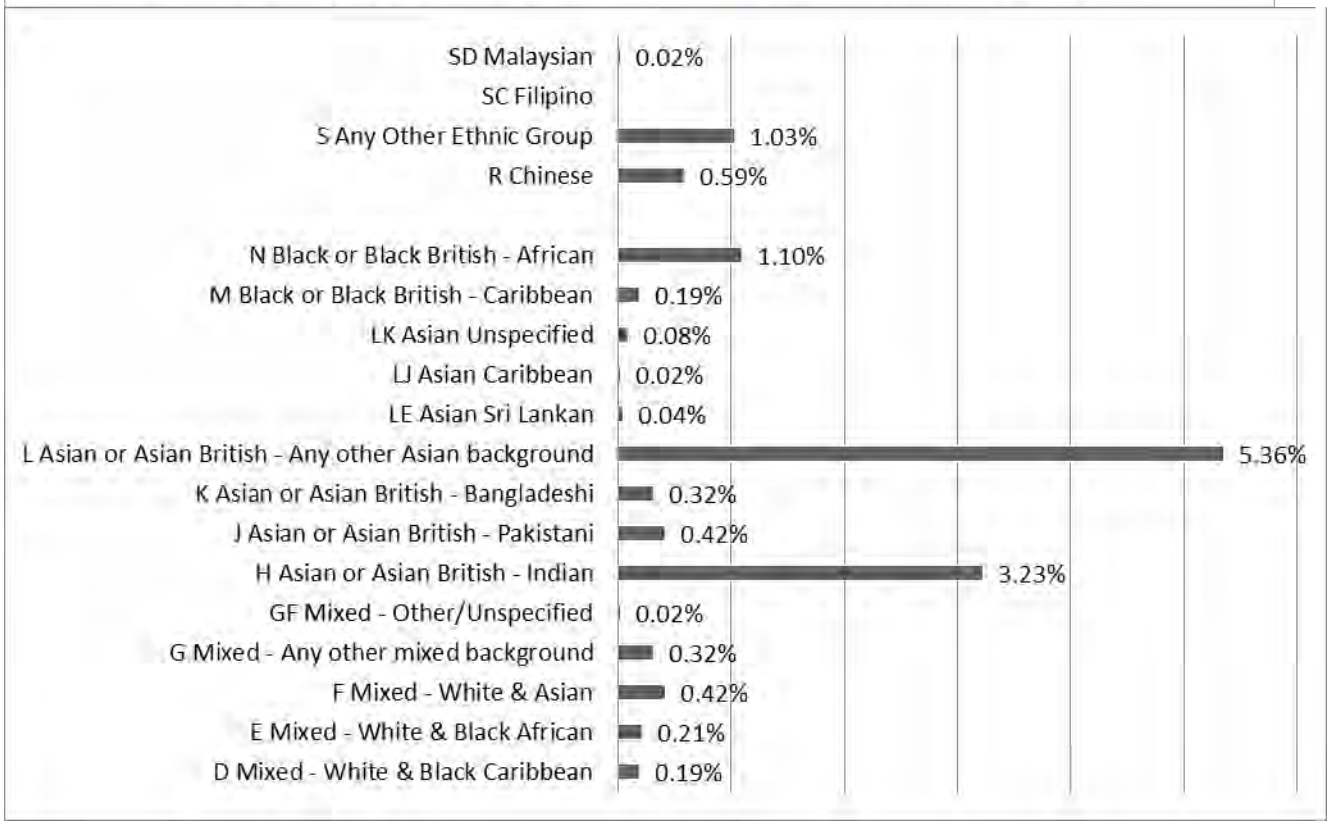
Minority Group Distribution



Workforce ethnicity breakdown

Overall, 13.7% of those staff choosing to disclose their ethnicity stated they were from a minority ethnic group. Currently 93% of the workforce has chosen to disclose their ethnicity.

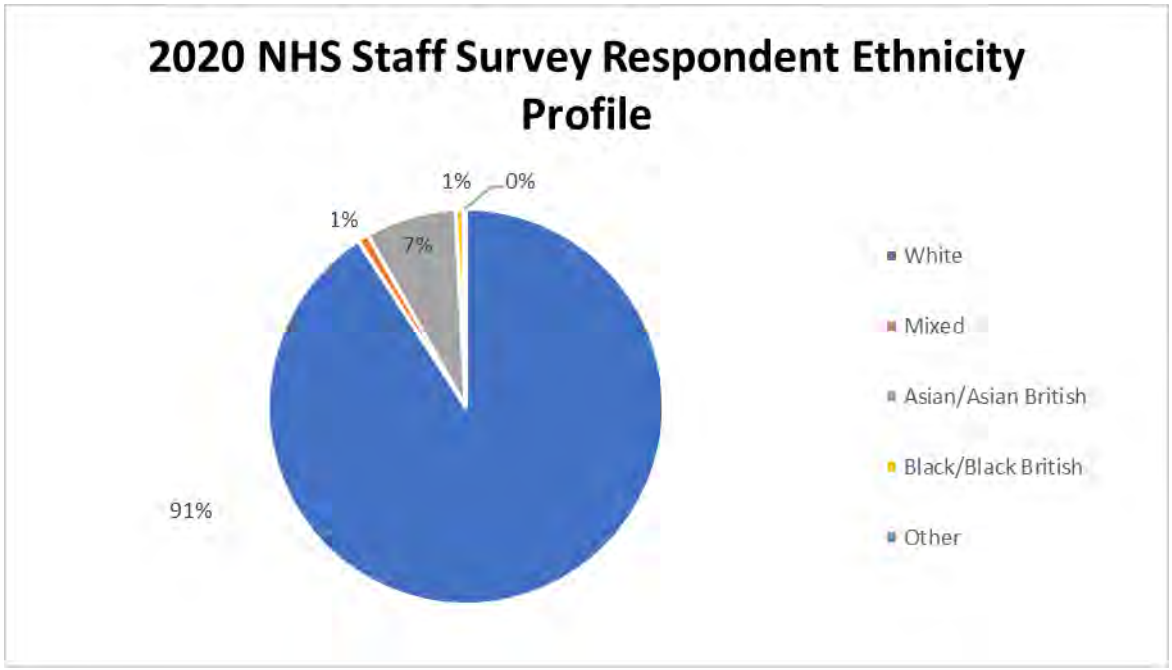




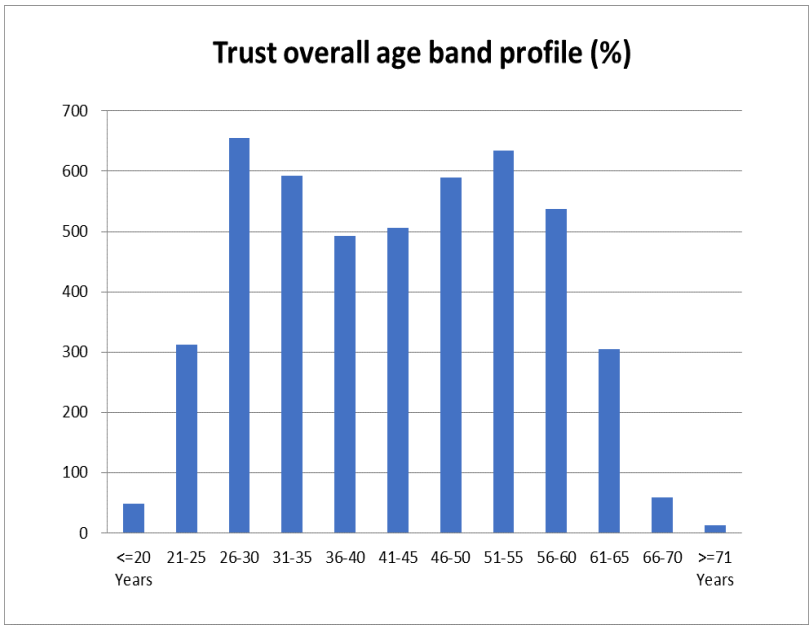
Staff Survey sample – ethnicity

From a census of all eligible staff, 1981 employees responded to the Trust Staff Survey in 2020, giving a total response rate of 46% - above the Picker Institute average for Acute Trusts of 45%.

The chart below shows how our staff respondents described their ethnic background when completing the survey. In total 90.3% were recorded as white groups and 9.1% recorded as minority groups.



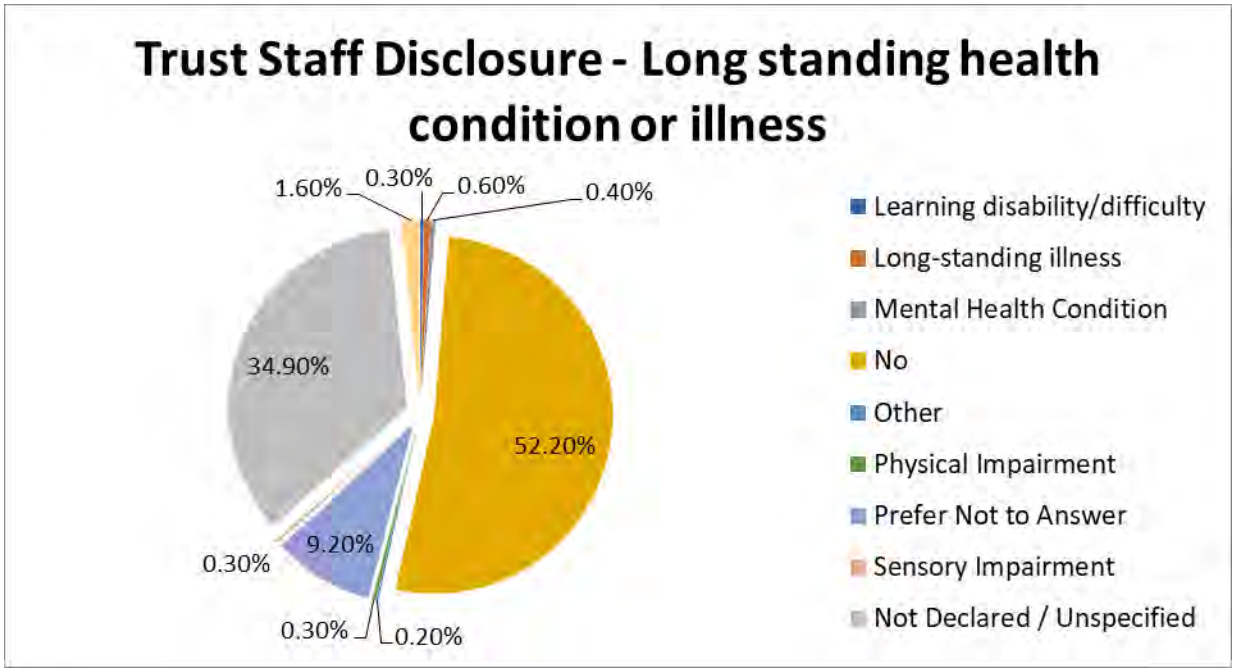
Age profile



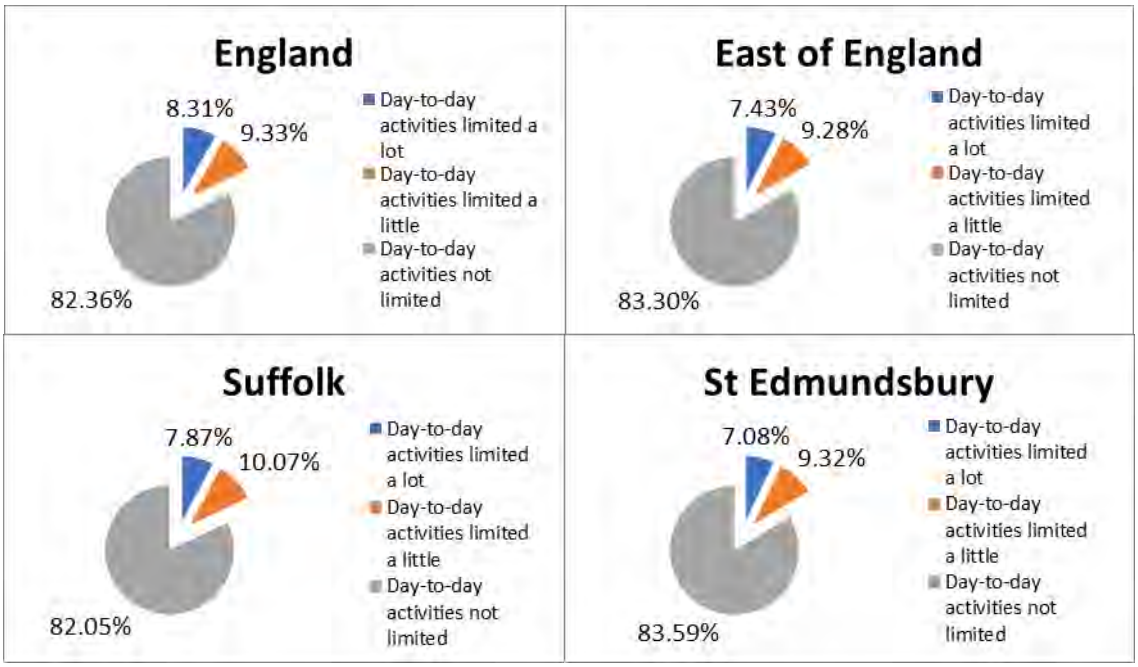
The average age for staff within the Trust is 44 years old. For female staff it is 44 and for male staff, 43.

Long standing health condition or illness

Trust disability data quality has improved and shows that over half of all staff members have a recorded disability disclosure.

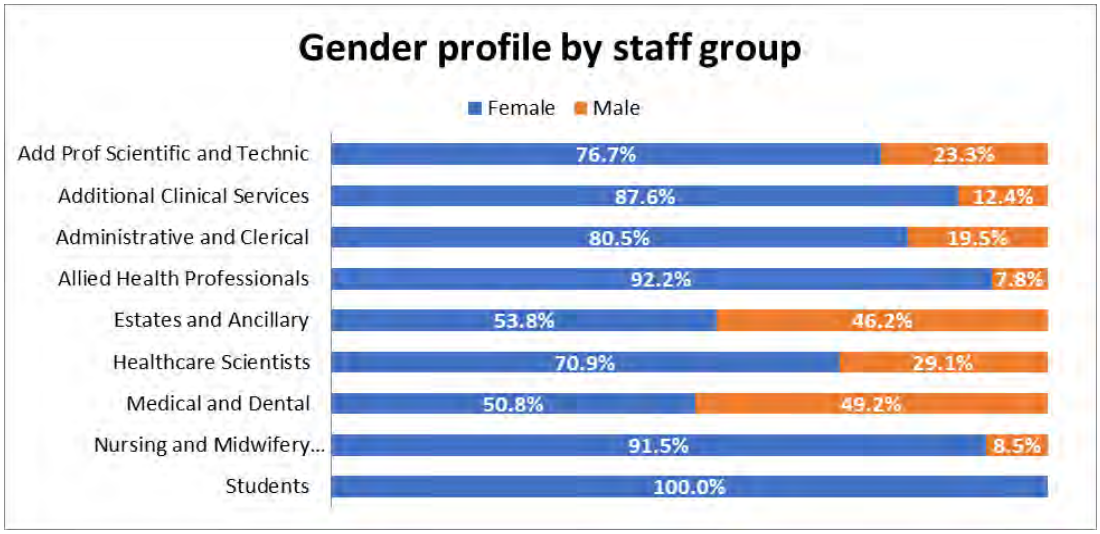


The data below shows the comparison between the locality, region and country as a whole in terms of the number of people who have either no disability/limitation with day-to-day activities, limited or more limited activity.



Gender identity

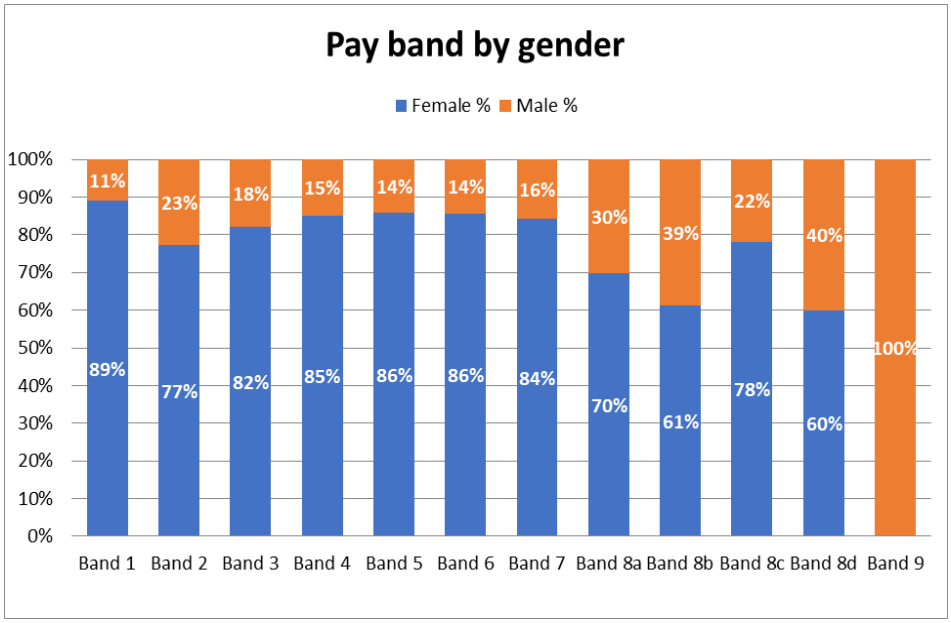
The gender split of the workforce remains reasonably constant; it comprises 80% female staff and 20% male staff. A similar distribution was seen amongst the respondents to the Trusts 2020 Staff Survey (78% and 16% respectively), with the inclusion of 0.4% of respondents preferring to self-describe and 5.3% of respondents preferring not to state – an increase by 3 % on last year.



The Trust has a consistently higher proportion of female staff compared to male staff with the exception of the medical and dental and estates and ancillary staff groups.

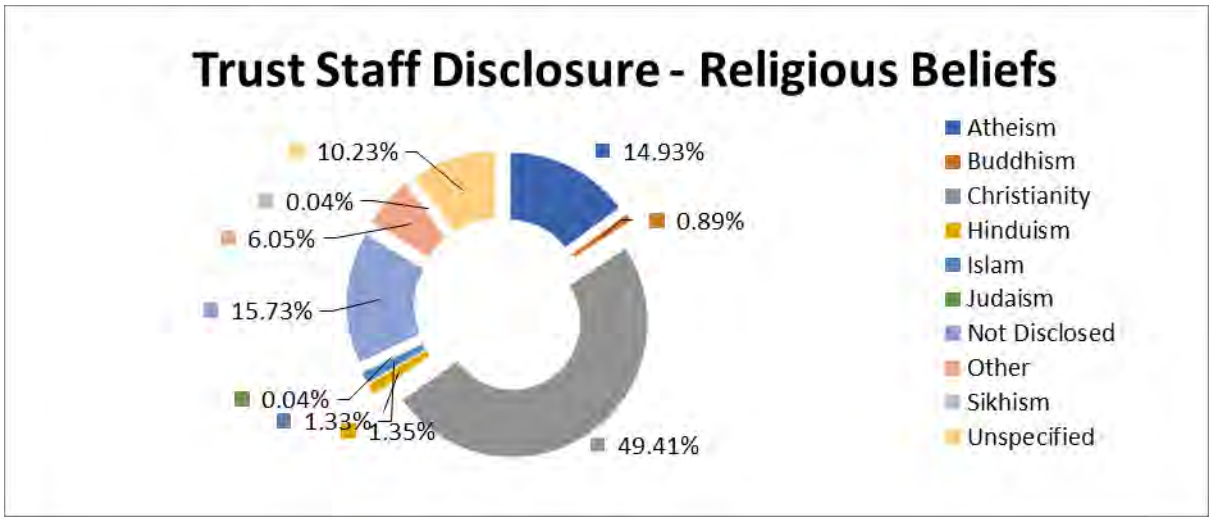
Pay

Pay band data by gender displays an approximate reflection of the Trust's 80/20 gender split. At band 8 and above the distribution of male/female staff at higher bands starts to change and we start to see an increase in the number of male senior staff.



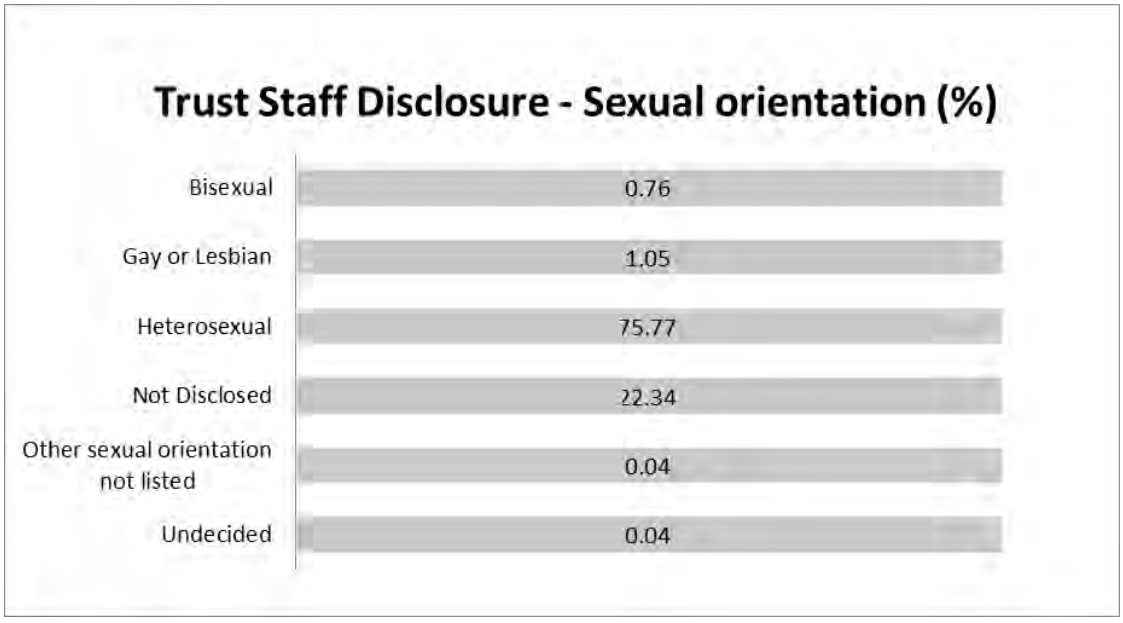
Religion and belief

The Trust workforce has a diverse range of faiths, with fewer staff choosing not to disclose their religion.



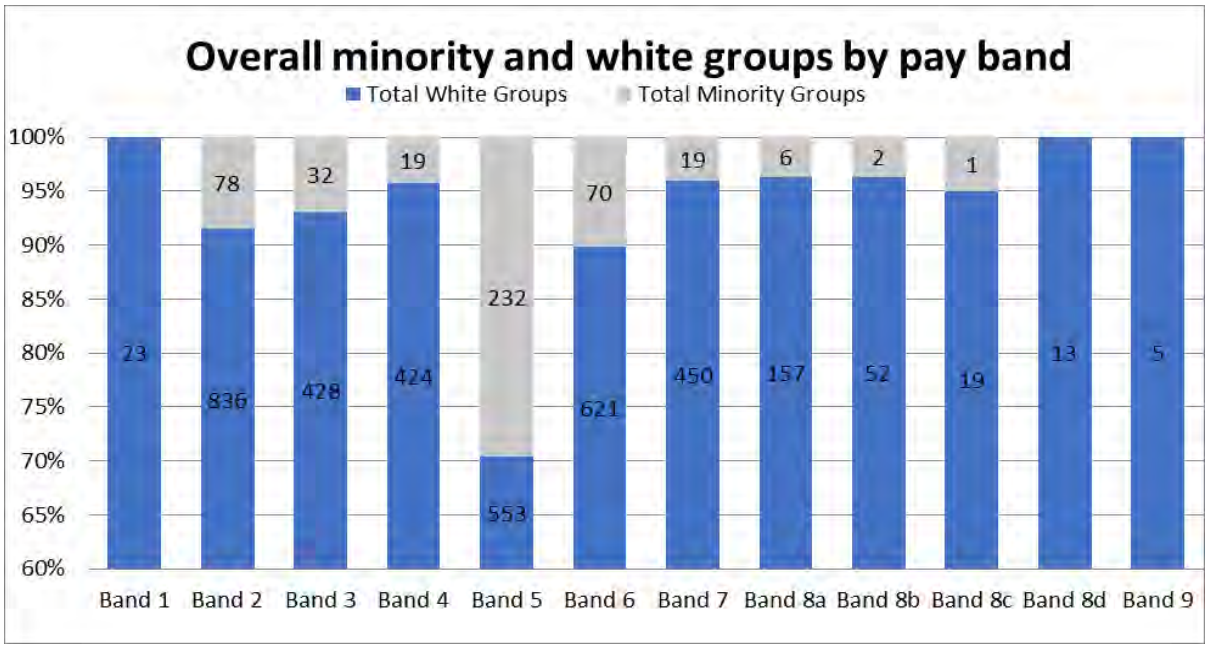
Sexual orientation

More staff members have chosen to disclose their sexual orientation since last year. The number of staff choosing not to disclose their sexual orientation has fallen by 2%



Pay band by ethnicity

Bands 2 - 6 show the largest distribution of Minority groups. There are few disclosed Minority groups in pay bands 8b and above.



EDS evidence showed that all staff, and therefore all protected groups, have nationally determined and locally agreed equal pay and related terms and conditions. The Trust is fully engaged with staff and unions and any potential or perceived unfairness in relation to pay and conditions are fully investigated with subsequent feedback to those concerned.

Data sources for this report

Electronic staff record (ESR)/Oracle Business Intelligence (BI)

Standard workforce figures for staff groups as at 31-March-2021
Trust diversity statistics as at 31-March-2021, for protected characteristics

Office for National Statistics (ONS)
Census information 2011
Population ethnicity profile 2011

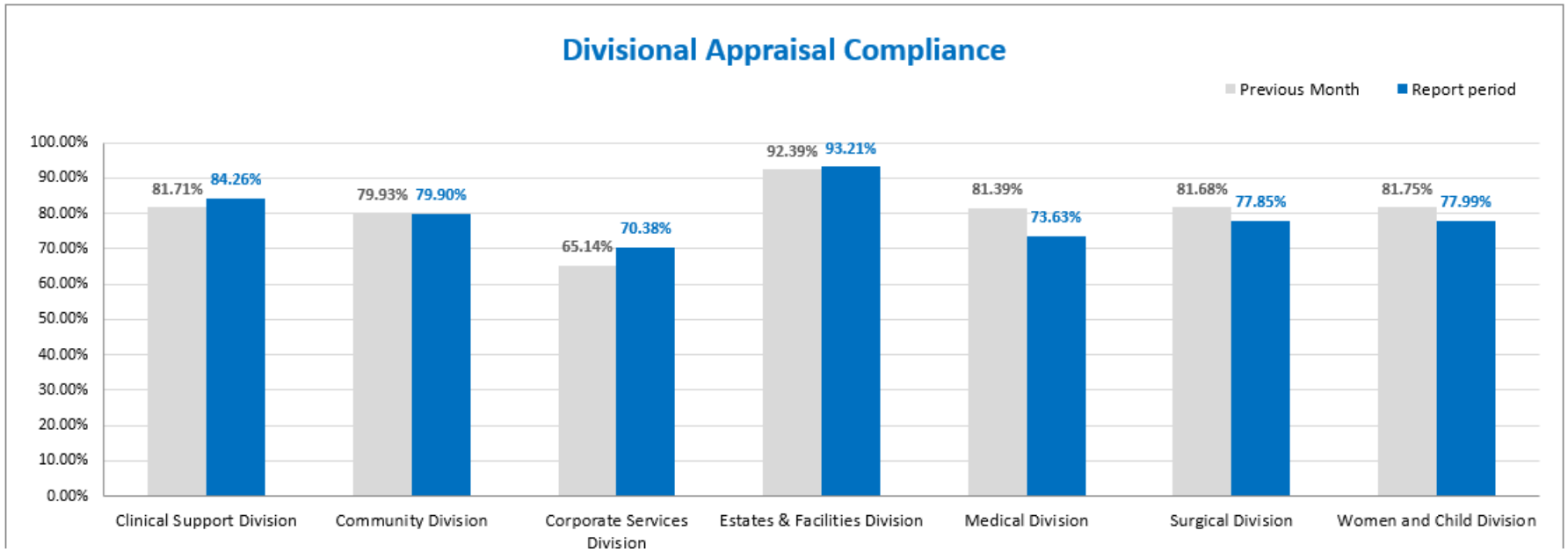
APPENDIX 3 – People and OD report

Divisional Appraisal Summary

Reporting date: 13/09/2021
Report period: 01/09/20 - 31/08/21
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 12 months)
Clinical Support Division	588	413	65	151	164	11	84.26%	2.55%	
Community Division	988	811	163	229	146	31	79.90%	-0.03%	
Corporate Services Division	436	368	109	66	60	8	70.38%	5.25%	
Estates & Facilities Division	421	383	26	107	35	3	93.21%	0.82%	
Medical Division	1000	842	222	158	137	21	73.63%	-7.76%	
Surgical Division	683	587	130	165	85	11	77.85%	-3.83%	
Women and Child Division	309	259	57	48	41	9	77.99%	-3.76%	
Trust total	**4425**	**3663**	**772**	**924**	**668**	**94**	**78.92%**	-1.75%	



Divisional mandatory training analyses September 2021

Division	Sept %	Red-rated subjects (less than 70%)	Change from July report %
Trust overall	90%	None	-1%
Clinical Support	94%	CR (64%); MHNC (69%)	-1%
Community	93%	MHNC (57%); BPT (47%)	No change
Corporate Services	88%	BPT (55%), CR e-learning (55%), CR classroom (56%) Safeguarding children level 3 (50% n=2)	-2%
Estates & facilities	92%	BLS (56%), CR (13%), MHC (64%)	+3%
Medicine	88%	None	-2%
Surgery	89%	None	-2%
Women & Children	91%	None	-3%

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

Staff group mandatory training analysis

Staff group	Complete	Overdue	Requirement	September %	Change from July report %
Add Prof Scientific and Technical	3206	245	3451	93%	+1%
Additional Clinical Services	15653	1311	16964	92%	-2%
Administrative and Clerical	13395	1334	14729	91%	-1%
Allied Health Professionals	7191	382	7573	95%	-1%
Estates and Ancillary	4841	581	5422	89%	-1%
Healthcare Scientists	1502	48	1550	97%	-1%
Medical and Dental	7224	2282	9506	76%	-5%
Nursing and Midwifery Registered	23695	1800	25495	93%	No change
Students	33	8	41	80%	-1%

APPENDIX 4 – People and OD Report

Education and Training Report October 2021

This report demonstrates how Education and Training is contributing to the three priorities of the Trust's proposed Strategic Framework 'Our patients, our hospital, our future, together'.

Priority 1: Deliver for today
- A sharp focus on improving patient experience, safeguarding patient safety and enhancing quality.
- Continuing to achieve core standards

Undergraduate Medical Education

- There are 39 students starting the Cambridge Graduate Couse in Medicine in September and we are looking forward to welcoming them to the Trust for their placements. The COVID-19 pandemic continues to result in change for the undergraduate medical students on regional clinical placements. All student placements have resumed at the West Suffolk Hospital. A blend of remote and face to face learning has been adopted which is working very well. A large number of WSH medical staff are involved in providing the teaching and we thank them for their continued enthusiasm and support.

Postgraduate Medical Education

- **Panopto & Bridge – blended learning platform**
  Licenses for all FY1/2, SAS and LED doctors continue for this academic year.

- **Foundation Weekly Teaching**
  Continues to be delivered via TEAMS and a room in the Education Centre for trainees to use. Sessions are recorded and uploaded on to 'Bridge/Panopto'.

- **Communication Courses**
  The SAS College Tutor, Dr Zulieka D'Souza will be running 2 'Communication Skills/Team Working/Collaborative Working' courses in October and November for our LEDs/Clinical Fellows/Senior Clinical Fellows/Non-training Grades.

- **Reporting to HEEoE on Fitness to Practice Concerns of Trainees**
  Three incidents reported on up to April 2021. The first was regarding an act of conduct and professionalism. No patient safety concerns. This is an ongoing HR investigation. The second was a never event. No Patient safety concerns. The third was an emerging incident. Review has taken place. No patient harm. Further investigation ongoing.

Nursing, Midwifery and Allied Health Professionals

- **Quality Performance Review (QPR) and student feedback**
  HEE continue to monitor the experience of our learners and an updated report was sent to HEE in September 2021 for which we are awaiting feedback.

  We have received our National Education Training Survey results from June 2021. This is a summary of our results compared to the national results and also our results from November 2020. A meeting has been arranged to discuss the results and to identify areas where we can improve (physiotherapy and foundation degree). Particular congratulations must go to midwifery who have improved their results from 2020 moving from red/amber to green in 3 areas.

		Learning environment and culture	Educational governance and leadership	Supporting and empowering learners	Delivering curricula and assessment
WSFT total 58 responses	**Nov 2020**	79.80 (76.39)	78.90 (76.59)	77.98 (72.81)	64.31 (65.97)
WSFT total 44 responses	**June 2021**	78.32 (75.91)	77.94 (72.99)	75.32 (72.55)	69.23 (65.81)
Nursing Adult 5 responses	**Nov 2020**	82.08 (77.11)	82.50 (76.42)	78.57 (70.31)	80.00 (65.69)
Nursing Adult 12 responses	**June 2021**	81.57 (77.12)	79.00 (72.91)	81.54 (72.22)	75.00 (67.18)
Midwifery 4 responses	**Nov 2020**	73.08 (76.13)	56.94 (66.86)	64.58 (69.86)	62.50 (66.96)
Midwifery 9 responses	**June 2021**	73.69 (70.80)	68.90 (60.27)	68.83 (65.31)	58.33 (60.20)
Diagnostic Radiography 4 responses	**Nov 2020**	85.13 (76.56)	75.00 (69.73)	77.14 (73.46)	75.00 (71.50)
Occupational Therapy 3 responses	**June 2021**	84.72 (85.45)	70.83 (72.42)	81.48 (81.78)	88.89 (82.47)
Physiotherapy 3 responses	**June 2021**	81.25 (88.11)	62.50 (73.22)	74.07 (86.03)	77.78 (83.63)
Nursing Child 4 responses	**June 2021**	84.00 (79.24)	88.24 (68.99)	81.25 (75.08)	68.75 (70.68)
Foundation Degree 4 responses	**June 2021**	60.98 (71.96)	82.35 (89.17)	50.71 (66.94)	47.92 (66.67)

- **Pre-registration Programmes**
  Over the Covid period we have purchased 27 laptops for our pre-registration students to use whilst undertaking placements in the community. This has meant that more students have been able to complete their placements in a safe environment and have had access to IT facilities.

  We have employed 100% of our ODP students who qualified this year and over 90% of our nursing students. This demonstrates the quality and strength of our clinical placements and teams. Recruitment for all programmes for 2021/2022 HEI programmes is strong and we are hopeful of hitting our targets for the majority of student programme placements.

- **Non-registered workforce**
  As part of the HEE ambition to reduce Nursing Assistant vacancies. WSFT have received funding from HEE to support our new non-registered workforce. This funding was used to support the secondment (6 months) of 2 x band 3 healthcare support workers to work alongside all new HCSWs to provide support, education and assess competence. We have received funding for a further 6 months so will continue to support our new support staff in the clinical areas. The data below demonstrates the work and support that the band 3 Care Certificate Support Workers have undertaken.

Month	Visits made	Acute staff	Community staff	WSP staff
May	86	73	12	1
June	111	91	15	5
July	90	66	20	4
August	111	67	43	1
Total	**398**	**297**	**90**	**11**

Support Workforce/Other Staff Groups

- **Apprenticeship levy:**
  The Trust is now able to commission apprenticeship training, which allows the education provider the opportunity to draw down the cost of the training from the Levy. We have 106 live apprenticeships and 7apprenticeships have been paused (e.g. due to maternity leave). WSFT staff are participating in 24 different courses and we are working with 10 providers. 59 learners have completed their apprenticeships.

Priority 2: Invest in quality, staff and clinical leadership

- Invest in quality and deliver even better standards of care which, over time, should deliver an 'outstanding' CQC rating

Postgraduate Medical Education

- **Director of Medical Education**
  This role has been advertised and interviews taking place in mid-October.

- **Royal College Tutor Roles**
  - Radiology – Flora Daley will cover maternity leave for Pilar Sanchez from 2.12.21
  - Surgery – Mr Krashna Patel replaces Ami Mishra wef 13.08.2021

- **Physician Associate Students**
  One 2nd year student started on 27.09.21 and a further two 1st year on 4.10.21. All have received an induction and placements organised at various departments within the trust. Additional measures taken to cover COVID such as risk assessments, training, PPE, COVID induction and signposting to Psychological Support/Intranet for support.

- **Foundation Quality Assurance Group**
  Continues with the new intake of FY1 Drs as part of the committee. This is via TEAMS each month and feeds into the Junior Doctors Guardian forum, which also meets once a month.

- **HEE East of England Quality Review Report**
  Response sent September 2021. All action points considered closed with the exception of further comments to be submitted upon release of Rapid Response Report, expected in due course.

- **GMC Survey Results 2021**
  Highlighted three departments requiring review: Anaesthetics, Surgery & Geriatric medicine. Each department devised an action plan, which was submitted to HEEoE end September that included: review dates, how to measure success and monitor going forwards. This ensures we aim to improve on our results for next year.

- **Education/Clinical Supervisors Training**
  Currently still being delivered online via video pack or e-learning through HEE.
  Face to face contact days are resuming at WSH with dates confirmed for Nov & Dec plus a further 5 dates for 2022. Sister sites (ESNEFT, NNUH, JPH) & GP's are also invited to attend.

- **Educational Supervisors for Trust Grade FY2 & LED Doctors**
  A further 6 ES's have been recruited to fulfil this role for our FY2 LED Drs moving forward. They are:
  Dr Sarahn Smith - Consultant Radiologist
  Balendra Kuma - Associate Specialist
  Mirela Marinescu - Consultant Cardiologist
  Tito Junco Russeau - Consultant Geriatrician
  Zuleikha D'Souza - Associate Specialist
  Jaspreet Sidana - Consultant Anaesthetic & ICU Paediatric Anaesthetic Lead
  Flora Daley - Consultant Radiologist

Nursing, Midwifery and Allied Health Professionals

- **International Registered Nurses**
  We continue to recruit nurses from Africa, the Philippines and India as well as supporting our own nursing assistants with an overseas nursing qualification

Induction month (cohort)	Number of staff	Number who have passed OSCE
Cohort 23 – June	5	5
Cohort 24 – July	6	5 (1 resit on the 4th October)
Cohort 25 – August	5	OSCE due 7th October
Cohort 26 – September	5	OSCE due 3rd November
Cohort 27 – October	2	TBA
Cohort 28 – November	7	TBA
Cohort 29 – December	8	TBA

The OSCE programme has been adapted to meet the challenges of Covid but exam pass rates remain consistent. A new clinical practice facilitator is being employed to further support our new staff in the clinical areas particularly following registration with the NMC. This person will start a 12-month secondment on the 24th October. The WiSH charity has purchased 14 Samsung tablets that are overseas nurses are able to use during their quarantine period to keep in touch with home and also attend some virtual teaching sessions. Our overseas staff have been extremely grateful for this kind gesture.

In partnership with NHSI/E the WSFT will be piloting a 'safe spaces' project. This will involve the clinical psychology team providing additional support for our overseas nurses and will be supported by a £30,000 payment from NHSI/E.

- **Advancing Practice**
  We continue to work with the regional faculty of advancing practice in establishing a regional and local directory of advancing roles and practitioners. It is recognised that advancing practitioners will have a key role in future workforce strategic planning and the WSFT is ensuring that policies and processes are in place to support this. There is a requirement for the organisation to employ a dedicated Lead ACP (8c) to lead this workforce through training and professional practice. Job descriptions and funding are being reviewed and developed. This post is critical to meet the requirements set by HEE and to enable a competent advancing roles workforce for the future.

Support Workforce/Other Staff Groups

Mandatory training

- All face-to-face mandatory training was stopped on 6th January 2021 due to the increase service pressures resulting from COVID-19 and resumed from 5th April. HR Business partners have plans in place to support their divisions to achieve target compliance of 90%. Since April 2021 overall trust compliance has been at least 90%.

Staff, management and leadership development and talent management

- On-line development workshops are available for WSFT staff both through bespoke workshops run for us by NHS Elect and via the East of England Leadership Academy. A task and finish group is working to ensure that our future programme will reflect the feedback from the What Matters To You staff engagement process around the importance of supporting all managers, particularly those who are new to the role. Future provision will be through a blend of on-line and face-to-face training.

- Development support has been available to individuals and teams and this includes provision of 1:1 coaching and 360-degree feedback for a number of staff.

- The Trust continues to support the Graduate Management Training Scheme as an element of our talent management strategy. We currently have one Management Trainee from the September 2021 intake on placement in Medicine.

- The 5 O'clock club continues to meet via Microsoft teams. Speakers since March have included Alex Staniforth a record-breaking adventurer, endurance athlete, author and mental health activist and Karen Hester, Chief Operating Officer of Adnams Plc.

Priority 3: Build a joined up future

- Reduce non elective demand to create capacity to increase elective activity. Help develop and support new capabilities and new integrated pathways in the community

Nursing, Midwifery and Allied Health Professionals

Promoting careers in health and care

- The organisation continues to host health and care academies on a regular basis to provide information and advice to students aged 16 – 21 who have expressed an interest in a career in health and care. A review of the past 12 months demonstrates that 149 young people have attended the six-week programme.

- We have also hosted our first adult careers advice programme held over 3 Saturday mornings for adults interested in a change of career/job role. A total of 18 attended 2 or 3 of the mornings and the feedback included:
  'really great session. I started out feeling like I didn't have much to offer but am now feeling more confident about the skills that I have and the jobs I could work in'

  'I found the entire course of great value. Very informative and engaging. I would not hesitate to recommend it'

- We have engaged with St John Ambulance to support their NHS Cadets Foundation programme. Although this has started as a virtual programme (due to Covid), this will move to a weekly meeting at the Education Centre, WSFT with the education team supporting learning. This programme will last for 12 months.

- Next steps

  - Continue to implement improvement plan and review at pre-registration meeting in October 2021
  - Continue to review student placement capacity on a three-monthly basis especially areas that may be closed or reopened due to Covid
  - Continue to support overseas OSCE programme particularly when NMC PIN has been gained
  - Continue to promote health and care academies and health ambassador work
  - Continue with advancing roles strategy

APPENDIX 5 - People and OD Report

Healthcare worker flu vaccination best practice management checklist

For public assurance via trust boards at the start of the 2021 flu season

A	**Committed leadership**	**Trust self-assessment**
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers	Trust Board Meeting 15th October 2021. WSFT ambition is to vaccinate all Trust staff, including all frontline healthcare workers
A2	Trust has ordered and provided a quadrivalent (QIV) flu vaccine for healthcare workers	5000 vaccines ordered
A3	Board receive an evaluation of the flu programme 2020/21, including data, successes, challenges and lessons learnt	The 2021 campaign is based on lessons learnt from 2020 campaign. The Trust are also running Covid-19 booster vaccinations alongside the Flu vaccination. A verbal update on the 2020 campaign was given to board directors in September 2021.
A4	Agree on a board champion for flu campaign	Dr Paul Molyneux, Medical Director
A5	All board members receive flu vaccination and publicise this	All board members will receive vaccination in line with Trust schedule for administration to patient facing and other staff
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	Flu team in place since April 2021. Joined with Covid 19 vaccination team to create a Winter Vaccination Team from July 2021.
A7	Flu team to meet regularly from September 2021	Flu Team has been meeting since April 2021 and will continue to meet regularly (weekly) throughout 2021 campaign
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	Communications plan in place. Launched in September 2021
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Flu Vaccinations for the 2021 campaign will be via booked appointments alongside the Covid-19 booster Vaccinations. This is to enable colleagues to receive both the Covid-19 booster vaccination alongside their Flu vaccination.
B3	Board and senior managers having their vaccinations to be publicised	Communications plan

B4	Flu vaccination programme and access to vaccination on induction programmes	Flu Vaccinations for the 2021 campaign will be via booked appointments alongside the Covid-19 booster vaccinations based in Quince House. Induction mainly e-learning due to pandemic.
B5	Programme to be publicised on screensavers, posters and social media	Communications plan
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	Appropriate feedback to be agreed depending on initial uptake.
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	Flu Vaccinations for the 2021 campaign will be via booked appointments alongside the Covid-19 booster vaccinations based in Quince House. This will be reviewed after initial phase.
C2	Schedule for easy access drop in clinics agreed	Flu Vaccinations for the 2021 campaign will be via booked appointments alongside the Covid-19 booster vaccinations based in Quince House. This will be reviewed after initial phase.
C3	Schedule for 24-hour mobile vaccinations to be agreed	Flu Vaccinations for the 2021 campaign will be via booked appointments alongside the Covid-19 booster vaccinations. These will be run initially over six days a week at a variety of times to capture all shift times.
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	No incentives to be offered again this year. A literature search demonstrated no evidence for value as incentives e.g. pens. Use of materials e.g. posters and stickers for promotional purposes only
D2	Success to be celebrated weekly	Communications plan

13. Integration report – Q2

To RECEIVE the report

For Report

Presented by Kate Vaughton and Clement Mawoyo

Trust Board Meeting - Friday 15 October 2021

Agenda item:	13			
Presented by:	Kate Vaughton, Director of Integration			
Prepared by:	Jo Cowley, Senior Alliance Development Lead, WSCCG Sandie Robinson, Associate Director of Transformation, WSCCG Rebecca Jarvis, Deputy Director of Integration, WSCCG Clement Mawoyo, Director of Integrated Adult Health and Social Care, West Suffolk Gylda Nunn, Integrated Therapies Manager and AHP lead, WSFT			
Date prepared:	27/09/2021			
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

15th October 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. The aim of the West Suffolk Alliance is to work together in West Suffolk to make lives better, and as a collaboration we do that through our transformation programmes, but also through the way we deal with challenges across the system – highlighted through the pandemic where partnership working, and flexibility were key to many of the changes made on the ground and in our approach to winter.

1.3. This autumn the health and care system are managing a number of challenges, including high demand in the hospital Emergency Department, waiting lists for treatment and issues with recruitment and retention across both the health and care sectors. This paper sets out the response to these issues, showing how we are working together, alongside the transformative work that is helping us to achieve our Alliance Ambitions for people in our area.

1.4. As well as action within the statutory sector, the voluntary and community sector continues to play an important part in supporting people to remain healthy and connected within their towns and villages. The Community Restart programme run by Community Action Suffolk is offering grants and support to reopen and restart services, and the Suffolk County Council Covid-19 Engaged Communities Fund provides funding opportunities for groups offering practical, social, and emotional support for those who need it to help stop the spread of the pandemic and reconnect with their local support networks.

2.0 Update on the Alliance response to pressures on system demand and capacity

2.1. Ordinarily this time of year provides some respite for our health and care services following the school holiday dip in workforce, allowing time for recovery and preparation for winter demand.

2.2. However, the system is currently extremely challenged with all partners reporting significant pressures. Key areas of concern locally are:

- Rising walk-in demand into the emergency department
- Hospital discharge delays due to paucity of domiciliary care and fragility of the domiciliary care market
- Rising community demand and complexity of care need likely from the impact of deconditioning

2.3. All of the above is compounded by capacity constraints in the hospital from the Roof Fail Safe work and workforce fatigue, and the anticipation of winter pressures.

2.4. Health and care partners continue to work together, with a shared ownership of the issues. A System Resilience Group includes all system partners, and as well as weekly

meetings there are daily health and care tactical calls to develop, manage and escalate local urgent plans.

2.5. The workplan to mitigate risks and build additional resilience has the following key areas:

1. Supporting people on waiting lists to prevent further deconditioning through extending virtual support through a helpline in partnership with a model of Surgery School, which aims to prepare people well for their operation. Plans are being progressed to also develop a community virtual Multi-Disciplinary Team (MDT) approach to support people with alternative offers of support to surgery.

2. A working group is focussing on demand into the Emergency Department (ED) with a focus on key areas:
    a. Reducing variation in utilisation of GP Streaming and matching capacity to demand. The CCG and hospital have agreed to increase streaming to operate for 7 hours every Tuesday, where there had previously been a gap, over the winter period when demand is at its peak
    b. Understanding the walk-in activity better so that targeted work can commence to support this demand differently and more appropriately
    c. Increasing access to admission avoidance in ED - two additional posts have now been funded to bolster the Early Intervention Team (EIT)
    d. Introduction of Red Cross into ED to offer non-medical support to people seeking help
    e. Relaunching the High Intensity User work that was paused during the pandemic
    f. Improving access and integration with mental health crisis support

3. Acute bed capacity modelling concludes that due to the Fail-Safe work the acute hospital is approaching winter with 31 less beds than was available last year and demand profiling predicts a further 50 community residential and nursing beds will be required to support hospital flow and discharge. Key actions to address this gap include:
    a. Convert Rosemary Ward at Newmarket Hospital into a 33 bedded inpatient unit supporting medically optimised patients from WSFT. The loss of the reablement beds will need to be re-provided elsewhere
    b. Maintain the 10 Ashmore Nursing Home Beds already commissioned.
    c. Commissioning of a further 34 residential and nursing home beds has been completed with a phased approach to opening of the beds.
    d. The commissioned residential and nursing beds are being funded from the Hospital Discharge Programme, as part of the national funding to support discharge.
    e. System wrap around support, including therapy and social care input will be provided to all patients admitted into the residential and nursing home beds.
    f. Reopen St Nicholas Hospice Beds to transfer people at end of life from WSFT – this is already in place for a 4-week period to support the current pressures
    g. Explore other offers of support from private housing organisations. Orwell Housing have offered their support and we are proactively working through the opportunities with them.

4. Domiciliary Care and lack of care workers is an extremely challenged area across the whole ICS and the solutions need to be considered by the system. An ICS wide workshop is being planned to explore the opportunities. Locally we have been building in urgent capacity through extending the utilisation of more agency staffing in Home First and Support to Go Home, increasing spot purchasing of beds and utilisation of Red Cross to support more discharges.

5. Reablement responsive support to admission prevention and discharge has been stretched through the increase in demand and complexity. A business case to maintain the current level of capacity and extend this to stretch the level of support for future demand is currently being considered.

6. District nursing demand has risen exponentially throughout the pandemic with significant rise in people requiring insulin injections. WSFT have approved a business case for a peripatetic nursing team of 6 (whole time equivalent) to bridge the capacity gap.

7. Finally, further work is underway to look at how we can build capacity to proactively support more people to live at home with frailty and rising risk. Recognising that these people may be seeking urgent help in the future. Social prescribing will be key in supporting this and the additional offer here is currently being explored.

2.6. By the end of September our first draft local resilience plan will be ready for submission to NHS England.

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

3.1. **Personalised Care:** The Alliance Strategy – All about People and Places – has a strong emphasis on ensuring that the health and care services we provide are co-ordinated, personalised and local. Recent funding from NHS England is supporting us to expand the programme of work to make this happen. The funding is in three parts and is being used to:

a) Create a new role of Personalised Care Programme Manager. This role is four days a week at Band 8a and is funded for 12 months. The anticipated start date for our successful candidate is mid-November. They will be working closely with Alliance partners and with Ipswich and East and North East Essex Alliances, as well as with regional and national colleagues. The “must dos” for the role from NHS England are very much in line with our Alliance transformation plans, for instance around social prescribing, shared decision making and ensuring that services and pathways are redesigned around the patient.

b) Implement the use of Personalised Care and Support Planning for people in West Suffolk living with severe mental illness, following their annual health check. About 10% of people receiving an Annual Health Check (AHC) and a health action plan are more vulnerable and experience barriers to accessing follow up appointments due to their diagnosis, personal circumstances, and mental health needs. It is these patients who are referred for Healthy Together peer support. Healthy Together peer support is designed around people’s individual needs, choices and what matters to them, providing meaningful intervention-based support, to help people meet their health goals to stay well.

This approach supports the move away from the Care Plan Approach (CPA), reducing the reliance on care coordinator. Additionally, it promotes the mentoring value of lived experience through peers delivering the support provided. Delivery of this project is by the Suffolk User Forum working closely with primary care and the Norfolk and Suffolk Foundation Trust.

c) Extend the reach of the West Suffolk Health Coaching Programme to a greater number of people working within community teams. The programme provides Health Coaching training as an essential component of person-centred care supporting the shift in emphasis towards prevention, empowerment and self-management. Designed as a multi-professional training delivered in 2-day courses to groups of staff and volunteers from across the system, to date the programme has seen 341 staff and volunteers trained from over 25 different organisations. This phase of training will be targeted towards those working in new roles within Primary Care Networks, such as social prescribing link workers, care coordinators, and those working within Integrated Neighbourhood Teams providing customer facing services. 99% of attendees on previous courses felt strongly that a health coaching approach can support professionals to make a 'mindset shift' in relation to how they work with patients or clients, and train the trainer is being considered within the expansion of the programme.

3.2. The West Alliance Personalisation Programme is part of a wider ICS initiative, as well as linking through to the regional and national support infrastructure and strategy provision. This will allow us to share best practice and reduce duplication across the three Suffolk and North East Essex Alliances.

3.3. A Thinking Differently About Personalised Care online event is planned for the 13th October, between 3.00 and 5.00 pm. This event will highlight work going on across the ICS to embed personalised care and will also identify areas for future action. A link to this and all the Thinking Differently events is on the Suffolk and North East Essex Integrated Care System website - https://www.sneeics.org.uk/thinking-differently/thinking-differently-together/

3.4. For more information about personalised care please contact jo.cowley@westsuffolkccg.nhs.uk

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

4.1. **Realising Ambitions final report:** Realising Ambition West was established to enable the Voluntary, Community and Social Enterprise (VCSE) sector to work in partnership with the wider health system to tackle shared strategic priorities. Realising Ambition West has funded 24 (4 micro [under £1,000] and 20 main) projects designed to address three higher strategic objectives:

1. Improving mental health and reducing suicides
2. Supporting neighbourhood action to reduce loneliness
3. Being more proactive in relation to obesity prevention and treatment.

4.2. The programme has been able to target investment into a range of small and medium sized, tightly localised community initiatives. These include projects which, without Realising Ambition, would be unlikely to be able to access health funding or be drawn into the ICS's co-ordinated partnership approach to tackling shared priorities. Suffolk Community Foundation (SCF) managed the bidding process, and supported successful projects through their delivery, often helping them to adapt during the pandemic. They also collected monitoring information and case studies.

4.3. The final report has now been produced by the Foundation. The key headlines are:

- £458,891 funding distributed
- Over £500,000 non-Realising Ambitions funding was attracted because of the SFC involvement and the nature of the projects
- 8662 people benefited from the funding
- 529 volunteers supported delivery

4.4. Organisations were asked to collect feedback data and case studies. An example of this is from the Greenlight Trust (GLT) who collected the following testimonials from people who took part in their programmes:

- "I would rate [GLT] courses I have attended as by far improving my wellbeing as compared with other courses including mindfulness. There is definitely more sense of community"
- *"Feeling useful has given me more confidence. [It has] improved [my] mental and physical health"*
- "[It's] been enjoyable. I opened up a lot"
- *"Outdoor activities [have been] good for [my] health. Great opportunity to spend time in a healing environment. I would love to do another course here"*
- "I have really enjoyed being back in Frithy Wood. The staff have provided a safe and desirable environment to be part of a friendly and encouraging group"
- *"I have enjoyed being with people and with GLT. They have helped me a lot"*
- "Really enjoyable, has been terrific - staff are deciding the 'destination' of the day but not the 'route' a lot is led by participants"

4.4.1. They also put together a you tube video showing one man's story and describing the impact the GLT support had had on his mental health and wellbeing - https://youtu.be/EVMjFPl8R9k

4.5. The Alliance Steering Group will be discussing the report to acknowledge the work that has gone on in each of the projects and to agree learning from the programme and next steps.

4.6. The full report is available on request from jo.cowley@westsuffolkccg.nhs.uk

5.0. 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)

5.1. **Suffolk Stroke Early Supported Discharge Service update:** The Suffolk Stroke Early Supported Discharge Service [ESD] was established in 2014 to allow a smooth and early transfer of stroke patients' care from an inpatient stroke unit environment to a community setting as soon as they are medically fit. It enables people to continue their rehabilitation therapy at home, with the same intensity and expertise that they would receive in hospital. The Suffolk ESD service was transferred to the Suffolk Alliance in April 2021 following an extensive period of co-production with the voluntary and community sector and with people with lived experience. The Suffolk ESD service embraced the concept of the Alliance from day one, drawing on its extensive operational networks and existing joint working relationships.

5.2. Within the first 3 months, The Suffolk ESD was successful in planning and implementing a joint project with Home first. Working with colleagues from Social Services, the joint taskforce managed, within 4 weeks, to establish a new workstream that utilised existing resources to maximise the rehab input to stroke patients by involving Home First reablement support workers in delivering specific elements of therapy. From drawing flowcharts and pathways, to developing handover sheets and

documentation, the taskforce took a very pragmatic and collaborative approach to make this possible and tackle all barriers.

5.3. This successful piece of work was replicated in a joint workstream with the Pathway 1 team, with the aim of optimising the use of resourcing and ensuring the continuity of care for patients. The Suffolk ESD service is also working very closely with the new specialist neuro community team (therapy and nursing) to establish systems to support the local community teams via education and joint sessions. Future work is underway for similar joint projects with Icanho and the voluntary sectors. Having our ESD service lead, Ehab Georgy sit as a chairman for specific task and finish groups as part of the ICS Neuro/Stroke boards meant that we are able to contribute to the strategic planning and development of the neuro services in the county as well as collaborate more effectively with other partners in the Alliance in a variety of innovative ways.

5.4. A case study showing the impact of the new service is attached as Appendix 1 to this report.

5.5. For more information about the Early Supported Discharge pathway please contact Gylda.nunn@wsh.nhs.uk

5.6. **Mental health support within primary care:** Our vision for West Suffolk is to improve lives for everyone, and this aligns with an NHS England (NHSE) requirement to focus on improving services for people with Severe Mental Illness (SMI). This includes people with eating and personality disorders, self-harm, coexisting severe mental health problems and substance misuse, experienced trauma etc (in addition primary care SMI register). Needs will be addressed by timely assessment, more rapid access to a comprehensive suite of interventions and community-based rehabilitation.

5.7. One of the priority actions for 2021/22 is to recruit mental health practitioners (MHPs) to work within Primary Care. These practitioners can support population health management through providing a combined consultation, advice, triage and liaison function. Working with other Primary Care Network-based roles, MHPs can address the potential range of biopsychosocial needs of patients with mental health problems, as part of a multi-disciplinary team.

5.8. For Adults and older adults, in 2021/22 the agreement is to recruit two roles using the Additional Role Reimbursement Scheme funding. For each PCN this means a Band 7 and a Band 6 member of staff. Recruitment has been successful, and we have just 3 Band 6 practitioners left to recruit. The table below shows the recruitment across the 6 PCNs in West Suffolk together with expected start dates of practitioners:

PCN	Band 7 Start dates	Band 6 Start dates
Bury St Edmunds	06.09.21	
Haverhill	In post	In post
WGGL	11.10.2021	
Sudbury GP Network	Est early November	
Forest Heath	06.09.21	06.09.21
Blackbourne	06.09.21	06.09.21

5.9. As the new MHPs come into post work is going on within each PCN to see how they can best work with the GPs and other members of the team. Learning from Haverhill, which was an early adopter site Is being taken on board as well.

5.10. These new staff are part of wider model for supporting people with mental ill health through primary care. The team supporting the PCNs will see the new PCN

practitioners working closely with Wellbeing Link workers and with social workers. In the coming months there will be additional Band 6 nurse capacity to support assessments and support from Senior Psychological Wellbeing Practitioners.

5.11. Also underway is action to support young people with mental health problems. New Band 7 PCN practitioners will be working with people aged under 18 years of age alongside the expansion of Mental Health Support Teams in Schools, ensuring an enhanced primary care model that works across education and primary care. A new pathway into mental health services in line with the THRIVE model is under development, with referral forms based on Signs of Safety/5Ps and including interim safety plans. A transition plan is to be put in place to address backlog and action needed to put new services into place.

5.12. **NHS reforms:** As the guidance from NHS England and the Local Government Association comes out it becomes more and more evident that the roles of the Integrated Care System (ICS) and the Alliances will change. Fortunately for the West Suffolk Alliance and the Suffolk and North East Essex ICS the reforms are in line with, and support, our direction of travel.

5.13. Alliance partners are fully engaged with the system wide discussions at ICS level, which are supported by two consultancy firms - Tricordant and Attain, as well as having input from the NHS Confederation and the Kings Fund. At an Alliance level we are taking the following actions:

- Making sure we have representation and influence at ICS wide events
- Keeping local partners up to date with system development through presentation and discussion at key Alliance forums
- Looking at how we maintain a strong clinical and professional voice locally, within both our Alliance governance and transformation activity
- Planning Alliance level workshops to involve and engage partners with the reforms.

5.14. For more information about this contact jo.cowley@westsuffolkccg.nhs.uk

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

6.1. Woolpit Health Centre and West Suffolk CCG shortlisted for 2021 Health Service Journal awards: Woolpit Health Centre and NHS West Suffolk CCG COVID vaccination drive through has been shortlisted for Primary Care Innovation of the Year at the HSJ Awards 2021, recognising an outstanding contribution to healthcare.

6.2. Woolpit Health Centre and NHS West Suffolk CCG were shortlisted for the COVID vaccination drive through because of the ambition, visionary spirit and the demonstrable positive impact that this project has had on both patient and staff experiences. Around 4600 local people received their COVID vaccination at the drive through events.

6.3. The press release included a comment from Dr Richard West MBE, GP at Woolpit Health Centre, "*We are so thrilled to have been shortlisted for Primary Care Innovation of the Year. This recognition really does reflect the collaborative efforts and dedication of our colleagues who have worked so hard to successfully deliver the COVID vaccination drive through. Knowing that there was such stiff competition this year really does make this announcement feel like a wonderful achievement for everyone involved and the nomination has been a tremendous boost to staff at Woolpit Health Centre and NHS West Suffolk CCG*."

6.4. For more information about the role of primary care in the vaccination programme contact Suzanne.Hoy@suffolk.nhs.uk

6.5. Vaccination inequalities – reaching people who work in factories in West Suffolk: As part of the programme to reach people who may be experiencing barriers to getting vaccinated the Alliance team has been working with several food production factories. From information from the site managers, we know that a large number of the workforce have not taken up the offer of a vaccination. By working with site managers, the Public Health Community Engagement Team and with the Health Outreach Service we have been able to offer bespoke clinics, with support for people who have English as a second language, including those with questions about the vaccine, and potential side effects.

6.6. Whilst the numbers have been small these clinics have helped reach some of our most under-vaccinated communities. We are also leveraging the relationships we have built up with site managers to propose some engagement work around health outcomes for people working in food factories in West Suffolk, that will go on into the autumn.

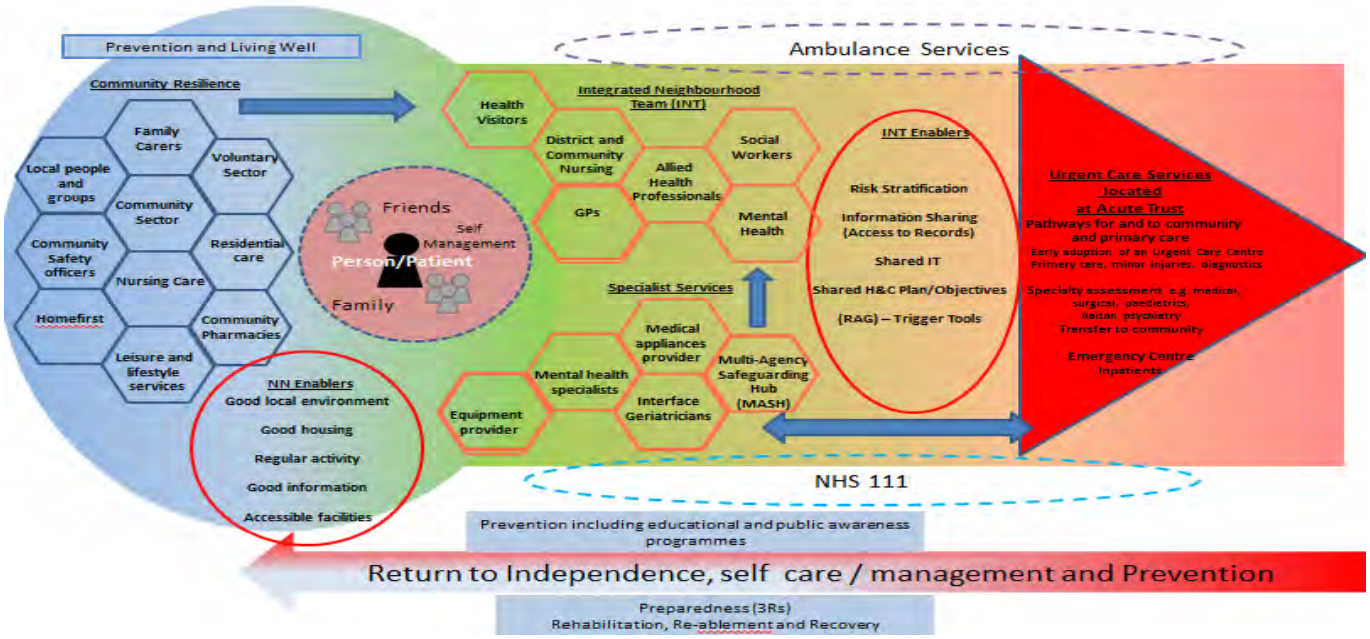
6.7. The Site Manager at direct table provided a testimonial for the work we have done with them. This is a small extract:

"The support we have received from WSCCG and Suffolk County Council's Public Health Team since then has been exceptional. We have been provided with lateral flow tests and access to community groups who offer practical advice and additional services to support the welfare of our staff.

"DTF is committed to the health and wellbeing of all its employees, especially during these unprecedented times. We thank our health and local authority partners for their continuing support and commitment to pooling resources to support individual needs."

6.8. For more information about the work we are doing to ensure equity in the delivery of the COVID vaccine contact Katrina.hawker@westsuffolk.gov.uk

6.9. Integrated Neighbourhood Teams – a comprehensive update: Integrated Neighbourhood Teams (INTs) are an important element of the West Suffolk health and care architecture and an integral component to the East and West Suffolk health and care model of care developed from the 2014 health and care review which informed the 2017 community services procurement through both the place-based Alliances as Most Capable Providers. The model of care is shown diagrammatically below (taken from the 2017 community services specification):



6.10. During the pandemic our local system has developed new ways of working to adapt to the crisis and we have seen good levels of acceleration of integrated health and care working progress faster than planned but some areas have stalled or even taken some steps backwards including elements of Integrated Neighbourhood Team development. The 2021/22 priorities and operational planning guidance seek systems to build on this progress with a set of priorities for the year ahead, against a backdrop of the challenge to restore services, meet new care demands and reduce the care back logs that are a direct consequence of the pandemic, whilst supporting staff recovery and taking further steps to address inequalities in access, experience, and outcomes. A key priority is a focus on continuing the work of transforming community services and improving discharge. Specifically, it seeks that by 31 March 2022 effective partnership working across systems must deliver on several ambitions:

1. Universal coverage of a 2-hour urgent community response at home service operating 8am-8pm 7 days a week at a minimum and using a model in line with national guidance. All services should be accepting referrals directly from all key sources incl. 111, 999, general practice, social care, care homes and SDEC services
2. Embed and mature the discharge to assess approach, improve patient flow out of hospital with a particular focus on reducing long length of stay, build the evidence base on discharge practices, use of pathways, outcomes and the impact of intermediate care
3. Deliver EHCH programme in full for care homes and explore extending this to the wider care sector. Support the development of an NHSEI care sector vision, strategy and operating model and care sector related restoration, recovery and transformation post-COVID-19
4. Drive a minimum standard of MDT anticipatory care drawing down on ARRS funding and develop clear ambitions and trajectory for AC delivery across the footprint, including structures to drive delivery through accessing ICS AC Lead funding. Systems should work towards a population health management and personalised care approach to improve health outcomes and health inequalities
5. Progress digital transformation including virtual wards and MDT communication systems.

6.11. As an Alliance we are supporting the development of the INTs through the One Team development programme which provides a springboard to strengthen integration at a neighbourhood level. The first cohort of colleagues have successfully completed the

programme. The additional two cohorts are due to complete the programme later this month.

6.12. Finally, the work being led by WSFT to shape the new hospital is driving a need to review the community model of delivery which will require the support and input from partners to ensure we take a whole system approach. This will need modelling support from analytics to help inform the model and trajectory for changes ahead of the new hospital opening.

6.13. Further information about the elements of the integrated community model and the activity going on to support delivery is attached as Appendix 2 to this report.

6.14. For more information about the development of Integrated Neighbourhood Teams contact sandie.robinson@westsuffolkccg.nhs.uk

7.0 Recommendation

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

Appendix 2 – Integrated Community Model

Core Integrated Neighbourhood Teams (INTs)
In autumn 2019 the transformation team developed a toolkit for supporting development of the six INTs. The maturity matrix toolkit aimed to provide the teams with a framework of self-assessment against a set of dimensions worked up with the locality operational leads as qualities of an INT. The first self-assessment was conducted in late 2019 and developmental action plans were being taken forward at each INT level. The pandemic paused further progress and more recently the integrated health and care operational structure development work paused this again until now. The maturity matrix has now been refreshed by the operational leads and is ready to be re-introduced to the INTs to revisit the baselines. Operational leads are preparing to do this for completion by October and then regularly going forwards to review trends, progress and system actions. As an Alliance we are supporting the development of the INTs through the One Team development programme with Module 3 scheduled to be launched shortly in September. The remaining key recommendations from the Rethink review[i] including developing coterminous boundaries, introducing capacity modelling tools and developing INT referral processes are being progressed by the transformation and operational teams alongside this as enablers to the INT work and an action plan picking these up is in place. The localities also have dedicated named links from the transformation team to support the operational leads with their action plans and implementation and regular meetings to progress this are either in place or in progress Bury Rural =Sarah Hedges Bury Town = Michelle Glass Mildenhall = Hannah Pont Sudbury = Becky Turner Haverhill = Cara Twinch Newmarket = Trisha Stevens
Ageing Well – Anticipatory Care *Helping people with complex needs stay health and functionally able*
One of three ambitions aligned to the national Ageing Well programme[ii], this is probably the least matured in terms of progress in West Suffolk. Pre pandemic the system had a model of support to people who frequently utilise the urgent care system (High Intensive Users), but the operational capacity was withdrawn to support our system covid response. This now needs to restart with a focus in each locality supported by an MDT infrastructure and access to a range of statutory and community support and is currently a priority for the system. Work has commenced to mature the Frailty and End of Life model of care in West Suffolk to ensure our most vulnerable are identified both proactively and reactively. This needs to be supported by risk stratification and aligned to ARRS funding to support cross sector MDT working including care coordination (links to maturity matrix) but is likely to take some time to mature given the demand pressures on the system. Requirement for reporting against this dimension is expected from Q3.
Ageing Well – Enhanced Health in Care Homes *Enhanced support and better coordinated care, reablement and rehabilitation*
A mature model of care that excelled in delivery during the pandemic now needs to be part of the integral offer of support at locality level integrated with each INT and PCN as part of national Enhanced Service. The national Ageing Well funding is aligned to this ambition. Our next steps are to embed operationally at locality level with each INT, embed the utilisation of the virtual ward technology '*whazam*' and implement the national deterioration on patient pathway. Tactical cell care home meetings continue to meet and considering stepping up the wrap around support operationalised in the pandemic over the winter months. Reporting already in progress.
Ageing Well – Urgent Community Response *2 hour standard for urgent community response, 2 day standard for reablement and a single point of access for UCR utilising NHS111*

Urgent community response (UCR) is the collective name for services that improve the quality and capacity of care for people through delivery of urgent, crisis responsive care within two-hours and reablement care responses within two-days. The national framework for UCR seeks a single, integrated service that covers all these types of care from crisis response to reablement. The model in West Suffolk brings the Early Intervention Team and Discharge to Assess pathway 1 together as a single responsive model working at INT level 24/7, 7 days a week. The responsive model is currently funded through the national Ageing Well allocations and the national Discharge from Hospital policy which expires at the end of September 2021. A funding paper outlining the capacity needed to meet the national standards for UCR and reablement for the rest of this financial year (and ultimately substantially) protecting our services over the winter surge period has been submitted for system approval. Further work will continue once this urgent funding approval is made to expand on the work to date to work through the opportunities for closer alignment and integration with local communities to strengthen the offer and ensure our collective resources are optimised.

Two key enablers to this model include:

1. A new role to the system which has been tested out over the last year and builds on the national learning from Integrated Health and Care Teams development around care coordination. Each INT will have an INT coordinator who is the single point of contact for the responsive model and will be integral to the development of the INT as the model of care matures.

2. Supportive digital technology to help more people virtually to be more independent by having access to self-monitoring devices that are viewed remotely by the INT coordinator and case manager.

National reporting against UCR standard must be in place end of Q3

Discharge to Assess

National guidance seeks local systems deliver same day discharge 7 days a week against all four pathways (not just pathway 1 in responsive) using the national criteria to reside guidance. In West Suffolk all four pathways are operational and supported by an integrated discharge transfer of care hub and dedicated system discharge coordinator. However, further improvement work is needed and being progressed in the following areas to optimise performance ahead of winter 21/22

1. Increase in same day discharge supported by access to a discharge data set that helps the system to plan, monitor and manage demand and ensure the 7-day working is consistently applied across the system

2. Stretch to deliver ECIST recommendations for number of discharges each day on each pathway – this is tied up into the Responsive funding paper

3. Embedding Pathway 1 into the Responsive offer of support as part of the community operating model

4. Ensuring alternative offers of support including social prescribing are fully integrated into all pathways including the Urgent Community Response

5. Developing an out of hospital bed modelling plan that supports the Fail-Safe acute hospital roof programme and associated capacity constraints

6. An urgent system therapy review to understand the opportunities of our system's collective therapy resources to meet the demands of the system throughout winter including a prioritisation process to maintain urgent and elective demand capacity.

[i] ReTHINK Community Services listening exercise December 2020 commissioned by WSFT

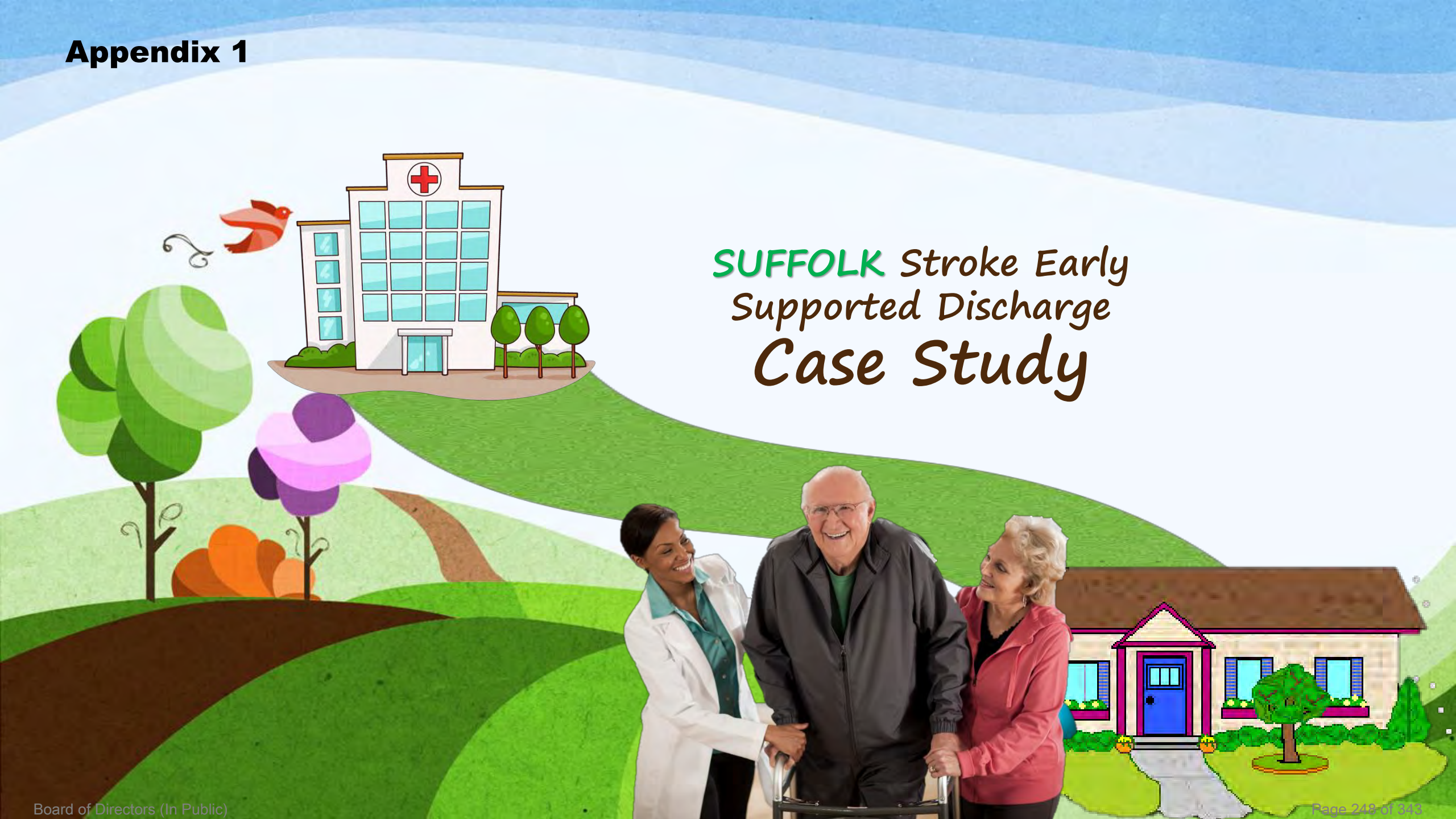
[ii] National Ageing Well Programme: The three priorities for this funding are:

• Deliver at pace Urgent Community Response (UCR) services to operate seven days a week, delivering against the national standards for Urgent Community Response (within two hours for urgent care and two days for accessing intermediate care and reablement services). Prepare for a rapid expansion of these services for 2021/22.

• Implement the clinical domains of the Enhanced Health in Care Homes framework by the end of 2020/21 supported by the network Direct Enhanced Service (DES) contract funding.

• Jointly with Primary Care Networks develop new service models of Anticipatory Care to help people stay well

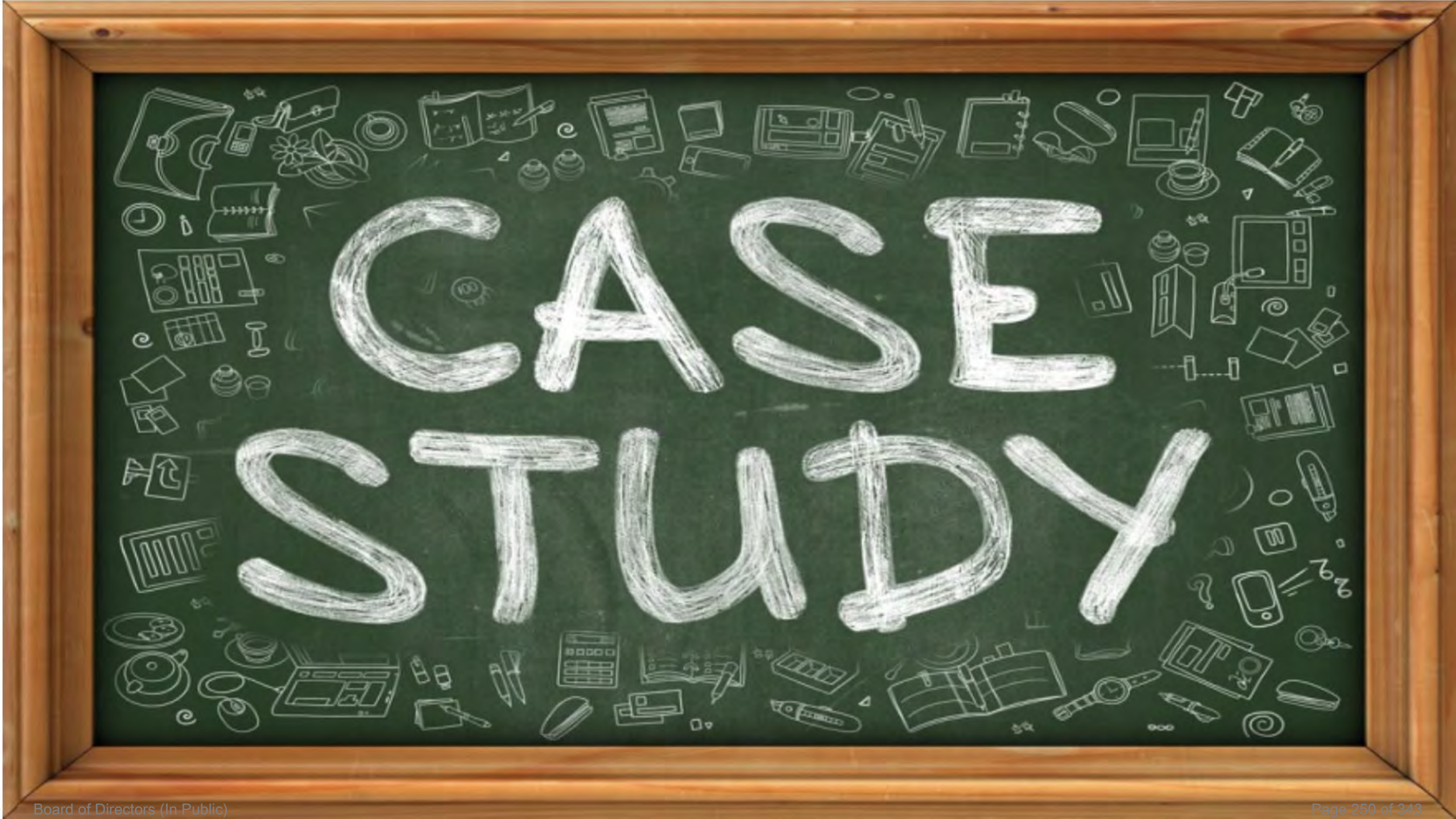
Appendix 1



SUFFOLK Stroke Early Supported Discharge Case Study

What is Early Supported Discharge?

- Early Supported Discharge is an intervention for adults after a stroke that allows their care to be transferred from an inpatient environment to a community setting as soon as they are medically fit.
- It enables people to continue their rehabilitation therapy at home, with the same intensity and expertise that they would receive in hospital.
- 50% of patients would be eligible.


CASE
STUDY

Patient profile

Age: 87

Presentation: moderate residual disturbed dynamic balance, dysphagia, independent with walking stick but high falls risk, assistance with personal care, meals and catheter care, in addition to cognitive deficit post-stroke.

Diagnosis: Left Partial Anterior Circulation Stroke – Left PACS.

Social history: Lives with wife and son in bungalow. Patient was main carer for wife as son works full time. Drives and still rides bike. Previously independent.

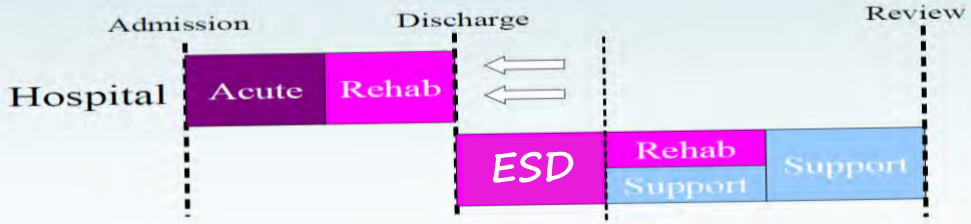
Support services: care package on discharge from hospital (new) from HomeFirst.

Input required: Was referred to ESD for OT, physio and SLT.

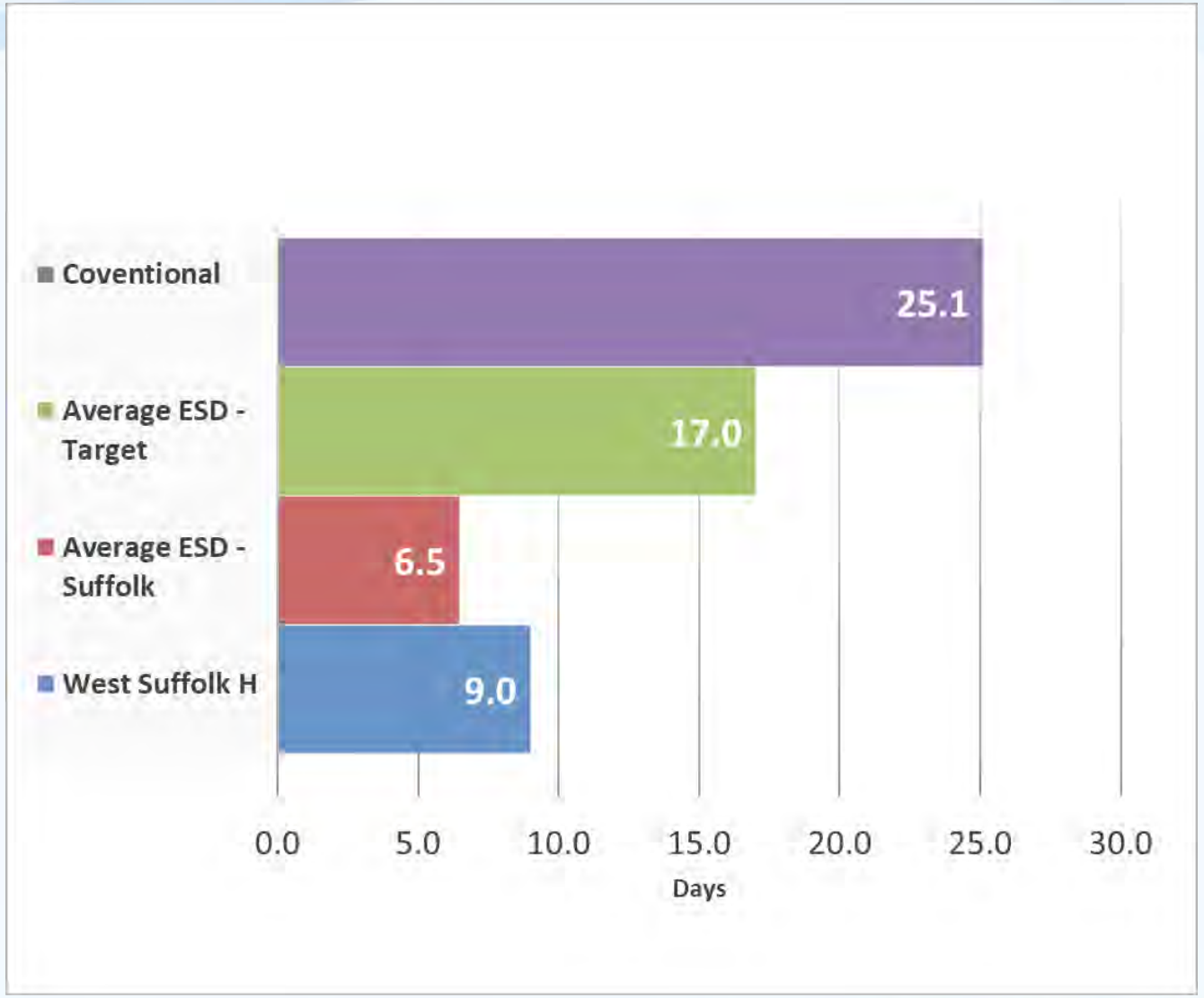
Length of hospital stay

Conventional services

Early supported discharge



9 days Acute Unit → 28 days ESD → 0 days LCHT



4- WEEK TAILORED REHABILITATION PROGRAMME

Patient discharged from acute hospital

- Referred as eligible to Suffolk Stroke Early Supported Discharge Service (ESD) and admitted for up to four weeks of therapy – an example is outlined below

Patient discharged from Suffolk Stroke ESD Service

- Patient discharge letter issued to patient, `GP and referring consultant

Week One

- Initial patient assessment.
- Patient's goals determined.
- Admission outcomes measures completed.
- Rehabilitation Programme developed.
- Visits arranged
- ESD Rehabilitation Assistants deliver therapy sessions.

Week Two

- Ongoing therapy sessions.
- Patient's progress assessed and programme reviewed.
- Secondary prevention, health promotion and stroke education offered.
- Identification of health needs that fall outside of the service and referral to appropriate team. For example, pressure area / wound care / continence.

Week Three

- Ongoing therapy sessions.
- Ongoing review of patient's goals, progress & programme.
- Mood screen.
- Carer Assessment as required
- Discharge planning with patient, carer & other local services for seamless transfer of care.
- Patient referred onto other services as required.

Week Four

- Ongoing therapy sessions.
- Review patient's goals
- Review Discharge Plan with patient & carer
- Complete outcome measures
- Complete discharge

Level of ESD service provision

Frequency: (2-3 x per week)

Occupational Therapy: 12 visits (9 by rehab assistants, 3 by qualified OT)

Speech and Language therapy: 10 visits (7 by rehab assistants, 3 by qualified SLT)

Physiotherapy: 1 visit (0 by rehab assistants, 1 by qualified physiotherapist)

Psychology: N/A

HomeFirst: a care plan was also handed over to HomeFirst RSWs for daily dressing, showering and breakfast prep practice.

Part of the joint project between Home First and ESD to maximise efficiencies, collaborative working for maximum patient benefits, and to maximise the rehab input to stroke patients by involving Home first Reablement support workers in delivering specific elements of therapy.

Excellent Alliance work

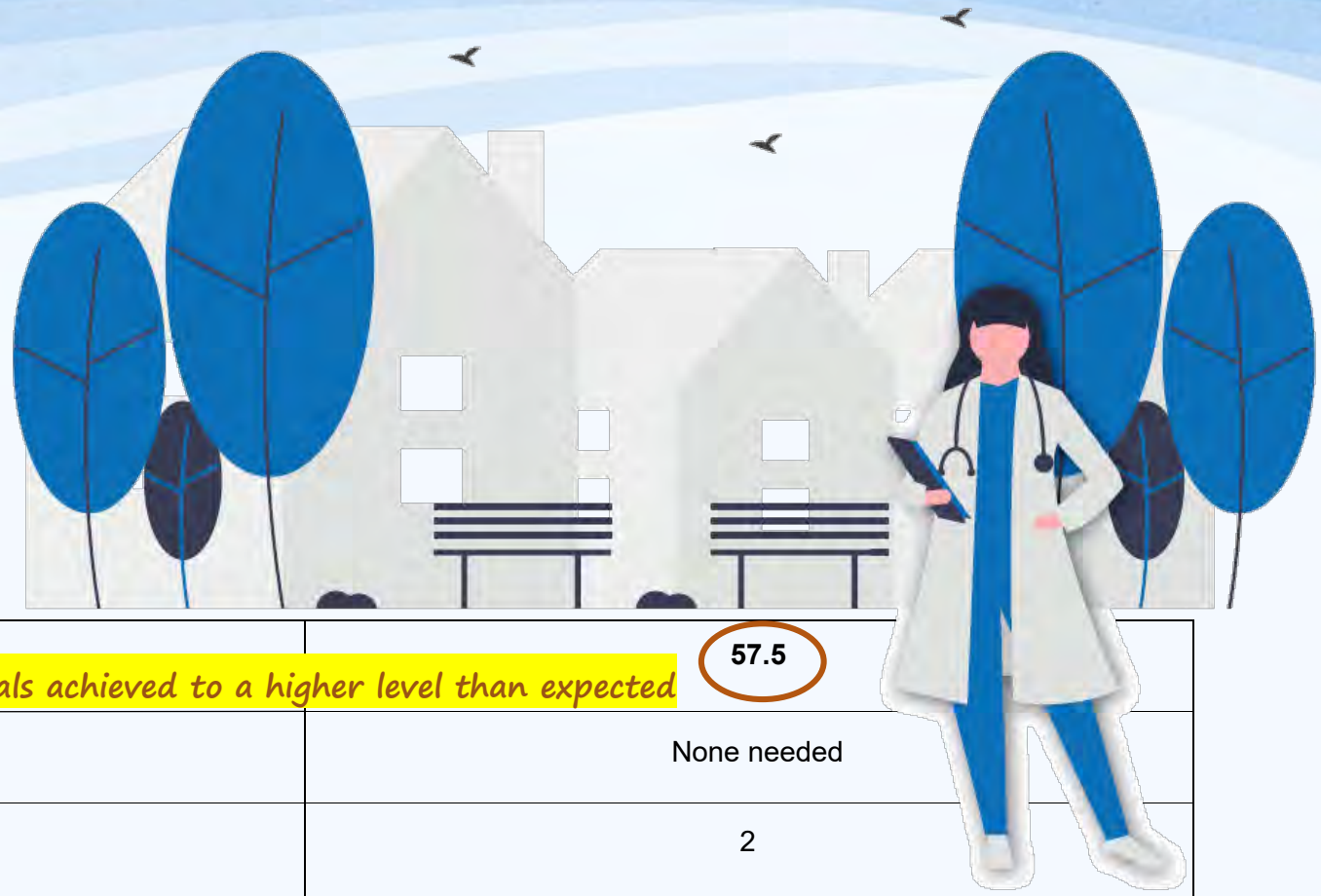
	Routine ESD	Joint work ESD + HomeFirst
Frequency & Intensity	Maximum 15 visits within 28 days	Up to 35 practice sessions within the 28 days
Context	Rehab Sessions/exercises	Rehab Sessions/exercises + Functional tasks retraining performing day-to-day tasks and activities
Timing	Rehab sessions as per scheduled visits	Practice sessions timed according to normal routine E.g., practice lunch prep at lunchtime, practice washing in the morning.
Repetition	Maximum 3 times/week	Daily practice

Goals

SMART GOAL	Importance	Difficulty	Baseline	Achieved
To be able to make breakfast and lunch independently in 4 weeks	2	1	-1	1
To be able to do the hoovering safely in 4 weeks	1	1	-1	0
To be able to hang the washing out safely in 4 weeks	1	1	-1	0
To be independent with showering and dressing in 4 weeks	2	1	-1	1

Key: -1: goal not achieved 0: goal achieved 1: goal achieved to a higher level.

Outcome measures



G oal attainment score	**33.1**	**57.5**
Care provision	BD care package	None needed
Modified Carer Strain index	6	2
Barthel Index	13 /20	16 /20
Modified Rankin Scale	**3** Moderate disability. Requires some help, but able to walk unassisted.	**1** No significant disability. Able to carry out all usual activities, despite some symptoms.
Discharge destination	**Home**	**Home**
Onward referrals	None needed	

Goals achieved to a higher level than expected


⇩ LOS
⇧Mood
⇧ Patient Satisfaction
⇧ Staff Satisfaction
⇩ Carer strain
⇧ Improved clinical outcomes
⇧ Carer Satisfaction

Reflection

- Patient D progressed really well and achieved all goals to a higher level than expected; a lot of this was down to the joint and inetrgrated alliance work between ESD and HomeFirst where day-to-day activities and tasks were practised both during rehab visits and daily as part of the HF input.
- By discharge the patient no longer required a care package for himself, he was independent with showering, dressing, breakfast, lunch, hoovering, and laundry/hanging the washing out.
- This is a good example of someone who benefitted from 4 weeks of intensive input, to the point where they felt confident going forwards, which meant a community therapy team referral was not required. This was only possible due to the enhanced package of ESD + HomeFirst.


Thank You!

11:15 BUILD A JOINED-UP FUTURE

14. EPRR Core Peer Review

For APPROVAL

For Approval

Presented by Helen Beck

Item 14 - WSFT - 2021 EPRR Core Standards v1.0

EPRR Core Standards

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Domain 1 - Governance											
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual	Helen Beck Chief Operating Officer detailed in WSFT EPRR Strategy approved Nov 2018. Louisa Pepper, Non-executive director EPRR. Reappointed 1 September 2021-31 Aug 2024	Fully compliant				
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	WSFT EPRR Strategy approved Nov 2018, Business Continuity Policy approved Sept 2019	Fully compliant				
3	**Governance**	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	Annual report 2019 - 20 (wsh.nhs.uk) Page 19	Fully compliant				
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	EPRR Strategy approved Nov 2018. EPO recruited 2021, Assistant EPO on Bank since 2019. Estates BC Planner.	Fully compliant				
6	**Governance**	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement	EPRR Strategy approved Nov 2018, Trust Lessons Identified / Lessons Learned database	Fully compliant				
Domain 2 - Duty to risk assess											
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	Corporate Risk Register, EPRR report to each quarterly Corproate Risk Committee and to the Red Risk Meetings for specific risks on a monthly basis.	Fully compliant				
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	EPRR Strategy approved Nov 2018 Section 5	Fully compliant				
Domain 3 - Duty to maintain plans											
11	**Duty to maintain plans**	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust Command, Control and Coordination (C3) Plan	Fully compliant				

EPRR Core Standards

12	**Duty to maintain plans**	**Major incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust Command, Control and Coordination (C3) Plan	Fully compliant				
13	**Duty to maintain plans**	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust Tactical Heatwave Plan dated November 2018	Fully compliant				
14	**Duty to maintain plans**	**Cold weather**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust Severe Weather Tactical Plan dated December 2018	Fully compliant				
18	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust Tactical Mass Casulaty Plan dated November 2019, Trust Operational Mass Casualty Plans (by dept / service)	Fully compliant				
19	**Duty to maintain plans**	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	ED Operational Mass Casualty Plan	Fully compliant				
20	**Duty to maintain plans**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust Tactical Evacuation Plan dated November 2018, Ward/dept operational emergency procedures.	Fully compliant				
21	**Duty to maintain plans**	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust Tactical Lockdown Plan (working document)	Fully compliant				
22	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Tactical High Profile Visitors and Patients Plan dated November 2018, visit-specific instructions.	Fully compliant				
Domain 4 - Command and control											
24	**Command and control**	**On-call mechanism**	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	Trust Command, Control and Coordination (C3) Plan	Fully compliant				
Domain 5 - Training and exercising											
Domain 6 - Response											
30	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has Incident Co-ordination Centre (ICC) arrangements	Y		Trust Command, Control and Coordination (C3) Plan, Strategic Commanders Aide Memoire, Tactical Commanders Aide Memoire	Fully compliant				
32	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans	EPRR Strategy approved Nov 2018,Trust Command, Control and Coordination (C3) Plan, Business Continuity Policy approved Sept 2019	Fully compliant				

EPRR Core Standards

34	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps	Trust Command, Control and Coordination (C3) Plan, Strategic Commanders Aide Memoire, Tactical Commanders Aide Memoire, incident and exercise reports.	Fully compliant				
35	**Response**	**Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'**	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	• Guidance is available to appropriate staff either electronically or hard copies	Ops Directorate 'Senior Managers on Call' folder and in ED	Fully compliant				
36	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y	• Guidance is available to appropriate staff either electronically or hard copies	Ops Directorate 'Senior Managers on Call' folder and in ED	Fully compliant				
Domain 7 - Warning and informing											
37	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	Trust Command, Control and Coordination (C3) Plan, Strategic Commanders Aide Memoire, Tactical Commanders Aide Memoire, Trust Tactical Communications Plan. Current operational response to RAAC.Trust Media policy and procedure dated December 2020.	Fully compliant				
38	**Warning and informing**	**Warning and informing**	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	Trust Command, Control and Coordination (C3) Plan, Strategic Commanders Aide Memoire, Tactical Commanders Aide Memoire, Trust Tactical Communications Plan. Current operational response to RAAC.Trust Media policy and procedure dated December 2020.	Fully compliant				
39	**Warning and informing**	**Media strategy**	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy	Trust Command, Control and Coordination (C3) Plan, Strategic Commanders Aide Memoire, Tactical Commanders Aide Memoire, Trust Tactical Communications Plan. Current operational response to RAAC.Trust Media policy and procedure dated December 2020.	Fully compliant				
Domain 8 - Cooperation											
42	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	Trust Command, Control and Coordination (C3) Plan linked to CCG/NHS E plans	Fully compliant				
43	**Cooperation**	**Arrangements for multi-region response**	Arrangements outlining the process for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.		• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs	Trust Command, Control and Coordination (C3) Plan, Strategic Commanders Aide Memoire, Tactical Commanders Aide Memoire, Trust Tactical Communications Plan. Current operational response to RAAC.Trust Media policy and procedure dated December 2020.	Fully compliant				
46	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	Trust Command, Control and Coordination (C3) Plan, Strategic Commanders Aide Memoire, Tactical Commanders Aide Memoire, Trust Tactical Communications Plan. Current operational response to RAAC.Trust Media policy and procedure dated December 2020	Fully compliant				
Domain 9 - Business Continuity											
47	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continutiy Management System (BCMS) in alignment to the ISO standard 22301.	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	WSFT EPRR Strategy approved Nov 2018, Business Continuity Policy approved Sept 2019	Fully compliant				

EPRR Core Standards

48	**Business Continuity**	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders	WSFT EPRR Strategy approved Nov 2018, Business Continuity Policy approved Sept 2019	Fully compliant				
50	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance	IMT Disaster Recovery Plan dated June 2017	Partially compliant				
51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	WSFT EPRR Strategy approved Nov 2018, Business Continuity Policy approved Sept 2019. Tactical Business Continuity Plan (working draft). Lacking full suite of operational BCPs.	Partially compliant	Develop/review all operational BCPs	ADOs	On-going	Incredibly difficult due to the RAC failsafe programme; will be on-going for the life of the structure.
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports	RSM Audit reports quarterly	Fully compliant				
54	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectivness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	WSFT EPRR Strategy approved Nov 2018, Business Continuity Policy approved Sept 2019	Fully compliant				
55	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	WSFT EPRR Strategy approved Nov 2018, Business Continuity Policy approved Sept 2019, EU Exit preparatory work and Annex to Trust C3 Plan. Trust Purchasing Procedures	Fully compliant				
Domain 10: CBRN											
56	**CBRN**	**Telephony advice for CBRN exposure**	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	Trust Tactical Counter-Contamination Plan dated November 2018, ED operational emergency procedures.	Fully compliant				
57	**CBRN**	**HAZMAT / CBRN planning arrangement**	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	Trust Command, Control and Coordination (C3) Plan, Tactical Commanders Aide Memoire, Trust Tactical Counter-Contamination Plan dated November 2018, ED operational emergency procedures.	Fully compliant				
58	**CBRN**	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	• Impact assessment of CBRN decontamination on other key facilities	Trust Command, Control and Coordination (C3) Plan, Tactical Commanders Aide Memoire, Trust Tactical Counter-Contamination Plan dated November 2018, ED operational emergency procedures. Decontainationa and Quick Don PPE Risk Assessments. ED rotas - capability being worked back up due to lack of availability of HART for PRPS training	Fully compliant				
59	**CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y	• Rotas of appropriately trained staff availability 24 /7		Partially compliant	Complete PRPS training for all required ED staff in accordance with the ED training plan	ED Manager	on-going	
60	**CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	• Completed equipment inventories; including completion date		Fully compliant				

EPRR Core Standards

62	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y	• Record of equipment checks, including date completed and by whom. • Report of any missing equipment				Fully compliant	
63	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y	• Completed PPM, including date completed, and by whom				Fully compliant	
64	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y	• Organisational policy				Fully compliant	
65	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y	• Maintenance of CPD records				Fully compliant	
67	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y	• Maintenance of CPD records				Fully compliant	
68	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	• Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • All service providers - see Guidance for the initial management of self presenters from incidents involving hazardous materials - https://www.england.nhs.uk/publication/eprr-guidance-for-the-initial-management-of-self-presenters-from-incidents-involving-hazardous-materials/ • All service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • A range of staff roles are trained in decontamination technique				Fully compliant	
69	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y					Fully compliant	

Item 14 - WSFT - 2021 EPRR Core Standards v1.0
Deep Dive

Ref	Domain	Standard	Detail	Evidence - examples listed below	Acute Providers	Organisational Evidence	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Oxygen Supply **Domain: Oxygen Suuply**											
DD1	**Oxygen Supply**	**Medical gasses - governance**	The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum HTM02-01 Part B.	•□Committee meets annually as a minimum •□Committee has signed off terms of reference •□Minutes of Committee meetings are maintained •□Actions from the Committee are managed effectively •□Committee reports progress and any issues to the Chief Executive •□Committee develops and maintains organisational policies and procedures •□Committee develops site resilience/contingency plans with related standard operating procedures (SOPs) •□Committee escalates risk onto the organisational risk register and Board Assurance Framework where appropriate •□The Committee receives Authorising Engineer's annual report and prepares an action plan to address issues, there being evidence that this is reported to the organisation's Board	Y	Meeting is quarterly, ToR is being formally reviewed as overdue review, minutes maintained and circulated, actions are not all managed effectively and a new chair has been appointed to resolve this (Lead Anaesthetist), Actions elevated to ED's as required, Policies and Procedures are up to date. Emergency Business Continuity Plan in-place. Risks are populated on Datix and elevated to the BAF as appropriate. Report awaited.	Partially compliant	Manage meeting actions	Lead Anaesthetist	01/02/2022	
DD2	**Oxygen Supply**	**Medical gasses - planning**	The organisation has robust and tested Business Continuity and/or Disaster Recovery plans for medical gases	•□The organisation has reviewed and updated the plans and are they available for view •□The organisation has assessed its maximum anticipated flow rate using the national toolkit •□The organisation has documented plans (agreed with suppliers) to achieve rectification of identified shortfalls in infrastructure capacity requirements. •□The organisation has documented a pipework survey that provides assurance of oxygen supply capacity in designated wards across the site •□The organisation has clear plans for where oxygen cylinders are used and this has been discussed and there should be an agreement with the supplier to know the location and distribution so they can advise on storage and risk, on delivery times and numbers of cylinders and any escalation procedure in the event of an emergency (e.g. understand if there is a maximum limit to the number of cylinders the supplier has available) •□Standard Operating Procedures exist and are available for staff regarding the use, storage and operation of cylinders that meet safety and security policies •□The organisation has breaching points available to support access for additional equipment as required •□The organisation has a developed plan for ward level education and training on good housekeeping practices •□The organisation has available a comprehensive needs assessment to identify training and education requirements for safe management of medical gases	Y	Plans recently updated, maximum flow rate being assessed, shortfalls managed with BOC under contract, site schematic is in-place, Equipment library managed by EBME, Ward Training not yet completed, AP's, CP's, AE's in-role - end-user training not complete	Partially compliant	Assess flow rate, train ward staff	Associate Director of Estates and Facilities	01/06/2022	A number of these items are continual, ward training is the time limited element and this needs to be coordinated with operational pressures
DD3	**Oxygen Supply**	**Medical gasses - planning**	The organisation has used Appendix H to the HTM 0201 part A to support the planning, installing, upgrading of its cryogenic liquid supply system.	•□The organisation has clear guidance that includes delivery frequency for medical gases that identifies key requirements for safe and secure deliveries •□The organisation has policy to support consistent calculation for medical gas consumption to support supply mechanisms •□The organisation has a policy for the maintenance of pipework and systems that includes regular checking for leaks and having de-icing regimes •□Organisation has utilised the checklist retrospectively as part of an assurance or audit process	Y	Safe deliveries in-place, no consistent calculation in-place the controls don't support this, checking and maintenance in-place, system monitored and checked in-line with checklist	Fully compliant				
DD4	**Oxygen Supply**	**Medical gasses -workforce**	The organisation has reviewed the skills and competencies of identified roles within the HTM and has assurance of resilience for these functions.	•□Job descriptions/person specifications are available to cover each identified role •□Rotating of staff to ensure staff leave/ shift patterns are planned around availability of key personnel e.g. ensuring QC (MGPS) availability for commissioning upgrade work. •□Education and training packages are available for all identified roles and attendance is monitored on compliance to training requirements •□Medical gas training forms part of the induction package for all staff.	Y	JD/PS reflect relevant roles, QC in-place, Additional AP and CP training taking place, Training supported, Included in Induction for relevant staff	Fully compliant				
DD5	**Oxygen Supply**	**Oxygen systems - escalation**	The organisation has a clear escalation plan and processes for management of surge in oxygen demand	•□SOPs exist, and have been reviewed and updated, for 'stand up' of weekly/ daily multi-disciplinary oxygen rounds •□Staff are informed and aware of the requirements for increasing de-icing of vaporisers •□SOPs are available for the 'good housekeeping' practices identified during the pandemic surge and include, for example, Medical Director sign off for the use of HFNO	Y	Oxygen Stewardship management in-place, escalation for devapouriser is in-place, Medical Director escalation in-place.	Fully compliant				
DD6	**Oxygen Supply**	**Oxygen systems**	Organisation has an accurate and up to date technical file on its oxygen supply system with the relevant instruction for use (IFU)	•□Reviewed and updated instructions for use (IFU), where required as part of Authorising Engineer's annual verification and report	Y	IFU in-place with BOC	Fully compliant				

Item 14 - WSFT - 2021 EPRR Core Standards v1.0
Deep Dive

DD7	**Oxygen Supply**	**Oxygen systems**	The organisation has undertaken as risk assessment in the development of the medical oxygen installation to produce a safe and practical design and ensure that a safe supply of oxygen is available for patient use at all times as described in Health Technical Memorandum HTM02-01 6.6	•□Organisation has a risk assessment as per section 6.6 of the HTM 02-01 •□Organisation has undertaken an annual review of the risk assessment as per section 6.134 of the HTM 02-01 (please indicated in the organisational evidence column the date of your last review)	Y	Risk assessment in-place relating to where limitations are although flow around site means local limitations aren't entirely clear - the site is not a ring-main, no formal risk assessment in-place this will be undertaken as part of an evapourator upgrade being undertaken shortly	Partially compliant	Upgrade evapourator, review risk assessment	Associate Director of Estates and Facilities	01/04/2022	The nature of the infrastructure means this will never be fully compliant, but the actions we can deliver on relate to this date

Trust Board meeting – 15 October 2021

Agenda item:	14			
Presented by:	Helen Beck – Chief Operating Officer & Accountable Emergency Officer			
Prepared by:	Barry Moss – EPRR Lead			
Date prepared:	08/10/2021			
Subject:	EPRR Core Standards			
Purpose:		For information	x	For approval

Executive summary:
NHS England requires Accountable Emergency Officers (AEO) to ensure Trust participation in the annual (2021-22) EPRR assurance process. This is the means by which NHS England obtains assurance that NHS funded organisation are sufficiently able to response to emergencies. This reduced submission (due to pressures of the pandemic), which has been reviewed and agreed with the CCG, states that the overall level of compliance is **'Substantially Compliant'** in that there are 3 core standards that we don't have full compliance with.

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

Previously considered by:	ECOO
Risk and assurance:	Core standards reviewed and approved by CCG emergency planning officer as part of formal assurance process.
Legislation, regulatory, equality, diversity and dignity implications	Nil

Recommendation:
The Board to endorse and support the Trust EPRR Core Standards report to NHS England.

WEST SUFFOLK NHS FOUNDATION TRUST 2021/22 EPRR CORE STANDARDS ASSURANCE REPORT TO THE TRUST BOARD

Background:

The Trust is required to participate in the annual EPRR assurance process as the means by which NHS England obtains assurance that NHS funded organisation are sufficiently able to response to emergencies. Organisations carry out a self-assessment against the core standards, which is subjected to executive scrutiny, and then CCG and Regional NHS E/I review. The submission includes a copy of the complete self-assessment.

Summary:

Due to the accepted pressures of the pandemic, this year's process has been reduced and abridged; we would normally report on 64 core standards (reduced to 46 for 2021/22) and produce an action plan (not required this year). Each year there is also a 'Deep Dive' into a specific topic that is for information purposes only and not used for the formal grading of compliance; this year the deep dive was in oxygen provision and sustainability, recognising the challenges in this area which the pandemic has highlighted.

As a result of self-assessment, the Accountable Emergency Officer (AEO) considers that the Trust is **'Substantially Compliant'** as there are **3** core standards where we are 'partially compliant'. This has occurred due to a factor's outside of the Trust's control. We reported 'substantial compliance' last year due to 2 core standards that were not fully met, and unfortunately these same 2 core standards are in the same position this year. It is important to point out that the impact of COVID and RAAC has substantially reduced capacity by diverting staff time to more pressing operational matters. In addition, on review by the CCG, the status of the IT disaster recovery plan was identified as only partially compliant.

Expanded Detail of Partially Complaint Core Standards:

CS 50 – Data Protection and Security Toolkit. We do not currently have the full toolkit in place, but have an approved workplan to do so. As part of their review of the standards, the CCG also raised concerns about the IM&T Disaster Recovery Plan. For the purpose of this report we are therefore reporting non-compliance but have already taken action to address the issue as a priority and a remedial action plan has been developed. The work is progressing rapidly and it is anticipated that a further verbal update of progress will be available at the board meeting.

CS51 – Business Continuity Plans. Despite doubling the size of the core EPRR team, there is a continuing lack of capacity to complete/update operational Business Continuity plans as this requires a substantial time commitment from subject matter experts within operational divisions, and from the EPRR staff. The key point to note is that conventional business continuity is almost a moot point due to the remaining life-span of the Hospital building due to the threat and impact of RAAC. It is more efficient to focus on the sustainability of services outside the RAAC structures, and on the post-RAAC incident business continuity. By association, any other incidents with business continuity implications will be assisted by such a process whereas the reverse would not apply. The Trust Estates & Facilities BC plans are in date and current, but some of the Trust operational area plans are out of date, and a few new plans are required for hospital and community sites. The working Trust Tactical BC Plan outlines the approach to solving BC problems, and consolidates the functional contingencies to do so; this will be further evolved as the new departmental/service operational BC plans are produced iteratively, and when they are reviewed; this will be a constant process until the old hospital building closes and, due to the dynamic nature of the BC challenge in a deteriorating structure and system, is unlikely to ever by 'finished'.

CS59 – Decontamination Capability Availability 24/7. NHS E standards require the Trust to have "*adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24/7*". We have had an inability to gain mandatory external support for

Powered Respiratory Protective Suits (PRPS) training as we are not qualified to deliver this training ourselves yet. We had a plan to gain such a qualification, and to train all the ED staff but this was compromised by the delay in receiving external support. We have compensated by expanding and increasing our dry decontamination and ad hoc 'quick don PPE' capability. Whilst the latter does not deliver the same protection factor as PRPS and as a result staff have to rotate more frequently and are unable to stay for long periods as would be the case in the PRPS suits. This is a reasonable substitute, and is in some ways more efficient and effective. Secondly, we have not met the requirement for sufficient Emergency Department staff to be current in Powered Respirator Protective Suits (PRPS), but this is as a result of a lack of Ambulance trainers during the COVID crisis.

Deep Dive- Oxygen Provision

Each year NHS E asks additional questions around a specific resilience topic to inform wider future planning. This year it has posed a number of questions around O2 supply and sustainability impact. The compliance with these questions does not affect the Trust's overall Core Standards rating and are to provide information to the Government's Environment Audit Committee. Of the 7 questions posed, the Trust had 'full compliance' with 4. The remainder were 'partially compliant' around the completion of the Medical Gas Committee ToRs, limitations to gas supply business continuity as a result of training, and further improvements to gas risk assessments; these are all being addressed by the Estates team.

Additional Comments: The CCG assessors especially commended the Trust's approach to command and control (enabled through the C3 Plan) and the Trust's proactive attitude toward addressing the RAAC problem, noting that many of the Trust approaches were now accepted as regional and national best practice.

Summary: This Trust continues to be held up as an example of how Resilience should be managed by external partners. That we declare as partially compliant to some core standards is a demonstration of how we strive to continuously improve and how we are confident that we can always do better. Staff have lived a resilience model of working for almost 2 years, and our level of working competence is now extremely high. Capacity is the issue and to deliver full business continuity and make the other minor improvements necessary we will need to find more in already overloaded people. Although staff capacity is continually denuded by the demands of 'real life' getting in the way, we have the compensation that we are delivering resilient services by the way we do business on a daily basis.

Helen Beck
Executive Chief Operating Officer and EPRR AEO 8th October 2021

15. Trust Strategy 2021-2026

To RECEIVE the report

For Report

Presented by Sheila Childerhouse and Helen Davies

WSFT Open Board Meeting - 15 October 2021

Agenda item:	15			
Presented by:	Helen Davies, head of communications			
Prepared by:	Anna Hollis, senior communications manager			
Date prepared:	8 October 2021			
Subject:	Trust strategy			
Purpose:	X	For information		For approval

Executive summary:

This report provides an update on the production of the Trust's new corporate strategy. Included here is the final draft, including case studies, which is now being designed.

It has been sent to the reader panel for a second time with feedback incorporated where appropriate.

Additional staff engagement around the new direction of the strategy, its aims, ambitions and values, took place previously, with feedback and contributions incorporated where appropriate. We also carried out a workshop with the Board and TEG previously, that considered how we would measure the success of the strategy, which have been included.

Engagement activity has included:

- All staff online briefings x 2
- Board
- TEG
- Scrutiny committee
- Involvement committee
- Trust Council
- Council of Governors
- Items in Green Sheet x 2
- Reader panel x2

We have worked with executive chief nurse Sue Wilkinson and chief information officer Liam McLaughlin to start to map the nursing, midwifery and allied health professional (NMAHP) strategy and digital strategy respectively, to the corporate strategy. This included facilitating a nursing, midwifery and clinical council workshop giving staff the opportunity to participate in scoping out the future NMAHP strategy.

Next steps: Design of the strategy publication and accompanying animation are in progress. Indicative timelines for the design phase will be approximately 8-12 weeks.

Launch date and communications and engagement strategy to embed the strategy going forward TBC.

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:							
Risk and assurance:	The Trust's current strategy is now out of date. We must effectively develop a new direction of travel that takes account of health and social care changes at a Trust, local and national level, and clearly outline our ambitious plans for the next five years.						
Legislation, regulatory, equality, diversity and dignity implications							
Recommendation: To provide final written draft of the strategy, which is now in the design phase.							

First for our patients, staff and community

West Suffolk NHS Foundation Trust

Our strategy 2021-2026

West Suffolk NHS Foundation Trust Strategy 2021-26

Foreword from chief executive and chair

In many cases, people have the right to choose where they receive NHS treatment. In addition, NHS staff can choose where and what NHS trust to work for. Our ambition is to be the first choice NHS provider for our patients, our people and our community and to prepare for the future health and care needs of our local population.

Since we published our last strategy in 2015, Our patients, Our hospital, Our future, together, West Suffolk NHS Foundation Trust (WSFT) has changed a lot. We are no longer just a hospital; we now work across two hospitals, a wide range of community locations, in people's own homes, in a GP surgery and in a reablement unit in a care home, where we offer temporary care after you are discharged from hospital. Over the past five years, there have been many highs and lows and there are both challenges and opportunities on the road ahead.

First and foremost, we are an organisation rooted in, and faithful to, our community. We are staffed by people living and involved locally, looking after local people, doing our best for each other. It is your families and ours who we have the privilege and pleasure of caring for.

The last 18 months has been an unprecedented time for all of us. COVID-19 has turned our lives upside down and has had a huge impact on the NHS. COVID-19 is by far the worst of many events that WSFT has experienced over the past five years. For many people it has been the worst time of their lives. Yet it has shown us that we can succeed, and that as long as we work together and look after each other, we can get through the tough times. We are proud to be part of the West Suffolk team.

As we look forward to better times, we know there is a lot of work ahead. We need to recover and repair, acknowledging our high emergency department and inpatient demand alongside dealing with our elective surgery waiting lists and working through our planned estates maintenance programme.

We will listen, and keep improving. We will celebrate success, and strive to learn from the things that go wrong.

The next five years will see more change, more uncertainty, yet we have real opportunities to transform how we provide care across our hospital and community services. We are delighted that the Trust has been named as one of 40 to benefit from the Government's New Hospital Programme. With the West Suffolk Hospital coming to the end of its life, a new healthcare facility is much needed and will help us to continue to deliver high quality, safe care for our patients and our community well into the future.

As we embark upon the next five years, we set out clearly in this strategy our future ambitions and how we are going to achieve them. We are grateful to the broad range of people who helped shape this strategy, both in the Trust and more widely.

Putting our patients, our people and our community first, is what drives us. Together, we hope we will look back in 2026 and feel proud of our efforts and successes.

Craig Black, interim chief executive and Sheila Childerhouse, chair

Future direction

Vision:
Deliver the best quality and safest care for our local community

Ambition:
First for our patients

- Collaborate to provide seamless care at the right time and in the right place
- Use feedback, learning, research and innovation to improve care and outcomes.

Ambition:
First for our staff

- Build a positive, inclusive culture that fosters open and honest communication
- Enhance staff wellbeing
- Invest in education, training and workforce development.

Ambition:
First for the future

- Make the biggest possible contribution to prevent ill health, increase wellbeing and reduce health inequalities
- Invest in infrastructure, buildings and technology.

Powered by our First Trust Values
Fairness; Inclusion; Respect; Safety; Teamwork

The West Suffolk NHS Foundation Trust

The Trust in numbers [Present statistics in graphic format]

A typical year pre-Covid-19: April 2019/March 2020

- 280,000 catchment population
- 4,353 staff
- 6,296 public and 5,196 staff foundation trust members
- 2,367 babies born
- 78,892 attendances at the emergency department
- 15,594 operations per year
- 264 people looked after at the end of their lives
- 341,965 visits to outpatients
- 225,166 contacts with patients through community services (including face to face, telephone and email)

Who we are and what we do

The West Suffolk NHS Foundation Trust (WSFT) provides hospital and community services to a population of around 280,000 people. Services are delivered over a largely rural geographical area of roughly 600 square miles.

The catchment area extends beyond Thetford in the north and Sudbury in the south, to Newmarket to the west and Stowmarket to the east. It serves the population of the west of Suffolk and parts of the neighbouring counties of Essex, Cambridgeshire and Norfolk.

The West Suffolk Hospital is the location from which the Trust provides a full range of acute and secondary care services. This includes an emergency department, maternity and neonatal services, a day surgery unit, eye treatment centre, Macmillan Unit and children's ward. It has approximately 500 beds in total and is a partner teaching hospital of the University of Cambridge.

Outpatient clinics and some diagnostic services (x-ray and ultrasound) are provided from a number of outreach sites including Newmarket, Botesdale, Thetford, Stowmarket, Haverhill and Sudbury.

The Trust provides community services for the residents of west Suffolk through the West Suffolk Alliance with Suffolk County Council, Suffolk GP Federation and Norfolk and Suffolk NHS Foundation Trust. A range of nursing and therapy services and specialist services are provided in patients' own homes, health centres and community buildings. The community paediatric service operates across Suffolk. Ongoing temporary care and rehabilitation services are provided with 20 inpatient beds at Newmarket Hospital, alongside facilities for other services. A further 20 reablement beds are commissioned from Care UK at Glastonbury Court, a care home in Bury St Edmunds, and staffed by WSFT nursing and therapy teams. In addition, we can share the use of 10-14 temporary care beds at Hazell Court in Sudbury.

The Trust is one of the largest employers in the area, employing nearly 5,000 staff.

Since April 2020, the Trust has also provided primary care services at Glemsford Surgery via a sub-contracting arrangement with the existing GP partners.

Our successes and challenges

The last five years [Present in a timeline from 2015 – 2020]

2015	2015-20 strategy published
Nov 2015	WSFT is the first trust in the East of England to introduce the new role of physician associate
May 2016	eCare, our electronic patient record, goes live
August 2016	Care Quality Commission rates our quality of care as Good
Sept 2016	West Suffolk Alliance forms between Suffolk County Council, WSFT, Suffolk GP Federation and Norfolk and Suffolk NHS Foundation Trust
Sept 2016	Trust announced as one of first 12 Global Digital Exemplars
Nov 2016	Suffolk and North East Essex sustainability and transformation plan is published
Feb 2017	Kings Suite at Glastonbury Court opens to provide a dedicated rehabilitation facility
Oct 2017	Community services formally join WSFT
Jan 2018	CQC rating rises to Outstanding
April 2018	The first UK link between two hospital electronic patient records is turned on between eCare at WSFT and eHospital at Cambridge University Hospitals NHS FT
May 2018	Sustainability and transformation partnership is formalised into Suffolk and North East Essex Integrated Care System
Dec 2018	Phase 1 of new acute assessment unit opens
Dec 2018	New cardiac centre opens
May 2019	Safety alert issued about reinforced aerated autoclaved concrete (RAAC) planks used in construction of main hospital building and former front residences – thorough maintenance programmes developed in response
June 2019	We learnt about the State of Suffolk, including that by 2037, Suffolk will need nearly two more West Suffolk Hospitals if current patterns of illness continue
Oct 2019	Final phase of acute assessment unit is completed
Oct 2019	West Suffolk Hospital named as a site for investment in the national New Hospitals Programme
Jan 2020	CQC rating drops to Requires Improvement
Mar 2020	Glemsford Surgery joins WSFT, creating WSFT Primary Care Services
Mar 2020	COVID-19 hits
April 2020	The Alliance starts working with the Institute of Healthcare Improvement to continue improving quality
Sept 2020	My Wish Charity celebrates 25th birthday
Sept 2020	WSFT's health information exchange now connects health records between GP surgeries, community care and hospitals throughout Suffolk and Essex
May 2021	WSFT announced as part of Suffolk and North East Essex Integrated Care System £10m 'elective accelerator' to speed up the recovery of routine services following the Covid-19 pandemic

What our community thinks of us

In 2020, 94% patients recommended WSFT as a place to receive care

In 2020, 83% staff recommended WSFT as a place to receive care

In 2020, 74% staff recommended WSFT as a place to work

Clinical achievements

- The endoscopy, radiology, housekeeping, catering, IT department and the Macmillan Unit all hold national accreditations for excellence.
- We regularly receive top A grade in overall assessment by the Sentinel Stroke National Audit Programme.
- Best for hip fracture care 2017, 2018, 2020 (England, Wales and Northern Ireland) according to the National Hip Fracture Database.

The impact of the Covid-19 pandemic

Across the country, the Covid-19 pandemic bought the tireless work of the NHS into sharp focus.

Our staff worked in uncertain, unpredictable circumstances, going above and beyond every day. We strained every part of our systems, processes and resources to serve the sickest in our community.

What has become more apparent through this unparalleled time is our resilience and determination to look after our patients and community in the best way we can. Day-in, day-out, our staff strive to deliver the best possible care for our patients.

There is no doubt that the pandemic has taken its toll on our staff and services. For many this period has been the worst of their lives. However, despite this they have stepped up to care for the sickest and most vulnerable in our community in extremely difficult circumstances.

As we cautiously move into a period of recovery, we are working hard to restore services affected by the pandemic. Our waiting lists grew longer as we had to pause services to focus our efforts on Covid-19. We know this is upsetting for patients – as well as our staff who want to do their best for people in their care.

As part of the Suffolk and North East Essex Integrated Care System we have been awarded funding and extra support to implement innovative ways to increase the number of elective operations. This work is not just about doing more of the same, but also thinking about how we diagnose, treat, and monitor our patients in ways that maximise our efficiency. For example, rather than bringing every patient in for routine review at set periods, we may offer individual support plans with a mix of in-person appointments, online consultations, and patient-led recovery techniques and support. This is better for patients, and means our staff can focus time on the patients who need it the most. We will continue to do all we can to work our way through these waiting lists and provide the care our community needs.

[Present statistics in graphic format]

April 2020/March 2021

- 1,016 Covid-19 + inpatients
- 759 Covid-19 + patients discharged
- 257 Covid-19 + patients died*
- 16,594 telephone clinics
- 1,041 video clinics
- 102,609 telephone consultations
- 2,889 video consultations
- 1,313 laptops provided to staff to support home working
- 16,000 local health and care staff vaccinated
- 40,859 calls made via our clinical helpline service
- 48 live virtual cardiac rehab groups delivered (17 April – 10 July); continue to offer six virtual cardiac rehab groups per week

*Death was within first 28 days of Covid-19 + swab

Boxout / case study

Staff support psychology service

Looking after our staff has never been more important. The staff support psychology team, set up in response to Covid-19, provides support to people in their time of need.

At the start of the pandemic, a staff support psychology team was put in place to provide extra emotional and mental wellbeing support for colleagues across the Trust.

Led by consultant clinical psychologist Emily Baker, the team is made up of highly trained mental health workers, offering sessions for individuals and teams throughout the week.

So far, the team:

- has seen more than 625 members of staff across the Trust
- sees on average 50-60 individuals per week (some single and some repeat appointments)
- has run 150 sessions for teams or small groups
- has run a series of online 'Wellbeing Wednesday' sessions to help staff overcome emotional and mental health challenges
- has held eight informal virtual coffee lounge events for staff to drop in to say hello and be greeted by a friendly face
- is supporting several staff with long COVID, including some who are returning to work after periods of absence or shielding.

Emily Baker explains: "Our main message is that it's ok not to be ok. We are here to help staff across the organisation with their wellbeing. We offer support with issues such as sleeping or coping with negative thoughts.

"We've found that a lot of the concerns staff have are from a mixture of challenges outside of work combined with the increased demands of working in the NHS during the pandemic. Staff haven't been able to do the things they would normally to help manage their wellbeing, such as going to the gym, going out with friends, seeing family or giving loved ones a hug.

"Our team has worked with people across the Trust in a wide variety of roles. I'd like everyone to know that we're only a message away and as a Trust we're one team and in this together."

Boxout / case study

Keeping in touch service huge success

The West Suffolk Hospital's 'keeping in touch' service was launched in April 2020. The aim was to help family and friends to contact loved ones who were in hospital during the pandemic.

With lockdowns and tighter visiting restrictions, the Trust's 'keeping in touch' service used technology to bring people closer together even though they, physically, had to be kept apart.

Not only were benefits felt by patients and family members, but ward staff could see the difference the calls made to their patients.

Having fallen whilst at home, Jackaleen, 91, came into our care at West Suffolk Hospital. 3,000 miles away in the USA, her daughter Lisa, and grandchildren, Emily and Katie, were very worried.

Lisa and the family were able to have video calls with Jackaleen during her stay through our keeping in touch service. Having had several video calls during her mum's stay Lisa said: "The keeping in touch team is a gift from heaven. Everyone in the team, including Dawn, Livvy, Chloe, Lauren and Natalie, went above and beyond loving and caring for us all. They all loved my mum during her stay, they were all so wonderful.

"From the bottom of my heart, I am so thankful. The hospital where I gave birth to my daughter 25 years ago, once again came through and brought us love and brought a family together."

Boxout / case study

Clinical helpline handles more than 40,000 calls

Our clinical helpline, launched in April 2020 following the national suspension of visiting in hospitals, has taken more than 40,000 calls in its first year.

Just one week into the first UK lockdown, the patient experience team saw the difficulty visitor restrictions was causing both patients and relatives. They came up with the idea of helping loved ones stay up to date with hospital care.

Initially the service used the skill and compassion of nurses who had to stop working on the frontline because they needed to shield themselves. The team of staff, each with a clinical background, ran a virtual helpline, often from their own homes.

Ward staff were able to keep focused on caring for patients while the clinical helpline took calls from worried family desperate for an update on the wellbeing of their loved ones.

The team could access e-Care, our electronic patient record, to keep up to date with the latest diagnoses and care being provided, giving family carers, spouses, children, and other family members regular clinical updates.

Trust head of patient experience Cassia Nice said: “Our clinical helpline was a true team effort and we couldn’t have done it without our amazing helpline clinicians. It provides clinical and wellbeing information to relatives and caregivers using our live digital healthcare records and helps communication between patients, relatives, carers and staff.

“Helpline staff offer support during a time of uncertainty, assisting relatives and carers to make sense of what they are being told while also looking for gaps in a patient’s medical history or their preferences. This helps us provide better care and improve patient safety.”

A family member of one patient said of the service: “After my father was admitted with a fractured hip I was able to get daily updates on his condition and care from the fantastic helpline team. I have chatted with staff who have been so helpful and explained everything

clearly. It has been extremely reassuring. The benefits are immense as it takes the pressure off the ward staff. I, the caller, get someone knowledgeable at the other end of the phone very quickly. It has taken away a lot of stress."

Dr Carolina Caprario, a respiratory consultant at the West Suffolk Hospital, said: "We fully support our dedicated helpline which enables families to receive regular updates and helps ease their concerns. It is a worrying time for families when a relative is admitted, especially when they are unable to visit their loved one in hospital.

"The helpline supports our frontline medical staff to focus more of their time on giving care to our patients without having to answer telephone calls. I think that even if full visiting is allowed again, our helpline will continue to play an integral role in helping us effectively deliver updates about loved ones in our care."

The success of the helpline means the Trust plans to continue with the service even after visiting restrictions have been fully relaxed.

Clinical helpline stats

Total calls received	28,785
Total calls made	12,074
Total calls handled	40,859
Total handling time	2,810 hrs 5 mins 46 seconds
Average wait time (seconds)	00:00:45

What's changed?

The national picture

Nationally, the NHS is being asked to focus on various ways to improve the care we provide and make sure that everyone gets the best possible experience of the NHS.

The NHS Long Term Plan says we need to:

1. Modernise the way we work and rely less on hospitals and giving people more control over their own health and where they receive their care.
2. Do more to prevent illness and reduce inequalities in health experienced by different groups of people.
3. Improve the quality of our care and the outcomes for the people we look after. We should especially focus on children and young people, those with cardiovascular disease, stroke, diabetes, respiratory disease, mental health problems, or cancer, and people waiting for an operation. We should use more research and innovation to get there.
4. Recruit more staff into a wider variety of jobs, and everyone needs to feel happy and valued in their work.
5. We should make the most of everything the digital world can offer us.
6. We need to keep living within our means, both in terms of money and how green we are.

We also need to adapt to the threat of new and untreatable infectious diseases ever present in the background.

To achieve all these things and more, the public, private and voluntary sector organisations which help to look after people's health, care and wellbeing, have started working more closely together. The Trust is a member of two groups in particular - the West Suffolk Alliance and the Suffolk and North East Essex Integrated Care System. Both groups have published their own strategies in the past five years. This new strategy of our own reflects the ways in which we are working with them towards two common aims: improving the health of our community and reducing inequalities.

New local partnerships - what are they?

The West Suffolk Alliance and the Suffolk and North East Essex Integrated Care System (SNEE ICS) are agreements between local organisations to work more closely together to make sure people get the best possible care. There is a long history of health and care organisations working together to make sure people get the best possible care. For example, by being a member of the East of England Cancer Alliance, we make sure our cancer treatment stays at the cutting edge. As members of the West Suffolk Alliance and SNEE ICS, we have signed up to working more closely with local organisations such as councils, volunteer groups, leisure centres and GPs. We call this 'integration' and refer to working as a 'whole system' to improve health and care. Together we consider the wider determinants of health - be that social issues, deprivation, inequalities or mental health.

The SNEE ICS covers a broader geography (Suffolk and North East Essex) and the West Suffolk Alliance focuses on a more local footprint to ensure we drive meaningful integrated services to our local population.

We know what our local people need because the Suffolk County Council Health and Wellbeing Board finds out through local health data research and engagement with local people.

[Present in graphic format – how partners link and work together]

[Present in graphic format - map our services in context of Alliance/ICS]

What does this mean for our patients?

What this means for the people we look after is that at the points in your life that you need the care of our specialists:

- We'll look after you in the way that you need, when you need it, in the place that is best for you
- We'll be as joined up as we can with everyone else who looks after you.

What does this mean for our staff?

What this means for our staff is that in many of our services we are working more collaboratively with staff from our partner organisations to provide the right service, in the right place, at the right time for our patients and members of our community. We are changing the way we are working, and joining up our care in ways that better meet the individual needs of the people we serve.

Our vision, ambitions and values

Our vision is to:

Deliver the best quality and safest care for our community

By putting our patients at the heart of our services, and working as part of the West Suffolk Alliance and the Suffolk and North East Essex Integrated Care System, we can make the greatest possible contribution to prevent ill health, increase well-being and reduce health inequalities.

This is our vision because:

- that is what our community needs and expects from us
- our staff want to deliver the highest quality care
- if we focus on quality and safety, then everything else will follow.

Boxout / case study

When we say quality, we mean care that is:

Safe – it does no harm

Effective – it works

Person-centred – it treats people as individuals and makes them feel cared for

Timely – it is provided for people at the time they need it

Efficient – there's no waste

Equitable – people get what they need regardless of their characteristics or circumstances.

Our ambitions

To *deliver the best quality and safest care for our local community* our strategy focuses on three key ambitions. They are:

- First for our patients
- First for our staff
- First for the future.

You can read more about these in the following pages.

First Trust Values

Powering our vision and ambitions are our 'First Trust Values'. They are the guiding principles and behaviours which run through our organisation and will help us deliver our vision and ambitions in the right way. We will use them to always strive to improve the services we provide to our community and the way that we work as a team and with our partners. To reflect the changes the Trust has been through in recent years, we have updated these values to reflect the evolution of the organisation, the journey it is on and the culture we are striving to create across the Trust.

They are:

Fair	We value fairness and treat each other appropriately and justly.
Inclusive	We are inclusive, appreciating the diversity and unique contribution everyone brings to the organisation.
Respectful	We respect and are kind to one another and patients. We seek to understand each other's perspectives so that we all feel able to express ourselves.
Safe	We put safety first for patients and staff. We seek to learn when things go wrong and create a culture of learning and improvement.
Teamwork	We work and communicate as a team. We support one another, collaborate and drive quality improvements across the Trust and wider local health system.

Ambition: First for our patients

Executive leads – chief nurse and director of integrated community health and adult social care

Our patients are at the centre of everything we do. The quality of care that we provide to them is our driving force. We strive to deliver the best patient outcomes and patient experience in the most appropriate setting available. We are committed to joining up services locally, collaborating with our partners and supporting our staff to make continuous improvements - no matter how big or small - that challenge us all to raise our standards.

Collaborate to provide seamless care at the right time and in the right place

- We will strive to provide a seamless experience, with good communication from beginning to end
- We will treat everyone with dignity and respect, and as quickly as possible
- We will continue to adapt to the presence of COVID so we can provide services without putting anyone at unnecessary risk of infection
- We will join up more care with our neighbouring organisations, following the West Suffolk Alliance strategy
- We will provide more care in people's own homes and in their local areas.

Use feedback, learning, research and innovation to improve our care and outcomes

- We will ensure patients and families can share their experiences, positive and negative, to help us improve through our experience of care strategy
- We will give everyone the tools and support they need to put quality and safety first, by:
    a. making sure everyone has the confidence to raise concerns and to make changes when things go wrong
    b. applying our safety and learning strategy to drive forward continuous improvement [link to document – needs publishing on website]
    c. training more staff in quality improvement methods, human factors and ergonomics
    d. sharing learning internally and looking outwards to learn from others
    e. taking care with how we use our money, staff, equipment and buildings, so we can continue to afford to invest in better care
- We will keep the good things that have come out of the Covid-19 pandemic, like the keeping in touch service
- We will do more clinical and non-clinical research, involving patients and members of the public
- We will support and celebrate new ideas and innovations in all parts of the Trust and across all teams.

Boxout / case study

Pathway achieves goals in helping patients recover at home

An innovative pathway that joins up health and care services has supported hundreds of people to be cared for at home.

'Pathway one' is an integrated way of working that helps with the safe and timely transfer of patients from the West Suffolk Hospital to their own home. Here they have an assessment of their health and care needs helping to reduce the reliance on hospital beds.

From May 2019 to March 2021, almost 1,425 patients have gone home with a pathway one referral, with their care transferred to our community therapists. Recently the service reached its target of achieving 100 discharges in a month. Overall, the pathway has saved almost 3,000 bed days at the hospital, and ensured people can achieve as much independence as possible at home whilst getting the care they need.

Responsive services team lead Jenny McCaughan explained that once wards identify a patient as being ready they are added to a dashboard providing a live list for all agencies to work from. This allows people to be discharged at a time that suits their medical needs and reduces the number of days a patient is on the ward.

"A partial assessment is done on the ward," explained Jenny, "and the team co-ordinates care and equipment requirements, but the full assessment is only done once the patient returns home. One of our community therapists and a social care colleague will assess the patient in the place where they are most comfortable." Traditionally the full assessment for therapy and care needs would have been done before leaving hospital and delayed discharge on average between one and ten days.

Jenny said: "The patient benefits under this way of working because pathway one helps as it removes steps and delays in getting patients back to their homes, and reduces risks associated with remaining in hospital. It gives the power back to the patient, and gives them a voice so that their individual needs can be met." Once at home the patient will be seen by their local community health team from day one, who regularly assess the best care for the patient going forward.

The service is a West Suffolk Alliance example of hospital and community teams working with our social care colleagues from Suffolk County Council and its Home First team for the benefit of patients.

Boxout / case study

Improvement and safety

The Trust is on a journey to develop its culture. As part of this we are continuing our work to embed quality improvement (QI) throughout the organisation.

By this we **mean the use of methods and tools to try to continuously improve quality of care and outcomes for patients.** We are creating a quality and safety framework that supports staff at all levels to build their QI skills, and explore and identify QI opportunities where they identify problems, test ideas to improve outcomes and learn from the results.

Quality improvement can be used for almost any project, big or small, clinical or non-clinical and is an ongoing process.

In addition, we are taking part in the national Patient Safety Incident Response Framework pilot, which is designed to help us further improve the quality and safety of the care we give to patients. As part of this work, we are using Trust data to help us understand and learn from the risks more common to the organisation.

We have taken on more staff to help develop our work on safety and quality improvement. With their focus, and a more joined-up approach across staff groups, we will build on work already undertaken. Involving our staff and patients in the design, management and delivery of QI, and giving them the tools and methods to do this in a more meaningful way, will help us achieve improved care, better measurable outcomes and positive patient experiences.

Boxout / case study

Research and development

Recent COVID-19 research studies carried out at the Trust recruited more than 2,700 people to take part.

Our research and development (R&D) team is funded by the National Institute for Health Research (NIHR) via the Clinical Research Network Eastern. It provides the Trust with the infrastructure to deliver high quality clinical research across the organisation.

The team consists of 10 research nurses and practitioners, supported by a dedicated office team.

Like the rest of the NHS, over the last 15 months the R&D team has concentrated on COVID-19 research, including the RECOVERY, SIREN and Clinical Characterisation Protocol studies, and the TACTIC-R trial. During this time more than 2,700 patients and staff have taken part in the various studies.

The RECOVERY trial aims to find treatments that may be help people hospitalised with suspected or confirmed Covid-19. One important discovery by the RECOVERY trial was that low-cost dexamethasone reduces death by up to one third in hospitalised patients with severe respiratory complications of Covid-19, which has been estimated to save around 22,000 lives in the UK alone.

The SIREN study looks for answers to the most important questions about reinfection and Covid-19 and how effective vaccines are. More than 600 members of staff have participated in this important research trial.

As the pandemic begins to ease in the UK and restrictions are lifted, the team is focusing on urgent Public Health research and the NIHR managed recovery programme.

Pre-pandemic, the R&D team typically participated in around 60-70 NIHR studies per year and supported NHS clinical research in more than 20 specialities.

Ambition: First for our staff

Executive leads: director of workforce and communications and medical director

We must all take good care of each other, so together we can take good care of our patients. We will strive together to build a culture of fairness, openness and learning, that is inclusive and supports all staff to be the best they can be. We want to be recognised as a great place to work.

Build a positive, inclusive culture that fosters open and honest communication

- We want everyone - no matter what role they play in the Trust - to embed a culture where everyone feels valued and listened to; where the interests of patients and staff are not at odds with one another; and where kindness, good communication and compassion towards one another are standard behaviours.
- We will deliver our first People Plan informed amongst other things by the findings of the 'What Matters To You' exercise we did with staff in the summer of 2020 [link to document – needs publishing on website]
- We will keep using this method of large-scale conversations with staff as an ongoing approach to hear how leadership in the organisation is working and how it could be better
- We will communicate and co-produce better within the Trust, with patients and families, and with the organisations we work with.

Enhance staff well-being

We knew it before - but Covid-19 has made it clearer than ever – looking after our staff is essential. Research shows that line managers play a really important role in how staff feel.

- We will do everything we can to protect and improve the health, wellbeing and safety of our staff
- We will promote the value of great line management and support and develop all our current and future line managers.

Invest in education, training and workforce development

As a learning organisation, we keep our staff up to date with best practice and train the next generation of NHS professionals. We want to help every member of staff reach their full potential in their role.

- We will maintain and build on our existing relationships with the University of Cambridge, University of Suffolk, University of East Anglia and West Suffolk College, training staff in a wide range of clinical and corporate roles
- We will provide career progression for all our staff to help them reach their potential
- We will continue to embrace new theories and platforms, such as virtual learning environments and blended learning
- We will create more new roles and use novel approaches to recruitment to reduce vacancies.

Boxout / case study

What Matters To You?

The Trust launched What Matters to You (WMTY) in 2020, a piece of work to identify how Covid-19 had impacted on our staff and ways of working. It included:

- Nearly **1,400** responses to a survey – good coverage across departments, groups, and between hospital and community staff
- **250** responses to a further survey of medical staff through our Better Working Lives Group
- **60** discovery workshops to listen further to staff experiences and ideas – good coverage across departments, groups, networks and between hospital and community staff
- More than **300** staff interactions and non-attributable feedback from our staff support psychology service.

Findings focused around five key themes:

- The importance of great line managers
- Creating an empowered culture
- Building relationships and belonging
- Appreciating all our staff
- The future and recovery.

How are we using the findings?

They have been used to inform the first West Suffolk NHS Foundation Trust **People Plan**, alongside the four priority themes of the national NHS People Plan: looking after our people; belonging in the NHS; new ways of working and delivering care; growing for the future.

The People Plan aims to prioritise the things that staff talked about, as well as identifying those actions in the national plan that will have the most positive impact at the Trust.

A central focus of the People Plan is our commitment to build an open, learning and restorative culture. The Trust is on a journey to improve and we are using the feedback from the WMTY survey and our Care Quality Commission report to guide this. We are taking steps to introduce and embed cultural change through the way that we manage employee relations and are determined to build an approach that is supportive, kind and compassionate. We believe in an open and transparent culture that supports staff to contribute freely and play a full part in our improvement. We want our colleagues to be confident to speak up and raise concerns about the care we provide, and confident that they will be treated fairly and given the time to learn from and heal when involved in patient safety incidents. There is more we can do. Over the coming years we will be working closely with staff to bring about change, for example through initiatives with our Freedom to Speak Up Guardians, the national Patient Safety Incident Response Framework, and bringing in new and improved HR policies and incident review processes. We will use findings from both the annual and quarterly NHS Staff Surveys to monitor progress.

Boxout / case study

Trust wellbeing resources for staff

The mental and physical wellbeing of our staff is a priority for the Trust.

Our occupational health team is a service supporting the health, safety and general wellbeing of all our staff in their working lives, including the annual free influenza vaccination programme. Health checks for the over 40s have also re-started. In December 2020 the Trust started to develop our vaccination drive against COVID-19, offering the first and second vaccinations to our staff and other health and social care workers from January 2020. More than 32,000 vaccines have been delivered.

We boosted our staff support psychology service, helping them to be there for anyone in need. The communications team ran a series of virtual events, from Pilates to cooking, in the first “Love Yourself Week”, an initiative that is set to continue.

The Trust has partnered with a local leisure company, Abbeycroft Leisure, to offer all staff free access to exercise classes and facilities. We have a staff physiotherapist for those needing consultation and treatment; and our education and training team ensure colleagues have access to learning about best practice to stay safe at work. We support the NHS cycle to work scheme, and encourage staff to walk or cycle to work where possible.

As well as our human resources team, there are peer support services available such as the trusted partners. Staff networks for black and minority ethnic; lesbian, gay, bisexual and trans people; people with disabilities; and those going through the menopause have been established. Access to counselling and support via Care First is available to all employees, covering a huge range of issues.

My WiSH charity has provided a range of benefits to staff, including welfare packs. Calm rooms and two marquees were furnished by the charity so that staff had somewhere to go to relax during the pandemic. Lastly, the Chaplaincy team offers friendship and support to our whole community, regardless of whether they identify as having a faith.

Boxout / case study

Investing in our staff

For Archie Libero, an endoscopy staff nurse, being a nurse was a family affair. She proudly followed in her mother’s footsteps – but that doesn’t mean it was an easy path.

Moving between the Philippines and the UK meant that although Archie completed her university nursing degree she wasn’t able to get the post-registration experience she needed to finalise her qualifications.

“Despite this,” she says, “I continued to work in healthcare. I worked in a dementia care home as a carer, then a team leader for three years until I got a job in the West Suffolk Hospital endoscopy unit as a senior endoscopy assistant.

“The education team in the Trust and my manager have been very helpful and supported me to become a UK registered nurse. Eventually, I was able to qualify for a two-year nursing degree apprenticeship programme.

“It was a very long process but the experience, skills and knowledge I have gained through the years has been invaluable to me in providing the best quality and safest care for my patients.

“The nursing profession is extremely rewarding, knowing that we are making a difference to people’s lives. I like how every day is different and love how I can help a patient get through their day. However, it can also be tough mentally, physically and emotionally.

“In early 2020 I moved to help on the winter escalation ward that was only meant to open until March, but we had to extend due to the pandemic. We were one of a few wards looking after non-Covid patients because many wards became Covid wards. There was a lot of anxiety because staff were also getting ill.

“Working through my dissertation and assignments while working full time during the pandemic was stressful but definitely a learning experience. Becoming a registered nurse has opened up a lot of opportunities for me in the nursing field. I one day hope to become a specialist nurse or a clinical nurse endoscopist.”

Ambition: First for the future

Executive lead – director of resources and chief operating officer

Advancing our digital and technological capabilities to better support the health and wellbeing of our communities is vital. We want to be at the forefront of these changes and have an opportunity to progress this through the planning of a new healthcare facility. Together with patients, public and staff, we will shape health and care services that are fit for current and future needs, helping people to stay well and get well.

Make the biggest possible contribution to prevent ill health, increase well-being and reduce health inequalities

By well-being we mean looking after the community's physical, mental, emotional, social, and economic needs. We're here to help make you better when you are ill, and to support you to help keep yourself well in the first place.

- We will adapt our services to do more to increase everyone's well-being and prevent ill health
- We will recognise and value the role you play in managing your own health and wellbeing, involving you in conversations and decisions about your health and care, moving from 'what's the matter with you?' to 'what matters to you?'
- We will maximise our social impact as an anchor institution rooted in our local community – providing training and employment opportunities for local people, buying from local businesses, supporting local charities and community groups
- We will minimise our environmental impact with our Green Plan. [link to document – needs publishing on website]

Invest in infrastructure, buildings and technology

With the expansion of our services over the last five years we now operate from just under 100 premises across Suffolk. Our main hospital building on our Hardwick Lane site is nearing the end of its life and the facilities we can offer vary considerably across our total estate. We need safe, modern, accessible buildings and the best technology to help us work well.

- We will maintain all our buildings, facilities and equipment to the best possible standard and make sure everyone has a comfortable environment to be cared for and work in
- We will finalise planning permission and detailed designs to progress the replacement of West Suffolk Hospital under the national New Hospital Programme
- We will make optimum use of the digital and medical technologies we already have available, and continue to be at the forefront of digital healthcare in the UK
- We will always have a non-digital offer for those that can't or don't want to use digital solutions
- We will sensitively, securely and responsibly use the wealth of data and information we have at our fingertips to understand quality and outcomes and tailor our care to people's needs.

Boxout / case study

New healthcare facility

In September 2019, the Government announced its Health Infrastructure Plan, which aims to deliver a long-term programme of investment in health infrastructure, including funding for 40 new hospitals.

The West Suffolk NHS Foundation Trust (WSFT) was named as one of 40 new hospitals and has started work on planning for a new healthcare facility.

This is an exciting opportunity to change the way healthcare is currently delivered in the west of Suffolk. We want to create a state-of-the-art healthcare facility that provides modern care that is fit for the future; makes the best use of digital technology throughout the building and in delivering better clinical care; and reduces our impact on the environment. This will be better for our patients, community, staff and partners.

The Trust and its partners within the local integrated care system (ICS) and West Suffolk Alliance are at the beginning of this project. We want to involve as many people as possible in the design and planning of the new healthcare facility.

At the end of 2020, we confirmed that the recently purchased Hardwick Manor had, following an extensive appraisal process, been selected as our preferred site for the new facility. The main benefits of the Hardwick Manor site:

- It is owned by the Trust
- It minimises disruption caused by re-location and allows us to continue using modern buildings on our current site, such as the Education Centre and Quince House, ensuring the best use of public funds
- It means we can still be close to co-located partners such as St. Nicholas Hospice and mental health provider Norfolk and Suffolk NHS Foundation Trust.

Next steps

We are now starting to look at how we will provide our services in the new healthcare facility – this is called the 'clinical model'. We are also doing in-depth work to look at how a new hospital on Hardwick Manor would affect our local environment – this is called an 'environmental impact assessment'. This work will inform our outline hospital designs and an application for planning consent.

The programme is overseen by a Board from across the Suffolk and North East Essex ICS. We have promised to make the new facility the most co-produced in the country – meaning that it will be designed by our people for our people.

For further information please visit https://www.wsh.nhs.uk/New-healthcare-facility/New-healthcare-facility.aspx

Boxout / case study

Sustainability

As an NHS organisation and a spender of public funds it is important that we work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities.

The Trust is currently developing its Green Plan, which replaces our current Sustainable Development Management Plan.

We will be following the NHS Green Plan guidance and addressing important issues such as reducing our carbon emissions and working towards net zero; lowering air pollution; looking at the direct impacts of our actions and the potential to improve our environmental sustainability across many areas; and our influence on local supply chain and our communities.

Some recent successes include:

- Generating energy via **Photovoltaic Panels** on our Quince House office building and our three accommodation blocks – in 2020/21 we generated 27,036 kWh and an income of £1,081.44
- Installing **LED** lighting across the main hospital and in new buildings and projects in the future. The LED lighting has improved the quality of light across the Trust, which also supports patient care. Since December 2019 we have saved 230MWh of electricity to date and £28,580.97 on our electricity bills.
- **Introducing reusable coffee cups.** As part of our response to staff wellbeing during the pandemic, free hot drinks are available for all staff based at West Suffolk Hospital. Waste data for 2020 shows that 480,000 single use cups were used at a cost of £25,910. In addition, this generated 7.68 tonnes of waste and 29 tonnes of CO2e with a disposal cost of £1,035. In March 2021, our hospital charity - My WiSH – worked with our catering department and estates energy and waste officer to distribute 5,000 reusable coffee cups, one for each member of staff. Single use coffee cups were removed from drinks machines around the hospital, but are still available in the staff restaurant. The impact on the volume of single use coffee cups is being monitored throughout 2021.
- The roll out of our **food waste scheme** (2020/2021), which diverted 33 tonnes of food waste originating from kitchen waste through the process of anaerobic digestion to create renewable energy. Not only has this led to environmental benefits, but we have also saved £1,771.25 on our waste costs.
- **Recycling** 11.28 tonnes of **plastic bottles** (2020/2021), an increase of 5.76 tonnes on the previous year. This is due, in part, to a further roll out of plastic bottle collection points in the Trust, with additional collection points planned for 2021/2022.

How we will know when we've got there?

One of the principles of continuous improvement is using measurement to know how we're getting on.

We will measure the progress we make against this strategy. We will need a wide range of measures to understand what is going well and what needs to change. We already use a lot of markers to show ourselves, our community and our regulators how we are doing, but they don't always all feel meaningful. To bring this strategy to life and to show how it relates to the people who are most important to us, we are going to focus on three key measures, one for each ambition, as well as our combined quality rating for our Care Quality Commission (CQC) assessment. This is in addition to the usual Board key performance indicators that the Trust works to.

In 2020 we were rated as requires improvement by the CQC.

We will aim for a combined CQC rating of good by 2026.

First for our patients

The Friends and Family Test is one of the ways that we ask for anonymous feedback from our patients or their carers. The test has one question: "Overall, how was your experience of our service?" Patients can rank their answers from "very good" to "very poor".

In our most recent score, 94% of people said their care was good or very good. That means 6% didn't.

We will aim for 95% of patients to recommend us as a place to receive care by 2026.

In the annual NHS staff survey, our staff are asked to rate our care against the question: "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation".

In 2020, 83% of staff said they would recommend us as a place to receive care. That means 17% wouldn't.

We will aim for 90% of staff to recommend us as a place to receive care by 2026.

First for our staff

In the annual staff survey, our staff are also asked to rate the Trust against the question: "I would recommend my organisation as a place to work".

In 2020, 74% of staff said they would recommend us as a place to work. That means 26% wouldn't.

We will aim for 81% of staff to recommend the Trust as a place to work by 2026.

First for the future

This ambition is harder to measure. We haven't got a good measure at the moment to rate our progress against all the different things we want to achieve. Many of the plans we have for the future rely on our relationships with our partner organisations, especially the members of the West Suffolk Alliance. The plans under this ambition also mean a lot to local

people and communities. To measure progress against this ambition, we will ask our Alliance partners and our community to help.

We will ask a panel of local representatives to score us once a year on how we are doing. We will work out a scoring system with their help and as soon as we have done that, we'll set ourselves an aim for what we want to achieve by 2026.

Boxout / case study

While we will always do our best to strive for 100% in scores, we have worked with our staff and Board to identify what we think are realistic targets to drive improvements, that consider previous trends and acknowledge the pressures we are facing as we emerge from the pandemic.

16. Future system board report

To APPROVE report

For Approval

Presented by Kate Vaughton

Public Board Meeting – 15 October 2021

Agenda item:	16			
Presented by:	Kate Vaughton, Director for Integration and Partnerships			
Prepared by:	Gary Norgate, Programme Director			
Date prepared:	22/09/2021			
Subject:	Update on the Future System Programme			
Purpose:	X	For information		For approval

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) of Hardwick Manor with no insurmountable issues identified to date.
2. Co-production workshops aimed at peer-reviewing and refining the initial clinical model have been progressed and continue to benefit from significant support.
3. Given the significant impact that our forecast of demand growth has upon our future schedule of accommodation, work has commenced with other parties in the National Hospitals Programme to ensure our calculations and assumptions are sound.
4. The team found time to submit an entry to the 2021 Wolfson Economics Prize which this year asks the question, "how do we design the hospital of the future". We didn't make the shortlist of finalists, however, elements of our paper (co-production, digital, integrated approach and garden hospital design) can be seen throughout the final six entrants, indicating that we are very much on the right track.
5. Leaders from the National Hospitals Programme have reached out to us for input into establishing the National Programme Management Office. We have also now scheduled a site visit for said leaders during which we hope to cement our status as a 'fast follower' and a project that has built a strong base that underpins our readiness and deliverability.
6. Following a presentation and discussion with our colleagues at the System Executive Group it is clear that we have to work as a system to ensure we collectively and effectively tackle the growing demand for services in a way that ensures the capacity of any hospital we build is not rapidly overrun.
7. As we progress towards the submission of a formal application for planning consent, our technical team have now drawn up an illustrative design typology that displays the size, form and positioning of a hospital on Hardwick Manor that provides us with maximum configurability and that will be the basis for our outline planning application.
8. A detailed and inclusive communication plan for the socialisation of this typology has been constructed.
9. Having submitted our request for the budget required to support the development of our outline business case, we expect a formal response within 4 weeks.

Business Cases and Project Plan – Further to last month's report I can now confirm that:

As reported last month, our strategic outline case (SOC) will, along with the SOC's and Outline Business Cases produced by other HIP projects, remain 'on-ice' until the National Hospital Programme can gain Treasury sign off for its overarching Programme case. That said, the recent recruits into the NHP team appear to be finding their feet and we have now been; allocated a delivery director, asked to contribute to establishing a national PMO, offered access to the central demand and capacity modelling team; approached by the market engagement director and been offered support from the national strategic communications team. Furthermore, the national and regional delivery director have now accepted our invitation to visit West Suffolk Hospital and to personally experience the reality of our situation and the opportunities that it presents.

Our application for funding has now been formally submitted. We have requested funds that will cover all of the activities required for the production of our outline business case (OBC). These costs include those professional and administrative fees associated with our planning application and the production of outline designs of our proposed facility. The most significant lines within this request are associated with technical advisors such as architects and structural engineers. Receipt of our application has been formally acknowledged and we have been told to expect a formal response within the coming weeks.

In terms of progress against the overall project plan (summary below), our key highlights are:

Town and Country Planning (purple section) – Building Typology for planning purposes was created on time and will be discussed later in this paper.

Rationalisation of SOA (Amber section) – Clinical / Architectural Engagement workshops have commenced on time and engagement remains strong.

Strategic System Solution (blue section) – Briefing sessions have commenced on-time

Outline Business Case (green section) – Zoe Selmes has commenced work on the creation of our economic and financial cases.

Strategic Analysis Of SoA	**2.6 wks**	**Tue 06/07/21**	**Fri 23/07/21**
Issue SoA (inclusive of 2031 growth modelling)	0 days	Tue 06/07/21	Tue 06/07/21
Review / Revisit SoA in Relation to "Core" Services & Type 1, Type 2 and Type 3 Accommodation &	2.2 wks	Wed 07/07/21	Wed 21/07/21
Agree "core" Type 1, Type 2 and Type 3 SoA's	2 days	Thu 22/07/21	Fri 23/07/21
Potential "Gap" Identified (at strategic level)	0 days	Fri 23/07/21	Fri 23/07/21
Town & Country Planning	**25 wks**	**Fri 23/07/21**	**Fri 28/01/22**
Agree / Issue 100,000m2 (Max) "Core" SoA to Support Planning Process	0 days	Fri 23/07/21	Fri 23/07/21
Review Building Typologies Against 100,000m2 SoA	1 wk	Mon 26/07/21	Fri 30/07/21
Finalise Building Typology Report	0 days	Fri 30/07/21	Fri 30/07/21
Review Building Typology Report with Stakeholders	2 wks	Mon 02/08/21	Fri 13/08/21
Building Typology Agreed for Planning Purposes	0 days	Fri 13/08/21	Fri 13/08/21
EIA Progression and Planning Design	17 wks	Mon 16/08/21	Fri 10/12/21
Public Engagement (Round 2)	6 wks	Mon 01/11/21	Fri 10/12/21
Collation of Application & Legal Review	5 wks	Mon 13/12/21	Fri 28/01/22
Submit Application	0 days	Fri 28/01/22	Fri 28/01/22
Rationalisation of SoA	**19.4 wks**	**Mon 26/07/21**	**Tue 07/12/21**
Scene Setting Briefings	1 wk	Mon 26/07/21	Fri 30/07/21
Phase 3 Clinical / Architectural Engagement	14.4 wks	Mon 02/08/21	Tue 09/11/21
Review Results of Rationalisation Process and Prepare Report on SoA & "Gap"	4 wks	Wed 10/11/21	Tue 07/12/21
Real "Gap" Confirmed	0 days	Tue 07/12/21	Tue 07/12/21
Strategic "System" Solution	**47.2 wks**	**Mon 26/07/21**	**Mon 04/07/22**
Arrange / Progress System Wide Briefing Sessions to Clarify / Agree Process	6 wks	Mon 26/07/21	Fri 03/09/21
System Wide Resolution for "Gap" (as Phase 3 Clinical Engagement Emerges)	13.4 wks	Mon 06/09/21	Tue 07/12/21
System Wide Resolution / Finalisation of "Gap" including Economic Modelling (Once Phase 3 Engagement is Complete)	27.8 wks	Wed 08/12/21	Mon 04/07/22
Outline Business Case	**63.6 wks**	**Wed 08/12/21**	**Mon 20/03/23**
Prepare OBC design for "Core" Services to be Delivered on Hardwick Manor	27.8 wks	Wed 08/12/21	Mon 04/07/22
Commence Economic & Financial Modelling (based on SoA's)	8 wks	Tue 07/06/22	Mon 01/08/22
Finalise Capital Costs	4 wks	Tue 05/07/22	Mon 01/08/22
Finalise Economic & Financial Case (based on Final Capital Costs)	8 wks	Tue 02/08/22	Mon 26/09/22
Finalise OBC Drafting	1.8 wks	Tue 27/09/22	Fri 07/10/22
OBC Approvals / Governance	8 wks	Mon 10/10/22	Fri 02/12/22
NHSE/I Approval	14 wks	Mon 05/12/22	Mon 20/03/23
Full Business Case (FBC)	**99.8 wks**	**Mon 07/11/22**	**Fri 11/10/24**
Construction & Occupation	**168 wks**	**Mon 14/10/24**	**Mon 03/01/28**

Estates–

We continue to progress our environmental impact analysis without identifying any significant concerns. This work remains on track for completion in December 2021. Similarly, the translation of our agreed heads of terms covering the rental of neighbouring fields for use as a site compound and estates road into a legally binding contract is set for a timely completion in October (in time for the second phase of our public planning engagement).

That said, the most significant advancement has been in the development of our proposed site typology.

Said typology, termed “Pavilions in the Park”, has been developed considering; the outline clinical design, modern methods of construction, the ecology and profile of our site, our neighbours and the desire to provide a stunning patient and staff experience. The chosen form and massing have been

specifically prepared in support of our outline planning application and provide us with maximum future flexibility. The level of detail being prepared goes beyond the minimum required for a planning application and as such is further evidence of our open / transparent / sharing approach as well as the maturity of our programme.

Clinical / Digital Workstream –

From March to July 2021, phase 2 of the clinical co-production developed the Strategic Outline Case model further to create 29 service visions. These service visions have been seen and scrutinised by the peer review panel (deputy directors), the community engagement group and the ACE learning disabilities forum.

Within the Outline Business Case plan, we have until the end of March 2022 to work up the collective system-wide plans about how to improve internal ways of working, relocate or transform services with alliance partners and the rest of the ICS, and prevent acute illness sufficiently to make a reasonable-sized, sustainable district general hospital viable.

With this challenge in mind:

- Hospital workstream – Phase 3 of our clinical co-production process seeks to rationalise and de-duplicate the service visions by exploring concepts such as 'zonal hubs' and assessing the ability of the latest digital techniques to improve spatial efficiency.
- Community Workstream - Our health planners Adcuris have commenced constructing a demand and capacity model for community services to help us understand the contribution an enhanced community services model could make to reducing demand for acute care, and the concomitant increase in resources that would be required to make that enhanced model possible. This is using and building upon the existing alliance work-up of the integrated neighbourhood team model (anticipatory and responsive services). The results will be ready towards the end of November / beginning of December. Alongside, the community co-production group will continue to develop the whole system service vision for the various aspects of that enhanced community model, including frailty assessment, end of life care and discharge to optimise and assess.
- Primary Care workstream – Based on suggestions that came out of phase 2, our primary care co-production leads are developing a method to co-produce viable alternatives to hospital-based care.

Alongside the individual workstreams, and incorporating intelligence from each of them, the demand and capacity model will also continue to be explored and refined. At the end of phase 3 we will bring all the outputs together into the next iteration of the schedule of accommodation.

Communications and Engagement –

Earlier this year, the first phase of planning engagement was launched in order to gather people's views about the preferred site, Hardwick Manor. In total more than 800 feedback forms were received and 150 people spoke to us both face to face and virtual events. We reached nearly 60,000 people online via organic & paid-for social media posts and adverts (59,655 to be exact) and we received nearly 7,000 hits to the website (6,681).

Feedback received from this exercise clearly highlights that the major concern among our public is 'access' (traffic, travel and parking).

With this in mind we have now built the content and structure for our next phase of planning engagement where we are hoping to share:

1) Our outline typology
2) Results from our traffic surveys
3) Options for site ingress and egress
4) Initial plans for parking (recognising that we will not be able to confirm these plans until our outline business case is signed off and the future of the Hardwick Lane is agreed).

Key messages for our second phase will be:

- Our project remains at an early stage of development
- We are applying for outline planning permission at this relatively early stage in order to reduce the risks of delay to future milestones and deliverables
- The illustrations and plans shown are indicative and adaptable to our changing clinical needs and provide flexibility for the future.

Our second phase of engagement will launch on Monday 1 November and run until Sunday 12 December. It will provide an update on the progression of the project and also include initial plans and illustrations setting out what might be possible to deliver on the site, as well as how feedback gathered at the first round of engagement has helped to influence and shape our early outline proposals. Our approach and methods of communication seek to engage as widely as possible within the local community and surrounding towns and villages given that people who use the hospital live across West Suffolk and across the border in Thetford. We will employ the fullest range of digital and traditional methods for gathering feedback to ensure responses are maximised. These include:

- Face to face events planned for Bury St. Edmunds, Newmarket, Thetford, Haverhill, Sudbury and Stowmarket
- Virtual meetings held for local residents, staff and the general public
- 4-page leaflet posted to the community and feedback form for all pop-up events.
- Articles placed in established project newsletter with a circulation of more than 200 people.
- Community pop-up events in Bury St Edmunds, Haverhill, Thetford and Newmarket, Sudbury and Stowmarket (pop up events for staff are also being arranged for the Hardwick Lane and

Newmarket hospital bases).

- Social media adverts to publicise the engagement events and drive traffic to the website.
- Organic social media posts.
- Stakeholder meetings with Parish Council, Town Council, West Suffolk Councillors, Suffolk County Councillors and MPs.
- Dedicated project website (including an online feedback form).
- Press releases to local media.
- Freepost address and project email address.
- Opportunity shared with members of the community engagement group, trust members, governors, charitable donors, volunteers, VOICE group and staff through existing channels.

This engagement approach underlines the commitment to the local community and surpasses the requirements set for planning engagement by the local planning authority. For phase 2 we have encompassed lessons learnt and will also be:

- Running additional face to face events at Brandon and Mildenhall as requested by local councillors
- Introducing a "sensory hour", this will be the first hour at each of our face to face events and include sensitive lighting, a limit on numbers and will be quieter.
- Working with our ICS colleagues to share the opportunity in primary care practices and with patients as well as the local LPC requesting they display information in their pharmacies.
- Working with students at West Suffolk College to develop promotional videos for social media

Information on the proposals and an online feedback form will be available on the dedicated website. To make sure everyone has a chance to share their views and get involved, the online form will be compatible with screen readers and the language will be able to be amended. Hard copy versions of the feedback form will be posted to households most affected by the proposals and will be available at each face-to-face engagement event. The feedback form will be provided with a return freepost address and will be available in an easy read format. For those not sent a copy, hard copy versions of the information and feedback form can be requested. Our materials will be translated into Polish and Portuguese.

This year's Wolfson Economics Prize posed the question, "how do we build the hospital of the future". With such a question in mind, our team felt compelled to submit our thoughts. Our submission had four central planks: a) hospitals should be co-produced by the community for the community, 2) a system wide approach is essential, c) we should be building garden hospitals that leverage the environment to aid recovery and d) digital enablement is key. Multi-national competition was fierce and, ultimately our submission wasn't shortlisted among the final 6, however, the ideas put forward by the finalists have several parallels to our own thinking i.e. hospitals should be; interwoven with communities, green with gardens, beautiful places to be proud of, green hospital design, the hospital imagined as the community, hybrid physical / digital ecosystem, hub models, so I am convinced we remain on the right track (hindsight is a wonderful thing, I sincerely believe that if we had chosen one of our four themes and focussed our submission around it, we would have made the final – but I would say that wouldn't I !!). More information on the finalists and the prize itself can be found at https://policyexchange.org.uk/wolfsonprize/ and copies of our humble submission are available upon request. May I offer huge thanks to those who contributed – if nothing else it was a really fun thing to do (it's not as if I'm competitive…… I just hate losing!).

Finance

As well as building our submission for funding, we are starting to build the plan for the construction of our economic and financial cases. These are the two key elements of the outline business case in which we are expected to layout which of our shortlisted options (BAU/Do Minimum (45k sqm), Do minimum plus (65k sqm), Hot site only (58k sqm + Cold site), Preferred (build a new hospital on Hardwick Manor ~75k sqm) and Do maximum (greenfield site)) makes best economic sense and how much we expect

this preferred option to cost.

Creation of these cases represent a huge amount of work and needs to happen in parallel with the development of our clinical model (which will largely inform the space required), the securing of planning permission, the 1:200 design of our proposed facility, the development of our procurement strategy and our contribution to the system-wide transformation work that ensures sustainability. Busy times ahead!

All in all, this is a period in which significant progress has been made in:

- The co-production / co-refinement of our clinical design.
- Our ability to fund the development of our business case.
- The development of our typology.
- The continued engagement of our community. and
- The development of a system wide approach to ensuring a sustainable service.

Next month, we see the continuation of staff and public engagement through the execution of Phase 3 of our Co-production process, the building of momentum for an ICS solution to our growth conundrum and the start our next phase of planning engagement.

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

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

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

Recommendation:

To note the report

11:35 GOVERNANCE

17. Risk Appetite Statement

To APPROVE the statement

For Approval

Presented by Ann Alderton

Board of Directors – 15 October 2021

Agenda item:	17			
Presented by:	Ann Alderton, Interim Trust Secretary			
Prepared by:	Ann Alderton, Interim Trust Secretary			
Date prepared:	21 September 2021			
Subject:	Risk Appetite Statement			
Purpose:		For information	X	For approval

Executive summary:

The Trust's risk appetite statement is a description of the type and amount of risk that the Trust is willing to tolerate to achieve its objectives.

The risk appetite statement is determined by the Board of Directors based on the nature and extent of the principal risks that the organisation is exposed to. It ensures that board decisions are consistent, 'risk- informed' and aligned with the Trust's strategic aims and it also supports robust corporate governance by setting clear risk- taking boundaries. When faced with difficult choices that might expose the Trust to different categories of risk, it will help the Board to prioritise the most important.

Following a Board risk workshop on 3 September 2021, the Board of Directors revised its risk appetite from the version approved by the Board in September 2020. The main change made was to separate Quality into its three component parts – Patient Safety, Patient Experience and Clinical Effectiveness – so as to reflect the different risk priority assigned to each.

Once approved by the Board, the Risk Appetite Statement will be incorporated into the Trust's Strategy and Policy for Risk Management.

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:	Board of Directors and Audit Committee September 2020

Risk and assurance:	This is part of the Trust's Strategy and Policy for Risk Management
Legislation, regulatory, equality, diversity and dignity implications	FT Code of Governance requirement
Recommendation: To approve the Risk Appetite Statement.	

Risk Appetite Statement 2021/22

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

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

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

Quality (Patient Safety)
The Board has a minimal risk appetite when it comes to decisions relating to patient safety, on which it places a very high priority. This means that we expect services to be delivered safely resulting in no harm to patients.

Quality (Patient Experience)
The Board has a cautious risk appetite when considering the effect a decision may have on the patient's experience of our services. This means that we expect patients to receive a positive experience whilst receiving services (as measured through the Friends and Family test and levels of complaints and compliments received). However, there will be times where other constraints prevail and safety will be prioritised over experience.

Quality (Clinical Effectiveness)
The Board expects the principle of "no harm" to be at the heart of every decision it takes relating to patient care and treatment and has a cautious risk appetite. It is prepared to accept some risk if, on balance, the benefits are justifiable and the potential for mitigation is strong. When taking decisions involving choices between a wide range of outcomes, it will prioritise the option resulting in the greatest aggregate benefit for the most patients.

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

Workforce

The Board has a cautious to flexible risk appetite when taking decisions relating to the workforce. Whilst it is prepared to take bold decisions relating to organisational change and which might have an effect on staff morale if there are compelling arguments supporting change, it places a high value on supporting an innovative, diverse and inclusive workplace which empowers people and drives cultural change. It places a high priority on being an involving and caring employer that encourages its staff to engage with and value colleagues, patients and stakeholders and to speak out when its values and culture are under threat.

Reputation

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

Commercial

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

18. BAF Summary – October 2021

To APPROVE report

For Approval

Presented by Ann Alderton

Board of Directors – 15 October 2021

NHS West Suffolk NHS Foundation Trust

Agenda item:	18			
Presented by:	Ann Alderton, Interim Trust Secretary			
Prepared by:	Ann Alderton, Interim Trust Secretary			
Date prepared:	21 September 2021			
Subject:	Board Assurance Framework			
Purpose:	X	For information		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.

At the previous meeting, BAF risks were allocated to the Board Committees. These have now been incorporated into future work programmes. Also, the Board recommended two risks for de-escalation as follows, which, following review by Improvement Committee and Involvement Committee respectively, have now been removed from the BAF.

There have been no other updates to the BAF and the current BAF is presented to the Board for information. Once the revised risk appetite statement has been approved, the BAF risks will be reviewed individually with the executive team and an updated report brought to the December meeting.

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 note the updated BAF and the following:

- 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

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.

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

Appendix 2 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 has been reviewed and will now 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
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**	2. 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
		3. 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
		4. 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
		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	Quarterly x Major = Red
		6. 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**	7. 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	
Scrutiny	**Identifies, oversees and monitors status of risks associated with major projects, investments and business cases**	8. 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
		9. 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

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 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
3. 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
4. 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
5. 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
6. 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
7. 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
8. 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
9. 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		

19. Governance report

To APPROVE the report

For Approval

Presented by Ann Alderton

Board of Directors – 15 October 2021

Agenda item:	19			
Presented by:	Ann Alderton, Interim Trust Secretary			
Prepared by:	Ann Alderton, Interim Trust Secretary			
Date prepared:	23 September 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. 147 – Lease between WSFT and West Suffolk Council relating to Mildenhall Health Hub, forming part of Mildenhall Hub, Sheldrick Way, Mildenhall IP28 7JX – Sealed by Susan Wilkinson & Paul Molyneux, witnessed by Daniel Moss (27 August 2021).

   Seal No. 148 – Variation agreement between Surrey & Borders Partnership NHS FT, WSFT, Leeds & York Partnership NHS FT, Guy's & St Thomas' NHS FT and the Collaborative Procurement Partnership LLP – Sealed by Craig Black & Helen Beck, witnessed by Karen McHugh (6 September 2021).

3. **Annual Members Meeting**
   The Annual Members' Meeting took place virtually for the second year running. In addition to the official business of receiving the Annual Report and Accounts for 2020/21, the meeting featured discussion of the Trust's experience at the front line of the pandemic and plans for the future.

4. **Directors' Remuneration**
   The Remuneration Committee met on 23 September and confirmed the uplift in remuneration for the Interim Chief Executive and Interim Director of Resources.

   The committee also discussed and approved a 3% uplift for the substantive Executive Directors backdated to 1 April 2021. This uplift does not apply to the interim roles and the future Chief Operating Officer, whose remuneration were set after 1 April but does apply to the remuneration of the Director of Resources prior to commencing his duties as Interim CEO.

5. **Terms of Reference**
   At the previous board meeting the terms of reference of the Involvement Committee and the Remuneration Committee were approved subject to review by those committees themselves. These reviews are now complete and no further changes were made.

6. **Governor Training Away Day**
   Governors and Non-Executive Directors met off-site for a training day on 22 September. For the governors appointed at the November 2020 elections, this was the first opportunity for them to meet

with many of their governor and NED colleagues face to face and to start building a working relationship between the Council of Governors and the Board of Directors. The Interim Trust Secretary shared the headlines from the recent Governor self-assessment survey and the proposed governors' work programme for the duration of this Council's term until November 2023 in advance of a more detailed report at the 13 October meeting of the Council.

7. **Governors' Work Programme – Strategic Briefings (for information – Annex B)**
We have prepared a draft programme of Governor/Director Strategic Briefings to support the Council of Governors in the fulfilment of its statutory duties. The objective of these briefings is to establish a shared understanding of the Board's strategic priorities and the principal risks to their achievement and to encourage an honest and open conversation about any challenges and difficult choices underpinning the Board's decisions. We feel that these sessions are important to ensure that we have a well-informed Council with a comprehensive understanding of the work of the Board and a sound basis against which to hold the NEDs individually and collectively to account for the Board's performance. These will be taking place from late October onwards.

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

Recommendation:

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

Annex A: Scheduled draft agenda items for next meeting – 17 December 2021

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

- Senior Leadership Team report - Remuneration committee report - Risk appetite statement - Scope for well led developmental review					
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

Annex B: Council of Governors' Strategic Work Programme (Draft)

Timing	Themes	Rationale	Led by
Oct 2021	Covid Recovery – the elective accelerator programme, what it is and what it means for the Trust, its patients and its staff	Interests of members and the public	Interim Chief Executive Chief Operating Officer, Insight Committee
Nov 2021	RAAC plank risks	Highest ranked risk in the Trust's Risk Register	Interim Chief Executive, Interim Director of Resources, Scrutiny Committee
Nov 2021	Rapid review report – next steps (timing may change depending on actual date of publication)	Important learning for culture and engagement	Chair, Senior Independent Director, Director of Workforce, Freedom to Speak Up Guardians
Dec 2021	Health and Social Care in Suffolk – Integrated Care and what it means	Interests of members and the public	Chief Executive, Director of Integrated Services, Chief Operating Officer
Jan 2022	Freedom to Speak Up Briefing	Interests of members and the public	Chief Executive, Director of Workforce, FTSU Guardians
Feb 2022	The People Plan	Interests of members and the public	Director of Workforce, Chief Nurse
March 2022 and beyond	Forward plan for 2022/Future System/ Annual Report/ Quality Report/ Agree 2022-23 work programme	Interests of members and the public	Chief Executive, Director of Resources, Trust Secretary

11:45 ITEMS FOR INFORMATION

20. 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

21. Date of next meeting

To NOTE that the next meeting will be held on 17 December in West Suffolk Hospital

For Reference

Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

22. 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