Board of Directors (In Public)

Schedule	Friday 17 December 2021, 9:15 AM — 12:15 PM GMT
Venue	Via video conferencing
Description	A meeting of the Board of Directors will take place on Friday, 17 December 2021 at 9:15am. The meeting will be held virtually via video conferencing 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".
Organiser	Karen McHugh

Agenda

AGENDA
Presented by Sheila Childerhouse

WSFT Public Board Agenda - 17 December 2021.docx

1. GENERAL BUSINESS
   Presented by Sheila Childerhouse

1.1. Apologies for absence:
   To Note - Presented by Sheila Childerhouse

1.2. Declaration of interests for items on the agenda
   To Assure

1.3. Minutes of the previous meeting - 15 October 2021
   To Approve - Presented by Sheila Childerhouse

Item 1.3 - Open Board Minutes 2021 10 15 Oct Draft.docx

1.4. Action log and matters arising
To Review

Item 1.4 - Board action points - Complete.pdf

Item 1.4 - Board action points current.pdf

1.5. Staff story - Patient Safety Specialists
To Note - Presented by Susan Wilkinson

1.6. Chief Executive's report
To inform - Presented by Craig Black

Item 1.6 - CEO Board report December 2021.docx

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2. FIRST FOR PATIENTS - ASSURANCE

2.1. Insight Committee Report - November & December 2021 - Chair's Key Issues from the meetings
To Assure - Presented by Richard Davies

Item 2.1 - Insights Chairs key issues - November and December 2021 meetings.docx

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2.2. IQPR - September & October 2021 data
To Note - Presented by Susan Wilkinson and Nicola Cottington

Item 2.2 - IQPR - data for September 2021.pdf

Item 2.2 - IQPR - data for October 2021.pdf

2.3. Improvement Committee Report - November 2021 Chair's key issues from the meeting
To Assure - Presented by Jude Chin

Item 2.3 - 21-10-11 - Chairs key issues - Improvement Committee report for board - October 2021.docx

Item 2.3 - 21-11-08 - Chairs key issues - Improvement Committee report for board - November 2021.docx

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2.4. Maternity services quality & performance report

To Assure - Presented by Susan Wilkinson and Karen Newbury

- Item 2.4 - December 2021 Maternity Quality Safety Perfomance Board Report.docx
- Item 2.4 Annex A - West Suffolk Maternity Team Survey Results Oct 2021.pptx
- Item 2.4 Annex B - Safety Action 10 HSIB ENS compliance Q2.docx
- Item 2.4 Annex D - Training needs analysis and tracker.pptx
- Item 2.4 Annex E - Safety Action 8 - MDT Training Plan 2021.docx
- Item 2.4 Annex F - Safety Action 5 Midwifery Staffing Report April to September 2021.docx
- Item 2.4 Annex G - Neonatal Transitional Care Audit Q2 2021.docx
- Item 2.4 Annex H - 2021 ATAIN Quarter 2 progress report.docx

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2.5. Infection prevention and control assurance framework

To Assure - Presented by Susan Wilkinson

- Item 2.5 - 2021 12 17 Board Report Covid process review.docx
- Item 2.5 - 21-12-17 COVID IPC assurance framework.docx
- Item 2.5 - IPC BAF.docx

2.6. Nursing staffing report

To Assure - Presented by Susan Wilkinson

- Item 2.6 - Nurse staffing report - September October 2021.docx

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2.7. Quality and Learning Report

To Assure - Presented by Susan Wilkinson

- Item 2.7 - 21-12-17 Quality and Learning report.docx

10.30 am - Comfort Break - 10 minutes

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3. FIRST FOR STAFF - CULTURE

3.1. Involvement Committee Report - November 2021

To Assure - Presented by Alan Rose

Item 3.1 - Chair's Key Issues - Involvement Committee - November 2021.docx

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3.2. People & OD highlight report

To Assure - Presented by Jeremy Over

Item 3.2 - People OD highlight report December 2021 FINAL.doc.docx

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3.3. Medical revalidation annual report

To Note - Presented by Paul Molyneux

Item 3.3 - Medical revalidation annual report.docx

3.4. Guardian of safe working report

To Assure - Presented by Paul Molyneux

Item 3.4 - Safe staffing guardian report coversheet July - September 2021.doc

Item 3.4 - Safe staffing Guardian Quarterly Report July - September.docx

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4. FIRST FOR THE FUTURE - STRATEGY

4.1. The Green Plan

To Approve - Presented by Craig Black

Item 4.1 - The Green Plan - WSFT Trust Board December 2021.docx

Item 4.1 - Green Plan 2021-25.pdf

4.2. Future system board report

To inform - Presented by Craig Black

Item 4.2 - Future system Public Board update December 2021.doc

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5. GOVERNANCE

5.1. BAF Summary
To Assure - Presented by Ann Alderton

Item 5.1 - BAF Summary.docx

5.2. Governance report
To inform - Presented by Ann Alderton

Item 5.2 - December Governance Report.docx

Item 5.2 Annex D - WSFT Annual Board Report and Statement of Compliance July 2021-3.docx

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5.3. West Suffolk NHS Foundation Trust Constitution
To Approve - Presented by Ann Alderton

Item 5.3 - Trust Constitution-cover sheet & summary.docx

Item 5.3 - WSFT Constitution December 2021 review - final with highlighted changes.docx

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6. ITEMS FOR INFORMATION

6.1. Questions from Governors and the Public
To Note - Presented by Sheila Childerhouse

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7. Any other business
To Note

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8. Date of next meeting - 28 January 2022
To Note - Presented by Sheila Childerhouse

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 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

AGENDA

Presented by Sheila Childerhouse

NHS
West Suffolk
NHS Foundation Trust

WSFT Board of Directors – Public Meeting

Date and Time	Friday, 17 December 2021 9:15 – 12:15
Venue	Microsoft Teams
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".	

Time	Item	Subject	Lead	Purpose	Format
1.0 GENERAL BUSINESS					
09.15	1.1	Apologies for absence	Chair	Note	Verbal
	1.2	Declarations of Interests	All	Assure	Report
	1.3	Minutes of meeting – 15 October 2021	Chair	Approve	Report
	1.4	Action log and matters arising	All	Review	Report
09:20	1.5	Staff Story – Patient Safety Specialists	Chief Nurse	Note	Verbal
09:35	1.6	CEO Report	CEO	form	Report
2.0 FIRST FOR PATIENTS - ASSURANCE					
09:45	2.1	**Insight Committee Report** – November and December 2021 – Chair's Key Issues from the meetings	NED Chair	Assure	Report
	2.2	IQPR – September and October 2021 data*	COO/ Chief Nurse	Note	Report
10:00	2.3	**Improvement Committee Report** – November 2021 Chair's Key Issues from the meeting	NED Chair	Assure	Report
	2.4	Maternity services quality and performance report	Chief Nurse	Assure	Report
	2.5	Infection prevention and control assurance framework	Chief Nurse	Assure	Report
	2.6	Nurse Staffing Report	Chief Nurse	Assure	Report
	2.7	Quality and Learning Report	Chief Nurse	Assure	Report
10:30 Comfort Break					
3.0 FIRST FOR STAFF - CULTURE					
10:40	3.1	**Involvement Committee Report** - November 2021	NED Chair	Assure	Report
	3.2	People and OD Highlight report	Director of Workforce	Assure	Report
11:00	3.3	Medical Revalidation Annual Report#	Medical Director	Note	Report
11:05	3.4	Guardian of Safe Working Report	Medical Director	Assure	Report
4.0 FIRST FOR THE FUTURE - STRATEGY					
11:15	4.1	The Green Plan	CEO	Approve	Report
11:45	4.2	Future System Board Report	CEO	Inform	Report
5.0 GOVERNANCE					
12:00	5.1	BAF Summary	Trust Secretary	Assure	Report
12:05	5.2	Governance Report	Trust Secretary	Inform	Report
12:10	5.3	West Suffolk NHS Foundation Trust Constitution*	Trust Secretary	Approve	Report

** These reports were reviewed, discussed and endorsed by the relevant Board committee and the committee provided an assurance overview in the report to the Board*
 # This report was circulated and approved using the Board's emergency powers

Time	Item	Subject	Lead	Purpose	Format
6.0 OTHER ITEMS					
12.15	6.1	Questions from Governors and the Public	Chair	Note	Verbal
	6.2	Any Other Business	All	Note	Verbal
	6.3	Date of next meeting **28 January 2022**	Chair	Note	

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 remainder of this meeting having regard to the confidential nature of the business to be transacted, publicly on which would be prejudicial to the public interest" Section 1(2) Public Bodies (Admission to Meetings) Act 1960

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 # This report was circulated and approved using the Board's emergency powers

Board Context

Trust Board Purpose
The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

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

Our Trust Values	
Fair	We value fairness and treat each other appropriately and justly.
Inclusivity	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.

Our Risk Appetite

1. GENERAL BUSINESS

Presented by Sheila Childerhouse

1.1. Apologies for absence:

To Note

Presented by Sheila Childerhouse

1.2. Declaration of interests for items on the agenda

To Assure

1.3. Minutes of the previous meeting - 15 October 2021

To Approve

Presented by Sheila Childerhouse

DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 15 OCTOBER 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 Finance	•	
Paul Molyneux	Interim Executive Medical Director		•
Jeremy Over	Executive Director of Workforce and Communications	•	
Louisa Pepper	Non Executive Director	•	
Alan Rose	Non Executive Director	•	
Sue Wilkinson	Executive Chief Nurse	•	
In attendance			
Ann Alderton	Interim Trust Secretary		
Helen Davies	Head of Communications		
Georgina Holmes	Trust Office Manager *(minutes)*		
Chris Lake	Integrated Development Ltd		
Clement Mawoyo	Director of Integrated Services		
Daniel Spooner	Deputy Chief Nurse		
Governors in attendance (observation only): Allen Drain, Liz Steele, Clive Wilson			

Action

GENERAL BUSINESS

21/162 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.

21/163 APOLOGIES FOR ABSENCE

Apologies for absence were noted as above.

- The Chair welcomed everyone to the meeting and apologised that this meeting was still having to take place virtually. She hoped that the next meeting could be face to face and available options were being looked into, however this would also depend on the Covid situation.

21/164 DECLARATION OF INTERESTS FOR ITEMS ON THE AGENDA

No declarations of interest were received.

21/165 QUESTIONS FROM THE PUBLIC RELATING TO MATTERS ON THE AGENDA

Q In view of the very clear Trust Strategy to be 'First' on the core objectives, is it acceptable that in being 'First for the Future' the Trust had an ambition of a CQC Rating by 2026 of 'Good' (Page25). Surely to be First the rating needed to be 'Outstanding'?

A The board had discussed this in depth. 'First' represented the Trust's values rather than a position in a competition. The metrics in the strategy document had been co-produced and reflected the collective views of a number of stakeholders. There had not been unanimous agreement about what the target should be, however it was felt that 'good' was entirely in the Trust's control and achievable. 'Outstanding' was not totally in the control of the Trust and would partly depend on the views of inspectors on the day. In addition, aiming to achieve 'outstanding' should not be at the cost of everything else and take the focus away from other challenges and issues within the organisation.

Q I was very impressed with what Professor Michael West had to say at the 5 o'clock club and it made me think about our reactions to challenges. The maternity whistleblowing being one and has created a subject that we are all talking/thinking about. The scrutiny on Maternity itself has created a lot of report writing which, I am sure, creates stress and anxiety to those producing it. If it is a given that we have to do this, could we now be bold and concentrate on the needs of our teams and the needs of our leaders, and in doing so resolve issues that face us?

A There was an industry, particularly in maternity, which required the production of a lot of reports, including those required nationally and by the regulator. However, with regard to the whistleblowing incident it was important not to produce action plans for the sake of action plans. This was more about improving services rather than writing endless reports and placing an additional burden on the teams. This needed to be looked at in a different way through the involvement committee.

21/166 REVIEW OF AGENDA

The agenda was reviewed and there were no issues.

21/167 MINUTES OF MEETING HELD ON 3 SEPTEMBER 2021

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

21/168 MATTERS ARISING ACTION SHEET

The ongoing and completed actions were reviewed and there were no issues.

21/169 PATIENT STORY

- The Chair welcomed and introduced Jane Sharland who was presenting this story on behalf of the community team, together with Denise Sacker, Integrated Neighbourhood Team (INT) coordinator and Kate Foxwell, community matron.
- In November 2019 a virtual ward had been set up which was managed by the Newmarket community team and with the aim of getting patients out of hospital quicker or supporting people at home so they did not have to go into hospital. It soon became about keeping people at home rather than getting people out of hospital
- This model had now been embedded across the community teams and had been renamed the enhanced support at home service.

- The story was about a gentleman who was originally referred to community physio following a fall and whose main goal was to regain some of his independence and be able to do his own admin again. His wife was his main carer and finding this very difficult. He also had a private once a day care package. There were also issues about the positioning and availability of power sockets in his home which made it difficult to connect necessary equipment to make things easier for him and his wife.
- Due to his health issues and the challenges in his home environment the decision was made to admit him to the enhanced care service and the professionals involved in his care met twice weekly. This was discussed and agreed with the patient and his wife.
- The care provided to the patient through the enhanced service was explained, including a twice daily care package and setting up the telehealth monitoring system due to his heart condition. However, due to his condition it was decided to admit him to the Rosemary Ward at Newmarket hospital for a period so that he could receive intensive therapy.
- Since being discharged his condition and mobility had improved and he had achieved his goal of sitting up and being able to do his own writing and admin. His next goal was to be able to walk out into his garden.
- He had been discharged from the enhanced support service but remained under the care of the Newmarket integrated neighbourhood team.
- This story highlighted the co-ordinated working between different care providers which enabled patients and their families to build up trust with professionals. It encapsulated what community care was all about and prevented a crisis occurring for patients.
- A letter had been received from the patient's wife in which she said that the care provided to her husband by the whole team involved in looking after him had been outstanding.

Q There appeared to be some frustration about the issue with power sockets in the patient's home to enable a mattress to be plugged in. Was it possible to find an electrician to solve this problem?

A The team worked closely with social services who had links with electricians etc. However, in this case it would have been very difficult due to the dynamics of the situation. The team tried to meet everyone's needs on an individual basis but this was not possible in this case.

Q There was only one community hospital in the alliance. Had the teams talked about rolling out this type of service in other areas, eg Sudbury, Haverhill etc?

A There were community beds in these areas, even though they did not have a community hospital; people could also go to Newmarket hospital. There was an enhanced support service in most of the areas of the alliance, using community beds, eg Hazel Court and Glastonbury Court.

The board thanked Jane, Denise and Kate for attending the meeting today and for all the work they and the teams were doing.

21/170 CHIEF EXECUTIVE'S REPORT

- Craig Black referred to the significant pressure that the organisation was currently facing which was similar to other parts of the system.

- The Trust had recently experienced the busiest days ever in the emergency department. Looking forward towards winter this created a level of concern in the organisation which would be reflected in other reports at the meeting today. Social care was also busier than ever before.
- He referred to the maternity whistleblowing incident and said that it was better that people spoke out than they didn't, although they might have chosen a different way. He would not want people to feel that they could not speak out and he thanked them for doing so as it showed they shared the Trust's values in providing the best quality of services possible.
- The issues that were highlighted, particularly around staff shortages, were something that the board had been discussing for a while and were concerns that they shared. The Trust, and NHS as a whole, needed to get much better at predicting what demand would be and ensuring that appropriate workforce plans were in place.
- It appeared that the external review would be published soon and it was now in the Maxwellisation process, which gave individuals who were criticised in the report the opportunity to challenge the fairness and factual accuracy. This process would be completed by the end of October and then the review team would need to respond to this.
- The vaccination programme was fully operational and this week over 1000 staff had been vaccinated. This programme would continue until the end of the first week in November with the aim of getting all staff vaccinated.

Q There were mixed messages coming out of the board papers and from interaction with people re the morale of staff. What was Craig's view on this as he went around the organisation and how was he responding to this?

A Craig was also getting mixed messages. Staff were still very passionate about the work they did, however things were very tough in the organisation and the level of demand meant that they could not provide the level of service they would like to for a number of reasons.

The executive team had discussed how to respond to staff, ie there was a balance between providing hope and optimism and trying to reflect the dilemma and challenges they were currently facing. The Trust was working across a number of areas to try and make things better but it was not going to feel great as the organisation moved into winter. He was not ignoring the reality and actions being taking to improve things but also looking into the future with the future system programme etc which a lot of staff were involved in.

DELIVER FOR TODAY

21/171 INSIGHT COMMITTEE REPORT

- This report outlined the chair's key issues (CKIs) for the last two meetings.
- The committee was developing very well and all the sub-committees that would be feeding into this committee had now met and were developing consistent reporting processes.
- This would allow the insight committee to have a proper oversight and governance role and the sub-committees appeared to be very positive about the opportunities that had been given to them.
- The mapping of the improvements required by the CQC were shown in 4.2 of this report.

- Waiting times were a key issue, particularly in some diagnostic specialties. There were clear plans to try to resolve the problem and this was being monitored. It was stressed that this would not be easy to resolve but actions were being taken and progress would continue to be fed into this committee

Q From a board assurance point of view what were the priorities of the committee to make sure it continued to mature so that the information it received came up to the board at the required level, ie was the correct data being fed up the line and nothing important being missed?

A As chair of this committee, the focus was to ensure that the sub-committees were doing their job properly and effectively and were getting clear information on what they were looking at and picking up areas of concern as well as noting what was being done well. This was also about actions being taken to address areas of concern and who was monitoring these, ie assurance that processes were working and developing effectively.

- With regard to how the community would be reflected in this, some of the information was included in the reports to this meeting. However, a group was now being established to provide the relevant information to reflect community performance.
- It was noted that the work of the insight committee and its sub-committees was encouraging and it was fundamental in identifying issues for follow up by the improvement committee. The fundamental success of this committee system was the flow from the governance committees to the insight committee and then to the improvement committee which would identify what it needed to focus on and move forward. So far, the improvement committee was only looking at issues that were already known about, ie PSIRF, CQC 'must' and 'should do's'.
- It was agreed that this was work in progress and part of a journey. The key issues for September and October represented a range of activities; items in the BAF column would already have identified key issues.
- In terms of adding or removing items in the BAF column, one of the plans for these committees was that items in the BAF should be reviewed by the appropriate committee rather than in another forum and this would be a maturity of this process.
- From an involvement committee point of view the flow of information was not yet happening and the sub-committees were not yet fully implemented. The committee would be undertaking a deep dive into midwifery whistle blowing incident

171.1 Finance and workforce report

- The Trust continued to break-even in August and September due to funding received for the first half of the year.
- Guidance had now been received for the second half of the year and it was anticipated there would be a reduction in income of approximately £1.7m. This was better than expected but would still present a challenge.
- The forecast currently remained at a deficit of £5m which was very prudent. This assumed the £1.7m reduction in income, as well as the challenges around operational pressures through the winter and the uncertainty around Covid.
- Trusts had been asked to resubmit their financial plans and this forecast might improve when looked at in greater detail.
- It was anticipated that WSFT could earn approximately £5m through the elective recovery fund (ERR), but it would cost a similar amount to the deliver the activity required.

- The need to refocus the organisation on the cost improvement plan (CIP), whilst recognising the challenges due to operational pressures, was gradually being introduced and was not coming as a surprise to staff. Each division attended the executive team meeting on rolling 5 weekly cycle to discuss their CIP position and plans.
- There was more of a focus on the CIP for next year rather than this year and a benchmarking exercise was being undertaken with ESNEFT to look at opportunities for delivering savings. The project management office (PMO) team had also been enhanced and was focussing on CIP.
- The Trust was very aware of the pressures that people were currently under. The aim was to link the CIP programme with quality improvement in the organisation. There also needed to be a strong line of governance so that this was still robust whilst at the same time reducing some of the big meetings which were time consuming for staff.

Q The year end forecast felt like it was out of the Trust's control and the income level that was determined elsewhere would drive the bottom line. Therefore, as so much was outside the organisation's control, what did the board need to focus on, ie managing the expenditure position as well as possible. Would it be possible to bring information back to future board meetings to provide the focus on how to ensure that the Trust was delivering value for money?

A This meant that the year-end forecast should not be the focus, but ensuring that the Trust was managing the resources of the organisation which would be largely through development of the CIP and looking at the benchmarking information.

ACTION: future finance reports to focus on delivering value for money and management of resources rather than the year-end forecast. **N Macdonald**

Q Re the benchmarking work with ESNEFT, was there room for a combined CIP across all three sites in selected areas?

A The ICS directors of finance met each week and had been sharing CIP plans for the future which is where the suggestion for using the same benchmarking model came from. This meant that like for like could be compared across the ICS, speciality by specialty. A wider system conversation could then take place about the most effective site for some services to be provided. WSFT was working very collaboratively with ESNEFT on this as organisations were now being judged as a system as well as individually.

Q Would it be possible to look at areas across the three sites where a bigger CIP could be achieved, ie service by service?

A Once the benchmarking information was received it would be possible to consider having these conversations.

Q If the Trust continually focussed on the same CIPs over a number of years the ability to find further savings would be severely constrained. The ICS would be setting targets for organisations and needed to start taking ownership of performance and think about doing things differently and different places. It was suggested that there was a need to understand the ICS's strategic thinking about how are where services should be provided.

A This was likely to be an ongoing discussion as the development of the ICS progressed.

171.2 Operational report

- This month there had been 155 patients who had waiting over 12 hours in the emergency department which was appalling and very concerning. Before this summer the Trust would not have seen this number waiting over this length of time in a year, yet alone in one month.
- This was a reflection of the pressures that the organisation was under. The nominal time people should have to wait was 200 minutes but 390 minutes had been the average for September, which was very concerning.
- This was due to lack of capacity in the organisation, however every organisation was seeing a similar level of performance even though they did not have RAAC plank issues.
- On the whole WSFT was still managing to maintain good performance in ambulance handover times. However, this meant that on occasions more ambulances were directed to WSFT as they could offload more quickly than other organisations.
- There were currently 198 stranded patients waiting over 7 days, 104 over 14 days and 64 over 21 days. The nominal performance measure was 39 patients waiting over 21 days. Again, these numbers reflected the problems in terms of availability of domiciliary care.
- The system was working together to address this but was being adversely affected by all the challenges. Staff were very tired and frustrated that they could not deliver the care they wanted to deliver and compassionate leadership would be a critical factor in supporting them.
- RAAC plank remedial work continued but work had been halted on F7 so that it could be opened for a temporary period.
- Paediatrics were due to move back to F1 next week. The Addenbrooke's team had been very supportive to WSFT during this period and Craig Black would be writing to thank them for this.
- It was noted that the bed model for the winter plan was based on average numbers over the last two years, which had been very unprecedented. There was lots of uncertainty and lots of unknowns due to Covid, emergency demand etc. In addition, the decant programme meant that there was much less flexibility in the system than before.
- The Trust had procured 45 beds in the community. This would enable change of use of Newmarket community beds over the winter and would mitigate the loss of a winter escalation ward on WSFT's site.
- One of the key objectives of the NHS planning guidance for the second half of the year was supporting the health and wellbeing of staff and taking action on recruitment and retention. However, at the same time Trusts would be required to deliver a lot of priorities all of which were appropriate and things that needed to be done.
- As a board and leadership team there was a need to be very careful about balancing these objectives. One of these was that by March 2022 there should be no patients waiting over 104 weeks for elective procedures, which would very challenging.
- A lot of work was being undertaken with ESNEFT in orthopaedics and some areas of gynaecology. The teams were working as a system to transfer patients, with their consent, to have their procedures at ESNEFT.
- It was likely that every Trust would have to go through a process where it measured its progress against 'levelling up goals', all of which were very worthwhile but not

achievable. Craig Black considered that it was his and the board's responsibility to prioritise goals as it would not be able to achieve them all.

ACTION: board discussion/workshop required to discuss Trust's priorities and what it would not be able to do.

S Childerhouse / A Alderton

- It was agreed that it was important to debate the priorities as a board. However, as well as recognising that staff were very tired and providing support to them, it was also important to recognise and consider the wellbeing of the executive team, particularly with all the changes that had recently taken place and the challenges it would be facing in the near future.

Q The modelling over the last two years had been very good and accurate, but there were some concerning uncertainties this year. Was it possible to think about the worst case scenario this year in advance?

A Regional and national conversations were currently taking place to discuss the unthinkable, eg appointment only attendance to the emergency department, but this carried significant risks as people would need to be directed to an alternative pathway. This would be a real challenge as GPs were also under considerable pressure.

The decant programme had been designed to ensure that two wards would not be closed during the construction industry bank holiday closure period. This would enable patients to be moved into these areas if absolutely necessary, although these would also need to be staffed.

Organisations were also being asked to discuss the use of temporary demountable constructions, ie tents, to cohort patients awaiting admission.

- There had also been a lot of thought and discussion about how to effectively communicate with the public around expectations and what they could do to help/look after themselves.

171.3 IQPR

- It was explained that the number of complaints relating to maternity and gynae was unusual.
- Those relating to gynae were all from patients about the management of their miscarriages and lack of communication and empathy. These were being investigated by the complaints team and were a reflection of the pressure the service was under. Since this had been discussed with staff the number of complaints of this nature had reduced.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

21/172 IMPROVEMENT COMMITTEE REPORT

- As well as flow of information this was also about pace. The committee was currently looking at existing/legacy issues. On the whole, these already had detailed action plans in place, the majority of which had been completed.
- The focus of the committee was to ensure that the final actions were completed as soon as possible and these would be followed up.
- The issue of deteriorating patients out of hours was highlighted. The committee had identified a need for additional resource in critical care and surgery and a business case for critical care had been approved this month.

- A business case for a critical care outreach team was still being worked on and would be reviewed as part of the winter plan.
- There was a need for swift action on this due to issues relating to serious incidents and patient safety. The committee had been assured that this would be moved forward rapidly.
- That was a need to understand the changes to the CQC assessment framework and how this would be monitored through the governance structure.

ACTION: Clarify self-assessment process and how this should be monitored through the new governance structure. **A Alderton**

- It was suggested that for any change that was made by the improvement committee, the involvement committee should consider if sufficient engagement had taken place with staff or patients who had been or would be affected by this change /improvement.

172.1 Maternity services quality and performance report

Karen Newbury, Head of Midwifery, joined the meeting for this item.

- The board were reminded that Paul Molyneux and Richard Davies provided additional support in their role as Maternity & Neonatal Safety Champions.
- The previous issues with e-Care were being resolved and the data for September had been available for the second week in October, which was very positive. The digital midwife had also started in her role.
- Due to recent issues three safety champion walkabouts had taken place in the August, but only one in September which took place in NNU.
- The survey of maternity staff, as a result of the whistleblowing incident, had now been completed and there had been a good level of feedback. The responses were now being looked at so that further action could be taken where necessary.
- The maternity dashboard showed that there had been no change from the last couple of months. The staff shortages impacted on appraisals and daily checks at weekends when there were less managers available. This was very high on the priority list to be resolved.
- All the required actions annex in B, workforce concerns action plan, had been completed.
- The 8 Point Maternal and Neonatal Service Action Plan (annex C) was a national response to the midwife staffing crisis, including Covid. The only incomplete action was the provision of vaccination clinics within antenatal clinics. It was planned that these would next week but would depend on availability of vaccine to the Trust.
- It was noted this department was a perfect example of the earlier discussion about the need to prioritise what could and could not be done, as it was trying to do more than it could ever possibly achieve, ie daily checks, appraisals etc. This meant that staff were being asked to do the impossible; the organisation needed to work together to agree what it could and couldn't do, as the pressure placed on individuals was huge.

Q Re the original issues about the uncertainty of vaccinating pregnant women and some of the anti-vaccine activity that has been happening around the region and also the disproportionate number of non-vaccinated pregnant women in hospital; was there any experience within the department at WSFT of anti-vaccine activity?

A There was not necessarily anti-vaccine activity but more an uncertainty about recommending pregnant women to have the vaccine. Staff now know that this is fine and have been actively encouraging women to have the vaccine. However, the majority of women do not want be vaccinated until they have had their babies, although staff who worked at the Trust and were pregnant have had the vaccine.

Q With regard to prioritisation, fixing the staffing issues etc was not easy. Were there enough staff in the department to service the reports required, eg admin, clinical etc?

A The recruitment process had been started for these positions and as soon as all the checks had been completed the individuals would be in post, which was seen as very positive by all staff.

Q Re the need to increase the number of staff in the neonatal unit, particularly to help with transitional care and improving unnecessary admission to the neonatal unit, was recruitment of neonatal staff as challenging as recruitment of midwives and was any support being provided to the department to help with this?

A Only a small number of additional neonatal staff were required and WSFT's neonatal unit was recognised as being very good so there should not be an issue with recruitment.

Now that there was a deputy midwife in post it would be possible to have more of an oversight of the neonatal unit and ensure that the areas were working together for the same goals.

Q As a result of the whistleblowing incident and work that had been done to help the morale of the midwives, did Karen Newbury think they now felt they were being listened to?

A They felt they were being listened to but this did not change the end result. She was trying to speak to every member of staff and explain that this was a long-term issue. There were now staff for all shifts, but if several were off at the same time due to Covid related issues this would be a problem.

The issue across the whole system was that there was no flex or spare staff so any slight changes had a big impact.

172.2 Midwifery whistleblowing response and action plan

- The report and appendices provided an overview of the whistleblowing incident and the actions already taken, ie 'you said, we did'. This was to demonstrate to staff that the Trust had heard and acted on some of the things suggested and was the start of a longer piece of work which would be overseen by the involvement committee.
- Work would continue with the involvement committee and teams so that they felt they had been listened to and the appropriate support was being provided.

172.3 Infection prevention quality and performance report

- An increase was being seen in the number of Covid patients coming into hospital and also requiring critical care, as well as an increase in deaths. This continued to be monitored as well as ensuring that these patients were in the appropriates area.
- The VRE outbreak across F6 and surgical areas continued to be focussed on and progress was being made.

- A report would be coming back to the board meeting in December on the learning from the Covid outbreaks that occurred earlier in the year, to try to prevent this happening again.

172.4 Nurse staffing report

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

- Staffing in the nursing workforce had been challenging for the second month in a row due to school holidays and an increase in sickness and the isolation rate. This was reflected in the fill rates which had been the lowest for some time.
- It was positive to note that this had not resulted in any decrease in patient care, and the number of falls and pressure ulcers had continued to reduce.
- There had been a slight decrease in vacancies for registered nurses and the establishment numbers had been maintained and were static.

Q With regard to fill rates not being associated with an increase in incidents, when there was a shortage of staff what sort of prioritisation took place of things that could be delayed without affected patient care in the short term but also in the longer term, ie appraisals and training? Although recognising this would not be sustainable and there was likely to be an increase in incidents if there were ongoing staff shortages.

A The fill rate also needed to be taken in context with vacancy rates. From April there was an uplift in a number of areas and a skill mix change, which meant that a lower fill rate this month might have been a favourable fill rate in March.

- A number of staff were concerned about how many times they were being moved to work in other areas and how the balance of risk was being managed across the organisation. In response to their concerns two risk seminars had recently taken place for two areas to review the quality of data, KPIs, sickness and other data measured on a regular basis. Conversations had also taken place with matrons and ward managers to find out how staff were feeling.
- Mindful that staff were feeling very vulnerable at the moment, particularly when working at night, the Trust was looking at what additional support could be provided to them, especially out of hours.

Q Does the nurse staffing model work for midwives or could the modelling be applied in anyway to community staffing so that assurance could be provided about the level of staffing?

A This modelling was not compatible with maternity as they had a nationally recognised tool. However, the establishment of midwives had been increased but this was a very different model with a bespoke way of measuring.

Modelling was difficult to translate to community staff who had their own tool, ie the Benson model. The tool used for inpatients was the NHSIE safer care tool and a similar model was being piloted in the community but the outcome was not yet known.

Until recently community teams were not on the electronic health roster but this had now been rolled out across all teams. The Benson capacity and demand model was also in use and a number of reviews had been undertaken of community teams using this. The final piece of the puzzle was the auto scheduling system, Malinko, which would be implemented in one of the community teams in November and then rolled out across all the teams.

Q Re staff feedback on fill rates; was there any evidence that staff were concerned about establishment numbers, ie were there any incidents where fill rates close to establishment were leading to staff complaints or concerns?

A The challenge was when there was any deviation, ie absences at short notice, and recruitment was still being undertaken. Staff had not yet experienced what a full establishment felt like as staff were still being moved around. Recently a ward sister had said that when they had a full establishment it was the right establishment.

A new initiative had recently been launched, ie a rapid response pool of nurses and nursing assistants who were expected to be more flexible. They understood that they would be asked to work anywhere in the Trust where there was a shortage of staff but were not booked into a specific area. It was hoped that this would result fewer staff needing to be moved around. This initiative had only been in place for two weeks but a good uptake was already being seen.

172.5 Quality and learning report

- The investigation into the reported never event relating to the intravenous connection of an epidural had been completed and the CCG had agreed that this should be downgraded and no longer reported as a never event.

Q Re item 7, 'route for raising concern', should there be a line in this report to record people who raised concerns outside the system, ie to the CQC or whistleblowing, where was this being recorded?

A This would be included in future reports.

ACTION: include line for people raising concerns via external sources. **S Wilkinson**

Q Detriment should not be experienced by anyone who raised a concern. Had there been a specific process to follow up these two issues?

A This would be followed up to ensure that these had been looked into. **S Wilkinson**

21/173 INVOLVEMENT COMMITTEE REPORT

- The key issues in this report were highlighted, in particular the need to embed involvement in any change management process and the creation of a staff and stakeholder forum to support the implementation of the people plan.
- It was noted that a governor representative would be invited to be a member of this committee and would be required to report on governor engagement. This was considered to be very positive.
- This committee was still finding its way as it did not have data driven tasks in the same way as the other two committees had. It would continue to learn how to bring things to this committee, how to be assured and how to make the most of this.
- It was proposed that the Trust's progress on values and behaviours should be monitored by this committee.
- The board approved the proposals in this report, ie to include a governor as a regular attendee and the de-escalation of BAF risk re engagement as a key partner in the alliance.

173.1 People & OD highlight report

- The citations for the Putting You First Awards for September were read out.

Liz White, speech and language therapy team, went to the aid of a driver who had collapsed at the wheel and the gave him CPR until the ambulance arrived.

Pete Southam, staff support psychology service, went above and beyond, sometimes in his own time, to ensure that staff received the relevant support. He and was approachable and emotionally available to every member of his team.

The board congratulated Liz and Pete for their dedication and for both going beyond their normal roles to care for the public and their colleagues.

- It was noted that some of the appendices to this report would also go through the involvement committee for greater scrutiny.

Freedom to Speak up guardians' quarterly report

Amanda Bennett joined the meeting to present this report; James Barrett sent his apologies.

- There had been an increase in concerns raised compared to a year ago which was seen as a positive.
- There had been a very good response to the request for volunteers to become freedom to speak up champions, with 48 expressions of interest to date. 22 people had already been trained in this role and it was hoped to launch this initiative in the green sheet next week.
- It was proposed that the plans for 'even better if' should be taken to the involvement committee for scrutiny, along with the 'what's going well' information.
- In addition to learning from the freedom to speak up guardians, the Trust would also need to provide support to them, particularly in light of the publication of the rapid review report.
- The board thanked Amanda and James for the all the work they were doing and congratulated them on the pace of this, particularly the recruitment and training of the freedom to speak up champions.
- The Equality, Diversity & Inclusion annual report was received and noted. It was explained that the steering group reported to the involvement committee and the action plan that was attached to this report had now been confirmed.
- The appraisal and mandatory training quarterly report was received and noted. The pressures in the organisation were reflected in some of the data in this report, ie mandatory training and appraisals.
- 13 members of staff were suffering from long Covid and the report gave details of the support being provided to them by the Trust.
- The board noted the following consultant appointments:

  Dr Claire Malcolm - Consultant Anaesthetist with an interest in critical care medicine
  Dr Ramasamy Radhika - Consultant Anaesthetist

21/174 INTEGRATION REPORT – Q2

- Staff in the community were experiencing the same pressures as those in the hospital. This report detailed how they were responding to the challenges being experienced, in particular the increase in complexities.

- There was a concern about staff as the organisation moved into winter. Ways in which to support their resilience and wellbeing were being looked at.
- A number of working groups were being co-ordinated with colleagues in order to support capacity in the community going into the winter period. This included admission prevention and providing non-medical support to people requiring it.
- Bed capacity across west Suffolk had been increased to 45. This had started to be utilised and there was the ability to spot purchase more if required.
- The teams were trying to ensure a smooth transfer of care from either acute or community beds; this included therapy intervention and social worker input to plan the support required when patients moved back in into the community.
- Work was also being undertaken with St Nicholas Hospice to increase bed capacity to support end of life patients.
- The domiciliary care market was currently very fragile and the west Suffolk system was collectively looking at how to manage this. This included working with independent care providers.
- A workshop had taken place to collectively look at measures that could be introduced particularly those that could be implemented quickly, recognising the long-term work required to strengthen the care market.
- The risks associated with the use of agency staff were acknowledged and the need to ensure that there was not a reduction in quality of care
- A business case was being looked at to support the focus on transfer of care when leaving hospital and community based support for adults in crisis, in order to prevent further deterioration. The system would be actively recruiting to bridge the capacity gap.
- The early supported discharge case study which was appended to this report highlighted the level of work and innovation within the service to support and empower the wellbeing of patients.
- The introduction of mental health practitioners in the primary care network would be a positive step to providing early support for adults where required.

Q Would it be possible for the team to develop some key data that would show results of work that was ongoing, eg delayed discharges, number of beds in the community, data trends?

A The team were looking at measures that would help to illustrate the impact of change being made in the system and would look at the most appropriate ones to present to the board.

There was already data and information available for some areas, eg numbers of stranded patients and number of medically optimised patients in beds but this needed to be presented in clear and meaningful way.

All these metrics showed that that the system was in a worse position than ever before.

ACTION: consider measures to illustrate impact of change for inclusion in report to board. **C Mawoyo**

BUILD A JOINED-UP FUTURE

21/175 EMERGENCY PREPAREDNESS, RESILIENCE & RESPONSE (EPRR) CORE PEER REVIEW

- This was a national core review self-assessment process. It had not taken place last year due to Covid and this year had been significantly reduced, ie 46 rather than 64 standards, together with a deep dive into oxygen provision as a result of Covid.
- It was considered that Trust was 'substantially compliant' against these standards, except for three where it was only 'partially compliant' due to factors outside its control.
- The self-assessment had been reviewed by Barry Moss (EPRR) lead, Helen Beck and the CCG who agreed with everything other than the assessment against IT data protection and the security toolkit. A robust discussion had taken place and it was agreed that there was some work to be done.
- A significant amount of work had been undertaken in a couple of days by the IT team, supported by Barry Moss, and the disaster recovery plan had now been updated and was going through the approval process. This would address the elements of the core standard that were required and should be completed by the end of November, apart from the security toolkit where work was ongoing.
- Business continuity was an ongoing challenge and an alternative approach had been agreed with a tactical plan that would deal with disaster recovery in the event of any issues relating to the RAAC programme. The Trust was not likely to be able to be compliant with the business continuity standards in the current circumstances, therefore it was not complete.
- Decontamination capability at the front door was an issue which was outside the Trust's control. Therefore, there was a mitigated solution as it was not possible to secure the training to use full powered respiratory protection suits. This was an ongoing challenge across a number of organisations and meant that people were protected for a shorter period of time. Therefore, there had to be a system to keep rotating staff through the decontamination facility.
- The CCG assessors had commended the Trust's approach to the command and control structure and its attitude toward addressing the RAAC problem. A number of its approaches had now been adopted as regional and national best practice.
- The board commended Barry Moss for his drive and initiative in completing this process and addressing the areas of concern.

Q How did this link with the BAF and which governance committee should oversee this?

A This was overseen by the health and safety committee and then went to the insight committee. The RAAC plank issue was already in the BAF. Decontamination was on the risk register but not the BAF.

- It was proposed that when feedback on this review was received from NHSE a deep dive could be undertaken by a governance committee or board workshop.

ACTION: Arrange for a deep dive following feedback from NHSE on EPRR review. — **N Cottington / A Alderton?**

21/176 TRUST STRATEGY 2021-2026

- This was the final version of the strategy which had been through a number of consultation/engagement processes and a reader panel. It was now in the design phase.
- A communications plan was being put together for the launch of the strategy and it was anticipated that the final version would be available before Christmas.

21/177 FUTURE SYSTEM BOARD REPORT

- The board received and noted this report.

GOVERNANCE

21/178 RISK APPETITE STATEMENT

- This statement was the outcome of a board risk workshop and set the parameters for risk that the board would be prepared to tolerate and bear.
- The Trust was more risk averse than before and had now separated quality into patient safety, patient experience and clinical effectiveness, with the most risk averse being patient safety.
- The board approved the risk appetite statement for incorporation into the Trust's Strategy and Policy for Risk Management.

21/179 BAF SUMMARY – OCTOBER 2021

- It was noted that this had not changed since it was previously presented to the board, apart from the removal of pathology and the alliance from the strategic risks.
- Following the board's approval of the risk appetite statement the risks would be reviewed individually with the executive team.
- The board noted the recommendations in this report.

21/180 GOVERNANCE REPORT

- The board received and noted this report.

ITEMS FOR INFORMATION

21/181 ANY OTHER BUSINESS

- Helen Beck would be retiring next month therefore this was her last board meeting. The Chair thanked her for everything she had done during her time at WSFT. She that she had always been very a professional and supportive member of the team and would be greatly missed.
- Liz Steele, thanked Helen on behalf of the governors. She was always smiling and friendly and happy to provide answers to questions, however challenging.
- Helen thanked everyone for their comments and said that she had really enjoyed her time at WSFT, although at times it had been a huge challenge. Her only regret was that she had not joined the Trust sooner as it had been the pinnacle of her career. It had been a difficult decision to make to leave but she was sure that Nicola Cottington would be very good in this role. She wished the Trust the best of luck as it moved into a very difficult and challenging time, but she was confident that it had the team and drive to succeed.

21/182 DATE OF NEXT MEETING

Friday 17 December 2021, 9.15am

RESOLUTION TO MOVE TO CLOSED SESSION

21/183 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

1.4. Action log and matters arising

To Review

Board meeting - action points

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
1999	Open	15/10/21	Item 11.5	Quality & Learning Report - include line for people raising concerns via external sources	**Actioned.**	SW	17/12/21	Complete	17/12/2021
2000	Open	15/10/21	Item 11.5	Quality & Learning Report - Issues raised - this would be followed up to ensure that these had been looked into	**Actioned**	SW	17/12/21	Complete	17/12/2021

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

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). **Current ongoing pressures have precluded progress in this matter. However, the Trust continues to focus on combining work with the info team on quality dashboard to support the infrastructure.**	SW	~~30/07/2021~~ ~~03/09/2021~~ 15/10/2021	Amber	
2002	Open	15/10/21	Item 14	Emergency Preparedness - Arrange for a deep dive following feedback from NHSE on EPRR review.	**It is proposed that a summary of the core standards review be presented to the Improvement Committee.**	NC/AA	17/12/21	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

1.5. Staff story - Patient Safety Specialists

To Note

Presented by Susan Wilkinson

1.6. Chief Executive’s report

To inform

Presented by Craig Black

Board of Directors – 17 December 2021

Agenda item:	1.6			
Presented by:	Craig Black, Interim Chief Executive Officer			
Prepared by:	Helen Davies, Head of Communications			
Date prepared:	13 December 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

Independent review

Last week, the independent review commissioned by NHS England and Improvement at the request of the Department of Health and Social Care, was published.

As a Trust we accept full responsibility for the failings and short comings which led to the review; we got it wrong and remain truly sorry to the staff and families affected.

We know that the actions taken by the Board which led to the independent review have understandably caused upset and anger amongst many of our staff, patients and their families, as well as our community, and this has bought unwanted attention to the Trust. We know for the individuals most directly affected the impact on their well-being has been significant.

Whilst the investigation has been taking place, we have been working hard to build an open, learning and restorative culture. Our aim is to help staff feel confident to speak up and be supported when they raise concerns, and for issues to be dealt with sensitively and appropriately.

The Trust board will be considering the findings and recommendations from the independent review in full over the coming days and weeks, and will be using those recommendations in our drive to improve.

Suspension of visiting

At the end of October, we took the very difficult decision to suspend almost all visiting at our sites. We did this because of the very high rates of Covid-19 in West Suffolk so as to protect our most vulnerable patients as well as our staff.

This was, without doubt, very difficult news for a lot of people. Whether you are in hospital or have a loved-one in our care, visiting is very important and we understand the repercussions limiting contact with our patients and their friends and families has. We do not take these decisions lightly.

To help alleviate the distress of being apart, patients are still able to keep up to date with how their loved ones are while they're in one of our hospitals via our dedicated clinical helpline. As well as this, we are continuing to run our 'Keeping in Touch' service which helps connect family via video calls if patients don't have access to digital devices.

With continued high case rates in West Suffolk and a new variant of concern – Omicron – we feel it is sensible to continue with these restrictions for the time being. Please be assured we are regularly reviewing decisions around visiting and will relax restrictions as soon as it is safe to do so.

Winter pressures
We are currently experiencing huge levels of demand at our Trust. While this isn't just a local issue, our staff are working very hard to ensure everyone who comes through our doors is cared for and supported in the best way possible.

As levels of Covid-19 continue to rise throughout West Suffolk and with Omicron projected to become the new dominant variant in the UK, we are still appealing to residents of Suffolk to continue getting their Covid-19 vaccinations as well as their boosters when they're called forward. With the government announcing over the weekend that all over-18s are to be offered boosters before the end of the year, we are working across our local healthcare system to help facilitate this and stand ready to play our part.

As well as helping to share the message about the importance of vaccination against Covid-19, we are also reminding the public about simple things like wearing face coverings in crowded places and washing hands. We need to continue to take all precautions necessary to protect ourselves and our loved ones this winter.

We are also encouraging residents, to help ease the demand on our emergency department, to utilise other options the NHS has to offer if they require support. Using a community pharmacy, GP surgery or telephoning NHS 111 could help avoid a long wait in A&E while freeing up our staff to support vital emergency cases.

Haverhill health centre
You may have seen the recent media coverage around the Haverhill health centre, which until recently, was the base for several teams who belong to our Trust, providing a range of services to the community, such as maternity, dermatology and paediatric physio.

We were recently informed by the owners of the building, NHS Property Services, that there were concerns about the condition of the building and they are currently carrying out a programme to identify issues. We took the decision to relocate our services – some remaining local to Haverhill and some coming back into our West Suffolk hospital site – until more permanent locations are sourced.

As with any situation like this, the health and wellbeing of both our colleagues and patients are paramount. All patients affected by the changes are being informed and we are working with them to ensure the changes do not affect the standard of the care they receive from us.

Saying goodbye to Helen Beck
November saw us say goodbye to our chief operating officer, Helen Beck, who has retired. Helen had been a mainstay of the Trust since joining us back in 2014 and I was lucky enough to work closely with her during her time with us.

Helen oversaw a lot of positive changes in her time with us, including leading the operational aspects of our e-care programme, which was very important to the Trust gaining digital exemplar status.

I know Helen was looking forward to spending a lot more time with her family in her retirement and we all wish her the best in all her future adventures.

As Helen departed, we were delighted to welcome back Nicola Cottington as her replacement. Nicola is already very well-known here, as she worked as associate director of operations in medicine. We are over the moon to see her return.

Nicola has recently spent some time at James Paget as deputy chief operating officer and she was central to the Paget's response to the Covid-19 pandemic. She has a really positive track record in delivering compassionate leadership that benefits staff and patients alike and I am delighted to have her joining the senior leadership team.

Freedom to Speak Up Champions

To support the growth of a listening culture, we now have 31 Freedom to Speak Up champions from across our Trust. The staff members, who have completed their training, are now working to make speaking up 'business as usual' in their teams.

The champions are promoting the value of speaking up, listening to others and following up concerns or issues raised and working closely with our two Freedom to Speak Up Guardians, Amanda and James.

When people in the organisation speak up it represents a brilliant opportunity for us to learn and improve. I want us all to make the most of these opportunities – our champions are a vital part of that and us all working together to ensure our Trust is the best it can be.

New healthcare facility engagement

Throughout November and into December, the Future Systems team have been hard at work engaging both staff and the public about the new healthcare facility.

This was the second period of pre-application planning engagement to support an outline planning application to build on the Hardwick Manor site in Bury St Edmunds – with the Trust aiming to submit an application in early 2022.

Securing outline planning permission is a significant milestone on our journey to building a new hospital and I'm excited that we have been able to include our local community in shaping the eventual outcome.

The team arranged a mix of Covid-secure face-to-face events throughout the county as well as online events. The feedback received will build on the 800 responses received in our first round of engagement and is an invaluable part of the process to make sure we build a facility to suit the needs of our communities.

Community colleagues move into new Brandon base

Members of the Mildenhall and Brandon community team have now moved from the Brandon Health Centre to new facilities at the town's leisure and health hub. As well

as custom-designed new office and clinical space, the site also offers facilities provided by Abbeycroft Leisure.

From talking to staff, the feedback from the team moving into their new home has been very positive and the facility enables healthcare services much closer to home. This saves some patients having to do a 40-mile round trip to West Suffolk hospital.

Midwifery awards

I want to extend my congratulations to three outstanding members of our midwifery team who were recognised for their work in our recent midwifery awards.

The awards, which are given out annually in memory of the late Hannah Seeley, an exemplary midwife who worked at our Trust and sadly passed away in 2012, celebrate colleagues in three categories:

- Midwife of the year
- Support worker of the year
- Student midwife of the year

Rebecca Lemesre took home the midwife of the year award. Rebecca, who has worked at the Trust since 2006, was commended for her ability to go above and beyond in caring for colleagues, women and birthing partners.

Support worker of the year award went to Jackie Cheek who has been at the Trust since 2008. Colleagues commented on Jackie's hard work but also being cheerful, adaptable and always supportive, helping women to receive excellent care.

Kirsty Kearns was awarded the student of the year award. Kirsty, who is in her final year of training was commended as a "real role model student" who worked hard in very difficult circumstances and is always dependable.

Congratulations to all three for their awards.

2. FIRST FOR PATIENTS - ASSURANCE

2.1. Insight Committee Report - November & December 2021 - Chair's Key Issues from the meetings

To Assure

Presented by Richard Davies

Board of Directors – 17 December 2021

Agenda item:	2.1			
Presented by:	Sheila Childerhouse, Chair Dr Richard Davies, NED, Insight Committee Chair			
Prepared by:	Ann Alderton, Interim Trust Secretary			
Date prepared:	8 December 2021			
Subject:	Insight Committee Nov & Dec 2021 – Chair's key issues			
Purpose:	X	For information		For approval

Executive summary:

The Insight Committee met on 1 November and 6 December 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 – 1 November 2021 meeting

Part A

Originating Committee	Insight Committee	Date of Meeting	1 November 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? ✓
6	**Further Fall in Appraisal Rates (Finance and Workforce Governance Group)** • Concern that these are not improving • Recognition that figures are better in the Women's and Children's division – perhaps reflecting the more proactive approach they are taking that others could learn from. • Agreement that this should initially be discussed at the next ED meeting • We will continue to monitor at Insight • Consider escalation to Improvement if figures remain a concern	**Assurance**		
7	**Patient Waiting Times (Patient Access Governance Group)** • 2ww position remains challenged with referrals increasing. Overall figures significantly influenced by particularly challenging position in dermatology. Noted there have been some teething problems with the AI solution for dermatology. However, these are being sorted out and once fully operational it is anticipated that this (in addition to ongoing extra consultant sessions) will bring about rapid improvement • Note that despite the 2ww figures in dermatology, the majority of patients currently wait only 2-3 weeks and 28 day data are good • 104 week wait position – target is zero patients by March. This target is not going to be met for a variety of complex reasons – mainly relating to capacity but also to patient choice etc. Encouraging and very useful collaboration with ESNEFT will help with position but not resolve it. • Diagnostics - some good news overall, e.g. in endoscopy with much improved figures. Non-obstetric U/S remains a challenge but clear	**Assurance**		

	trajectory for recovery of position by January with increased off-site capacity • Pressures across organisation remain very high – with significant bed delays particularly as a result of difficulty in discharging patients into community. This is a focus of attention across the system			
8	**Duty of Candour. Patient Quality and Safety Governance Group** • Despite lots of discussion about this and focus from CQC, this remains a significant concern. • A Duty of Candour group is under development, led by Dr Margaret Moody with plans to report to the Patient Quality and Safety Governance Group next month • However, in view of ongoing concerns about this issue it was agreed that this should **be escalated to the Improvement Committee** for targeted quality improvement work in collaboration with the CoG group	**Escalation**		
9	**Papers from Adult and Paediatric Community Services** • Where these services feed into the Trust governance structure continues to develop • Recognition of importance of factoring in Community Services with Trust Strategy • Importance of developing appropriate KPIs (currently using rather crude waiting time indicators only). Anticipation that this should be a relatively quick win as there is recognition across the system of the importance of better patient centred performance metrics • Challenges facing Haverhill Teams as a result of the Haverhill Health Centre RAAC plank issue – need for interim 'home' whilst considering the future. Possibility of providing a better long-term solution by expediting plans for a Haverhill Hub. This remains in discussion	**Assurance**		
13	**IPB decommissioning plan** • This was discussed and agreed as an effective way forward • This will need to be disseminated and agreed by the other 3i committees	**Escalation**		
Date Completed and Forwarded to Trust Secretary		**4 November 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			

Chair's Key Issues – December 2021 meeting

Part A

Originating Committee	Insight Committee	Date of Meeting	6 December 2021
Chaired by	Sheila Childerhouse	Lead Executive Director	Nicola Cottington

Agenda Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref	Paper attached? ✓
5	**Schedule of Operational Actions from CQC Improvement Board** • It was confirmed that the action relating to Quality and Performance information and the IQPR will sit with the Insight committee and not the Improvement committee. The committee requested an update on the Information Strategy and the IQPR review for its January meeting	**Assurance**		
6	**Finance and Workforce Governance Group** • Appraisal compliance was flagged as an area of concern, being both below target and showing a deteriorating trend. The committee considers this to be an important indicator for staff morale, particularly during periods of pressure and noted that this had been subject to executive attention.	**Assurance**		
7	**Patient Access Governance Group** • The 2WW figures remain a challenge with a significant underperformance in Breast and Skin as a result of a high volume of referrals. The Dermatology AI analytics software launch does, however, appear to be having a positive impact on performance. • 104 week waits are not improving in line with the trajectory to get to 210 by the end of March. The situation has deteriorated as a result of the delay to the theatre programme. Following discussion on the risk consequences of this, it was agreed that the risk register entry relating to this item be reviewed to ensure that the risks relating to deconditioning were being adequately managed.	**Assurance**		
8	**Patient Quality and Safety Group** • The committee escalated high incidences of restraint and staff reporting aggression and violence consistently among the same words and has	**Assurance**		

	requested a review and provision of training of managing patients with acute delirium in addition to conflict resolution			
9	**Community Governance Group** An emerging concern was reported by the Community Paediatric Services relating to support for Children and Young People with Avoidant and Restrictive Food Intake Disorder. Working within the eating disorder clinical network this issue has been escalated to the CCG	**Assurance**		
12	**CQC Insight Publication** • It was agreed that the committee would receive a quarterly report on the Trust's information on CQC Insight, the intelligence tool used by the CQC to identify quality outliers through national benchmarking. This was considered to be a helpful assurance tool, though many of the sources were out of date. Not only does this highlight potential CQC red flags, but it highlights whether the Trust's own assurance and escalation mechanisms are giving early warning of the same outliers. Of the 10 areas flagged as worse or much worse than the national average, all of the areas reported in the latest publication relating to 2020/21 data had been escalated already through the Trust's governance committees.	**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			

2.2. IQPR - September & October 2021 data

To Note

Presented by Susan Wilkinson and Nicola Cottington

Trust Board report - 17 December 2021

Agenda Item:	2.2			
Presented By:	Helen Beck & Sue Wilkinson			
Prepared By:	Information Team			
Date Prepared:	Sep-21			
Subject:	Performance Report			
Purpose:	**X**	**For Information**		**For Approval**

Executive Summary:

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

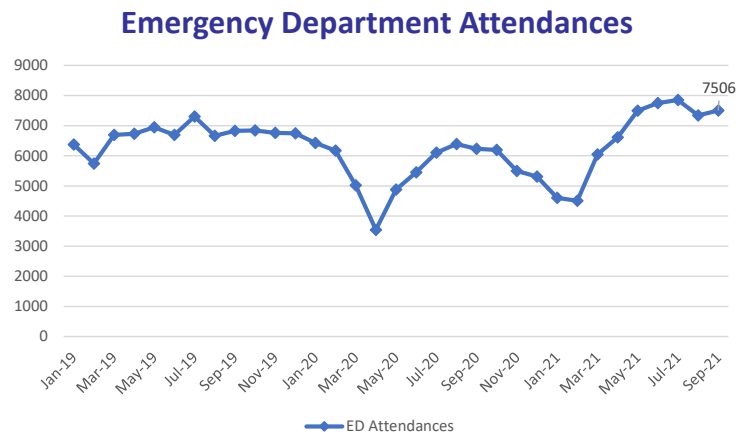
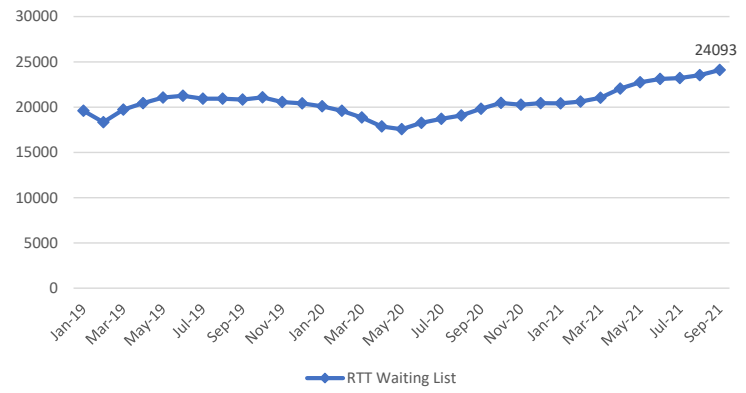
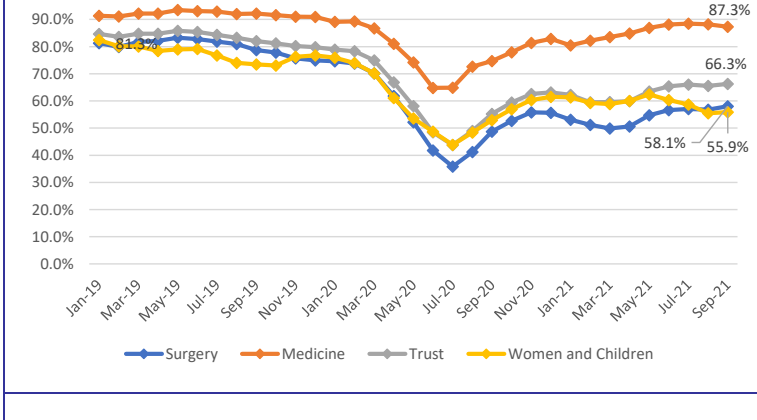
Trust Priorities [Please indicate Trust priorities relevant to the subject of the report]	**Delivery for Today**	**Invest in Quality, Staff and Clinical Leadership**	**Build a Joined-up Future**
	X		

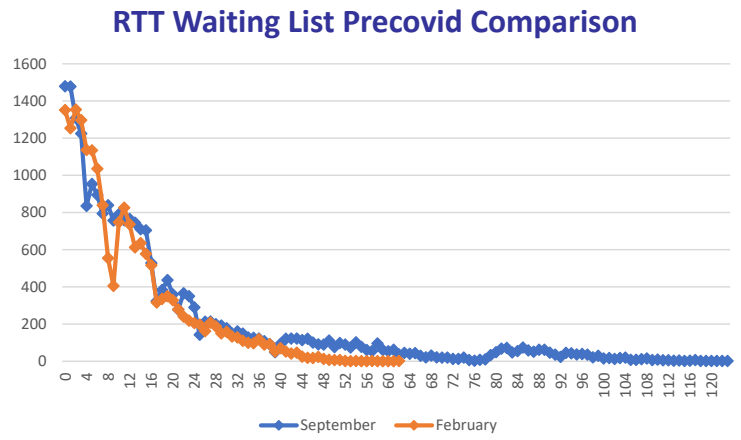
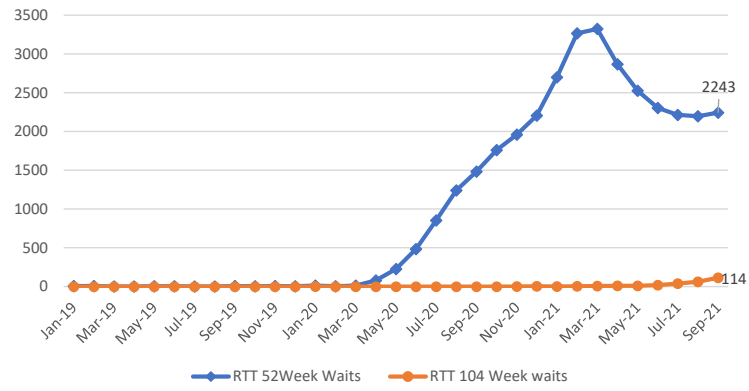
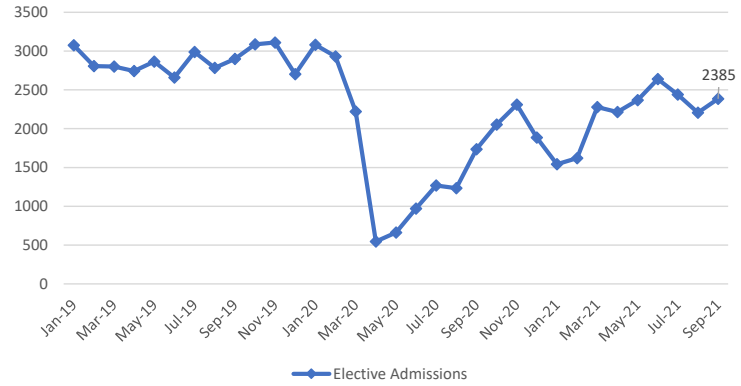
Trust Ambitions [Please indicate ambitions relevant to the subject of the report]	Deliver personal care	Deliver safe care	Deliver joined-up care	Support a healthy start	Support a healthy life	Support ageing well	Support all our staff
		X	**X**				**X**

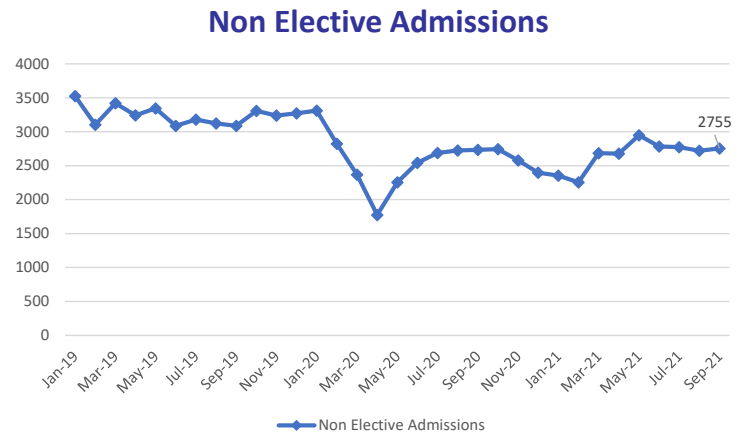
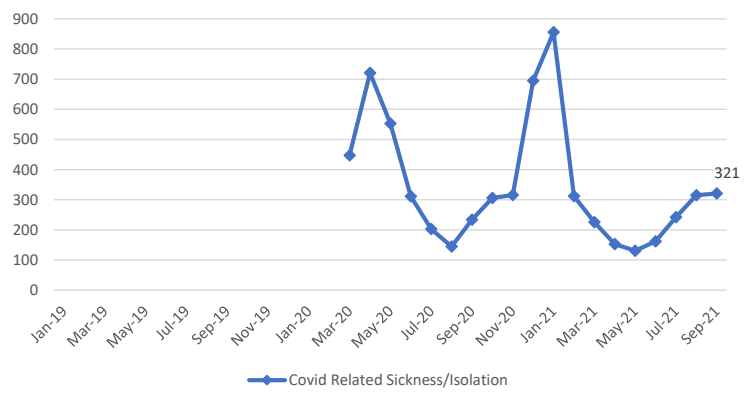
Previously Considered by:	
Risk and Assurance:	
Legislation, Regulatory, Equality, Diversity and Dignity Implications	

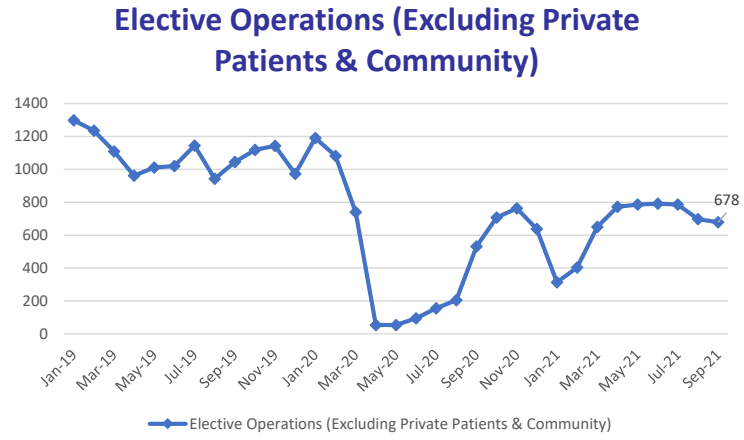
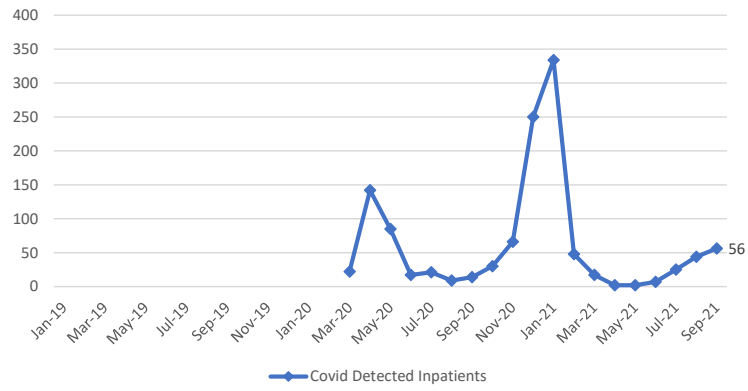
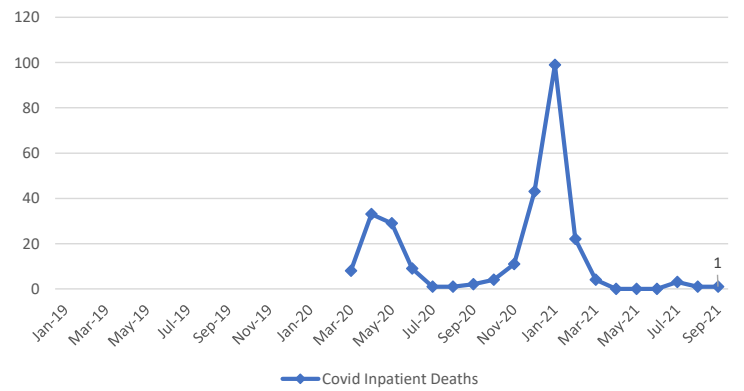
Recommendation:

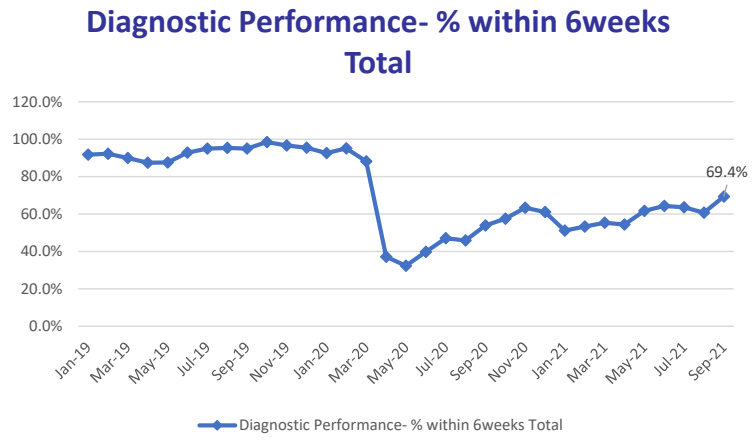
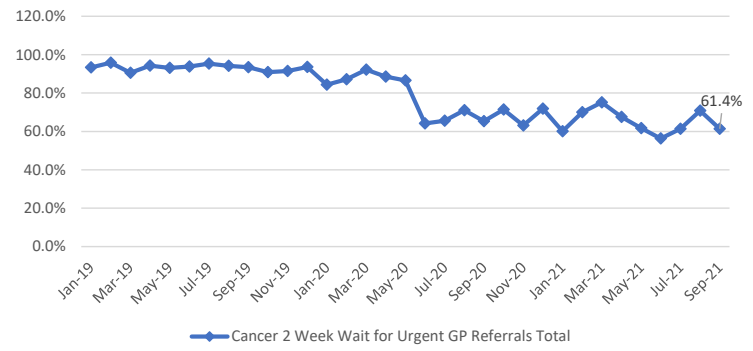
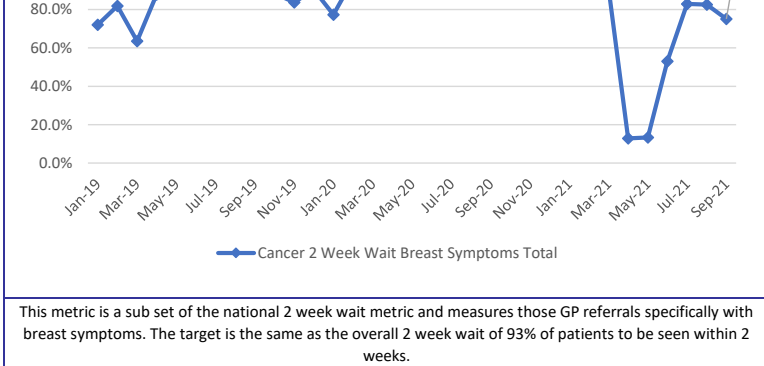
For report to be noted

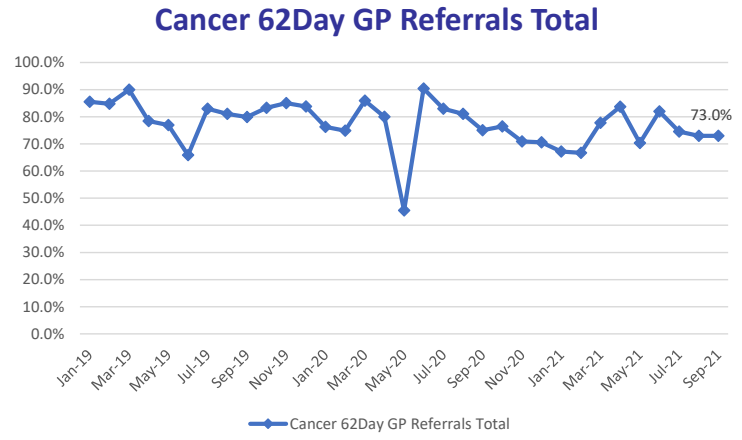
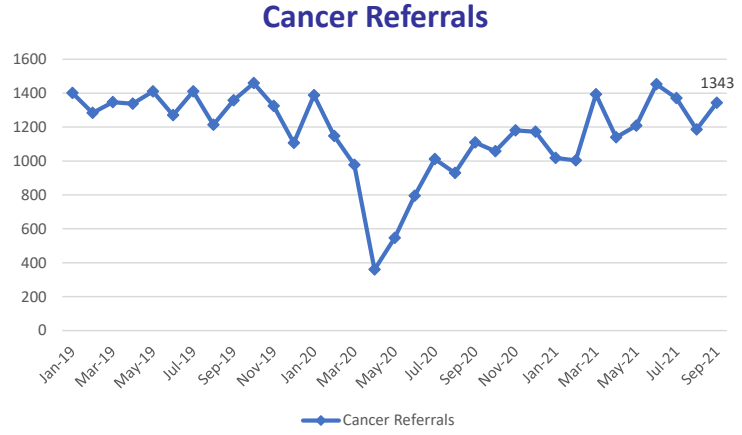
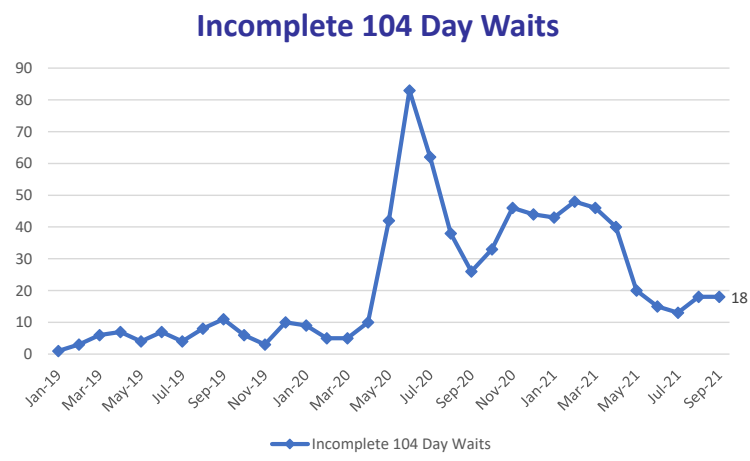
Board Report KPIs	Narratives
	A slight rise in attendances of 166 compared to August. Non-elective admission numbers remain relatively static. Work is ongoing to look at front door models, patient signing and analysis of walk in patients. We now have a GP streaming service all day on a Tuesday.
A count 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 raising and reduced capacity to treat patients. 2WW referrals were the highest in September than we have seen since January 2020. In addition, less clock stops were completed in August.
A count of the patients on the waiting list for treatment.	
	A very small improvement in overall performance, medicine and women's and children fairly static and some improvement within Surgery, with continued improvement within Ophthalmology, General Surgery and ENT specifically.
% of patients on incomplete RTT pathways	

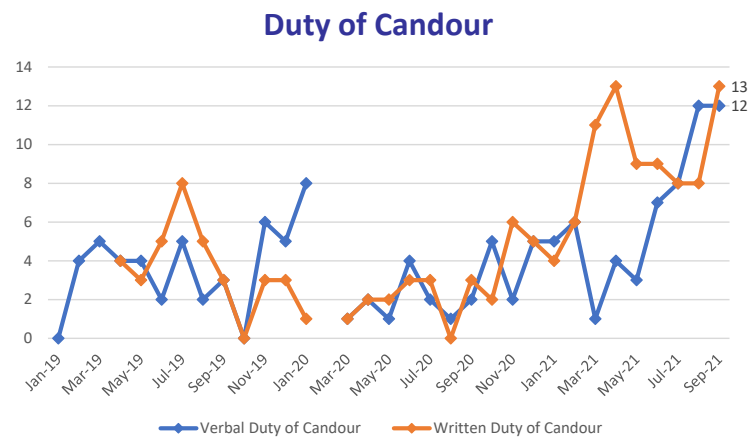
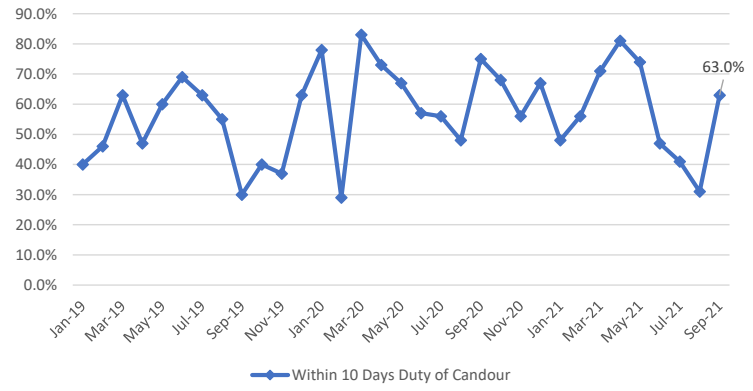
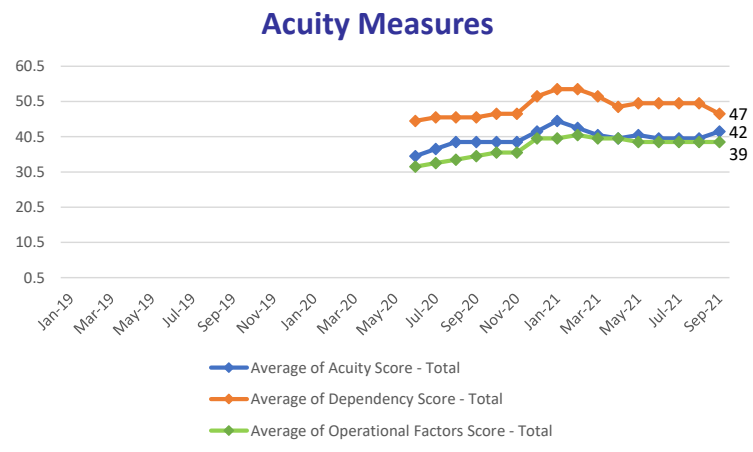
Board Report KPIs	Narratives
	The overall tail continues to increase and the patients waiting over 78 weeks is still increasing, again this is mostly within Surgical specialities and Gynaecology due to the limited main theatre access. The front end of the waiting list is now back up to that of pre-Covid, which shows the referral numbers increasing.
A year on year comparison of the number of patients waiting for treatment.	
	For the first month since March 2021 the 52 week wait position has increased, this will be a result of the lack of theatre capacity but also the reduction in treatments during August and some of September. Patients waiting over 104 weeks continues to increase as does the volume over 98 weeks, however the 78-98 volume has slightly decreased. The 104-week waits are mostly in Gynaecology and Orthopaedics, with a few in other specialities.
A count of the number of patients who are waiting for treatment and have been waiting longer than 1 year for treatment. This is a national key performance indicator with a national expectation of 0.	
	Increase in admissions as we would expect in September, however not to the same level as we saw in June 2021.
A count of the number of patients that were admitted for an elective/planned procedure. This is a local metric used to monitor changes in activity.	

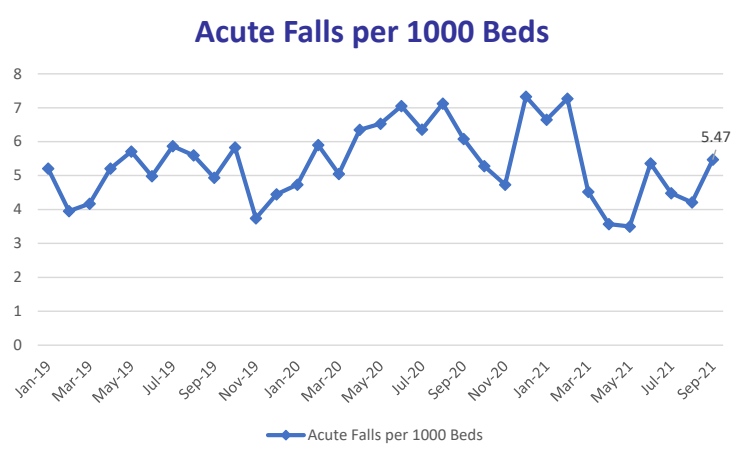
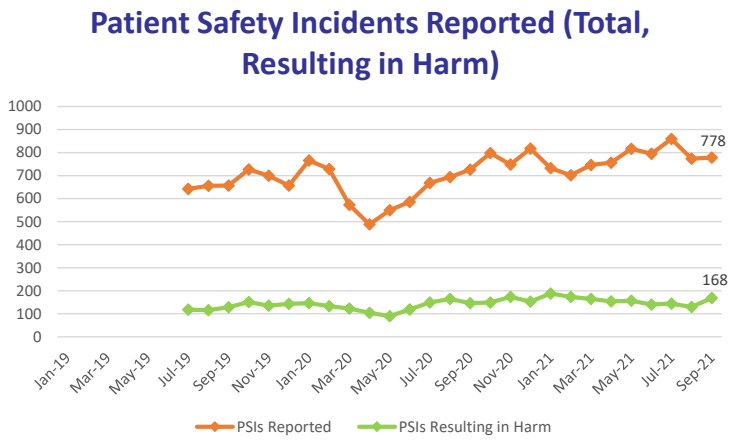
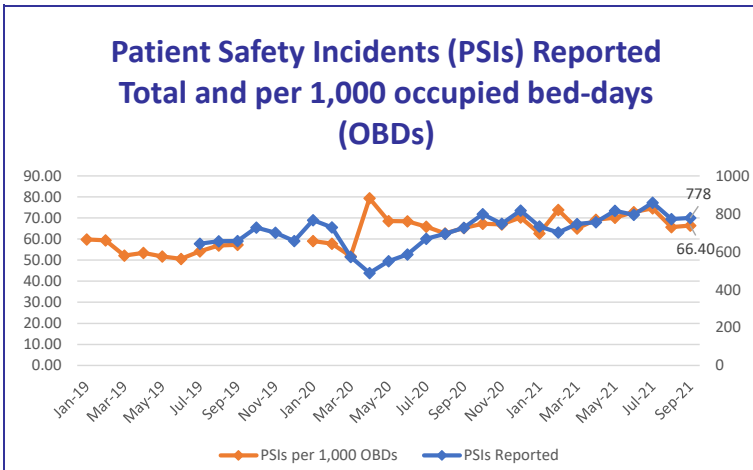
Board Report KPIs	Narratives
	Non-elective admissions remain relatively stable with a very slight increase on August. In September there was a further increase in paediatric admissions from 121 in August to 166, whilst most other specialities saw a small reduction.
A count of the number of patients who 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 September 2021 was 4.2%, a slight increase on August 2021 figures of 4%. This continues an upward trend over the last few 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 September 2021 there were 321 episodes recorded which is a very small increase on August 2021 which recorded 315 episodes of COVID-19 related sickness.
A count of our staff who have been off sick with a Covid related symptoms or to isolate. This is a local metric to monitor the impact of Covid on our workforce.	

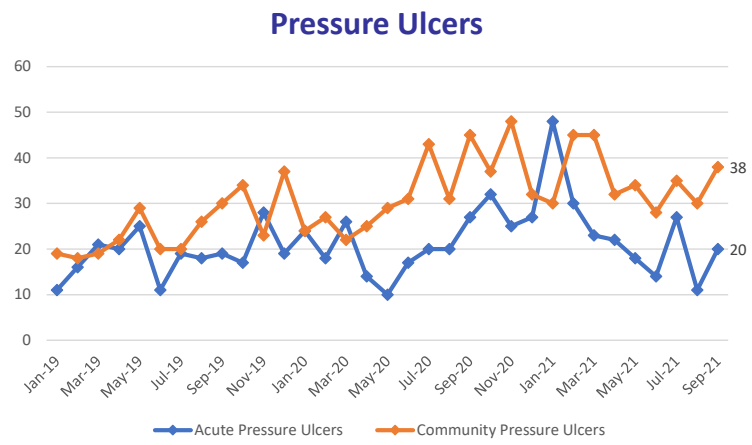
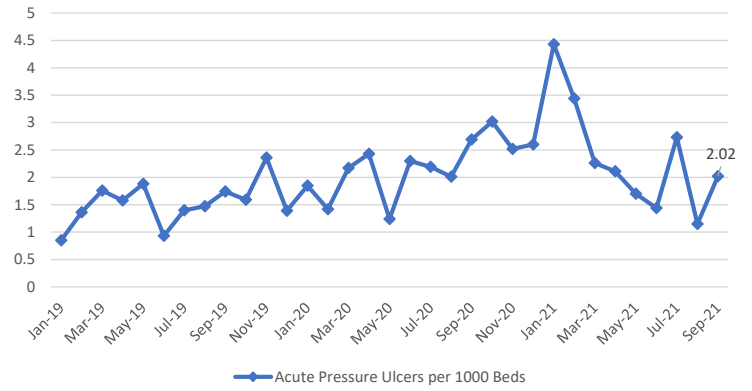
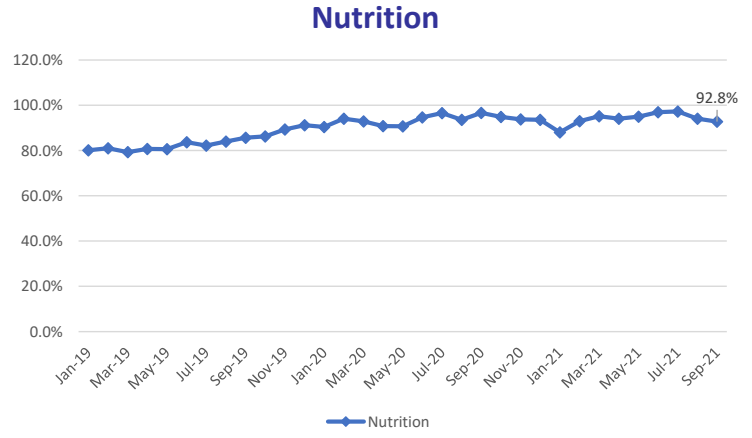
Board Report KPIs	Narratives
	The amount of operations has dropped slightly in September this is due to a combination of dropped lists in DSU, and an increase in larger cases resulting in less patients treated within main theatre (19 less patients).
This is a count of the number of operations that were carried out. This is a local measure to monitor our productivity and recovery from Covid.	
	There were 56 individual patients admitted during September, who had their first diagnosis of Covid-19. In September the highest number of Covid positive inpatients residing in the trust on any one day was 19.
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 September. The total is now 271. 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.	

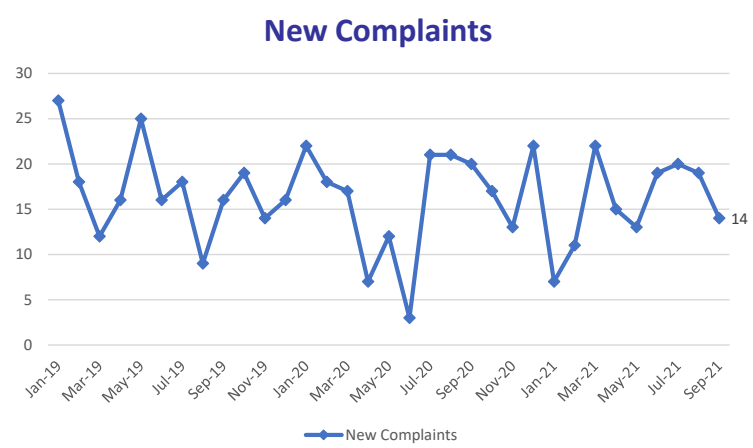
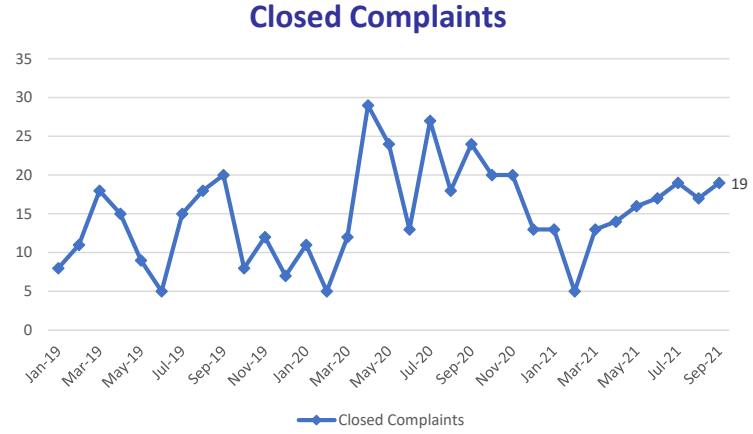
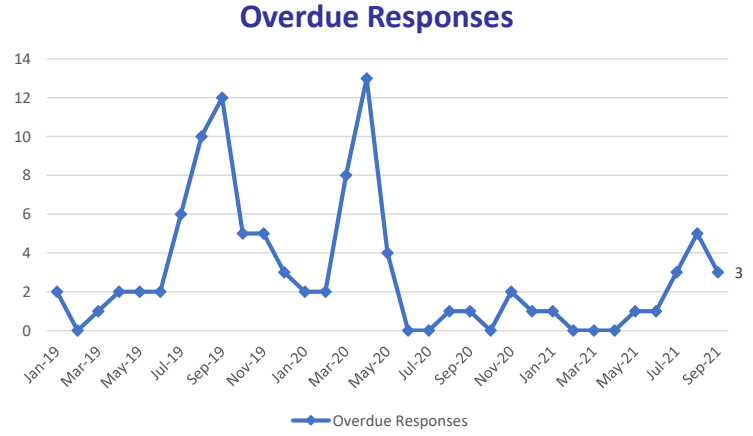
Board Report KPIs	Narratives
	Increase in diagnostic performance, particularly within Colonoscopy and Gastroscopy which have achieved over 80% for the first time since March 2020. Ultrasound continues to be a pressure point, in conjunction with a drop-in performance for ECHOs
To measure compliance with 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.	
	Performance for 2WW has dropped in September largely due to the volume of referrals received, particularly in Breast, Colorectal and Skin.
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.	
	Dip in breast performance due to increase in 2WW referrals and the need to triage and prioritise.
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.	

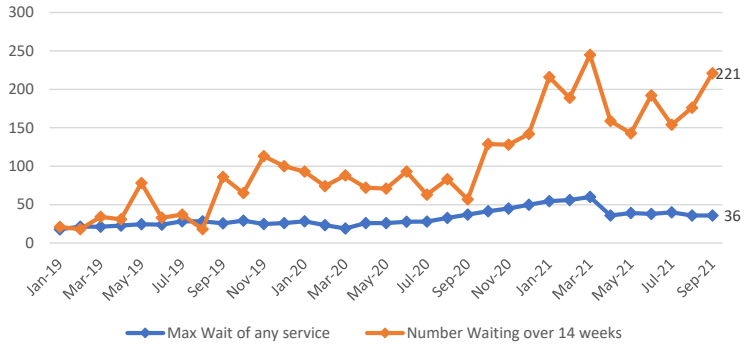
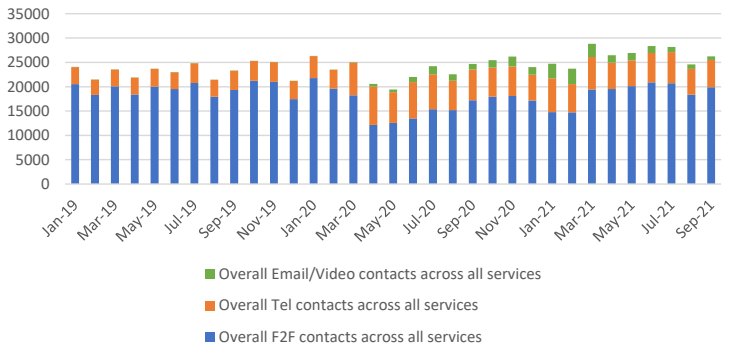
Board Report KPIs	Narratives
	Static position for 62 day performance, this will likely remain the case until theatres are back online in the new year with the majority of the breaches being within Colorectal and Urology and mostly between days 62-90.
To measure compliance with the national standards 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.	
	Spike in 2WW referrals, whilst the graph also includes breast symptoms, general 2WW referrals were higher than have been received since January 2020.
A count of the number of patients referred to the hospital with suspected cancer, requiring investigation. This metric shows the activity by month for cancer services, which informs the national metric which measures the number of these patients that were seen within 2 weeks (further in the performance pack).	
	104 day waits fairly static, continues to be a priority however there are a number of patients with multiple complexities which is impacting the ability to reduce the volume.
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.	

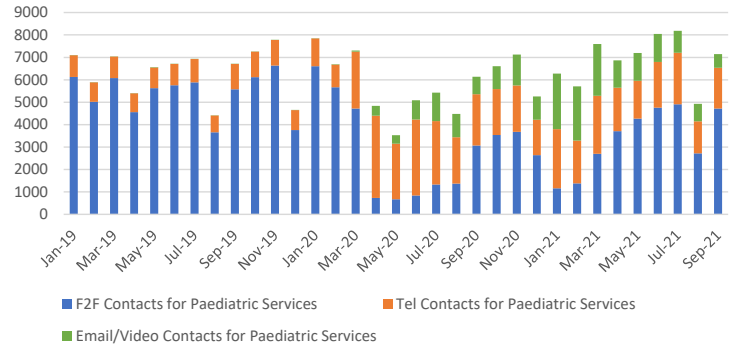
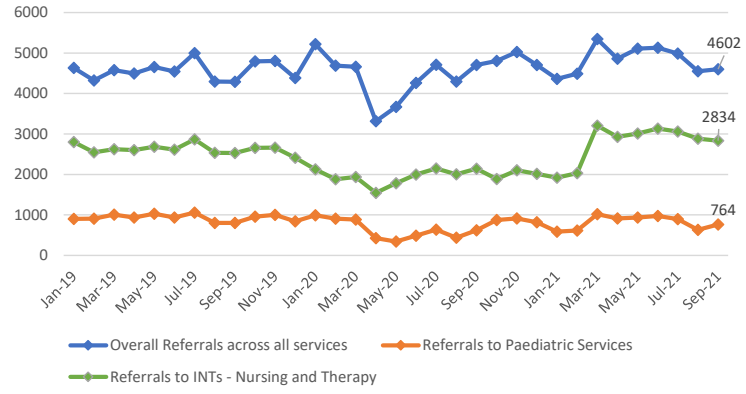
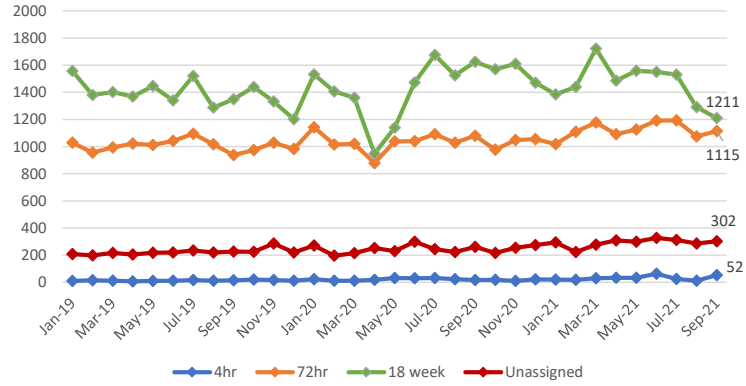
Board Report KPIs	Narratives
	
This is a count of the number of verbal and written duty of candour overdue for the reporting month (and earlier) as at the date of report issue	We have identified a need for more robust system review and management of Datix on a regular basis to ensure timely compliance with duty of candour. This will be in conjunction with the duty of candour improvement plan.
	
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 a slight decrease in dependency and an increase in acuity through the month of September, consistent with anecdotal pressures experienced through the organisation during the month. This intelligence has been acknowledged during the daily safety huddles, where senior clinical leads meet to discuss incidents and pressures each day. This information assists with staffing decisions and is utilised in conjunction with safecare data which is recorded by the wards daily. 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. Some wards are experiencing an increase in the number of complex patients with challenging behaviour, which is also placing the workforce under increasing pressure. Nurse staffing, in particular, remains under pressure and focus during September due to vacancy, isolation and high levels of 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.	

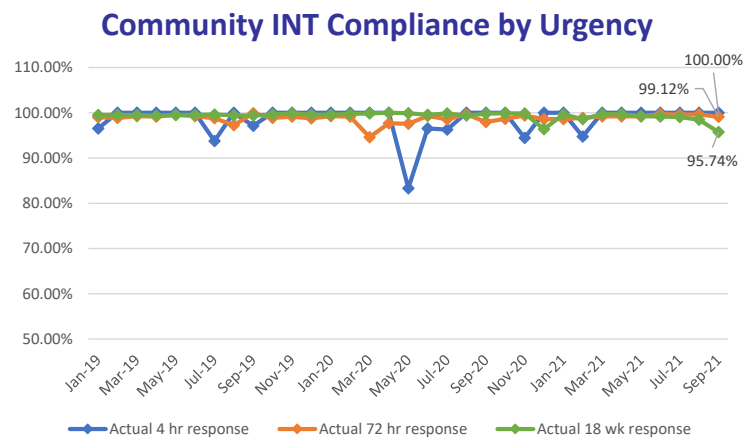
Board Report KPIs	Narratives
	This is now reported in Staffing paper.
A measure of the number of falls in the acute hospital measured per 1000 bed days. Community falls are excluded from this metric.	
	The number of PSIs reported is on average with recent months however the number of incidents reported with harm has risen however remains on average as per 1000 bed days.
A count of the number of patient safety incidents reported in total and those resulting in harm	
	The number of PSIs reported is on average with recent months however the number of incidents reported with harm has risen however remains on average as per 1000 bed days.
The number of patient safety incidents reported as a percentage of occupied bed days to measure reporting rates	

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

Board Report KPIs	Narratives
	14 formal complaints received which is typically lower than average and our lowest volume received since May 2021. A reduction in complaints relating to communication which is positive to see and furthermore a reduction in complaints relating to the emergency department. We have however seen an increase in complaints relating to patient care, including nutrition and hydration across a number of wards. We are working with ward managers to identify these issues and investigate how we can improve moving forward.
New formal complaints received and accepted, this counts both West Suffolk Hospital and Community	
	19 complaints closed in September. We often see that there is a natural increase in annual leave over the summer and staff return back in September, meaning we can obtain responses required.
Formal complaints signed off by the CEO, this counts both West Suffolk Hospital and Community	
	Remaining 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.
Any complaints which were sent outside of the given timeframe and no extension was agreed, this counts both West Suffolk Hospital and Community	

Board Report KPIs	Narratives
Community Non Consultant Led 18week Max Wait  Services covered: Adult SLT, Heart Failure, Neurology Service, Parkinson's Nursing, Wheelchairs, Paediatric Occupational Therapy, Paediatric Physio and Paediatric Speech and Language Therapy, There are no patients waiting over 52weeks for treatment from referral, so community look at number of patients waiting over 14 weeks. Historically, 14 weeks was agreed on as an internal measure because it gives an approx. number of patients who would breach the 18 week target at the end of the next month.	The number of services with patients waiting over 18 weeks has decreased to 2 in September. At the end of September these services were: Paed SLT and Wheelchairs. The maximum wait for each of these services are: Paed SLT - 30 weeks (No change from August) Wheelchairs - 36 weeks (No change from August) Paed SLT and Wheelchair services were both exceeding the wait times prior to COVID, these 2 services have papers and support from the CCG both in understanding demand and increasing resources. The lack of face to face group work and restrictions in schools etc are having a continued profound effect on Paed SLT activities, as are vacancies within the service. Wheelchairs has a high number of patients who are shielding or just unwilling to have home visits at this time, access to Special Schools and Care Homes has been limited because of COVID, staff numbers have been affected because of COVID and BREXIT has affected the supply of equipment that has been stuck at ports. The number of child breaches may be increasing but the number of handovers is actually increasing significantly.
Community Non Consultant Led 18week Compliance  Services covered: Adult SLT, Heart Failure, Neurology Service, Parkinson's Nursing, Wheelchairs, Pead OT, Pead Physio and Pead SLT. RTT nationally is for consultant led services but the community services are required to report on compliance to 18 week Referral to Treatment locally to our CCG. Target is 95% of referrals are given a first definitive treatment within 18weeks	The aggregated % of patients treated within 18 weeks for all community services in September was 94.58% with the lowest individual service being Wheelchairs at 88.56%.
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. The last 7 months have been exceptionally above the levels of the same 7 months in the last 2 years of 2020 and 2019.

Board Report KPIs	Narratives
Contacts for Community Paediatric Services 	The Paediatric services have moved a high proportion of their activity to telephone and email/video contacts but they are still unable to carry out any group work due to social distancing requirements. There are also shortages in clinic availability in certain locations. The wearing of masks and social distancing means Speech and Language therapy is particularly hard to do. The services are reviewing all possible options.
Activity is counted as a face to face/telephone/email/video contact with a patient/carer/parent which is clinically relevant. This means activity that a clinician carries out which is writing reports, liaising with other healthcare professionals is NOT counted as activity. This is in line with acute systems where there is an assumption that clinicians will carry out related activities that result from contact with a patient.	
Community Referrals 	Referrals to the majority of the community services in the last 7 months have exceeded the levels of the same months in 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.	
Community INT Referrals by Urgency 	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 September.
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)	

NHS
West Suffolk
NHS Foundation Trust

Trust Board report - 17 December 2021

Agenda Item:	2.2			
Presented By:	Nicola Cottington & Sue Wilkinson			
Prepared By:	Information Team			
Date Prepared:	Oct-21			
Subject:	Performance Report			
Purpose:	**X**	**For Information**		**For Approval**

Executive Summary:

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

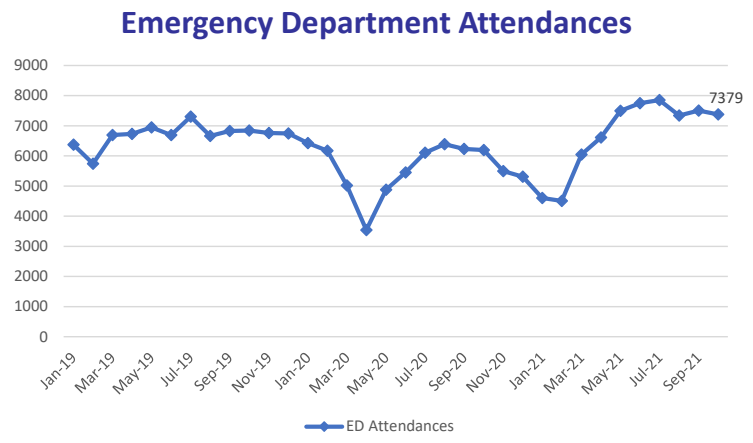
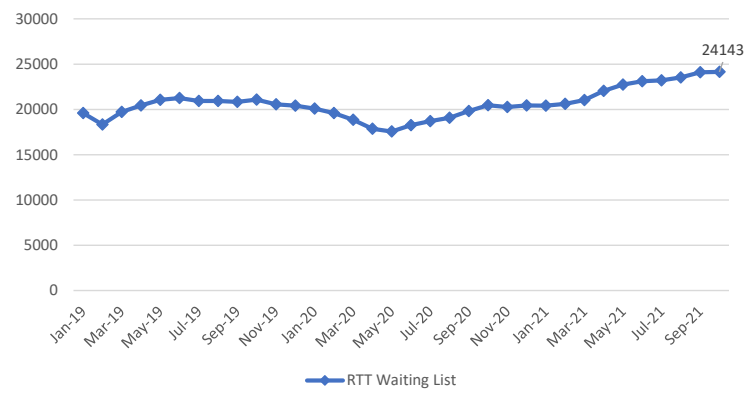
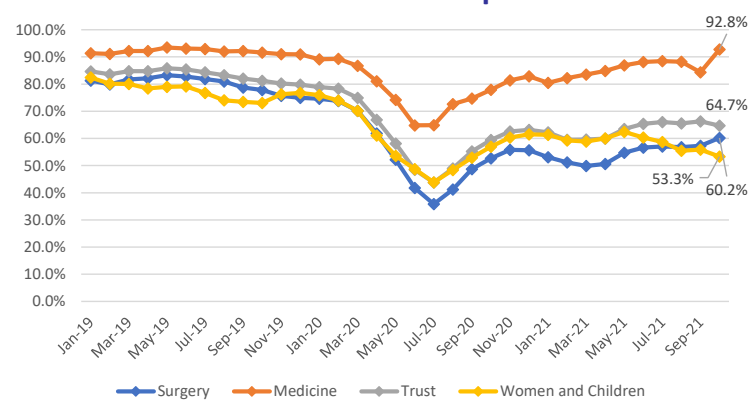
Trust Priorities [Please indicate Trust priorities relevant to the subject of the report]	**Delivery for Today**	**Invest in Quality, Staff and Clinical Leadership**	**Build a Joined-up Future**
	X		

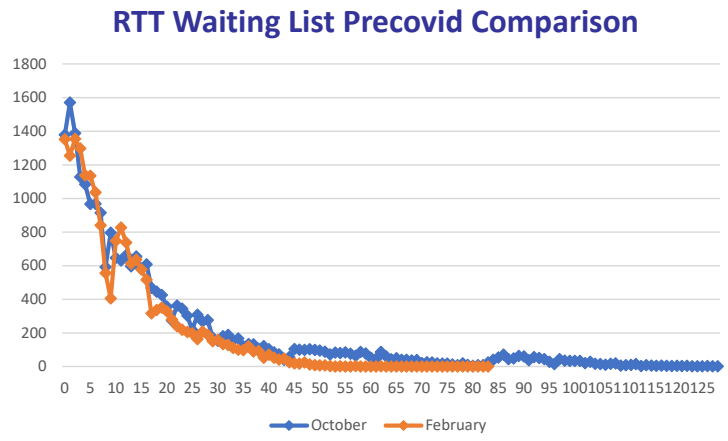
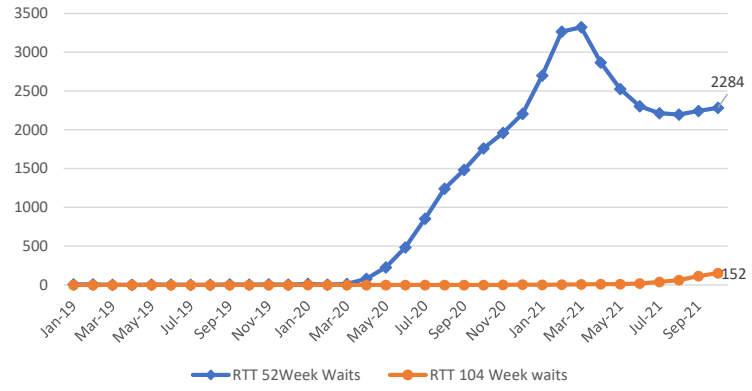
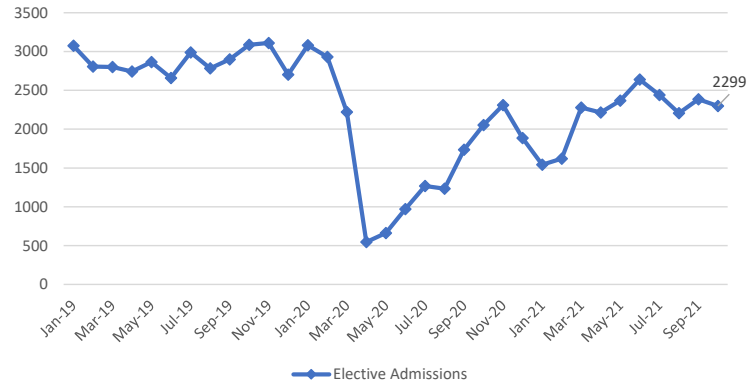
Trust Ambitions [Please indicate ambitions relevant to the subject of the report]	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
		X	**X**				**X**

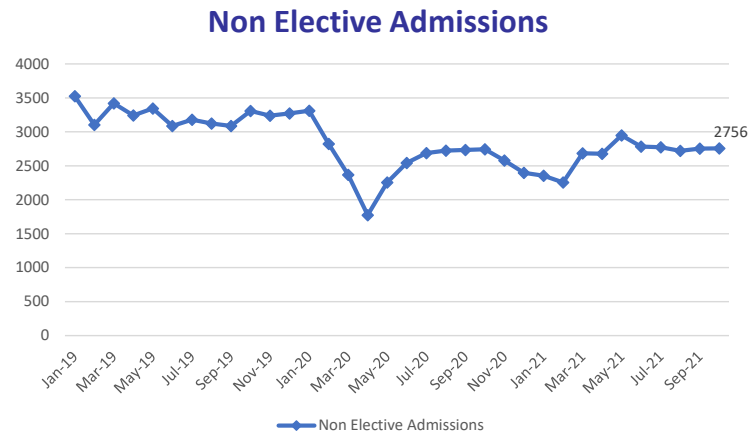
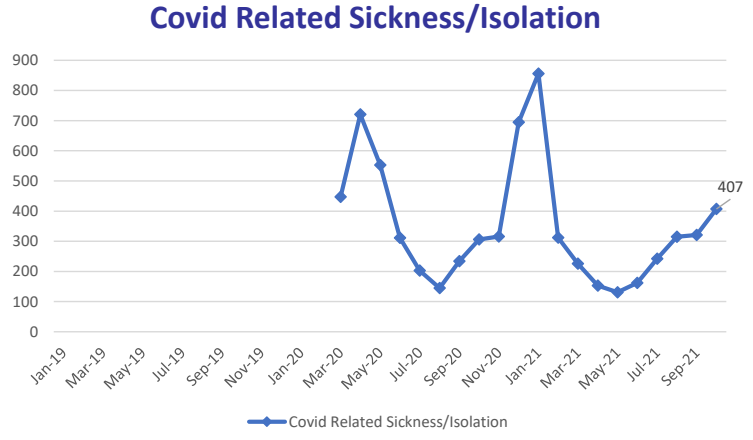
Previously Considered by:	
Risk and Assurance:	
Legislation, Regulatory, Equality, Diversity and Dignity Implications	

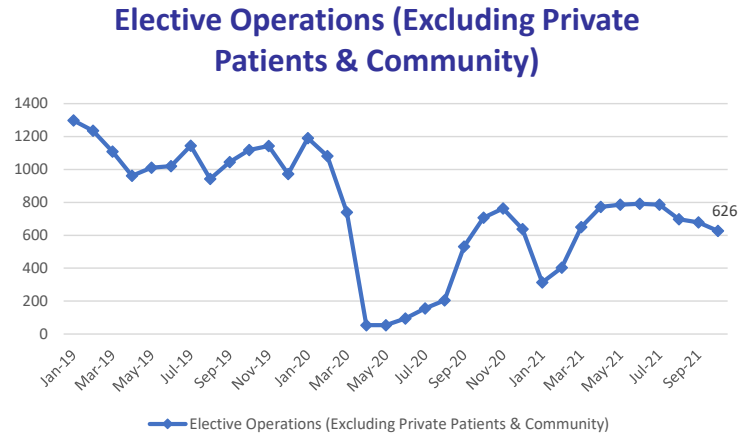
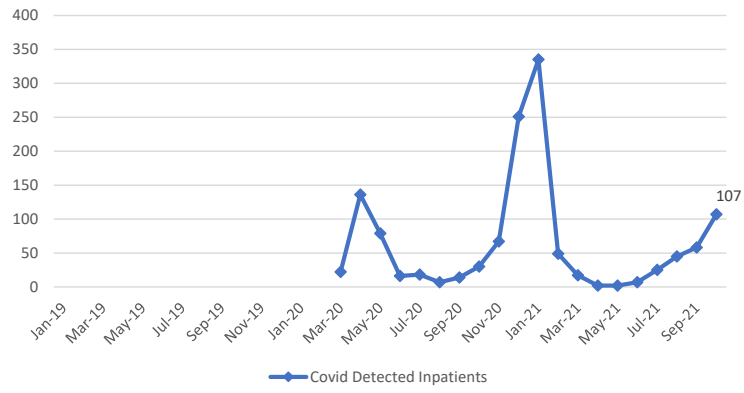
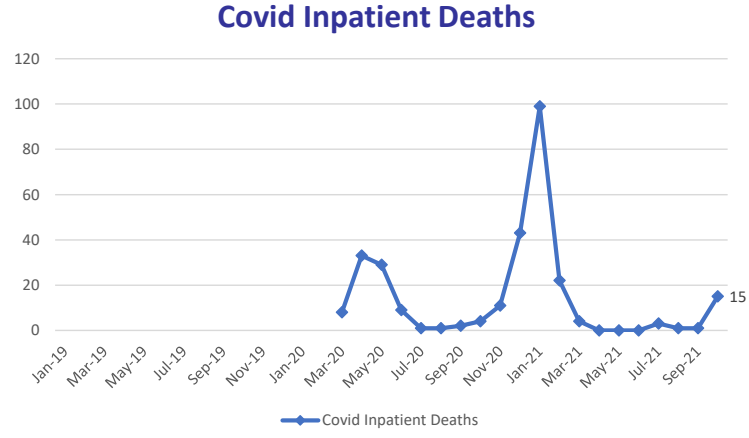
Recommendation:

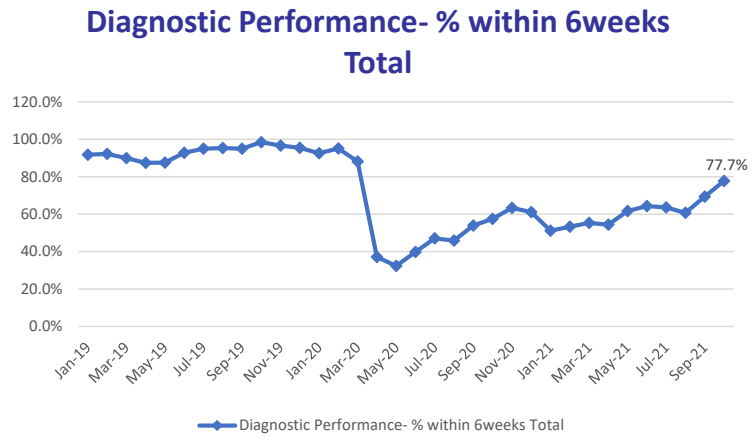
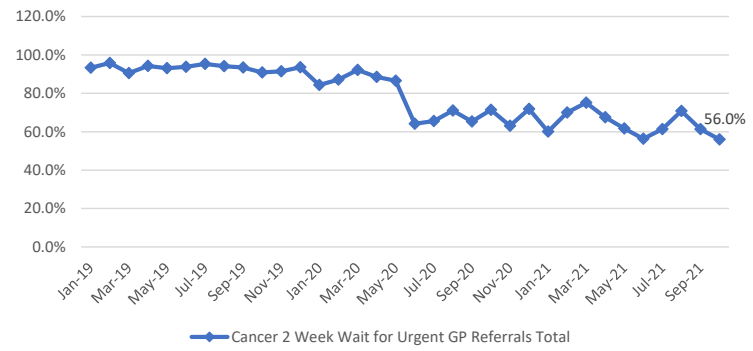
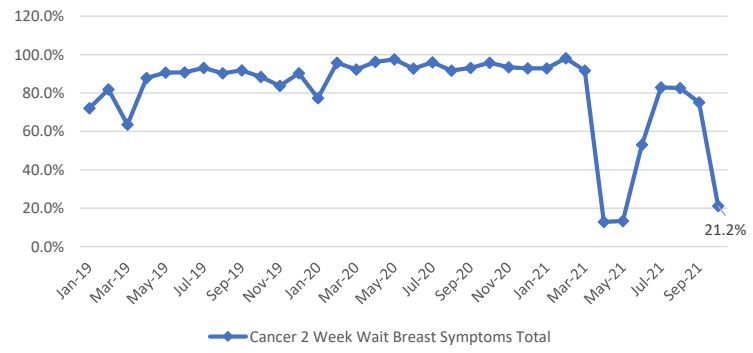
That Board note the report.

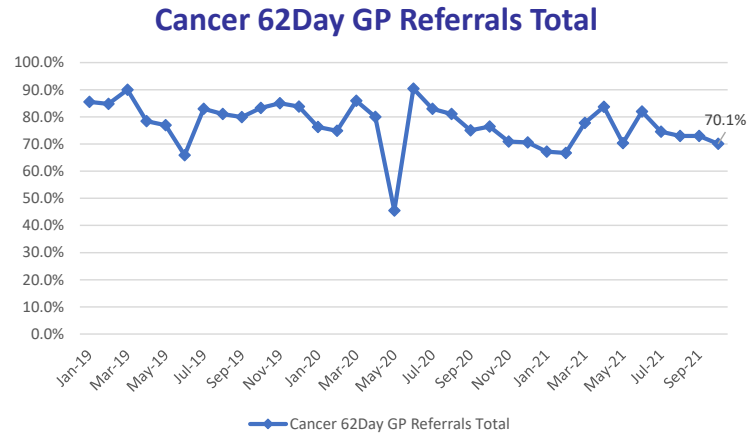
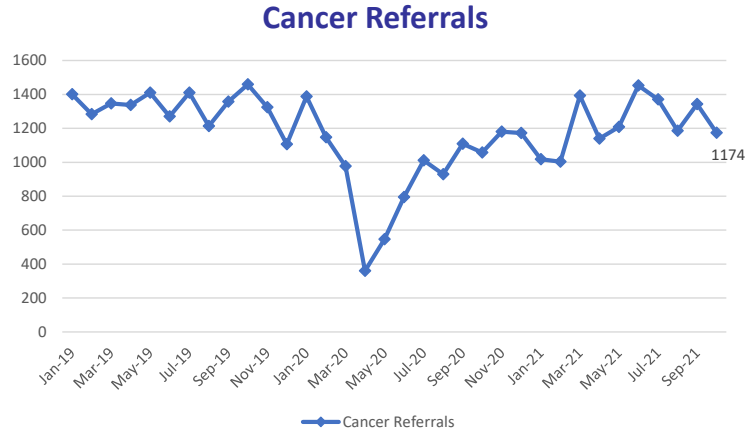
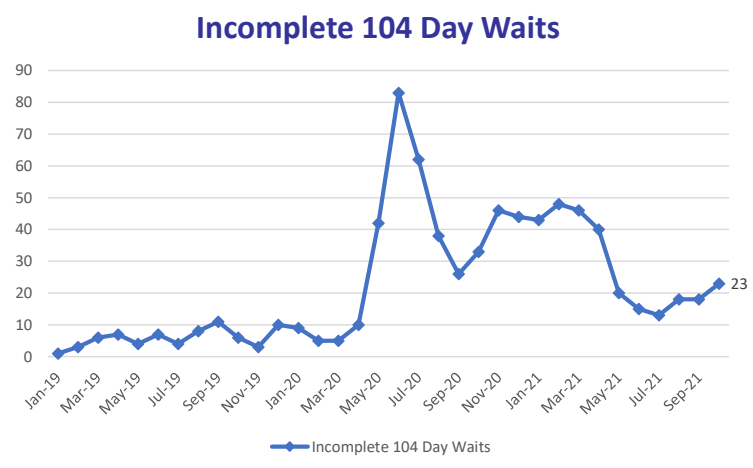
Board Report KPIs	Narratives
	A slight decrease of 127 attendances for the month of October compared with September. Work continues to review front door models, analysis of our walk-in patients and patient signposting.
A count of the arrivals at the Emergency Department. This metric has no national target but is key to understanding demand for non elective services.	
	The total waiting list has grown again in October although only by a small amount. As in previous months, we are seeing an increase in referrals in certain areas and a current inability to treat volumes of patients surgically due to theatre restrictions.
A count of the patients on the waiting list for treatment.	
	Overall Trust performance has declined slightly, mostly due to the continued reduction in performance within surgical specialities and Gynaecology in line with the continued reduction of inpatient theatre capacity, a continued improvement in Ophthalmology compliance should however be noted.
% of patients on incomplete RTT pathways	

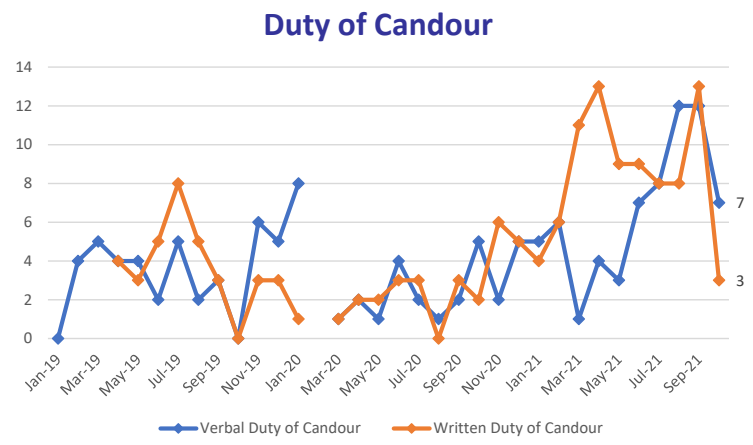
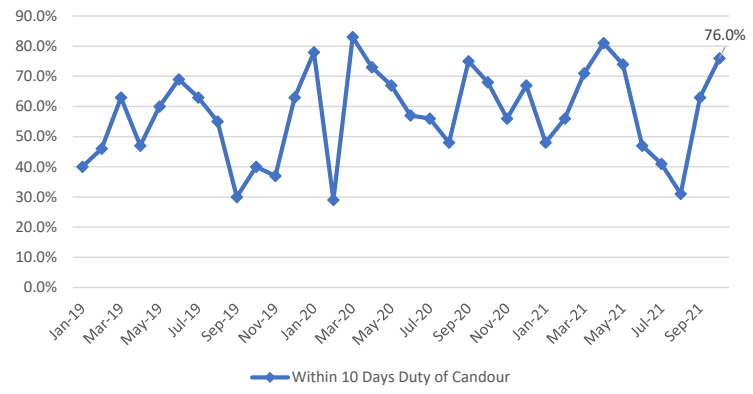
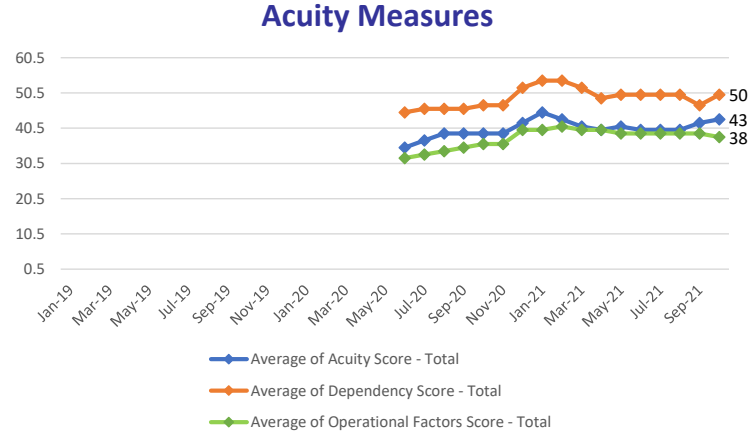
Board Report KPIs	Narratives
	As in previous months the waiting list shape remains very similar with the tail continuing to increase.
A year on year comparison of the number of patients waiting for treatment.	
	The number of patients waiting over 104 weeks has increased up to 152 in October with 97 of those within Trauma and Orthopaedics and 30 within Gynaecology. The overall 52-week waits are now at 2284. The 104-week numbers will continue to increase for the next couple of months, theatre capacity that comes back on line in December as well as independent sector capacity and mutual aid will assist with reducing this number in the longer term.
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 had dropped in October, there was one week in October when main theatre was reduced to just one elective theatre.
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.	

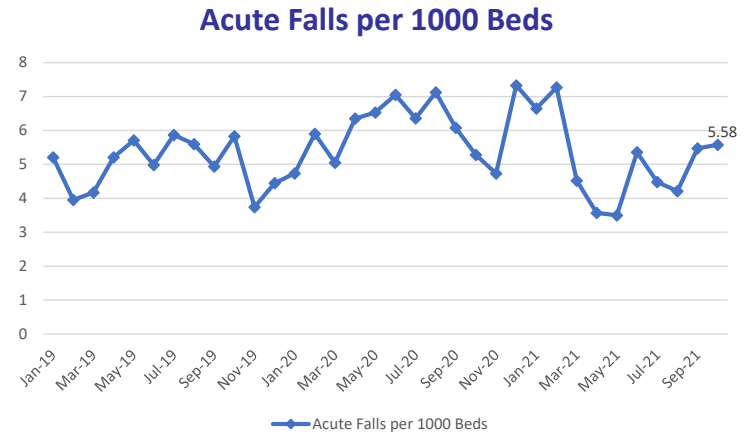
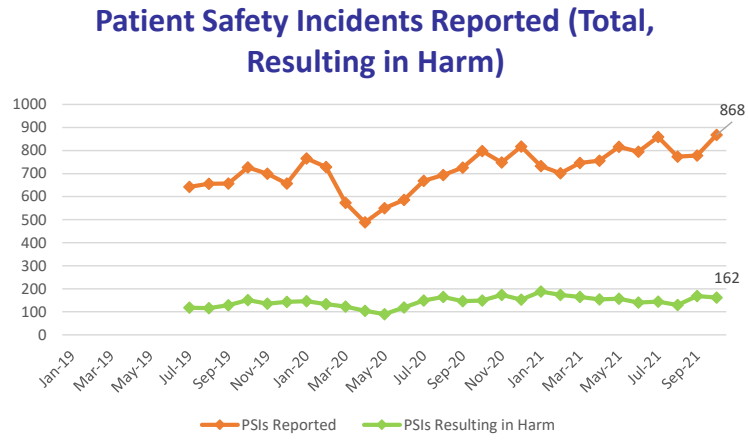
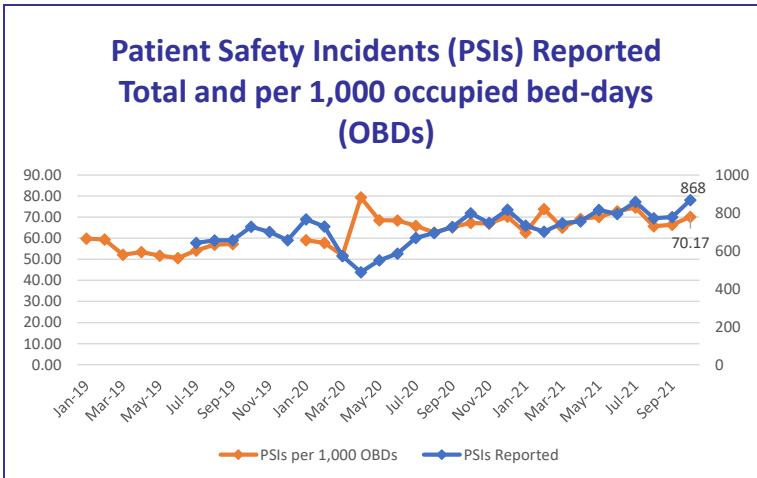
Board Report KPIs	Narratives
	October showed an increase of one admission in comparison to September. Over all admission numbers remain relatively stable. There were very slight increases in medical and surgical admissions, with slight decreases in Orthopaedic, Obs and Gynae and Paediatric admissions.
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 October 2021 was 4.2%, remaining consistent with September 2021 which was also recorded at 4.2%.
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 October 2021 there were 407 episodes recorded which is an increase on September 2021 which recorded 321 episodes of COVID-19 related sickness.
A count of our staff who have been off sick with a Covid related symptoms or to isolate. This is a local metric to monitor the impact of Covid on our workforce.	

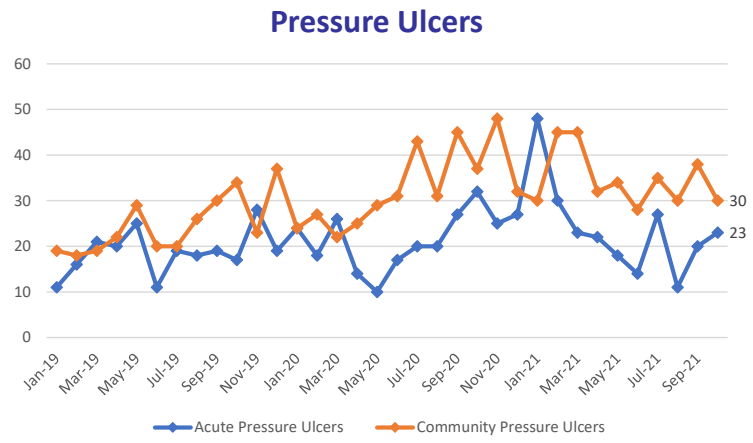
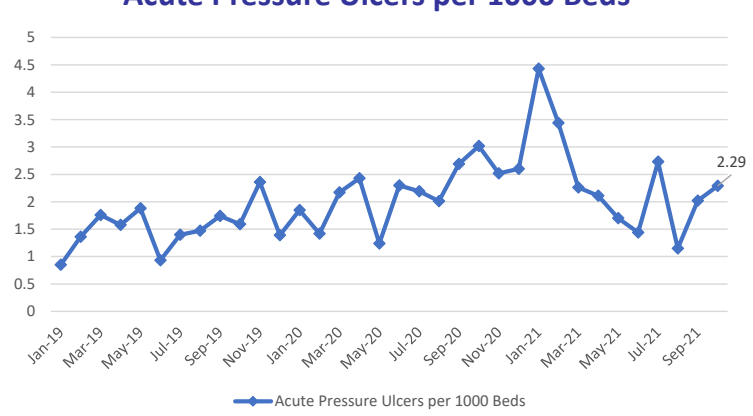
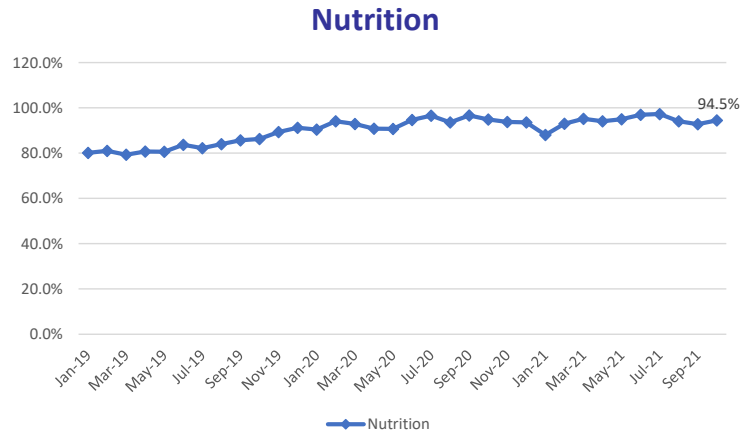
Board Report KPIs	Narratives
	Elective operations declined in October, this is in line with reducing to just one elective main theatre during one week in October, in addition numbers were slightly reduced during half term week.
This is a count of the number of operations that were carried out. This is a local measure to monitor our productivity and recovery from Covid.	
	There were 107 individual patients admitted during October, who had their first diagnosis of Covid-19. In September the highest number of Covid positive inpatients residing in the trust on any one day was 35.
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 15 patients who died within 28 days of a positive Covid result in October. The total is now 286. 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.	

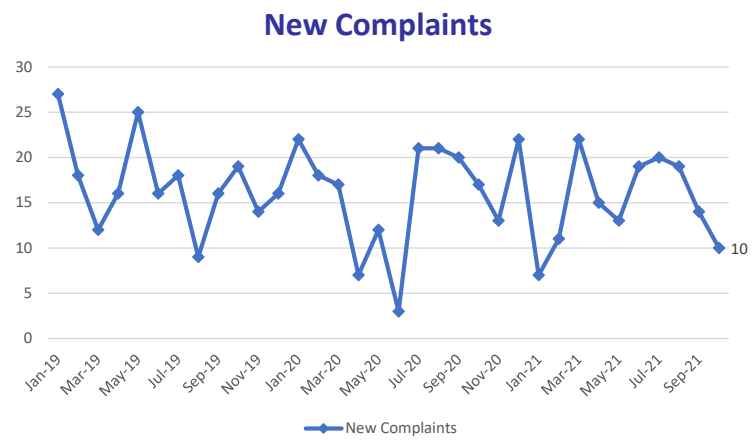
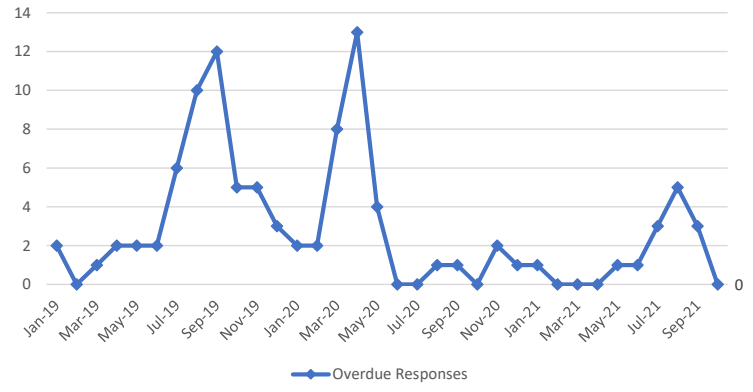
Board Report KPIs	Narratives
	Diagnostic performance continues to improve. MRI and CT continue to hit 100%, with large improvements made in Audiology, Gastroscopy, Colonoscopy and improvements in ECHOs and flexible sigmoidoscopy. Ultrasound remains well under performance at 58%. Recovery plans for ultrasound are in place with performance expected to recovery by the end of January 2022.
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.	
	October performance decreased again from September. Significant underperformance had continued in October for Skin, although it should be noted that performance is much improved for November with the introduction of Skin Analytics. Breast performance has also significantly reduced in October owing to huge increases in referral numbers of up to 50% more than the previous month.
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.	
	Breast performance has significantly reduced once again in October due to the huge increase in referrals during the month of September and October. Patients are currently being seen at between 2-3 weeks.
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.	

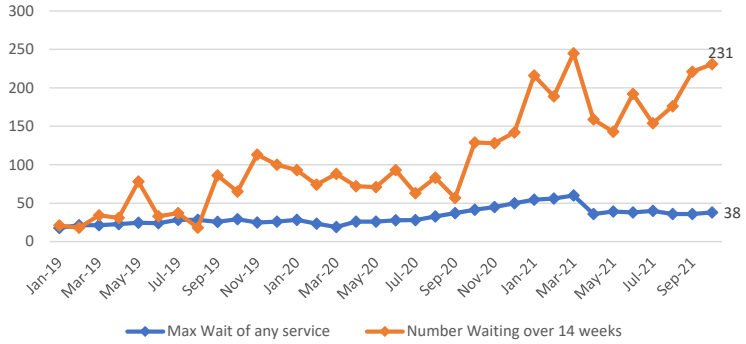
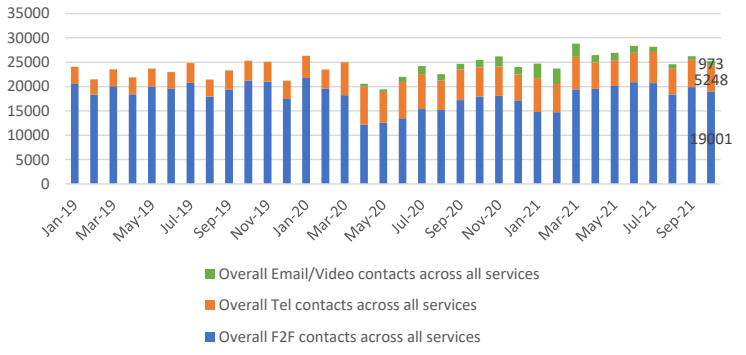
Board Report KPIs	Narratives
	62-day performance remains a challenge, particularly in Colorectal and Urology in October in line with theatre capacity available to flex capacity.
To measure compliance with the national standards for access to cancer treatment. This metric measures the percentage of patients 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 have continued to increase throughout October 2021, with the largest numbers in Breast, Colorectal and Skin.
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).	
	The number of 104-day waits had increased by 5 as at the end of the October. There was larger than average numbers for Urology this month, due to case complexities and patient choice factors. These patients are reviewed in detail each week with RCA's and harm reviewed once patients are treated.
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.	

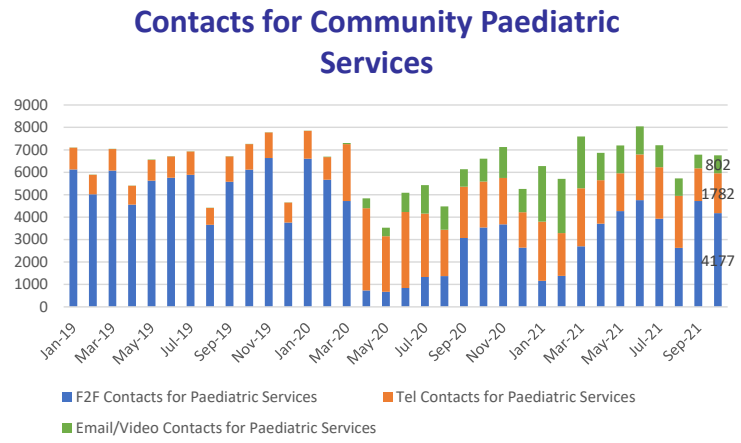
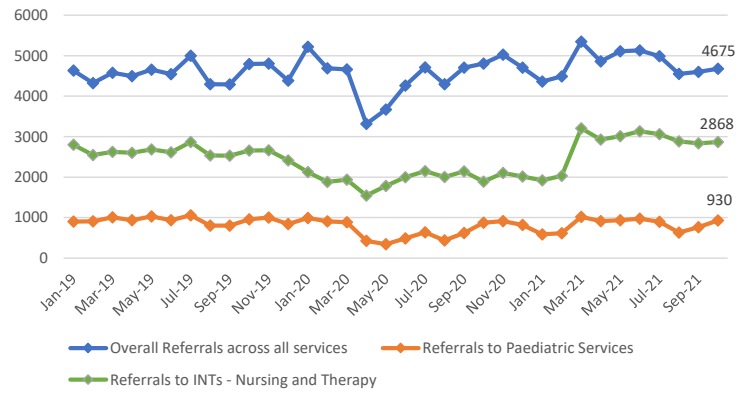
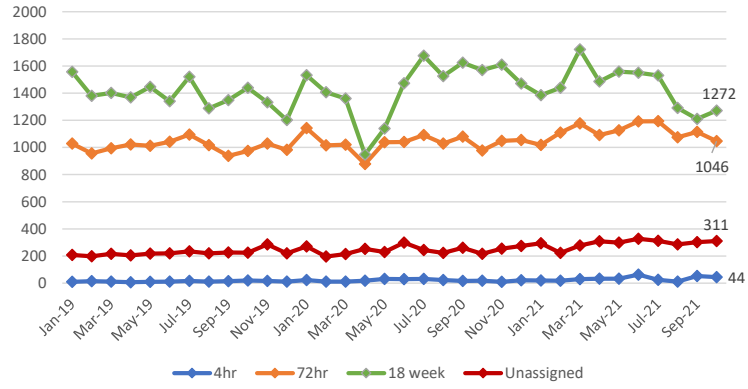
Board Report KPIs	Narratives
 This is a count of the number of verbal and written duty of candour overdue for the reporting month (and earlier) as at the date of report issue	A system and process review has enabled more timely management of Duty of Candour compliance. This will continue in conjunction with the duty of candour improvement plan.
 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.	Overall acuity and dependency increased in October and this was also the experience anecdotally, with the organisation being under increased pressure through the month. This intelligence has been acknowledged during the daily safety huddles, where senior clinical leads meet to discuss incidents and pressures each day. This information assists with staffing decisions and is utilised in conjunction with safecare data which is recorded by the wards daily. On review of the metrics, there are several areas who continue to experience higher than average acuity and / or dependency which correlates with the pressures the wards and departments are continuing to experience. Some wards are experiencing an increase in the number of complex patients with challenging behaviour, which is also placing the workforce under increasing pressure. Nurse staffing, in particular, remains under pressure and focus during October due to vacancy, isolation and increasing levels of sickness, however this is not reflected in these measures.

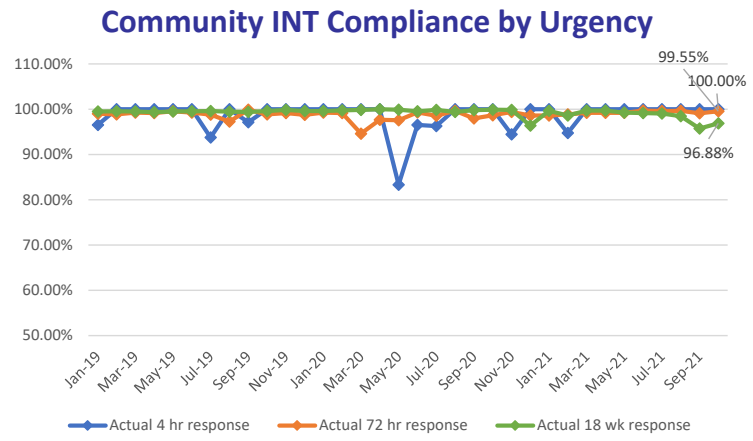
Board Report KPIs	Narratives
	This is now reported in Staffing paper.
A measure of the number of falls in the acute hospital measured per 1000 bed days. Community falls are excluded from this metric.	
	There has been a rise in the number of PSI's reported, although a minimal reduction in PSI's with harm. This remains on average as per 1000 bed days.
A count of the number of patient safety incidents reported in total and those resulting in harm	
	There has been a rise in the number of PSI's reported, although a minimal reduction in PSI's with harm. This remains on average as per 1000 bed days.
The number of patient safety incidents reported as a percentage of occupied bed days to measure reporting rates	

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

Board Report KPIs	Narratives
	10 formal complaints received which is our lowest amount received since January 2021. The complaints ranged over a number of departments with no specific trends. It is positive to see that no complaints were received for the emergency department or gynaecology, which we have seen in recent months.
New formal complaints received and accepted, this counts both West Suffolk Hospital and Community	
	9 complaints closed in October. We experienced some annual leave in October which meant a slight drop in complaints responded to.
Formal complaints signed off by the CEO, this counts both West Suffolk Hospital and Community	
	All operational issues seemed to have been resolved. Furthermore, complainants have been kept up to date with any delays (if applicable)
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 remained at 2 in October. At the end of October these services were: Paed SLT and Wheelchairs. The maximum wait for each of these services are: Paed SLT - 34 weeks (increased from 30) Wheelchairs - 38 weeks (increased from 36 weeks) Paed SLT and Wheelchair services were both exceeding the wait times prior to COVID, these 2 services have papers and support from the CCG both in understanding demand and increasing resources. The lack of face to face group work and restrictions in schools etc are having a continued profound effect on Paed SLT activities, as are vacancies within the service. Wheelchairs has a high number of patients who are shielding or just unwilling to have home visits at this time, access to Special Schools and Care Homes has been limited because of COVID, staff numbers have been affected because of COVID and BREXIT has affected the supply of equipment that has been stuck at ports. The number of child breaches may be increasing but the number of handovers is actually increasing significantly.
Community Non Consultant Led 18week Compliance  Services covered: Adult SLT, Heart Failure, Neurology Service, Parkinson's Nursing, Wheelchairs, Pead OT, Pead Physio and Pead SLT. RTT nationally is for consultant led services but the community services are required to report on compliance to 18 week Referral to Treatment locally to our CCG. Target is 95% of referrals are given a first definitive treatment within 18weeks	The aggregated % of patients treated within 18 weeks for all community services in October was 91.12% with the lowest individual service being Wheelchairs at 82.10%.
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.

Board Report KPIs	Narratives
	The Paediatric services have moved a high proportion of their activity to telephone and email/video contacts but they are still unable to carry out any group work due to social distancing requirements. There are also shortages in clinic availability in certain locations. The wearing of masks and social distancing means Speech and Language therapy is particularly hard to do. The services are reviewing all possible options.
Activity is counted as a face to face/telephone/email/video contact with a patient/carer/parent which is clinically relevant. This means activity that a clinician carries out which is writing reports, liaising with other healthcare professionals is NOT counted as activity. This is in line with acute systems where there is an assumption that clinicians will carry out related activities that result from contact with a patient.	
	Referrals to the majority of the community services for 2021 YTD has exceeded the same periods of 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 October.
Referrals into the Integrated Neighbourhood Teams have urgencies of Red (within 4 hours), Amber within 72hrs) and Green (within 18 weeks). These contractual urgencies are locally agreed pan Suffolk with the CCG and there is a 98% response target for Red, Amber and Green response times have a 95% threshold (These are local contractual targets)	

2.3. Improvement Committee Report - November 2021 Chair's key issues from the meeting

To Assure

Presented by Jude Chin

Board of Directors – 17 December 2021

Agenda item:	2.3			
Presented by:	Jude Chin, Non-executive Director			
Prepared by:	Ann Alderton			
Date prepared:	Grace Condliffe, EA to Executive Chief Nurse			
Subject:	Improvement Committee report and Chair's Key Issues			
Purpose:	X	For information	X	For approval

Executive summary:

The Improvement Committee met on 11 October 2021. The transition to the committee operating as a board assurance committee is still in progress, further steps towards which included the decommissioning of the Improvement Programme Board.

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

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

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

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

Recommendation: To approve the report

Chair's Key Issues

Part A

Originating Committee	Improvement Committee	**Date of meeting**	11 October 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	**Patient quality and safety governance group:** The minutes of the meeting were received and noted; there were no items for escalation	**Assurance**		
4.2	**Clinical effectiveness governance group:** The report was received and noted; there were no items for escalation. The group provided assurance that the clinical audit work from the Improvement Programme Board was being picked up.	**Assurance**		
5.1.1	**Obstetrics/maternity:** A maternity improvement board was meeting twice a month to monitor and drive improvement based on NHSE visit recommendations, CQC findings, QI projects etc. Staffing issues remained the main concern, which was a national as well as local issue. Red risks include the availability of an obstetric doctor outside of normal hours and a second out of hours emergency theatre. Further work was being completed on job planning to understand the scale of the problem, prior to review by the executive directors.	**Assurance**		
5.1.2	**Pathways of surveillance:** All the surveillance pathways were reviewed and the overall plan was now rated green. The only outstanding issue related to an e-Care tool to manage patients as worklists were still held by individual departments. An escalation process was in place, a monthly oversight meeting and weekly discussions regarding recovery action plans. An internal audit had been completed and reasonable assurance found; additional in-house audits had also commenced and reported to the Insight committee. This area, which had been a PSIRF priority, would not be on next years programme due to the work completed however KPI reporting would continue to the Insight committee.	**Assurance**		
5.2	**Improvement Programme Board:** It was agreed the old improvement programme board actions should be reviewed to ensure it was clear which	**Assurance**		

	3i committees had responsibility for monitoring which actions and that these were included in any forward planning for reporting purposes.			
5.2.1	**Decommissioning tracker update:** Work is to be carried out to ensure that outstanding points are allocated to the appropriate committee. It is anticipated that any red actions would be on the risk register. Some concern was expressed at the level of progress being made on actions that remained red; this will be followed up at subsequent committee meetings.	**Assurance**		
5.3.2	**VRE outbreak:** The committee received an update of the work to date. The Infection Prevention team had been working closely with Public Health England (PHE) and their epidemiology team to reduce infection rates. The Trust had engaged in screening programmes and typing organisms to try and understand how they were being spread. The main focus had been on the surgical ward F6 but extended to critical care and F3. The infection prevention team had increased their presence on the wards, visiting several times a week and sometimes daily if capacity allowed. New national standards for cleaning were being introduced and a working group set up to review cleaning responsibilities which would ensure the unification of standards across the organisation. It was noted that work in this area was being monitored by the Infection & Prevention Control Committee which reported into the Patient Quality & Safety group	**Assurance**		
5.5	**Specialist committee updates:** There were no updates or escalations from specialist committees. It was proposed that committees which produced annual reports eg Infection Prevention and Control, could report to the Improvement Committee.	**Assurance**		
6.1	**Forward plan:** It was agreed that the committee should produce a forward plan to include items from the governance committees, PSIRF programme, improvement programme board outstanding actions, annual reports from specialist committees, patient access, corporate risk and finance/workforce groups, as well as Insight and Involvement escalation/deep dives, Trust policies, Trust Board eg BAF/risk register and the QI projects/dashboard.	**Assurance**		
Date completed and forwarded to Trust Secretary				

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 – 17 December 2021

Agenda item:	2.3			
Presented by:	Jude Chin, Non-executive Director			
Prepared by:	Ann Alderton			
Date prepared:	25 November 2021			
Subject:	Improvement Committee report and Chair's Key Issues			
Purpose:	X	For information	X	For approval

Executive summary:

The Improvement Committee met on 8 November 2021. The transition to the committee operating as a board assurance committee is still in progress, further steps towards which included the approval of its terms of reference and the decommissioning of the Improvement Programme Board.

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

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

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

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

Recommendation: To approve the report

Chair's Key Issues

Part A

Originating Committee	Improvement Committee	**Date of meeting**	8 November 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	**Improvement Committee oversight of Duty of Candour project:** First meeting of the DoC group scheduled for Friday 12 November 2021. A robust governance process will make people more confident and feel supported. The main focus was to improve quality by establishing a support network and training across the organisation.	Assurance		
5.1	**PSIRP plan for 2022:** Improvement plan to be created, priorities to be identified, deadlines for monitoring by committees/governance groups to be set where appropriate; key indicators to be identified where no end dates possible.	Assurance		
5.2	**Improvement Programme Board update** - **Pathology:** KPIs being developed for monitoring, quarterly reporting to Clinical Effectiveness governance group, clear escalation route through the ADO, accreditation process starting in December, transformation group and pathology board established and representation on clinical service governance groups, reporting framework being updated in line with new committee structure. Reporting to improvement committee to be reduced to 6-monthly.	Assurance		
5.3	**National safety priorities – Learning from deaths:** Need to clarify context of LfD group (assurance or management). Concerns raised regarding a low number of preventable deaths being identified by the medical examiner making the Trust an outlier and likely to come under scrutiny. More assurance was needed that this was a true picture; a peer review was proposed. To be escalated to the Trust board for information.	Assurance		
6	**Board Assurance Framework (BAF) risk review - Quality governance or service failure:** The majority of controls are reported to the Trust	Assurance	1.1 (222)	

	board. Further scrutiny was welcomed if deemed necessary: an internal deep dive was proposed to provide assurance.			
7.1	**IPB decommissioning (referral from Insight):** The main concern was how to demonstrate that actions were embedded and moved to business as usual. Further confirmation was needed regarding reporting and responsibility for monitoring, sign off etc.	Assurance		
7.2	**Forward plan:** A new structure was proposed for next year; information and reporting would be similar but under new headings e.g. patient safety priorities (which would include PSIRP, specialist subjects/committees), quality priorities/QI projects, risk management/governance. Plan to be drafted with frequency/month identified for clarity.	Assurance		
7.3	**QI project future reporting:** The clinical effectiveness governance group will lead on ensuring that QI can develop links with the Trust/PSIRP priorities. Ways to disseminated and spread the message regarding quality improvement to be explored.	Assurance		
7.4	**Committee membership:** To be reviewed as part of the annual report process.	Assurance		
Date completed and forwarded to Trust Secretary				

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			

2.4. Maternity services quality & performance report

To Assure

Presented by Susan Wilkinson and Karen Newbury

Trust Open Board– 17 December 2021

Agenda item:	2.4			
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:	December 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;

- e-Care
- Maternity improvement plan
- Safety champion feedback from walkabout
- National Staff Satisfaction Survey Results (Annex A)
- Service user feedback
- National best practice publications
- Reporting and learning from incidents
- Compliance with reporting incidents to HSIB and NHSR (Annex B)
- Maternity Clinical and Quality dashboard (Annex C)
- Training Needs Analysis and Tracker – Quarter 2 (Annex D)
- Training programme plans – Safety Action 8 (Annex E)
- Midwifery Staffing report – Safety Action 5 (Annex F)
- Neonatal Transitional Care Audit (Annex G)
- ATAIN Quarter 2 report (Annex H)

<u>e-Care</u>

Data collection is an improving picture and issues due to workflow and user input are slowly being resolved. The e-Care and Information team continue to work closely with maternity team to address this. Currently we are provided with maternity data in the second to third week of the month for the previous month. The digital midwife and information team identify there is still data correction and cleansing required, however there is a marked improvement. e-Care pathway modification continues and on-going training has been provided to all staff groups.

<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, the plan has captured the actions needing completion from the 6 Supportive Steps visit from NHSE/I and continues to be reviewed by the Maternity Improvement Board every two weeks.

Safety Champion Walkabout feedback

The Board-level champion undertakes a monthly walkabout in the maternity and neonatal unit. 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 Executive Safety Champion undertook monthly feedback in October 2021 via a maternity staff survey discussed in the next section.

The Safety Champion Walkabout took place on 30/11/2021 across F11 and Maternity Day Assessment (MDAU). Discussions raised:

- Completing Mandatory training in own time
- Appraisal seen as 'tick box' exercise
- Occasional difficulty in accessing medical staff to review women and birthing people in MDAU
- Increase in number of ward clerks most welcome and will make a real difference
- New MDAU lead midwife making a positive difference
- Positive reaction to F2 overnight cover

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'.

Maternity Staff Survey Results (Annex A)

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. It. 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 an open, supportive and 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, which closed in October. Feedback was given via a PowerPoint presentation (Annex A) which was shared at the Maternity Clinical Audit and Education Meeting, emailed to all midwifery staff and shared via Take 5. To move forward, volunteers have been sought to attend solution focused groups.

Service User feedback via F&FT and Health watch Suffolk

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.

Ward/dept	September survey returns	September FFT score	October survey returns	October FFT score
F11	24	100%	16	100%
Antenatal	27	100%	39	95%
Labour Suite	6	100%	Nil	
Postnatal Community	38	100%	48	100%
Combined (Labour Suite & Birthing Unit)	10	100%	Nil	

Healthwatch Suffolk asked people to share their experiences of having a baby in east and west Suffolk in August 2021. The comments received were a mixture of positive and negative experiences across the county and reflective of staffing and quality standards at the time. The health and wellbeing of

service users and their families is paramount to our maternity staff and there continues to be close work with our service user group Maternity Voice Partnership (MVP) to act upon feedback and coproduce our services. In response to national midwifery staffing shortages, the Trust has partnered with the LMNS to undertake a National Recruitment drive, engaged with the regional team regarding International recruitment and continues to have a rolling advert out for midwives. To note the region have agreed the funding for 8 International Midwives and the interviews are due early December 2021.

The Trust has responded to feedback from midwifery staff, service users and external visits, by approving a business plan to increase the numbers of support staff including Maternity Care Assistants, Ward clerks, Nursery Nurses to support and enable midwives to undertake their role more efficiently.

The Trust is also working with the LMNS to reinstate infant feeding peer support workers who have undertaken specific Baby Friendly Initiative training.

National best practice publications

The publication of the Induction of Labour (IOL) NICE guidance has been discussed and a GAP analysis has been completed with the action plan in place to address areas for improvement. Due to concerns raised via the MVP regarding this new guidance, a representative has been invited to join the IOL task and finish group to review the guidance and subsequent Trust guideline and patient information leaflets.

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 has closed and we are still awaiting feedback. The final report was received early December 2021 and is being reviewed to determine if there is any additional learning not identified in previous external reviews of these cases.

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, in addition this month the quarter two PMRT report will be shared. 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 October and November.

Compliance with reporting incidents to HSIB and NHSR (Annex B)

The Report for Safety Action 10 for (CNST) – reporting to Healthcare Safety Investigation Board (HSIB) and NHS Resolutions (NHSR) gives assurance that the maternity service is compliant with reporting qualifying incidents to HSIB and NHSR. The requirement is to demonstrate that in 100% or qualifying cases the Trust has systems and processes in place to report incidents to HSIB and NHSR within the timeframes and families give their consent and are kept informed and involved of the processes involved for review. In Quarter 2, July 2021-Sep 2021 100% compliance was achieved.

Maternity dashboards (Annex C)

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). From this month onwards, red rated data will be represented in line with the national NHSI model of SPC charts.

Indicators	Narrative
Total number of Caesarean sections and emergency sections	Trends reviewed and expected variance in conjunction with patient choice
Induction of labour	Expected increase due to increase in antenatal surveillance. In line with region and national picture.
Post-partum haemorrhages >1500mls	In line with increase of caesarean section and induction of labour, however QI project continues.
Breastfeeding initiation rates	Patient choice and reflective of support able in hospital and community.
Swab count compliance	Awaiting mandatory field on e-Care, currently documented in several places and therefore difficult to audit.
Labour Suite coordinator supernumerary status and	Compliance reflective of increased staffing absence due to Covid 19, staffing shortages as well increase acuity over this period. The escalation policy activated
Emergency equipment checks	Reflects staffing issues at present, however ongoing monitoring and compliance checks in place.
Training compliance	Reflects staffing shortages due to Covid.
Decision to delivery times for grade 2 sections	Business case for F2 doctors approved. QI work continues. No adverse effects reported despite delay.

Training Needs Analysis and Tracker – Quarter 2 (Annex D)

For the reporting quarter 2 (July 21-September 21) the MDT training compliance was not achieved. This was due to limited availability of data to fully complete the report especially around medical staffing and Neonatal Life Support (NLS) training, difficulties with releasing medical staff to attend training and limited availability of training rooms for face to face training due to Covid.

Training programme plans – Safety Action 8 (Annex E)

The Training programme plan provides evidence that local training is in place to ensure that all six core modules of the Core Competency Framework will be included over the next 3 years, starting from the launch of Maternity Improvement Scheme (MIS) year 4 (August 2021). Included is a breakdown of each training session with its content, to evidence compliance with this standard.

Midwifery Staffing report – Safety Action 5 (Annex F)

This report is to provide oversight of midwifery staffing/safety issues within the timeframe of April 2021 – September 2021. This report will provide evidence against the Year 4 Maternity Incentive Scheme (MIS) Safety Action 5 and includes an action plan that will be monitored at the service Maternity Quality and Safety Meeting and Women's and Children's Divisional Board.

The maternity service has taken steps to ensure that recruitment to the required staffing levels is ongoing and there is an active escalation of staffing concerns on an ongoing basis when activity and acuity is raised.

Neonatal Transitional Care (NTC) Audit (Annex G)

This audit covers quarter 2(July 2021-September 2021) The objectives are to demonstrate whether the standards for clinical criteria for admission and the operational standards in relation to midwifery, neonatal and medical staffing are in accordance with the current policy.

The overall aim is to determine whether there are modifiable factors which can be addressed as part of an action plan in order to improve the care for mothers and babies.

Overall, the admissions to NTC were slightly less than the previous quarter 78 ↓ 84. The significance of this was difficult to interpret, however, it appears that NTC is reducing admissions to the NNU and the overall picture looks very positive.

There was a significant reduction in term babies admitted to the neonatal unit from 6% in quarter 1 down to 3% in quarter 2. Review of current NTC provision is underway to prevent further admissions to the Neonatal Unit (NNU) and more importantly prevents the separation of mothers and their babies.

ATAIN Programme Quarter 2(Annex H)
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, i.e. ≥ 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)

In quarter 2 (July 2021- Sep 2021) there were no potential avoidable term admissions to the NNU under these 4 areas however, appropriate staffing improvements to the NTC was identified which would prevent babies from admission to the NNU. This has been acted upon and currently the recruitment process for Band 4 Nursery Nurses has been commenced.

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	

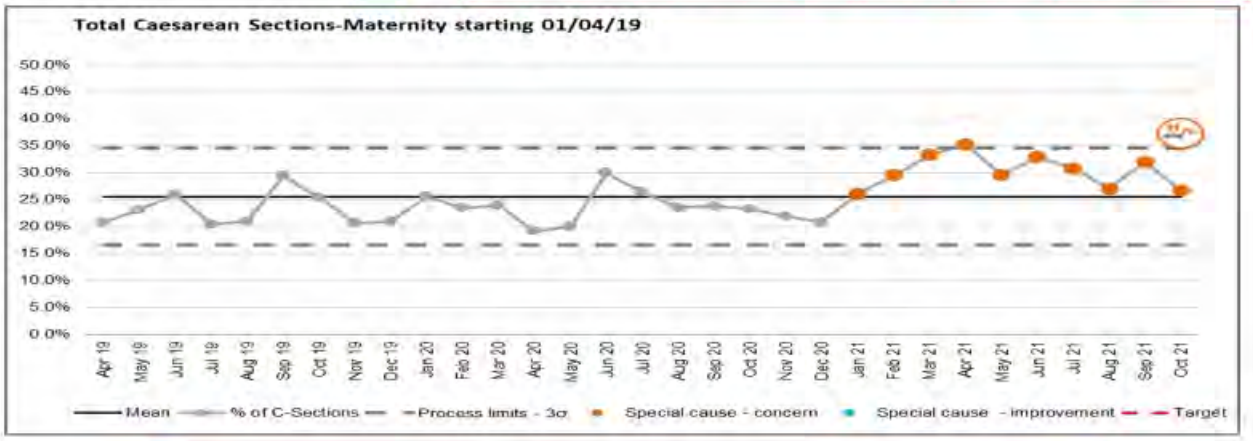
Annex A Maternity Staff Survey Results

Annex B Compliance with reporting incidents to HSIB and NHSR

Annex C Maternity SPC charts from Clinical and Quality & Safety Dashboards

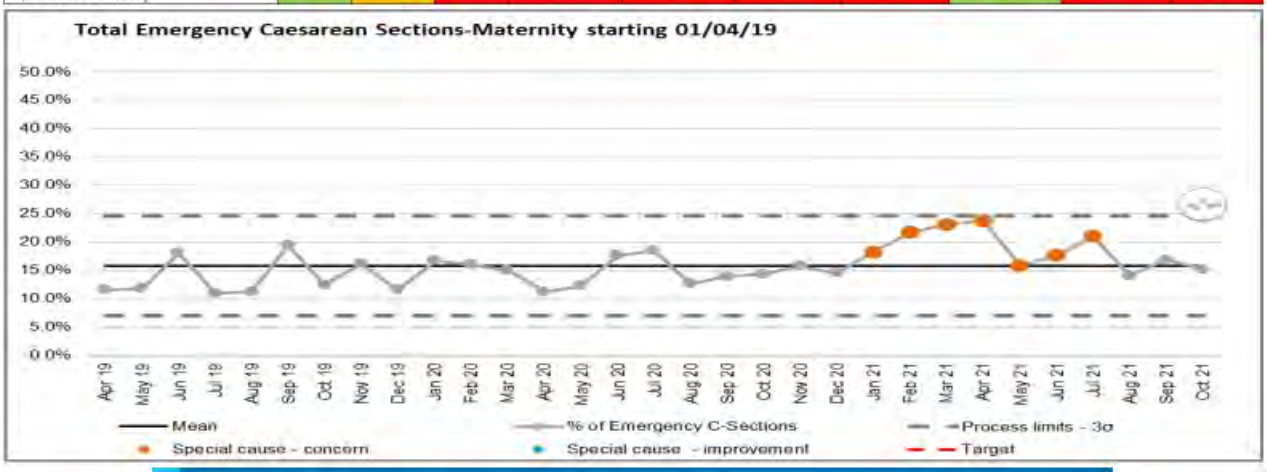
NHS West Suffolk NHS Foundation Trust

Descriptor	Green	Amber	Red	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Total number of caesarean sections (expressed as % of all deliveries)	<26.9		> 26.9	55 35.2%	54 29.6%	56 32.9%	68 30.8%	54 27%	65 32%	53 26.7%



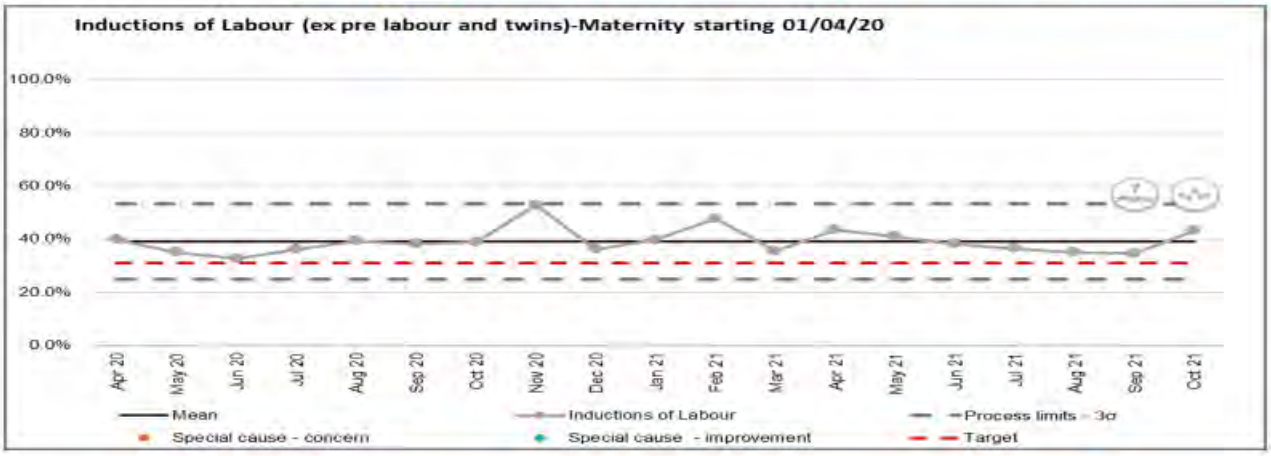
NHS West Suffolk NHS Foundation Trust

Descriptor	Green	Amber	Red	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Total number of emergency (Grade 1,2 &3 LSCS) (expressed as a number & % of all deliveries)	14.3%	14.4%-14.9%	15% or more	37 23.7%	33 20%	36 21.4%	45 20%	25 14%	23 14.9%	30 19.1%



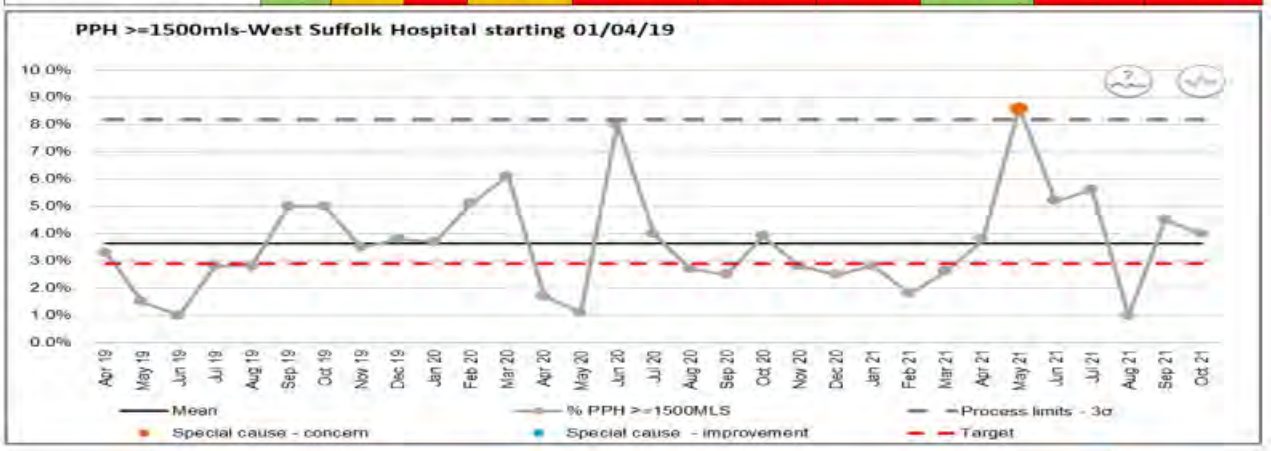
NHS West Suffolk NHS Foundation Trust

Descriptor	Green	Amber	Red	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Total number of IOL (expressed as a number & % of all deliveries) (ref NMPA)	<31%	>31% - 32.9%	>=33%	67 43.5%	74 41%	65 38.2%	78 38.4%	71 35.%	69 34.6%	85 43.3%

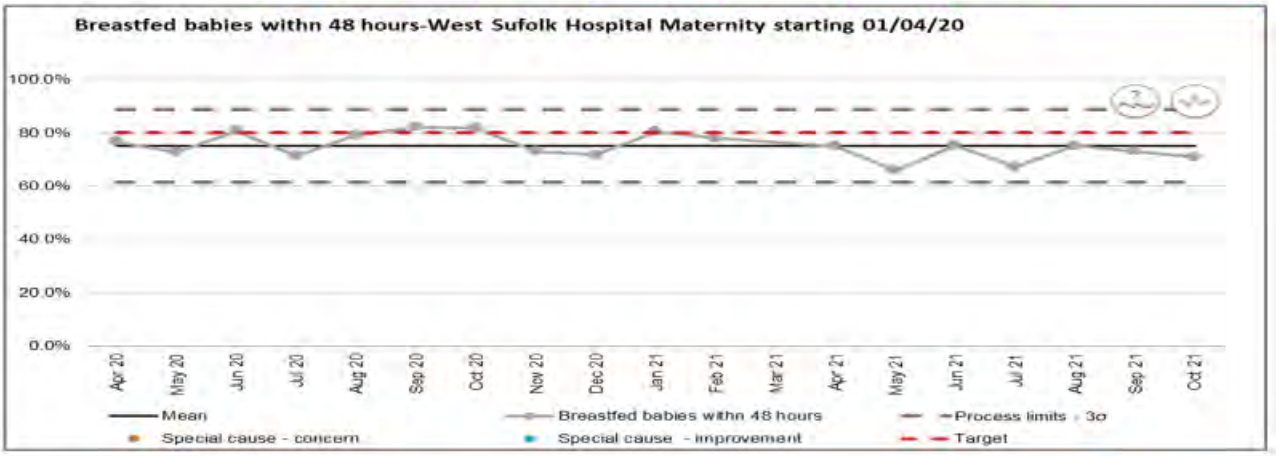


NHS West Suffolk NHS Foundation Trust

Descriptor	Green	Amber	Red	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Total of PPH over 1,500 mls as a % of deliveries	<3.5%	3.5% - 3.8%	>3.8%	6 3.8%	16 9.6%	9 5.2%	12 6.6%	2 1%	9 4.5%	6 4%

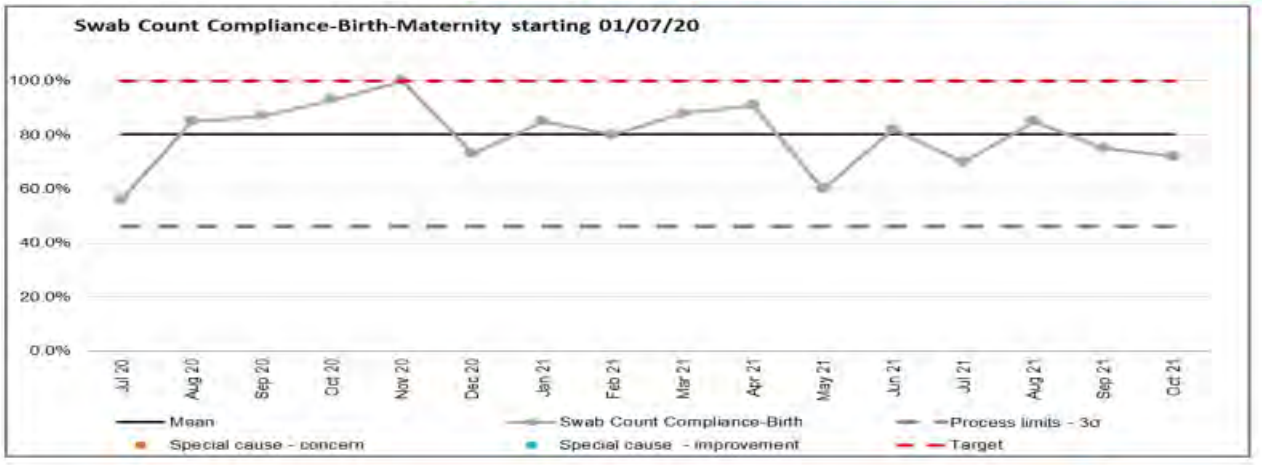


Descriptor	Green	Amber	Red	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Includes all babies receiving breastmilk within 48 hours of birth as a % of all births	>80%	75-80%	<75%	115 75%		128 75.3%		75.2%		



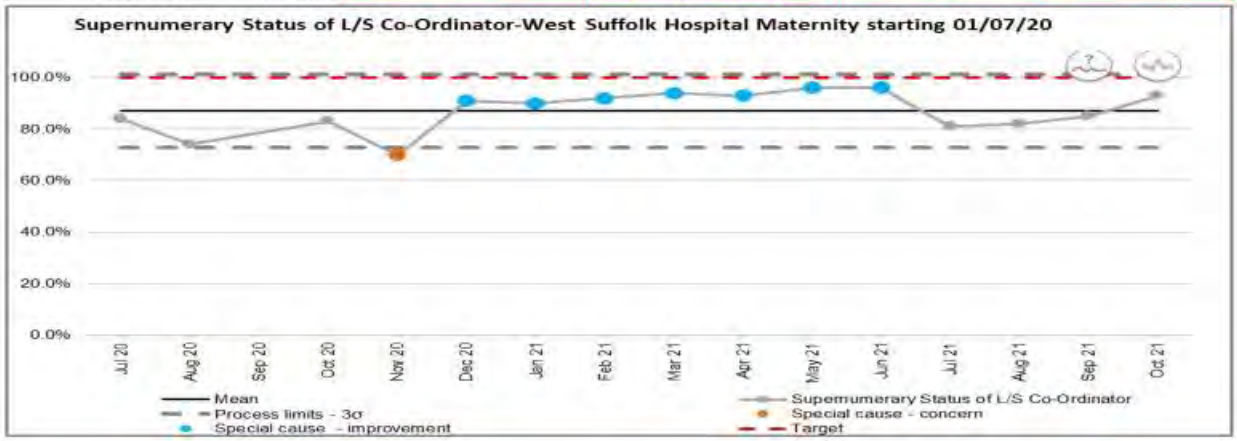
Quality& Safety Dashboard SPC charts

DOCUMENTATION & CARE AUDITS	Standard	March	April	May	June	July	August	September	October
Swab Count Compliance-Birth	100%	89%	91%	86%	82%	70%	83%	75%	72%



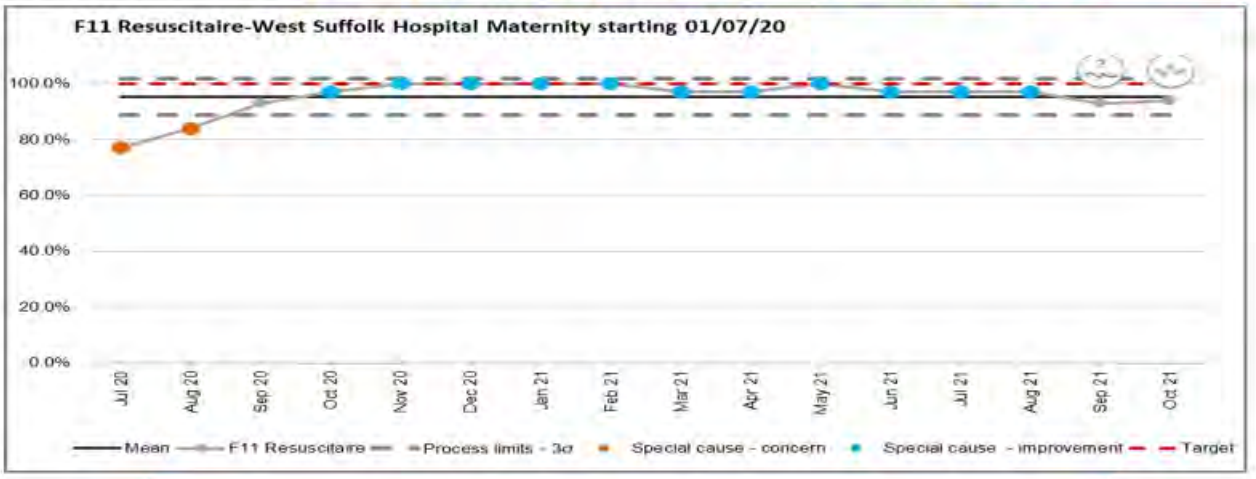
NHS
West Suffolk
NHS Foundation Trust

	Standard	March	April	May	June	July	August	September	October
Supernumerary Status of LS Coordinator	100%	94%	93%	96%	96%	83%	83%	85%	90%



NHS
West Suffolk
NHS Foundation Trust

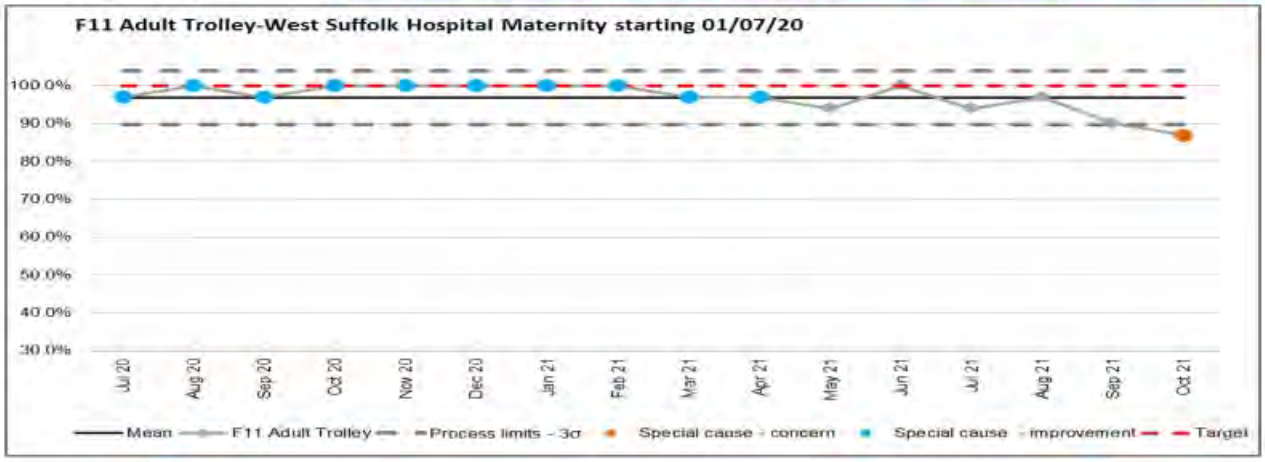
	Standard	Feb	March	April	May	June	July	August	September	October
Ward F11: Resusciteire	100%	100%	97%	97%	100%	97%	97%	97%	93%	90%



Delivering high quality, safe care, together

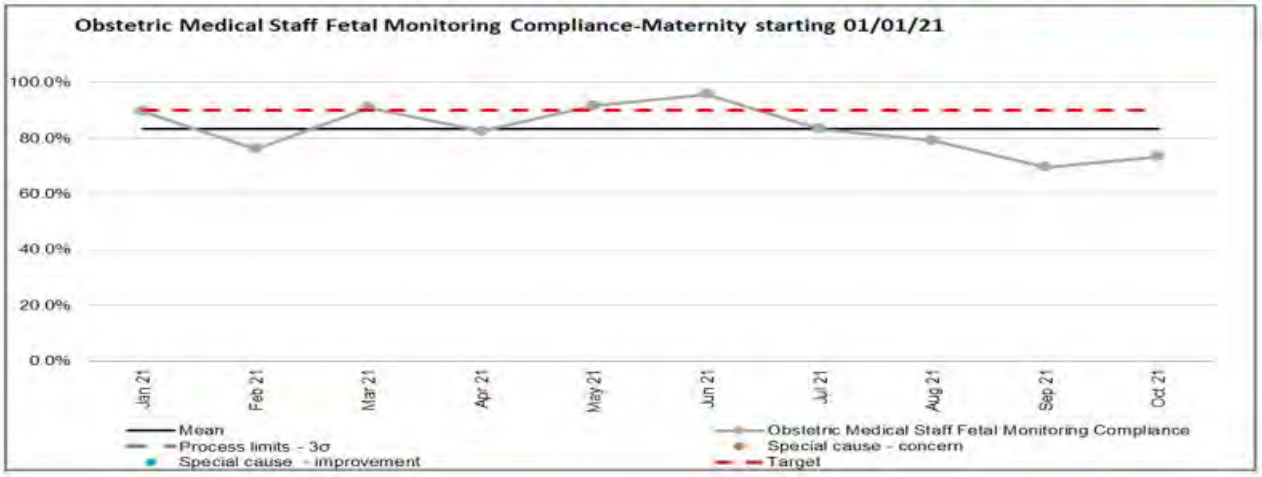
NHS
West Suffolk
NHS Foundation Trust

	Standard	March	April	May	June	July	August	September	October
Ward F11: Adult Trolley	100%	97%	97%	94%	100%	94%	97%	90%	87%

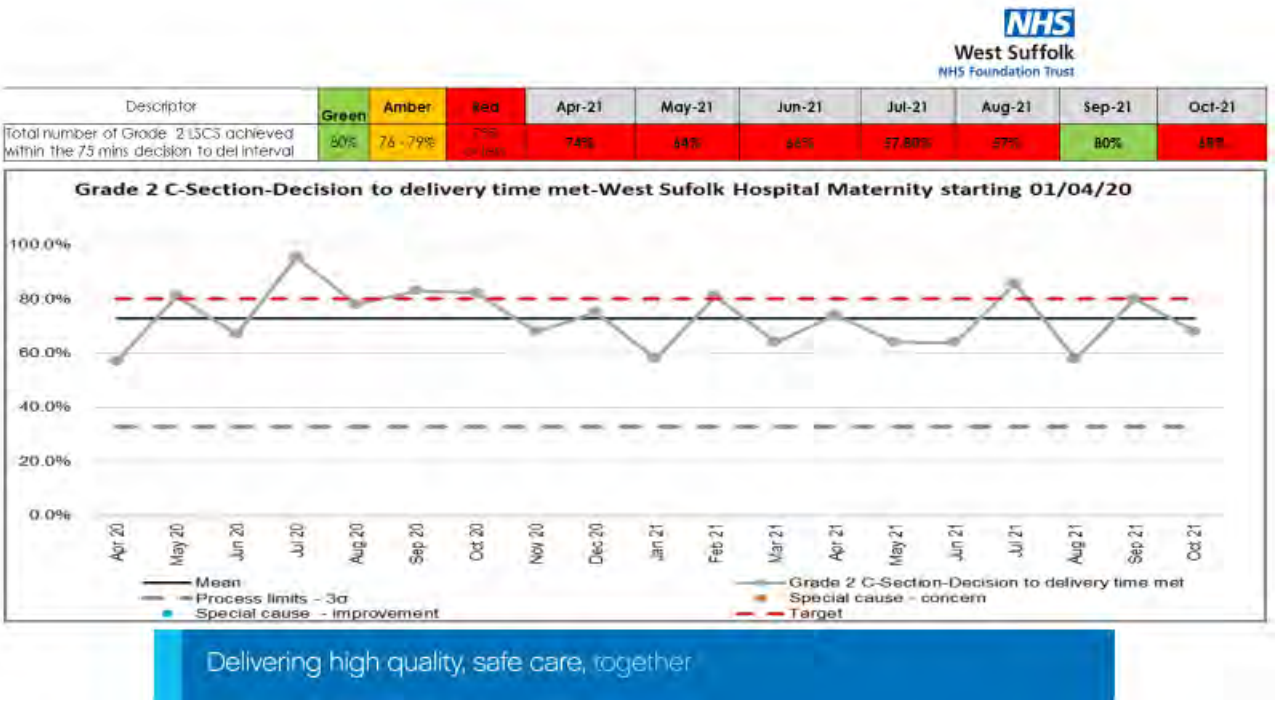


NHS
West Suffolk
NHS Foundation Trust

Mandatory Training Overview	Standard	March	April	May	June	July	August	September	October
Obstetric Medical Staff: % compliance with **All Fetal Monitoring** training	90%	90.9%	82.8%	91.7%	95.8%	85.4%	78.1%	88.4%	73.4%



Delivering high quality, safe care, together



Annex D Training needs analysis and tracker

Annex E Safety Action 8 – MDT training plan

Annex F Safety Action 5 – Midwifery Staffing Report April- September 2021

Annex G Neonatal Transitional Care Audit Q2 2021

Annex H ATAIN Q2 progress report 2021

NHS
West Suffolk
NHS Foundation Trust

Putting you first

West Suffolk Hospital Midwifery Survey Results

Compiled by various contributors including:

Analysis by Giles Turner, Head of Workforce Research and Information, and;

Colleagues from WSFT

28th October 2021 and 10 November 2021

CAN DO HEALTH & CARE

NHS West Suffolk NHS Foundation Trust

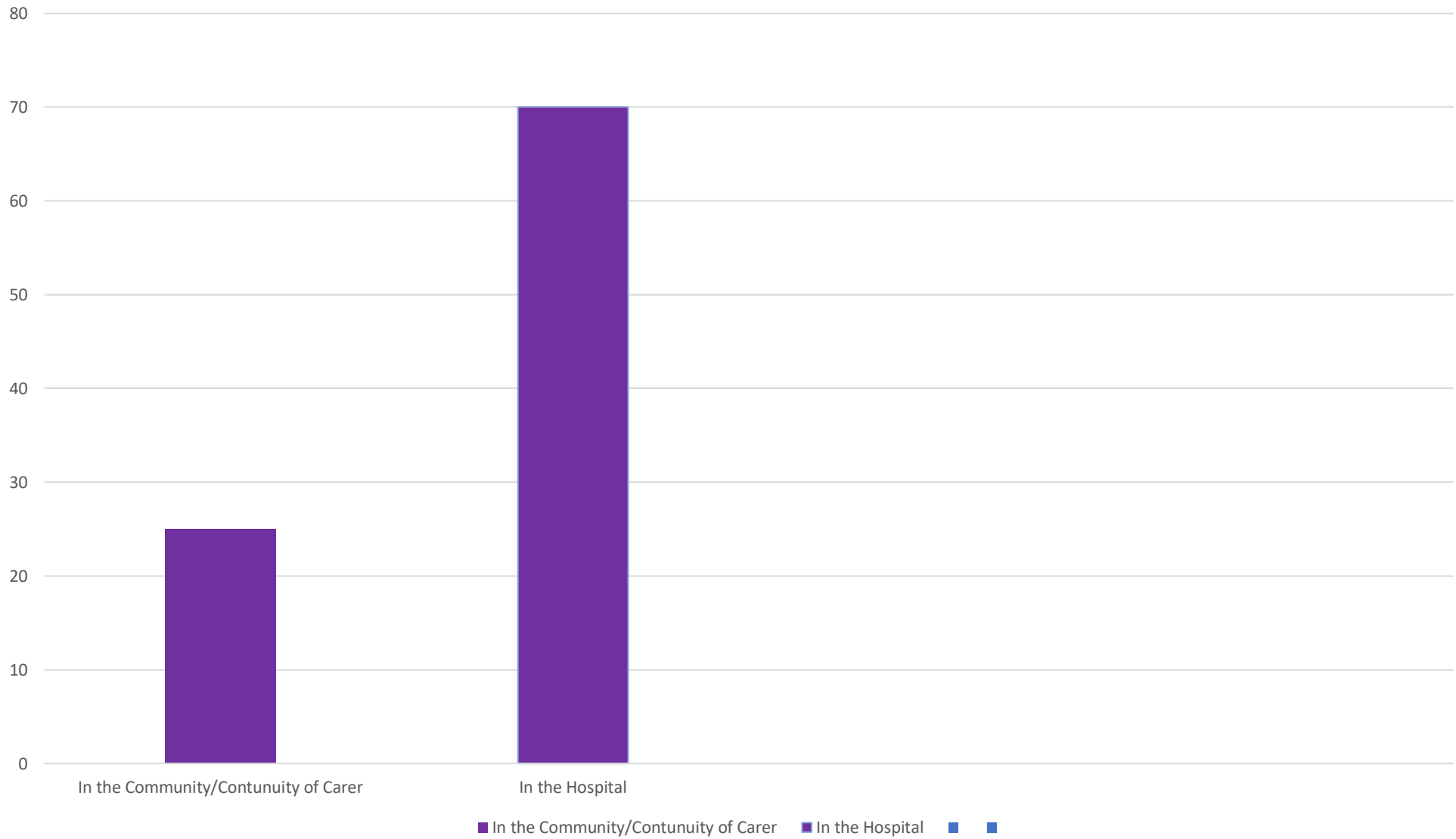
Introduction

- Thank you, you have been honest and thoughtful in your responses.
- This is of course a very emotive and raw subject, but you all do a brilliant job in very difficult circumstances.
- You have great ideas on how to fix issues not just within WSFT but in the NHS as a whole.
- Staff are the most important asset the NHS has.

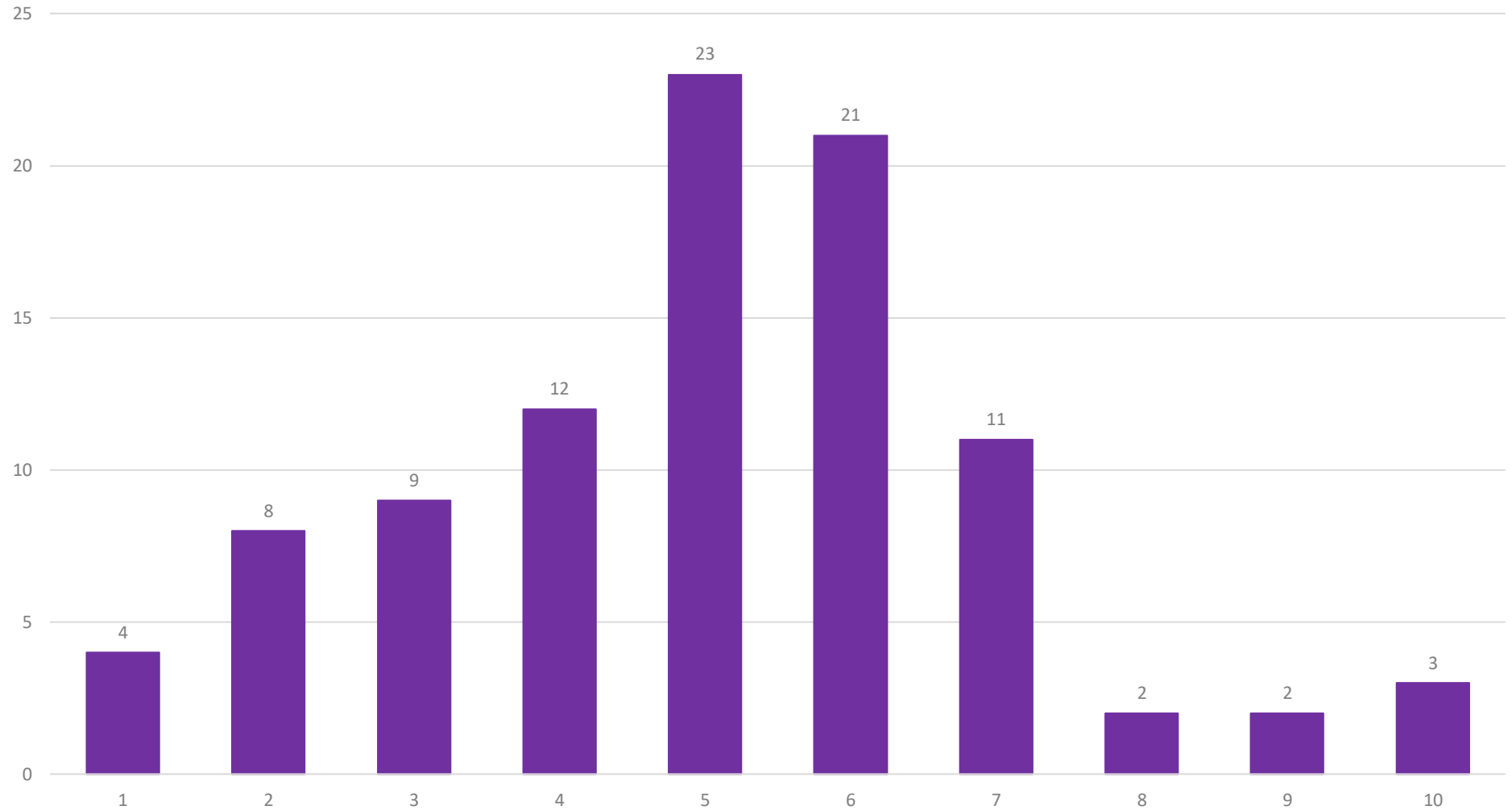
WHAT YOU TOLD US

Results of Midwifery Staff Survey September 2021

Base of work for Midwives who completed survey



Maintaining your health and wellbeing is key to your ability to offer high quality, safe care at this challenging time. On a scale of 1 (most negative) to 10 (most positive), how are you?



Areas where you cited we all do well

- *The Midwifery team are all dedicated to providing good care to our women and babies, the PMA service has been very useful*
- *The thankyou Thursdays have been a really nice introduction, this was a good idea and more stuff like this to make staff feel valued would be great*
- *We have a very supportive team and we all look out for each other. We strive to give the best care we can under difficult circumstances.*
- *We are all passionate about providing good safe effective care and the frustrations we feel are related to the ability to be able to do this.*
- *Team work and flexibility works very well. Good positive communication daily using WhatsApp - ensures team members are supported.*
- *Good team spirit on F11. Ward Manager is very supportive and often works late to fill shortfalls. Senior management very approachable and obviously keen to rectify the situation*
- *I feel well supported by my specialist midwifery colleagues It would be great if we could meet outside work or even at work for a meeting every now and then. However I feel that our new line manager has started to do that.*

Themes


Staff Shortages
Workload
Rest Breaks
Work Life Balance
Poor Support
Sickness Absence
Lack of Clarity of Role
Low Morale

What are the main issues having a negative impact on your wellbeing at work at the moment?

Summary

- **Staffing Shortages:** You have told us that the current staff shortages are impacting on both your physical and mental health. That this is effecting nearly every facet of your working life and has a serious impact to your home life as well.
- **Workload:** You are exhausted. You feel you are expected to do more tasks in less time and are not able to give the level of care you aspire to. You are scared of missing something and feel you will be held to account for it.
- **Rest Breaks:** You told us you do not get time to eat, drink or use the toilet, let alone a real rest break.
- **Work life Balance:** You have no work life balance, due to the current work patterns, working over your hours, lack of control over shift types, on-calls on rest days and not being able to take annual leave when you want.
- **Poor Support**: You told us you feel unappreciated, that your voice and concerns are not always heard. You feel that there is a disconnect between what is actually going on the ground and the senior leadership team, that it is about numbers not people. You do not feel that there is support for less experienced or new staff.
- **Sickness Absence**: You have said that there is high sickness absence and that this is impacting on everyone's wellbeing.
- **Lack of Clarity of Roles**: It is felt that there is a disparity between roles and that these roles are misunderstood. This has led to feelings of resentment.
- **Low Morale**: You have said that the department suffers from low morale and that workplace relationships have become strained.

As well as understanding the issues affecting your wellbeing, we are keen to identify anything that can be done to improve wellbeing at work. Please list all the suggestions you have for improving wellbeing at work below

Summary

- **Staffing Shortages:** You have said that ideally you would like more midwives but know that there is a national shortage. You have suggested that we look at more support roles at work – house keepers, support workers, nursery nurses, admin roles to allow you to focus on actual midwifery. An example you gave was a 24 hour ward clerk answering telephones looking for notes and house keepers to help cleaning rooms. You have asked us to look differing ways that we can help towards the rota.
- **Workload:** You have identified that we need to look at new roles and ways of working. You have suggested reducing the amount of hours spent at meetings. Digital menus, so patients can do that for themselves or housekeepers to help. Ensure Clinical Areas are appropriately stocked. Ensure all MCAs trained to undertake baby observations and phlebotomy Core staff remaining in areas they should be working (LS, F11, MLBU) not being continually pulled to work in other areas. You have asked for better support with e-care.
- **Rest Breaks:** We must ensure you get rest breaks**.** You have suggested a more robust overview of rota's that they factor in staff rest breaks.
- **Work life Balance:** You have suggested that we need to identify a preferred work shift pattern for staff with a rolling rota. We should ensure that on-calls are not set for rest days. Staff wishes when they want annual leave should be taken into account.
- **Poor Support**: You would like more appreciation and understanding from the senior leadership team, you have suggested a staff forum so that you can voice your concerns and feel listened to. You would like better support and understanding in regard to staff's mental health. You feel that there is poor understanding of work life balance.
- **Sickness Absence**: You have suggested that we provide healthy meals, exercise classes or mindfulness and meditation areas, easier access to staff counselling and talk therapies.
- **Lack of Clarity of Roles**: You have said that there needs to be better understanding of the roles people do.
- **Low Morale**: You have identified team building, free hot drinks, tea runs, Thank you Thursday and just by being kind as ways in which we can lift morale.

As well as understanding the issues affecting your wellbeing, we are keen to identify anything that can be done to improve wellbeing at work. Please list all the suggestions you have for improving wellbeing at work below

- *Thank you Thursdays – more initiatives like this would be well received*
- *Continue with positive daily communication using WhatsApp*
- *Digital menus*
- *Review how support workers support wards*
- *On call for everybody*
- *Review of rotas*
- *Flexible shifts*

Where we are

- *Business plan has been agreed by the Board in relation to support staff (if you're unclear on what this is, please ask your manager)*
- *Advertised, interviewed and appointed to these posts and are awaiting start dates*
- *International recruitment bid for eight international midwives has been authorised by NHSE&I*
- *Continued rolling advert out for Band 6 midwives*
- *International recruitment of 1 Registered Nurse due to start next month*
- *Recruitment process in place for further Registered Nurses for F11*
- *Working with our HR Partners to monitor sickness as per Trust policy*
- *Wellbeing Team are actively supporting our Department*
- *PMA's, Safety Champions, Freedom To Speak Up Guardians, Union, Manager, Chaplaincy are available and continue to offer support*
- *Regular updates via Unit meetings, Take 5 and Staff Facebook page which provide the opportunity for two way communication*
- *Specialist Midwives are posting on Facebook 'A Day In The Life Of ….' to explain their roles*

What we are considering next

- *Volunteers sought for solution focused groups – with an interest in supporting how we continue to move forwards, please email Sue Ridley with your interest by 1st December 2021*
- *Volunteer roles to support the service such as infant feeding peer supporters*
- *Considering different ways of working*
- *Allocating breaks at the start of the shift to ensure breaks are taken*
- *How we embed Civility and Respect into everything we do as a Team*

Maternity Incentive Scheme

Report Title	Report for Safety Action 10 – reporting to Healthcare Safety Investigation Board and NHS Resolution Quarter 2 July – September 2021
Report for	Approval and Information
Report from	Maternity Services
Lead for Safety Action	Karen Green Clinical Quality and Governance Midwifery Matron
Report Author	Beverley Gordon, Project Midwife

1. **Report Title –** Compliance with reporting of qualifying incidents to HSIB and NHSR

2. **Purpose of the Report**
   To demonstrate that the Trust has systems and processes in place to report incidents to HSIB and NHSR within the timeframes and families give their consent and are kept informed and involved of the processes involved for review.

3. **Background**
   Year 4: Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?

4. **Required standard**

   A) Reporting of all qualifying cases to HSIB for 2021/22.

   B) For qualifying cases which have occurred during the period 1 April 2021 to 31 March 2022 the Trust Board are assured that:

   - the family have received information on the role of HSIB and the EN scheme; and
   - there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.

5. **Minimum evidential requirement for trust Board:**

   - Trust Board sight of Trust legal services and maternity clinical governance records of qualifying HSIB/EN incidents and numbers reported to HSIB.
   - Trust Board sight of evidence that the families have received information on the role of HSIB and EN scheme.
   - Trust Board sight of evidence of compliance with the statutory duty of candour.

6. Technical guidance

Where can information on HSIB be found?

Information about HSIB and maternity investigations can be found on the HSIB website https://www.hsib.org.uk/

Where can I find information on the Early Notification scheme?

Information about the EN scheme can be found on the NHS Resolution's website

- EN main page
- Trusts page
- Families page
- Trust communication

Changes in the EN reporting requirements for Trust from 1 April 2021

Following communication to Trusts in April 2021 all eligible maternity incidents should still be reported to HSIB. HSIB will then inform NHS Resolution of the case.

Changes in the EN investigation processes from 1 April 2021

From 1 April 2021, due to a number of factors such as advances in neonatal cooling, NHS Resolution made two key improvements to streamline the investigation process:

- No steps will be taken to investigate eligibility for compensation until HSIB has completed a safety investigation. This will reduce duplication and enable Trusts to focus on liaison with HSIB and the family. Instead, on receipt of the HSIB report on relevant cases, NHS Resolution will overlay an investigation into legal liability. Where families have declined an HSIB investigation, no EN investigation will take place, unless the family request this.

- The criteria for an investigation by NHS Resolution will be narrowed to those cases where there is evidence of or the potential for a brain injury. This will ensure that the scheme is focused on those cases where there is potential for a high value compensation payment.

The changes were formally communicated to panel, external stakeholders and Trusts in March 2021 via comms letters.

What are qualifying incidents which need to be reported to HSIB?

- Qualifying incidents are term deliveries (≥37+0 completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories:

- Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) [OR]

- Was therapeutically cooled (active cooling only) [OR]

- Had decreased central tone AND was comatose AND had seizures of any kind.

What if we are unsure whether a case qualifies for referral to HSIB?

If the case meets Each Baby Counts criteria it should be reported to HSIB only. If in any doubt a case should be submitted and rejected by the HSIB

Candour

Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 provides that a health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided.

In accordance with the statutory duty of candour, in all relevant cases, families should be advised of what enquiries in relation to the incident the health body believes are appropriate and details of any enquiries to be undertaken. This includes details of enquiries undertaken by HSIB and NHS Resolution.

Trust Boards should be aware that if a breach of the statutory duty of candour in relation to a qualifying case comes to light which calls the validity of certification into question this may result in a review of the Trust submission and in addition trigger escalation to the CQC.

4. Compliance with Standards

Evidence Required	WSH Compliance	Progress Report	Evidence Source
a) Reporting of 100% qualifying incidents for 2021/22 to HSIB:	**0 case referred to the HSIB in Q1** **1 case referred to HSIB in Q2 – 100% achieved**	**2021/22 Q1 -** **2021/22 Q2 –**	❖ Maternity Database ❖ Legal Services database ❖ NHSR Legal Services manager confirmed that cases have been submitted and they formally report to the Trust Board that they have complied with this.
b) 1. The family have received information on the role of HSIB and the EN scheme;	**0 case referred to the HSIB in Q1** **Q2 - 100% achieved**	**2021/22 Q1 -** **2021/22 Q2 –**	Letter uploaded to Datix incident reporting system Departmental held records retain copy
b) 2. There has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.	**0 case referred to the HSIB in Q1** **Q2 - 100% achieved**	**2021/22 Q1 -** **2021/22 Q2 –**	Record on Datix incident reporting system Trust Quality and Safety Team oversight

Conclusions
This standard is achieved by the Trust in all aspects.

6. Recommendations
There is a need to continue to monitor the compliance and ensure parents get the correct information in order to be fully informed of what has happened and why.

7. Actions required
Include compliance on the Maternity and Gynaecology Quality and Safety agenda and on Trust Board reports.

Action	Person Responsible	Date	Evidence Required
1. Monthly compliance report on referral to HSIB and ENS. 2. Quarterly report to Board.	1. Maternity Quality and Safety Team 2. Compliance Manager	1. Monthly governance reports 2. Quarterly Board Reports	Minutes of Maternity and Gynaecology Quality and Safety meetings and Maternity Safety Champions. Board reports
3. Monthly compliance on parents being informed of HSIB and ENS and compliance with Duty of Candour regulations. 4. Quarterly report to Board	3. Clinical Quality and Governance Matron 4. Compliance Manager	3. Monthly governance reports 4. Quarterly Board reports	Letters available in patient records and on datix. Copy filed in local drive.

West Suffolk NHS
NHS Foundation Trust

TRAINING NEEDS ANALYSIS AND TRACKER FOR LMNS

Author: Justyna Skonieczny Deputy Head of Midwifery

CORE COMPETENCY TRAINING FRAMEWORK TRAINING COMPLIANCE (TARGET 90%)

Must include consideration of human factors, local transfer processes and policies (hospital and community settings), use of locally agreed safety language and communication with women, families and staff, particularly where debrief is required as part of emergency scenario training. Training should include sharing of local learning from maternal and neonatal outcomes (including learning from in-situ simulation) and ideally benchmarked against other units.

SAVING BABIES LIVES CARE BUNDLE

MINIMUM REQUIREMENT	Number of attendees in month (TARGET 90%)	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	April 22	Current %age completion
Smoke free pregnancy	Midwives	100%	100%	100%	100%							100%
	Obstetrician*	NA	NA	NA	NA							
Monitoring growth restriction (as for GAP)	Midwives	81.7%	91.3%	90.1%	95.10%							89.5%
	Obstetrician	96%	95.8%	95.8%	100%							96.9%
Fetal movements & Fetal monitoring	Midwives	89.6%	94.1%	88.6%	88.7%							90.2%
	Obstetrician	83.3%	79%	69.9%	73.4%							76.4%
Pre-term birth *	Midwives	NA	NA	NA	NA							
	Obstetrician	NA	NA	NA	NA							

GAP AND GROW TRAINING

MINIMUM REQUIREMENT	Number of attendees in month	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	April 22			Current %age completion
Training and competency assessment in: • Measuring SFH with a tape measure • Plotting measurements on charts • Appropriate interpretation • Appropriate escalation and referral (TARGET 90%)	MIDWIVES	81.7%	91.3%	90.1%	95.1%									89.6%
	CONSULTANT OBSTETRICIANS	96%	95.8%	95.8%	100%									98.3%

* This sessions were not cover within 2021/2022 training plans. MIS year 4 standard were published in August 2021 during the running of already agreed programme.

CORE COMPETENCY TRAINING FRAMEWORK TRAINING COMPLIANCE (TARGET 90%)

Must include consideration of human factors, local transfer processes and policies (hospital and community settings), use of locally agreed safety language and communication with women, families and staff, particularly where debrief is required as part of emergency scenario training.
Training should include sharing of local learning from maternal and neonatal outcomes (including learning from in-situ simulation) and ideally benchmarked against other units.

FETAL SURVEILLANCE IN LABOUR

MINIMUM REQUIREMENT	Number of attendees in month	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	April 22	Current %age completion
Risk assessment throughout labour Fetal monitoring – Intermittent auscultation (IA) Fetal Monitoring – Electronic Fetal Monitoring (EFM) Use of local case histories (TARGET 90%)	MIDWIVES	89.6%	94.1%	88.6%								90%
	CONSULTANT OBSTETRICIANS	83.3%	79.2%	69.6%								77.4%
	ALL OTHER OBSTETRICIANS	TBC	TBC	TBC								TBC

NB: Fetal monitoring training should be based on the previously recommended: multi-professional case history discussions that demonstrate the use of local fetal monitoring tools and resources for risk assessment, classification and escalation.
All content should be based on current evidence, national guidelines and local systems and risk issues.
Training should also include human factors and situational awareness.
Completion of an electronic training package such as Health Education England's e-Learning for Healthcare Learning Paths on eFetal Monitoring or the Fetal monitoring modules of the K2 Perinatal Training Programme would count as one half day' worth of training.

MATERNITY EMERGENCIES AND MULTIPROFESSIONAL TRAINING												
MINIMUM REQUIREMENT	Number of attendees in month	July 21	Aug 21*	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	April 22	Current %age completion
Locally identified training needs relating to emergency scenarios which might include: Antepartum Haemorrhage and Postpartum Haemorrhage Impacted fetal head Pre-eclampsia/eclampsia, severe hypertension Uterine rupture Maternal resuscitation Vaginal breech birth Shoulder dystocia Cord prolapse Include: • The use of maternal critical care observation charts • Structured review proformas • Deterioration and escalation thresholds • Timing of birth and immediate postnatal care (TARGET 90%)	OBSTETRIC CONSULTANTS	1	NA	0	3							94.6%
	ALL OTHER OBSTETRIC DOCTORS CONTRIBUTING TO THE ROTA	0	NA	4	4							
	OBSTETRIC ANAESTHETIC CONSULTANTS	1	NA	1	2							87.5%
	ALL OTHER OBSTETRIC ANAESTHETIC DOCTORS CONTRIBUTING TO THE ROTA	1	NA	2	2							
	MIDWIVES	14	NA	16	15							97.2%
	MATERNITY CRITICAL CARE STAFF **	NA	NA	NA	NA							NA
	MATERNITY SUPPORT WORKERS AND HEALTH CARE ASSISTANTS	5	NA	2	2							96%

NB:

- * 10 PROMPT training sessions are run over the 12 months period. August is one of the month where no PROMPT training is provided
- These training sessions should also cover an understanding of Covid-19 specific therapies in pregnancy and the importance of twice-daily multidisciplinary structured reviews to ensure comprehensive, multi-disciplinary and coordinated care across different care settings. Training should include a general overview of care principles, and individual susceptibility e.g. ethnicity, hypertension and diabetes.
- All other obstetric doctors = Staff grade doctors, obstetric trainees (ST1-7), sub specialty trainees, obstetric clinical fellows and foundation years doctors contributing to the obstetric rota.
- All other obstetric anaesthetic doctors = staff grade and anaesthetic trainees contributing to the rota.
- ** Maternity critical care staff = operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit- NA for WSFT

PERSONALISED CARE

MINIMUM REQUIREMENT	Number of attendees in month Target 90%	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	April 22	Current %age completion
Ongoing antenatal and intrapartum risk assessment with a *holistic view from a woman's personal perspective, offering her informed choice.* *	Midwives	NA	NA	NA								
	Obstetrician	NA	NA	NA								
Maternal mental health	Midwives	98%	100%	99%								99%
	Obstetrician*	NA	NA	NA								
Vulnerable women and families Social factors requiring referral	Midwives	98%	100%	99%								99%
	Obstetrician	96%	93%	93%								94%
Families with babies on NICU *	Midwives	NA	NA	NA								
	Obstetrician	NA	NA	NA								
Bereavement care	Midwives	98%	100%	99%								99%
	Obstetrician	TBC	TBC	TBC								TBC

NB:

- * This sessions were not cover within 2021/2022 training plans. MIS year 4 standard were published in August 2021 during the running of already agreed programme.
- There should be training for all maternity carers to recognise, triage and care for women with mental health and safeguarding concerns in pregnancy. This should include information on local pathways and procedures to ensure face-to-face assessments and fast-track access to specialist perinatal mental health and safeguarding support services.
- Training should also include recognition of concerning "red flags", particularly repeated referrals that should prompt urgent review.

CARE DURING LABOUR AND THE IMMEDIATE POSTNATAL PERIOD

MINIMUM REQUIREMENT	Number of attendees in month TARGET 90%	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	April 22	Current %age completion
Management of labour	MIDWIVES	NA	NA	NA								
	OBSTETRICIANS	NA	NA	NA								
VBAC and uterine rupture	MIDWIVES	NA	NA	NA								
	OBSTETRICIANS	NA	NA	NA								
GBS in labour	MIDWIVES	NA	NA	NA								
	OBSTETRICIANS	NA	NA	NA								
Management of epidural anaesthesia	MIDWIVES	NA	NA	NA								
	OBSTETRICIANS	NA	NA	NA								
Operative vaginal birth – ROBuST	MIDWIVES	NA	NA	NA								
	OBSTETRICIANS	NA	NA	NA								
Perineal trauma – prevention of and OASI pathway	MIDWIVES	NA	NA	NA								
	OBSTETRICIANS	NA	NA	NA								
Maternal critical care including care of pregnant and postpartum women with suspected or confirmed Covid-19	MIDWIVES	97%	NA	98%								97.6%
	OBSTETRICIANS	96%	NA	100%								97%
Recovery care after general anaesthetic		NA	NA	NA								

NB:

- * This sessions were not cover within 2021/2022 training plans. MIS year 4 standard were published in August 2021 during the running of already agreed programme.
- ROBuST = RCOG Operative Birth Simulation Training
- OASI = Obstetric Anal Sphincter Injury
- These training sessions should also cover an understanding of Covid-19 specific therapies in pregnancy and the importance of twice-daily multidisciplinary structured reviews to ensure comprehensive, multi-disciplinary and coordinated care across different care settings. Training should include a general overview of care principles, and individual susceptibility e.g. ethnicity, hypertension and diabetes.

NEONATAL LIFE SUPPORT

West Suffolk NHS
NHS Foundation Trust

MINIMUM REQUIREMENT	Number of attendees in month Target 90%	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	April 22			Current %age completion
Identification of a baby requiring resuscitation after birth and support immediate neonatal resuscitation until specialist neonatal help is available Assessed ability to deliver inflation breaths Knowledge and understanding of the NLS algorithm How to call for help within the organisation Situation, Background, Assessment, Recommendation (SBAR) or equivalent communication tool handover on arrival of help Recognition of the deteriorating newborn infant with actions to be taken	NEONAL CONSULTANTS OR PAEDIATRIC CONSULTANTS COVERING NEONATAL UNITS	TBC	TBC	TBC										TBC
	NEONATAL JUNIOR DOCTORS WHO ATTEND ANY DELIVERIES	TBC	TBC	TBC										TBC
	NEONATAL NURSES BAND 5 AND ABOVE	0	1	2										85%
	ADVANCED NEONATAL NURSE PRACTITIONERS (ANNPs) *	NA	NA	NA										NA
	MIDWIVES	14	x	16	15									97.2%

* ANNP's not in post yet

Summary

Unit: Maternity Service at West Suffolk NHS Foundation Trust

Reporting period (quarter): July 2021-September 2021

Was MDT nature of training achieved as required during the period? No

If not, why not, and how was this/will this be mitigated?
- Limited availability of data to fully completed the report especially around medical staffing and NLS training;
- Difficulties with releasing medical staff to attend the training
- Limited availability of the training rooms in Education Centre for face to face training

Is training completion meeting the expected trajectory? No

If not, why not, and how was this/will this be mitigated?
- Training plans put in place with the start date from January 2022 to meet the recommendation of MIS year 4
- Limited availability of data to fully complete the report especially around medical staffing and NLS
- Difficulties of releasing medical staff to attend the training
- Availability of the training rooms in Education Centre for face to face training

West Suffolk NHS
NHS Foundation Trust

Training programme plans for Maternity Incentive Scheme Safety action 8

Authors: Justyna Skonieczny
Deputy Head of Midwifery,
Beverley Gordon Project Midwife

1. Introduction

NHS Resolution (NHSR) is operating the Clinical Negligence Scheme for Trusts (CNST) and year 4 of Maternity Incentive Scheme to support the delivery of safer maternity care was launched on 9 August 2021. As in previous years, there are ten maternity safety actions. If WSFT can demonstrate they have achieved full compliance of all the ten safety actions, then the Trust will recover their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds. In addition, the Ockenden report 2020 had 7 immediate and essential actions required to improve and standardise maternity care throughout the NHS.

2. Standards to be met

NHSR Maternity Incentive Scheme (MIS)- year four
Safety action 8:

Provide evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in the training programme over the next 3 years, starting from the launch of MIS year 4 (August 2021).

Provide evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4.

Required standard and minimum evidential requirement:

1. A local training plan is in place to ensure that all six core modules of the Core Competency Framework, will be included in the training programme over the next 3 years this includes:
    a. Saving Babies Lives Care Bundle to include
        - Smoke free pregnancy
        - Monitoring growth restriction
        - Fetal movement
        - Fetal monitoring
        - Pre-term birth
    b. Fetal surveillance in labour
    c. Maternity emergencies and multi-professional training.
    d. Personalised care
    e. Care during labour and the immediate postnatal period
    f. Neonatal life support

2. 90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day, to include maternity emergencies starting from the launch of MIS year four:
    a. Antepartum Haemorrhage and Postpartum Haemorrhage
    b. Impacted Fetal Head
    c. Pre-eclampsia/eclampsia sever hypertension

   d. Uterine Rupture
   e. Maternal resuscitation
   f. Vaginal breech birth
   g. Shoulder dystocia
   h. Cord prolapses

3. 90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day, to include antenatal and intrapartum fetal monitoring and surveillance, starting from the launch of MIS year four:
   a. Risk assessment
   b. Intermittent auscultation
   c. Electronic fetal monitoring
   d. System level issues e.g. human factors, classification, escalation and situational awareness
   e. Use of local case histories
   f. Using their local CTG machines

4. 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended in-house neonatal life support training or Newborn Life Support (NLS) course starting from the launch of MIS year four.

Minimum evidence required

- Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.

- Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session.

- LMNS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data.

- Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.

- A clear trajectory in place to meet and maintain compliance.

Ockenden Immediate and Essential Actions (IEA) – some of these are in more than one IEA so only one section is included

IEA3

Q17 Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.

A clear trajectory in place to meet and maintain compliance as articulated in the TNA.

LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data.

Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session.

Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.

Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.

Q21 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session

A clear trajectory in place to meet and maintain compliance as articulated in the TNA.

Attendance records - summarised

LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.

The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime, we are seeking assurance that a MDT training schedule is in place.

3. Maternity unit staff groups attendance

Which maternity staff attendees should be included for the 'in house' maternity emergencies multi-professional training day?

Maternity staff attendees should include 90% of each of the following groups:

- Obstetric consultants
- All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota
- Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)
- Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum)
- Obstetric anaesthetic consultants
- All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota

Which maternity staff attendees should be included for the local intrapartum fetal surveillance in labour and Saving Babies Lives Care Bundle (SBLCBv2)?

Maternity staff attendees should be 90% of each of the following groups:

- Obstetric consultants
- All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota
- Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres.

Neonatal Resuscitation

Staff in attendance at deliveries should be included for immediate newborn resuscitation training as listed below

- Neonatal Consultants or Paediatric consultants covering neonatal units
- Neonatal junior doctors (who attend any deliveries)
- Neonatal nurses (Band 5 and above)
- Advanced Neonatal Nurse Practitioner (ANNP)
- Midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and Maternity theatre midwives who also work outside of theatres.

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

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

Maternity theatre staff are a vital part of the multidisciplinary team and are encouraged to attend the Covid-19 related training, however they will not be part of MIS year four compliance assessment.

Maternity theatre staff group includes:

- Scrub nurses
- Circulators
- Surgical care practitioners

5. Training programme:

Six Multidisciplinary meetings were held between September 2021- November 2021, including:

a. Deputy Head of Midwifery
b. Clinical Lead Obstetrician
c. Obstetric Lead for training
d. Practice Development Midwives
e. Fetal monitoring and surveillance leads
f. Inpatient Service Matron
g. Quality and Safety Matron
h. Project Midwife

To meet the requirement of the MIS year 4 plans have been put in place to deliver the training sessions as below:

Year 4- 2022/2023	Year 5- 2023/2024	Year 6- 2024-2025
Midwifery Mandatory training day 1  Midwifery Mandatory Training Medical staff to complete only: - Safeguarding Level 3 training - Bereavement e-learning - PNMH training	Midwifery Mandatory training day 1  Midwifery Mandatory Training Medical staff to complete only: - Safeguarding Level 3 training - Bereavement e-learning - PNMH training	Midwifery Mandatory training day 1  Midwifery Mandatory Training Medical staff to complete only: - Safeguarding Level 3 training - Bereavement e-learning - PNMH training
Saving Babies Lives/ Midwifery Mandatory Training day 2  SBLMM2Year1.docx Medical staff to complete only - Smoking Cessation - Pre-Term Birth eLearning for Healthcare on line can be used: SBLCB Training Programme	Saving Babies Lives/ Midwifery Mandatory Training day 2  SBLMM2Year2.docx Medical staff to complete only - Smoking Cessation - Pre-Term Birth eLearning for Healthcare on line can be used: SBLCB Training Programme	Saving Babies Lives/ Midwifery Mandatory Training day 2  SBLMM2Year3.docx Medical staff to complete only - Smoking Cessation - Pre-Term Birth eLearning for Healthcare on line can be used: SBLCB Training Programme
PRactical Obstetric Multi-Professional Training- PROMPT:	PRactical Obstetric Multi-Professional Training- PROMPT	PRactical Obstetric Multi-Professional Training- PROMPT

PROMPT2022.docx		
Fetal monitoring and surveillance training: Fetal Monitoring and surveillance trai	Fetal monitoring and surveillance training: Fetal Monitoring training 2023.docx	Fetal monitoring and surveillance training: Fetal Monitoring training 2023.docx

Additional information:

a) Covid-19 specific e-learning training has been made available to the multi-professional team members

c) There is a commitment by the trust board to facilitate multi-professional training sessions, including fetal monitoring training once when this is permitted.

d) All content should be based on current evidence, national guidelines and local systems and risk issues.

e) The content can be locally produced or using the national available resources including video simulations, on-line presentations, national resources and/or interactive video-conferencing.

f) Participation should be recorded, ideally through the standard Trust Managed Learning Environment (MLE) or equivalent database for recording training with simple evidence of reflection.

g) Staff on long term sickness during the MIS reporting period should not be counted towards compliance.

h) Self-isolating or shielding staff should access the remote training resources.

MIS and Covid-19 specific e-learning training

Based on the MBRRACE-UK findings and recommendations, maternity units should provide training for the following elements that relate to care of pregnant and postpartum women during the current Covid-19 pandemic.

There should be unit level multi-professional training for all staff caring for pregnant & postpartum women with suspected or confirmed Covid-19, including a general overview of care principles, and individual susceptibility e.g. ethnicity, hypertension and diabetes.

In addition, there should be specific training concerning women requiring maternal critical care and also the triage of pregnant & postpartum women with mental health concerns.

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

MATERNITY SERVICES
Midwifery Staffing Report

Report Title:	Bi-Annual Report on Midwifery Workforce – November 2021 for period 1st April 2021 to 30th September 2021
Report for:	Information and approval
Report from:	Head of Midwifery
Lead for safety action:	Head of Midwifery
Report authors:	Karen Newbury Christine Colbourne
Frequency of report:	Bi-Annual information report for Trust Board. Reporting periods: • April 1st 2021 to 30th September 2021: Ratification at November 2021 Maternity Quality and Safety Meeting then to Board in December 2021. • 1st October 2021 to 31st March 2022: Ratification at May 2022 Maternity Quality and Safety Meeting then to Trust Board in June 2022. All reports will be shared with Maternity Safety Champions and the LMNS.
Date of this report:	1 November 2021

Executive Summary:

- The maternity service monitors the staffing levels required using the Birthrate + (BR+) establishment tool. Results of these assessments are translated into reports and proposals which are submitted to the Board for agreement if the establishment needs to change to reflect changes to the numbers and acuity of the women using the service. Independently to the BR+ report, the Trust supported an uplift in the establishment of midwives and there has been an active recruitment programme to meet these needs.
- There has been a response to the Better Birth's initiative to introduce continuity of carer teams which requires reconfiguration of the establishment to address the changes to the organisation of care pathways. This has also been supported by the publication of recommendations within the Ockenden (2020) report.
- Staffing shortages are covered with bank staff and existing staff working additional hours within safe standards. The escalation policy is appropriately implemented when required.
- An active recruitment programme is in place but delays in the process and availability of midwives nationally, can lead to a hiatus between staff leaving or vacancies being advertised and the staff being in post.
- In the first 3 months of this reporting period, the labour suite co-ordinator was supernumerary over 90% of the time but in the last 3 months (July to September), this had dropped to between 80 and

85%. The definition of supernumerary needs to be standardised across all maternity units to ensure that there is parity in reporting this.

- The ability to provide one to one care in labour as a basic need has been reported as between 98.9% and 100% with the last 3 months of the reporting period being 100% consistently.
- The midwife to birth ratio has been adversely affected by staffing shortages and the impact of continued issues relating to Covid 19 and vacancies.
- The number of red flags reported in the last 3 months of the reporting period has significantly increased, mainly due to delays in being able to proceed with induction of labour due to staffing shortages.

Summary of actions taken

The maternity service has taken steps to ensure that recruitment to the required staffing levels is ongoing and there is an active escalation of staffing concerns on an ongoing basis when activity and acuity is raised.

The midwifery management team have explored alternative strategies for increasing staff on the ward.

An action plan has been developed and attached as Appendix 1 to highlight where (and how) the service needs to improve compliance.

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1. Background

In 2018 NHS Resolution introduced a Maternity Incentive Scheme (MIS) to support the delivery of safer maternity care. Comprising a total of 10 Maternity Safety Actions, Safety Action 5 focusses on midwifery staffing and asks if the Trust can provide evidence to demonstrate ***'an effective system of midwifery workforce planning to the required safe standard'.***

Each year NHS Resolution updates the Safety Actions to reflect progression and improvement maternity services are expected to make against the published standards. The Year 4 Safety Actions were released in August 2021 with a number of revisions to Safety Action 5 and to meet the required standard the service now needs to demonstrate and evidence:

a. A systematic, evidence based process to calculate midwifery staffing establishment is completed
b. The midwifery co-ordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is oversight of all birth activity within the service.
c. All women in active labour receive one-to-one midwifery care
d. Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months during the MIS year four reporting period (August 2021 - June 2022)

This report will provide evidence against the Year 4 Maternity Incentive Scheme (MIS) Safety Action 5 and includes an action plan that will be monitored at the service Maternity Quality and Safety Meeting and Women's and Children's Divisional Board.

In addition, the **Ockenden report (2020)** outlines the requirements in the Immediate and Essential Actions for Workforce that midwifery staffing is a key component of safe working within Maternity Services nationwide.

The requirement in question 46 is to: *Provide assurance to 'demonstrate an effective system of midwifery workforce planning to the required standard'*. In order to do this, the report on staffing levels from Birthrate + should be used to submit proposals to the Trust Board for staffing requirements and receive a formal agreement within minutes of Board meetings, for funds to be allocated to do this.

The purpose of this report is to provide evidence and give Board assurance that work continues to be undertaken within maternity services at West Suffolk, to demonstrate progress towards meeting safe staffing standards within the midwifery workforce.

2. Year 4 evidential requirement:

In response to section (d) of the Year 4 Safety Standards, this report for Trust Board will provide information to meet the minimum evidential information including:

- A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.
- Details of planned versus actual midwifery staffing levels. To include evidence of mitigation/escalation for managing a shortfall in staffing.
- An action plan to address the findings from the full audit or tabletop exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified.
- Maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover shortfalls.
- The midwife to birth ratio
- The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in the clinical numbers. This includes those in management positions and specialist midwives.
- Evidence from an acuity tool (may be locally developed), local audit and/or local dashboard figures demonstrating 100% compliance with supernumerary status and the provision of 1-1 care in labour, including plans for mitigation/escalation to cover any shortfalls.
- Information on the monitoring of red flag events associated with midwifery staffing.
- Information on service compliance with 1-1 care in labour.

The information in the sections below provides information on all these elements.

3. Assessment of required midwifery staff.

A full BirthRate Plus (BR+) assessment was completed in April 2019 which demonstrated the actual funded establishment of clinical midwives was in line with their recommendations at that time. Within the BR+ report, it highlights that staffing in smaller maternity units may require senior management to set their own minimum staffing levels to safely staff all clinical areas and this has been applied at West Suffolk. This has been applied and calculated using local calculations to determine minimum safe staffing levels in each of the inpatient clinical areas.

Following the CQC report in 2019, significant investment in the midwifery establishment was made with an uplift in specialist midwives in particular.

Since BR+ assessment was last carried out, the government have introduced a national ambition to improve the stillbirth and neonatal mortality and morbidity rates, with Better Births [1] published in 2016 as the central driver for achieving this. Better Births has 'continuity of carer' as a key element, which has led to each maternity unit being challenged with changing existing service models to reflect smaller community-based teams, with each midwife providing antenatal, intrapartum and postnatal care to a caseload of 36 women.

This new way of working requires additional resources and the senior midwifery team at West Suffolk have worked in partnership with the LMNS, national lead for Better Births and the CCG to review the midwifery workforce needed to provide this model of care. Using a recognised, national workforce model, moving to full continuity of carer will require an additional investment of midwives. The uplift of just under 28 wte midwives has been agreed by the Trust board and is to be phased in over 2021/22 as the service is able to employ midwives.

Alongside this, the publication of the Ockenden report in December 2020 came with additional monies to uplift the midwifery workforce by 6 wte midwives. These midwives were employed by September 2021 and as the money is non-recurring these post have not been added to the establishment.

The increase in midwifery establishments is demonstrated in the following table:

Midwifery Establishments 2021/22			
Band	Funded WTE M5	Ockenden WTE	Funded WTE M6
Band 5	9.12		9.12
Band 6	71.07	6.00	77.07
Band 7	30.73		30.73
Band 8	3.00		3.00
Grand Total	**113.92**		**119.92**

The Trust Board have funded the continuity of carer model with an additional 12 Band 6 midwifery posts. These will be phased into the budget as successful recruitment takes place from month 7.

4. Recruitment of midwifery staff

Recruitment of qualified midwives is currently posing significant challenge to maternity services nationally and at West Suffolk hospital. The service has also explored the recruitment of registered nurses to join the team on the postnatal ward and this is currently in progress.

There has been concentrated effort placed into recruitment of midwives including:

- Regular advertising on NHS jobs including recruitment into specialist midwife and governance roles.
- Rolling advert for midwives on NHS jobs which is constantly monitored and any suitable applicants are fast tracked and interviewed within 2 weeks of application.
- Collaborative work with LMNS to target attraction of midwives to work in Suffolk and North Essex.
- Exploring appointment of overseas midwives.

[1] Better Births. Improving Outcomes of Maternity Services in England. (NHS England 2016)

- An increase in midwifery students to enable a larger pool of newly qualified midwives to recruit from in future years.
- Focussed work with HR partners to look at improved ways of retaining staff. This includes work exploring themes around why staff are leaving the Trust following exit interviews.
- 'Growing our own' future midwifery workforce, through:
    - Collaborative working with local HEI's to increase student midwife places each intake
    - Accessing the 18 month course to encourage nurses to train as midwives

The number of vacancies at the end of September 2021 was 27.18 wte.

The service is currently employing approximately 10.00 wte midwives each month through the bank and staff working additional hours. As additional staff are proving a challenge to recruit, further roll out of continuity of carer has not taken place and will not progress beyond the two existing community based teams, plus caesarean section team, until there are enough suitably trained staff to safely staff this new way of working.

The effort to recruit midwives and nurses into the current vacancies will continue as a high priority for the service. The national 'pool' of available midwives is currently reduced as all Trusts in the country are facing similar challenges with the uplift in staff to meet the continuity of carer agenda. This coupled with the alarming reports that a number of midwives are considering leaving the profession adds to the difficulty in attracting staff and encouraging them to move to West Suffolk when they are being offered similar opportunities elsewhere. The longer term strategy of 'growing our own' will help ease the problem in future years, but there is going to be a time lag of at least 2 years before this realises noticeable gains due to the length of training.

5. Monitoring midwifery staffing

Availability of midwifery staff has steadily become more of a challenge since April 2021. Whilst there are no longer any mandated staff shielding, the increase in staff being sick or absent due to isolation needs associated with coronavirus has been noticeable and is ongoing. This along with the vacancy levels, has led to the service not always achieving the minimum expected levels on some shifts.

To mitigate against this:

- The service employs midwives from the established in-house bank plus staff have also been willing to undertake hours in addition to contract.
- An uplift in pay for staff working these shifts has been agreed and welcomed by the staff and has had the effect of encouraging more cover.
- The escalation plan has been initiated appropriately with staff in specialist roles working clinically to ensure women receive safe care.

Midwifery staffing is monitored continuously:

- There is a daily manager on call and unit bleep holder who liaise with the matrons, deputy HOM and HOM to discuss strategies and actions needed to balance acuity against staffing levels.
- The BR+ app is completed 4-hrly with information informing decision making by the senior team.
- Staffing levels are discussed and recorded at the daily safety huddle and actions shared with the MDT.

- Weekly staffing meetings with ward managers and matrons take place to plan ahead and discuss gaps in the rosters and options for maximising staff deployment.

The Head of Midwifery provides a monthly report to the Trust Board highlighting the staffing issue faced in the previous month. Key elements of this report are number of shifts not filled, 1-1 care in labour and the MW to birth ratio.

6. Details of planned versus actual midwifery staffing levels

The service currently publishes the daily record of the number of staff on duty against the minimum staffing levels expected in each clinical area. E-Roster gives more detailed information on the numbers of staff on duty, absences, and unfilled shifts. Developments on E-Roster continue to ensure a robust system is in place to easily calculate the fill rates.

The Head of Midwifery provides information monthly on the wte number of registered midwife shifts that have not been filled:

Number of RM shifts not filled		
Month	**WTE**	**Shifts per week**
April	6.61	18
May	5.43	16
June	6.91	21
July	7.32	22
August	5.84	18
September	6.23	19

7. Status of the labour suite co-ordinator (LSC) in relation to being supernumerary

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

The table below shows compliance with the supernumery status of the LSC between April and September 2021:

Supernumerary Status of Labour Suite Co-ordinator	
Date	% Compliance
April	93%
May	96%
June	96%
July	81%
August	82%
September	85%

The current staffing challenges previously identified have impacted on the services' ability to maintain the supernumerary status of the LSC and at times the postholders have needed to provide direct care for women in addition to leading the shift at times of heightened acuity

During the last year, significant investment has been made into Band 7 clinical posts and the additional funding has enabled the service to plan to have 2 band 7 midwives on duty each day and night shift, 7 days a week to assist in maintaining the supernumerary status of the LSC.

The BirthRate Plus® app for acuity has been introduced and monitoring of the supernumerary status of the labour suite co-ordinator is now established and reported monthly on the service Quality Dashboard. It is also discussed and recorded at the daily safety huddle.

8. Provision of 1-1 care in labour

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

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

Monitoring of this standard is provided monthly using the maternity information system e-Care. Midwives enter the information as part of their delivery records and this information is collated monthly and reported on the service quality dashboard.

The provision of 1-1 care is prioritised by the senior management team with staff movement and escalation processes being deployed to ensure women are provided with safe care. In spite of the current staffing level challenges, the team have succeeded in providing 1-1 care to the majority of women over the last 6 months.

1-1 Care in Labour	
Date	% Compliance
April	No data
May	99.5%
June	98.9%
July	100%
August	100%
September	100%

The change-over form Euroking to e-care maternity system was not without challenges in producing accurate and robust data and in April during the change-over time, information on 1-1 care in labour could not be produced.

In May and June, a total of 7 women were reported as not having 1-1 care in labour. All records were reviewed, and the table below shows the findings.

MAY	**3 women did not receive 1-1 care in labour** i. Rapid labour, unplanned home birth, MW arrived just prior to babies birth ii. Concealed delivery: birthed at home attended by paramedic iii. Precipitate labour, unplanned home birth before arrival of professionals.
JUNE	**4 women were reported as not receiving 1-1 care in labour. Following review, it appears a recording error was made and the actual number for the month was 3.** i. Woman advised to come to hospital. Labour rapidly progressed and birthed at home attended by paramedic. ii. Woman admitted to labour suite and after initial observations was thought to have a UTI. Labour progressed rapidly and MW attended for birth. No labour care given. iii. Rapid delivery at home attended by partner. No services called and woman not booked at West Suffolk.

From July to September, all women attending for birth with the maternity service at West Suffolk have received 1-1 care in labour.

9. Midwife to birth ratio

The monthly midwife to birth ratio is calculated using information from both e-roster for staffing and E-Care for activity.

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

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

The table below demonstrates and confirms that staffing shortages described throughout this report have impacted negatively on the MW to Birth ratio.

MW to Birth Ratio Standard = 1:28	
Date	**Ratio**
April	No data
May	1:28
June	1:30

July	1:33
August	1:30
September	1:30

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

10. Monitoring of Red Flags in relation to midwifery staffing

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

RED FLAGS relating to midwifery staffing:
Redeployment of staff to other services/sites/wards based on acuity
Staff absences due to illness/isolation/shielding/symptoms for Covid-19
Delayed or cancelled time critical activity
Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing)
Missed medication during admission to hospital or MLBU
Delay of more than 30 minutes in providing pain relief
Delay of 30 minutes or more between presentation and triage
Full clinical examination not carried out when presenting in labour
Delay of two hours or more between admission for induction and beginning process.
Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)
Any occasion when one midwife is not able to provide continuous 1-1 care in established labour
Unable to facilitate women's choice of birthplace
Labour suite co-ordinator not supernumerary.

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

Number of Red Flags reported each month	
Date	**Number**
April	5
May	1
June	4
July	17
August	18
September	15
TOTAL	**60**

Following an update for staff on the reasons for submitting a red flag and the use of the BR+ app, reporting of red flags has become more robust and a noticeable increase in submissions has been noted.

For the period April to September 2021, a total of 60 red flags were submitted for the following reasons:

- 45 reported delays in continuation of induction of labour due to high activity on labour suite – these can be partly due to staffing and partly to do with workload and available space to provide safe care.

- 10 reported occasions where the labour suite co-ordinator was not supernumerary for the whole shift
- 1 occasion where there were delays in administering medication.
- 1 episode where observations of vital signs were delayed.
- 1 occasion where there was delay in treatment and medication due to ward activity and availability of staff to provide care.
- 2 episodes where women booked to give birth on the MLBU had to be cared for on labour suite due to availability of staff to care for them.

There were no instances where staff have been redeployed to other areas in the hospital to work between April and September. Collation of staff absences due specifically to Covid-19 has historically been collated through the e-roster system. An action from this report will be to collect and collate this information in future using the Red Flag processes.

The number of red flags each month is recorded on the quality dashboard and is monitored at the Maternity Quality and Safety Group meeting. Red flags are discussed and recorded at the daily safety huddle which is attended by medical and midwifery staff. Actions taken to mitigate and escalate are documented and the team ensure reporting via the datix system has taken place. When a red flag datix is submitted care is reviewed by the senior team to assess impact and identify trends.

11. Specialist Midwives (SpMW) in post

The funded establishment for Band 7 specialist MW post is totalled as 8.25 wte and the following are in post:

- 1.20 wte Antenatal and Newborn Screening MW (2 x 0.60)
- 1.76 wte Practice Development MW. (1 x 1.00, 1 x 0.60)
- 2.00 wte Clinical Risk MW. (2 x 1.00)
- 1.00 wte Clinical and Quality Assurance MW
- 0.20 wte Fetal Monitoring MW
- 0.96 wte Bereavement MW
- 0.60 wte Safeguarding MW.
- 0.53 wte Diabetes MW.

The funded establishment for band 6 SpMW is 2.6 wte and this comprises:

- 0.60 wte Infant Feeding MW
- 0.80 wte Smoking Cessation MW
- 0.60 wte Clinical Practice Facilitator
- 0.60 wte Antenatal Screening MW

The service has two band 7 MW posts that are externally funded:

- 0.80 wte Perinatal Health MW
- 0.60 wte Clinical Practice Facilitator

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

When taking this into consideration, the pure specialist MW element of their roles, constitutes just over 9% of the total midwifery workforce, which is in line with BirthRate Plus methodology.

12. Conclusions

The maternity service has taken steps to ensure the recommendations from the BR+ report have been analysed and actions have been taken to address the findings. Whilst the service funded establishment now exceeds the BR+ recommendations, there are now challenges in recruiting into the vacancies. There is a smaller 'pool' of midwives as all Trusts are in a similar position and midwives are being offered opportunities in their existing Trusts. The intake of student midwives has increased but this will not be realised for at least 2 years.

In addition, Covid-19 continues to impact on the midwifery service this year, so the increased investment and appointment of new staff has not appeared to have had a positive benefit on morale as there has been no obvious improvement to the day-day staffing. The on-going staffing challenges have also delayed the full introduction of Continuity of Carer and prevented some service and staff developments associated with the various clinical teams.

The midwifery management team have explored alternative strategies for increasing staff on the ward by advertising for nurses to work in postnatal care, looking to employ overseas midwives and increasing the clinical and non-clinical support staff. This does take time and any benefits of this will not be realised in the short term.

An action plan has been developed and attached as Appendix 1 to highlight where (and how) the service needs to improve compliance. Some actions from the previous report have been carried over for continued monitoring and completed actions have been highlighted. This action plan will be monitored quarterly at the Maternity Quality and Safety meeting and will be updated for the next Board Report due in June 2022.

The completed action plan for the previous report in April 2021 is available below. Where actions are still 'work in progress', these have been carried over into the action plan in appendix 1.

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idwifery%20Staffing%

Appendix 1 Action Plan

Action Plan Owner:	Name: Karen Newbury	Role Title: Head of Midwifery	Contact: Karen.newbury@wsh.nhs.uk

RECOMENDATION		ACTIONS REQUIRED	ACTION BY DATE	PERSON RESPONSIBLE	COMMENTS/ACTION STATUS
1.	The funded establishment against vacancies to be monitored monthly	Monitor establishment versus vacancies monthly via the current vacancy control processes.	On-going monthly	HOM	
2.	Embedding of all elements of the BR+ acuity app into practice	Embedding of the app is needed to ensure robust and reliable data is produced monthly.	End of Q1 2022/23	Matron: IP services Ward Manager: Labour Suite Band 7 MW	
		Include training on BR+ APP is included in all new LSC induction programme to ensure			
3.	Monthly monitoring of 1-1 care in labour	1-1 care in labour compliance will continue to be monitored monthly through e-Care and reported on the service quality dashboard.	On-going monthly	Risk and Governance Team	
4.	Midwife to birth ratio to be maintained at or below 1:28	The MW to birth ratio will continue to be monitored and reported monthly on the service quality dashboard.	On-going monthly	Risk and Governance Team	Multiple recruitment initiatives in place with new starters due to commence in Q3 2021/22
5.	Monitoring of Red Flag information	Ensure staff are completing Red Flags for 'staff absences due to illness, isolation shielding and or symptoms for Covid -19' are reported.	On-going monthly	Risk & Governance team	Improvement in reporting noted in October 2021.
		Red flags will continue to be reported through the BR+ app and discussed at the daily safety huddle.	On-going monthly	All maternity staff	Profile of Red Flag recognition and reporting has high profile within the

					service as discussed daily with all members of the MDT
6.	Enable accurate electronic recording of planned versus actual staffing on E-Roster	Review rules and templates on E-Roster to enable the system to generate accurate reports on planned versus actual staffing levels. Successful completion of this will be dependent on roll out of continuity of carer model of care	Revised completion date by Q4 2021/22.	Matron IP services. Ward Managers	Delayed due to adaptations required due to introduction of continuity of carer.
		Data continues to be collected and collated by the senior midwifery team on a monthly basis.	On-going	Head of Midwifery	
7.	Review staffing levels once Continuity of Carer is implemented to ensure safe standards of care are maintained	Review all methodology of monitoring safe staffing levels and acuity when continuity of carer teams are implemented and established. Service has had agreement to employ the required MW to implement continuity of carer. This will be phased in over the next 12 months.	Currently no published dates. Service will work in partnership with LMNS and CCG to progress with any recommended implementation.	HOM Matrons LMNS CCG	April 2021: Implementation of continuity of carer model has been delayed due to Covid - 19 and ability to recruit into newly established vacant posts.
8.	Monitor supernumerary status of Labour Suite Co-ordinator	Reporting of supernumerary status of LSC to be audited monthly and reported on the service Quality Dashboard	On-going monthly	Matrons QA Midwife	
		Reported incidents will be monitored to determine impact on care when LSC is not supernumerary.		Risk MW	

West Suffolk NHS
NHS Foundation Trust

Audit of the Operational Pathway of Care into Neonatal Transitional Care July -September 2021

Date: Report November 2021

Introduction

Neonatal Transitional Care (NTC) is not a place but a service and can be delivered either in a separate Neonatal Transitional Care area, within a postnatal ward, within the neonatal unit and /or in the postnatal ward setting.

The principals of NNTC include the need for a multidisciplinary approach between maternity and neonatal teams; an appropriately skilled and trained workforce, robust system for data collection with regards to activity and appropriate admissions and a link to community services.

Keeping mothers and babies together should be at the cornerstone of newborn care. Neonatal Transitional Care (NTC) supports resident mothers to be the primary care providers for their babies when they have care requirements in excess of normal well newborn care, but do not need continuous monitoring in a special care setting.

NTC avoids separation of the mother and baby and facilitates the establishment of breast feeding whilst enabling safe and effective management of a baby with additional care needs.

NTC also has the potential to prevent admission to the neonatal unit and to provide additional support for small and/or late preterm babies and their families.

NTC helps in the smooth transition to discharge home from the neonatal unit for recovering sick or preterm babies whilst providing specialised support away from the more intensive clinical setting.

At the West Suffolk babies meeting the criteria for Neonatal Transitional Care, are admitted to a defined 5 -bedded area within F11, the postnatal ward and cared for by midwifery and neonatal teams. Babies admitted from home requiring NTC are admitted to a side room on the Neonatal Unit.

CNST maternity incentive scheme

NHS Resolution is operating a fourth year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme published August 2021 to continue to support the delivery of safer maternity care.

Neonatal Transitional Care is included in Safety action 3: **Can you demonstrate that you have Neonatal Transitional Care services to support the recommendations made in the Avoiding Term Admissions to the Neonatal units Programme**

CNST Required Standards revised and updated March 2021 (new to year 4 in red)

A) Pathways of care into Neonatal Transitional Care have been jointly approved by maternity and neonatal teams with neonatal involvement with the focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.

B) The pathway of care into Neonatal Transitional Care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion. Local Maternity and Neonatal System (LMNS), commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter.

C) A data recording process for capturing existing Neonatal Transitional Care activity, (regardless of place - which could be a Neonatal Transitional Care (NTC), postnatal ward, virtual outreach pathway NTC.) has been embedded.

If not already in place, a secondary data recording system is set up to inform future capacity management for late preterm babies who could be cared for in an NTC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.

D) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 are available to be shared on request, with the Operational Delivery Network (ODN) and commissioners to inform capacity planning as part of the family integrated care component of Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies.

E) Reviews of term admissions to the neonatal unit to continue on a quarterly basis and findings shared quarterly with the Board level Safety Champion. The reviews should report on the number of admissions to the neonatal unit that would have met the current NTC admissions criteria but were admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were admitted to, or remained on Neonatal Units because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis.

F) An action plan to address local findings from the audit of the pathway (point b) and Avoiding Term Admissions into Neonatal units (ATAIN) reviews (point e) has been agreed with the maternity and neonatal safety champions and Board level champion.

G) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champion, LMNS and ICS quality surveillance meeting.

Audit Aim

The aims of the audit are to identify whether the agreed standards within the local Policy ‘Operational Policy for Neonatal Transitional Care (NCT) June 2020 enables mothers and Babies to receive appropriate Neonatal Transitional Care at the West Suffolk Hospital.

The objectives are to demonstrate whether the standards for clinical criteria for admission and the operational standards in relation to midwifery, neonatal and medical staffing are in accordance with the current policy.

The overall aim is to determine whether there are modifiable factors which can be addressed as part of an action plan in order to improve the care for mothers and babies.

Methodology

A review of the data collected monthly of the pathway of all cases identified between July 2021 and September 2021 (Quarter 2) The data was taken using BadgerNet, eCare and Neonatal Admission book.

Results July 2021 - 23 babies were admitted to NTC

7 babies admitted from birth from labour Suite /MLBU / Home

Clinical Standards		**Criteria for admission met**
Criteria for immediate admission		
Gestational age >34+6 weeks	All babies > 39 weeks gestation.	**100%**
Not requiring intensive or high dependency care	None	**100%**
Birthweight >1800g	All babies between 3-4 kilograms	**100%**
Maternal suspected /confirmed sepsis in labour	4 mothers had suspected sepsis	**100%**
Neonatal risks of Sepsis.	3 babies were admitted with suspected neonatal sepsis	**100%**
Preterm	No babies were preterm	**N/A**

8 babies admitted due to clinical conditions developing on the Postnatal ward

Clinical Standards		**Criteria for admission met**
Criteria for admission – developing: Risk factors		
Risk factors for sepsis requiring IV antibiotics	3 babies developed symptoms of suspected neonatal sepsis. • Tachypnoea at 12 hours • Jaundice at 13 hours not requiring phototherapy) • Neonatal Pyrexia 3 mothers developed suspected sepsis post-delivery requiring babies to receive IV antibiotics.	**100%**
Neonatal hypoglycaemia	2 babies developed hypoglycaemia requiring closer monitoring. (Both babies had risks for hypoglycaemia Prematurity, Intrauterine growth restriction.)	**100%**

3 babies admitted from the community setting

Clinical Standards		Criteria for admission met
Criteria for readmission from community met:		
Requiring phototherapy and serum bilirubin monitoring	All three babies were readmitted due to jaundice and required phototherapy. Day 2, day 4 and Day 5. All less than 38 weeks gestation.	**100%**

5 babies stepped down care from NNU to NTC

Clinical Standards		Criteria for admission met
Criteria for step down from NNU:		
Pre-term born >33+5 following at least 48 hours observation on NNU and are clinically stable.	4 babies were greater than 37 weeks gestation at birth. 1 baby was 35 weeks gestation at birth.	**100%**
Observations required no more than 3 hourly	All babies met these criterion	**100%**
Stable baby with sepsis requiring antibiotics	All babies met this criteria, 1 baby continued on antibiotics.	**100%**
Continuing phototherapy when bilirubin has stabilised	No babies required phototherapy.	**100%**
Criteria for discharge met:		
Feeding established and baby is maintaining or gaining weight.	All babies met this criterion on discharge home	**100%**
Course of IV antibiotics is complete	All babies met this criterion on discharge home.	**100%**

Results August 2021 - 29 babies were admitted to NTC.

12 babies admitted from birth from labour Suite / MLBU / Home

Clinical Standards		Criteria for admission met
Criteria for immediate admission		
Gestational age >34+6 weeks	4 babies were between 35-37 weeks gestation 8 babies were between 37 – 40+4 weeks gestation	**100%**
Not requiring intensive or high dependency care	None	**100%**
Birthweight >1800g	Birth weights range from 2300 kg – 4200 kg	**100%**
Maternal Sepsis suspected /confirmed	3 mothers had suspected sepsis in labour.	**100%**
Neonatal risks of sepsis	4 babies with suspected sepsis	**100%**
Preterm with Risk factors	4 babies preterm with risk factors for sepsis.	**100%**
Other	1 baby required NN oversight due to a known abnormality.	**100%**

4 babies admitted due to developing clinical conditions on the Postnatal ward

Clinical Standards		Criteria for admission met
Criteria for admission – developing: Risk factors		
Risk factors for sepsis requiring IV antibiotics	4 babies required IV antibiotics for suspected sepsis. • 1 mother commenced on the sepsis pathway • 3 babies developed symptoms for possible sepsis	**100%**

8 babies admitted from the community service

Clinical Standards		Criteria for admission met
Criteria for readmission from community met:		
Requiring phototherapy and serum bilirubin monitoring	7 babies admitted were due to jaundice – gestations from 37+0 to 37+6 • 5 Admitted on day 3 • 2 admitted on day 4 3 required phototherapy • 1 baby was admitted day 6 with poor feeding and weight loss (initially admitted with jaundice readmitted day 3)	**100%**
Comments	1 baby admitted with Jaundice on Day 3 met criteria for NTC but parents opted not to stay with baby.	

5 babies stepped down care from NNU to NTC

Clinical Standards		**Criteria for admission met**
Criteria for step down from NNU:		
Pre-term born >33+5 following 48 hours observation on NNU and clinically stable	All 5 babies were at term	**100%**
Observations required no more than 3 hourly	Yes all babies	**100%**
Stable baby with sepsis requiring antibiotics	1 baby continued on antibiotics	**100%**
Continuing phototherapy when bilirubin has stabilised	No babies continuing phototherapy	**N/A**
Criteria for discharge met:		
Feeding established and baby is maintaining or gaining weight.	Yes	100%
Course of IV antibiotics is complete	Yes	100%

Results for September 2021 26 Babies were admitted to NTC

11 babies required admission following birth from labour Suite / MLBU / Home

Clinical Standards		**Criteria for admission met**
Criteria for immediate admission		
Gestational age >34+6 weeks	2 preterm babies 35+ 6 & 36+6 9 term babies	**100%**
Not requiring intensive or high dependency care	None	**100%**
Birthweight >1800g	Birth weight between 2500 kg and 3800 kg	**100%**
Maternal Sepsis suspected /confirmed	7 had suspected maternal sepsis in labour	**100%**
Neonatal risks of sepsis	4 babies • 1 Risks PROM poor condition at birth • 1 Neonatal pyrexia & PROM • 2 babies both preterm had PROM and mothers had GBS.	**100%**
Comments	2 mothers were positive for Covid 19 during labour.	**-**

1 baby were transferred to NNTC from the Postnatal ward

Clinical Standards		Criteria for admission met
Criteria for admission – developing: Risk factors		
Risk factors for sepsis requiring IV antibiotics	1 mother commenced on IV antibiotics for fluctuating pyrexia, GBS present.	**100%**

7 babies admitted from community services

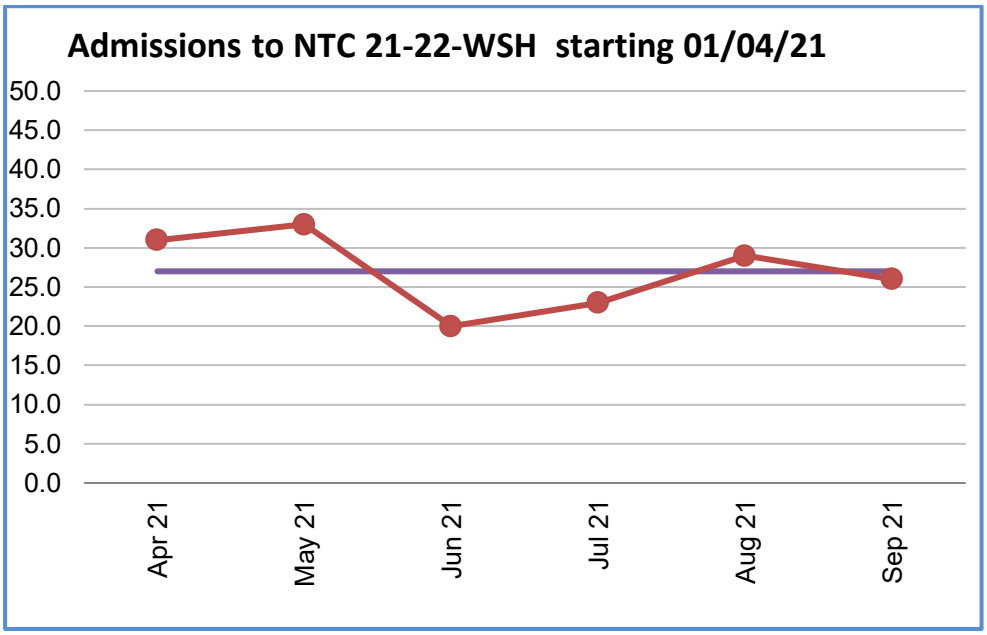
Clinical Standards		Criteria met
Criteria for readmission from community met:		
Requiring phototherapy and serum bilirubin monitoring	All 7 babies admitted due to jaundice – gestations from 37+3 to 39+4 1 admitted day 2 4 Admitted on day 3 (1 baby also >10% weight loss) 1 admitted on day 5 1 admitted on day 6 1 admitted day 7 7 babies received phototherapy.	**100%**
Comment	1 baby admitted with Jaundice on Day 3 met criteria for NTC but parents opted not to stay with baby, therefore, was cared for on NNU.	

6 Babies stepped down care from NNU to NNTC

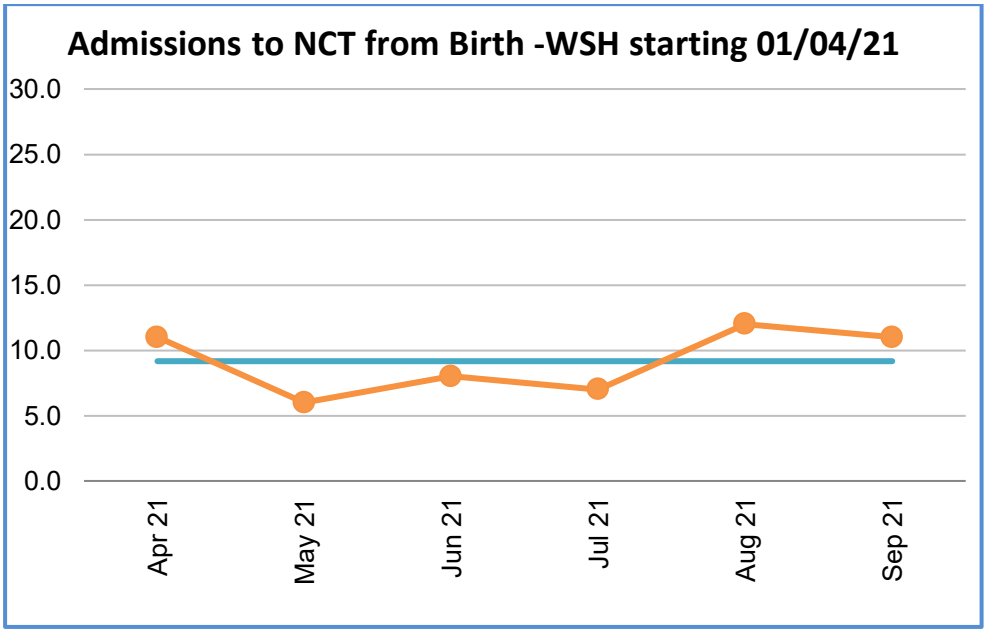
Clinical Standards		Criteria met
Criteria for step down from NNU:		
Pre-term born >33+5 following 48 hours observation on NNU and clinically stable	4 term babies 2 preterm 35+1 &36+6	**100%**
Observations required no more than 3 hourly	Yes	**100%**
Stable baby with sepsis requiring antibiotics	2 babies continued on Abx	**100%**
Continuing phototherapy when bilirubin has stabilised	1 baby stepped down from triple phototherapy.	**100%**
Continued support	2 babies continued feeding support.	**100%**
Criteria for discharge met:		
Feeding established and baby is maintaining or gaining weight.	Yes	**100%**
Course of IV antibiotics is complete	Yes	**100%**

Summary of Results for July -September 2021

78 babies were admitted to NTC in Quarter 2 (84 previous quarter)



30 babies required admission from birth: (25 previous quarter)



- 14 babies followed the local pathway for septic screening and intravenous antibiotics when the mother was treated for suspected or confirmed sepsis in labour.
- 10 babies followed the local pathway due to risks associated with sepsis and had partial sepsis screening and intravenous antibiotics.

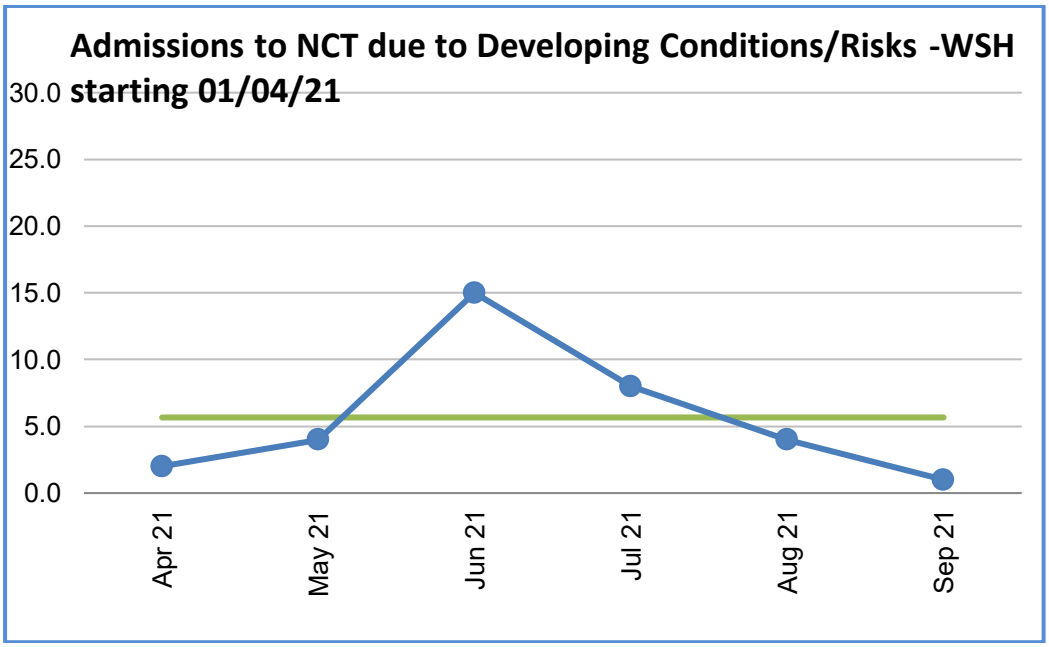
- 4 babies were admitted for reasons relating to prematurity and associated risks such as maternal Group B streptococcus, Maternal Covid 19 positive.

- 1 baby had a management plan for neonatal oversight due to an abnormality.

There were 2 mothers in this cohort who were positive to Covid 19 during labour, neither baby had a positive result.
All cases appeared to be appropriate for admission to NTC from birth.

13 babies admitted from the postnatal ward with developing or new risk factors:

(22 previous quarter)



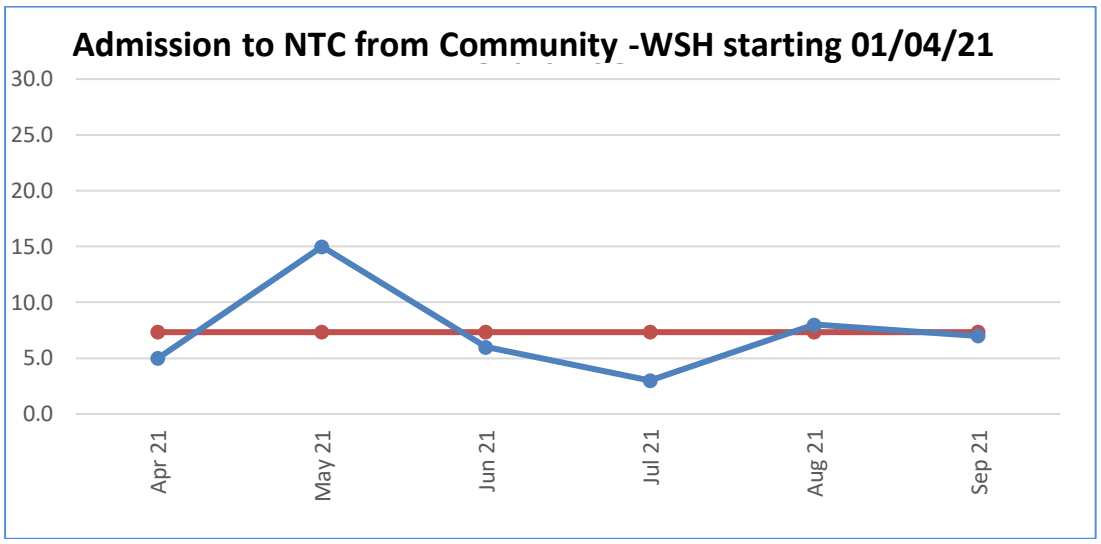
- 5 women developed suspected/ confirmed sepsis postnatally requiring IV antibiotics. as per the East of England Neonatal Antibiotic Policy 2019, all babies were appropriately referred for sepsis screening and commenced on IV antibiotics.

- 6 babies developed signs of sepsis e.g. pyrexia, early onset jaundice, tachypnoea these had not been present at birth therefore required sepsis screening and intravenous antibiotics as per the above policy.

- 2 babies developed hypoglycaemia requiring close monitoring on NTC both babies had risk factors i.e. prematurity and intrauterine growth restrictions.

All cases were appropriate for NTC and transfer in accordance with local and regional guidelines.

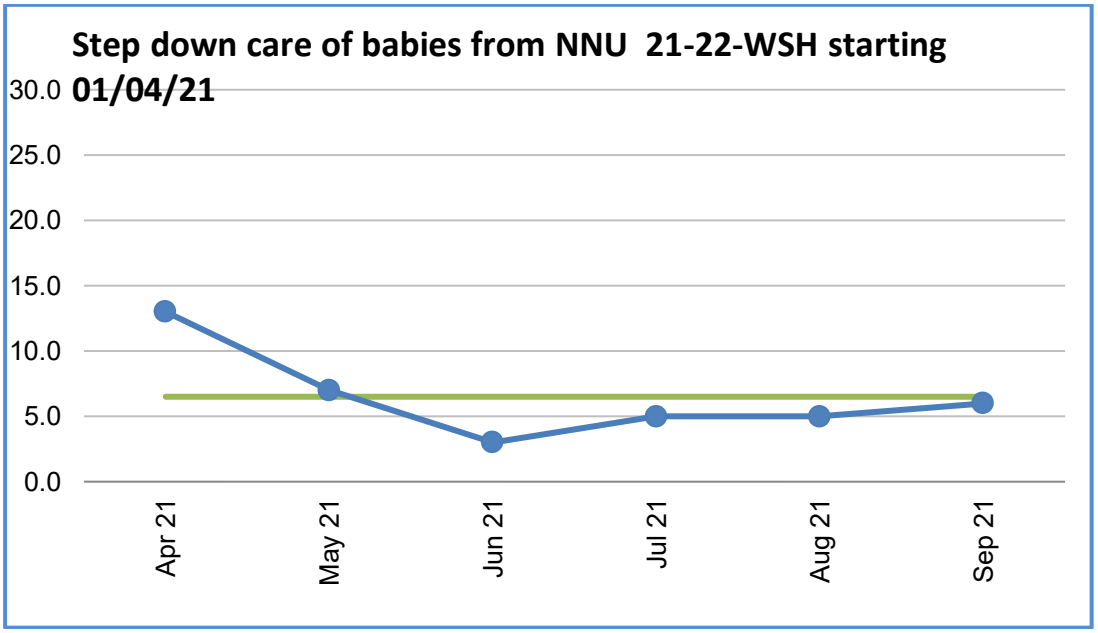
18 babies readmitted from the community service (26 previous quarter)



- 17 babies were admitted with jaundice of which 12 required treatment with phototherapy.
- 1 baby was admitted to NTC with jaundice on day 3 and readmitted with poor feeding weight loss.

There was one baby admitted from the community with jaundice however the parents opted not to remain in hospital with baby therefore baby remained under neonatal care.

16 babies had their care from the Neonatal Unit stepped downed to Neonatal Transitional Care (23 previous quarter)



Of the 16 babies who stepped down their care to NTC from the NNU, all met the standard for transfer. Following last quarter and amendments which were made to the audit tool to there has been an improvement in the data collected.

Conclusions

Overall, the admissions to NTC were slightly less than the previous quarter 78 ↓ 84. The significance of this was difficult to interpret, however, if we look at it more widely in whether NTC is reducing admissions to the NNU the overall picture looks very positive.
There was a significant reduction in term babies admitted to the neonatal unit from 6% in quarter 1 down to 3% in quarter 2. Full implementation of NTC has the potential to prevent admissions to the NNU and more importantly prevents the separation of mothers and their babies.

Accurate Data collection Timing of transfer to NTC

This second audit continues to highlight issues in the accuracy of the data in particular around the appropriate type of care the baby is initially under. The importance of documenting the correct type of care (either neonatal or transitional care) has been highlighted to the paediatric team following the previous audit. Further work needs to be undertaken to improve this further. An action has been included on the action plan.

Data Collection

There continues to be delay in collecting the data on a monthly basis. Currently the neonatal unit does not have dedicated time to collect timely data for NTC admissions and relies on staff reviewing babies as and when they can. This can result in delays in Quality and Safety team producing a report. The maternity service is currently reviewing this issue. An action has been included on the action plan

Criteria for admission

Identified Themes for admission at birth

The majority of babies admitted to NTC at birth was due to confirmed or suspected sepsis in either the mother or baby and were all appropriately eligible for NTC. Clinical audits were highlighted in the previous audit to identify if there are any modifiable factors for sepsis to address management around late pregnancy and during labour. These have been included on the current maternity audit plan.

Babies admitted with developing conditions/risks

There was a significant reduction from Quarter 1 of babies developing risks /conditions not present at birth. All were managed appropriately and met the criteria for admission.

Community

The audit showed a reduction from last quarter of babies admitted from home, the majority of admissions were due to jaundice, with only 1 baby being readmitted due to poor feeding and weight loss, a significant reduction from last month. The reduction in the readmissions of babies with poor feeding may be a result of the re-introduction of face to face post-natal appointments by the community teams. The audit noted that a significant number of readmissions with jaundice were babies under 38 weeks. A clinical audit should be undertaken

to include identification of any modifiable factors for this particular gestation of babies. An action has been included to address this particular finding.

Step down care from NNU

The number of babies who stepped down their care from the NNU has also reduced this quarter, this may be as a result of the reduction of term admissions to the NNU. All babies were considered that they had stepped down their care at the appropriate time and the expected criteria was met in all cases. Collecting accurate data for this group of babies continues to be challenging. The timing in the records is not always clear as to when this occurred. Success with this issue demands joint working between with the neonatal, midwifery and paediatric teams. An action has been included in the action plan.

Audit of Operational standards

Operational Standards - Midwifery Staffing:		**Criteria met**
Midwife from F11 is allocated to care for women every day and night shift	A midwife is allocated on every shift to NTC on the postnatal ward to care for women and undertake joint care of babies with the allocated neonatal nurse.	**100%**

Operational Standards – Neonatal Staffing:		**Criteria met**
A Neonatal nurse or nursery nurse from the NNU is allocated to care for babies on NNTC every day and night shift	A neonatal nurse is allocated on every shift to care for babies receiving Neonatal Transitional Care on whether the baby is receiving care on the NNU side room or on the postnatal ward.	**100%**

Staffing

Currently the allocated NTC neonatal nurse is based on the neonatal unit and may have other babies to care for on the Neonatal Unit.
The Trust has been exploring the feasibility of increasing neonatal unit staffing to support a member of the Neonatal team on F11 Neonatal Transitional Care bay 24/7 and it has been agreed to increase the neonatal team to enable provision of a member of the neonatal team to be present in NTC 24/7.

Operational standards Neonatal medical staff		**Criteria met**
A daily review of babies on NTC is conducted by a consultant paediatrician or the paediatric registrar allocated to the NNU.	A Paediatric ward round led by a consultant or allocated registrar ward round is undertaken daily for all babies receiving NTC on the postnatal ward and on the neonatal unit.	**100%**

Ward rounds

The paediatric team undertake a daily ward round for babies receiving NTC, however on some occasions the presence of the parent/ parents /carer was not always clear in the records. An action has been included to address this issue.

Recommendations

- Support to the paediatric team to improve the documentation of the appropriate type of care on initial review and when care is stepped down from the NNU.
- Dedicated time for neonatal staff to collect timely data each month.
- Review the increased number of babies admitted to NTC with jaundice and are less than 38 weeks to identify any modifiable factors.
- Support the paediatric team to improve documentation of parental presence on ward rounds

Audit findings are shared with the

- Maternity and neonatal clinical staff
- Maternity and Neonatal Safety Champions
- Maternity and Gynaecology Quality & Safety meeting
- Paediatric governance

References:

British Association of Perinatal Medicine A Framework for Neonatal Transitional Care 2017

'Operational Policy for Neonatal Transitional Care (NCT) June 2020.

East of England Neonatal ODN East of England Neonatal Antibiotic Policy 24th October 2019 amended February 2020.

Maternity Incentive Scheme (CNST) Year Four Ten Maternity Safety Actions. Safety Action 3

Action Plan

Project title	Quarterly 2 Audit of the Operational Pathway of care into Neonatal Transitional Care

Action plan lead	Name: Jane Lovedale	Title: Midwife Quality & Risk	Contact: 3275

Recommendation	**Actions required** *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Comments/action status**	**Status of Action**
Support the paediatric team to improve documentation of parental presence on ward rounds.	Discuss with the e Care team of the feasibility of included the question on e-Care and re-audit in quarter 3.	December 2021	J Lovedale Midwife Q&S		
Dedicated time required for neonatal staff to collect timely data each month.	Review of NNU staffing including roles and responsibilities to be undertaken. Identify who is responsible for collecting data and agree timeframe for completion each month.	November 2021	J Skonieczny Deputy HOM		

Support to the paediatric team to improve the documentation of the appropriate type of care on initial review and when care is stepped down from the NNU.	Develop posters highlighting issue. Share with paediatric team, via posters, email, departmental meetings. Re-audit in next quarter	December 2021	J Lovedale Midwife Q&S		
Review the increased number of babies admitted to NTC with jaundice and are less than 38 weeks to identify any modifiable factors.	Audit to identify any modifiable factors for babies readmitted with jaundice in gestations < 38 weeks	February 2021	J Lovedale Jane midwife Q & S		

CNST requirement Quarterly Audit findings shared with the Neonatal Safety Champion, Local Maternity and Neonatal System and (LMNS), Quality Surveillance meeting and Trust Board.	Neonatal Safety Champion,		Quality and Safety team	
	Local Maternity and Neonatal System and (LMNS),		HOM	
	Quality Surveillance meeting		HOM	
	Trust Board.		HOM	

NHS
West Suffolk
NHS Foundation Trust

ATAIN Programme

Avoiding Term Admissions to the Neonatal Unit

Progress Report
Quarter 2
JULY - SEPTEMBER 2021

OCTOBER 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

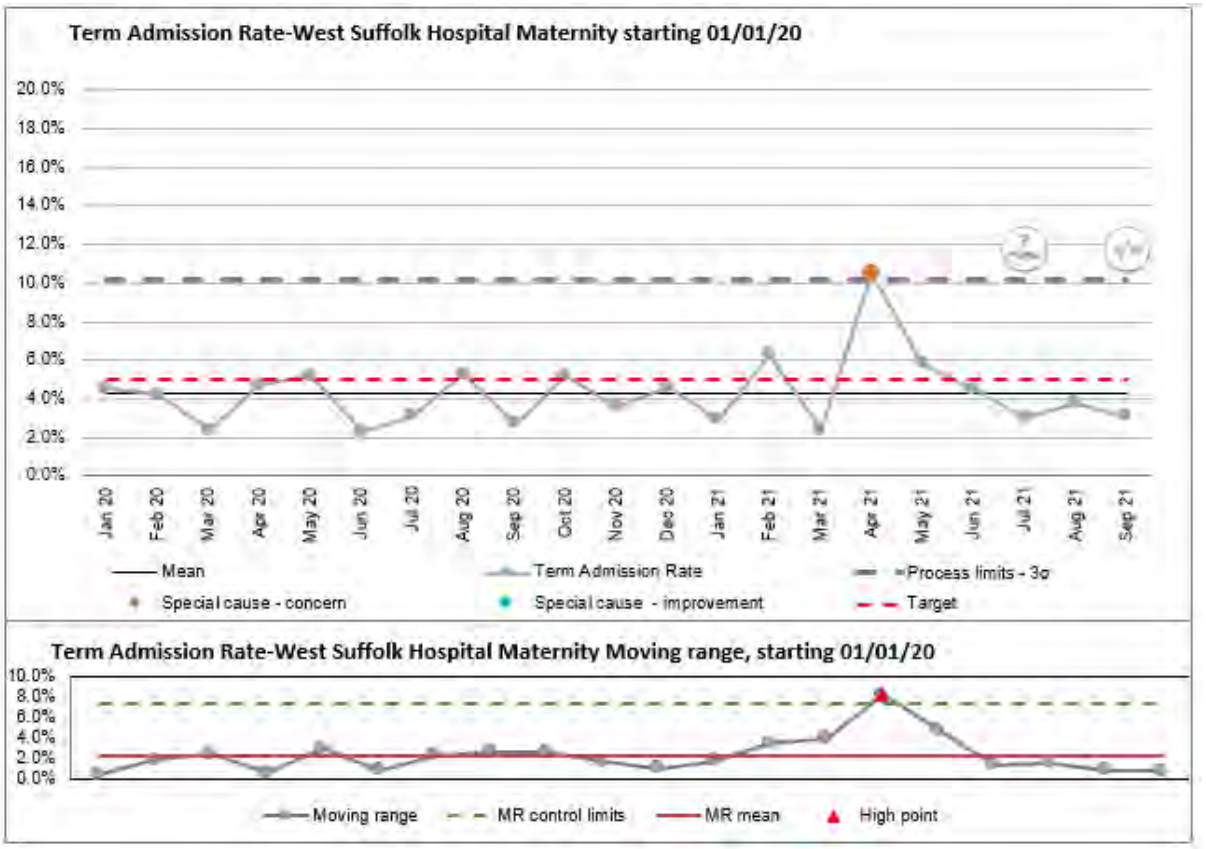
The neonatal and midwifery team review the maternal and neonatal records prior to the ATAIN meeting using the approved NHS improvement tools. Cases identified which require in depth obstetric review are discussed with a consultant obstetrician to determine if different care in labour may have reduced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

Findings

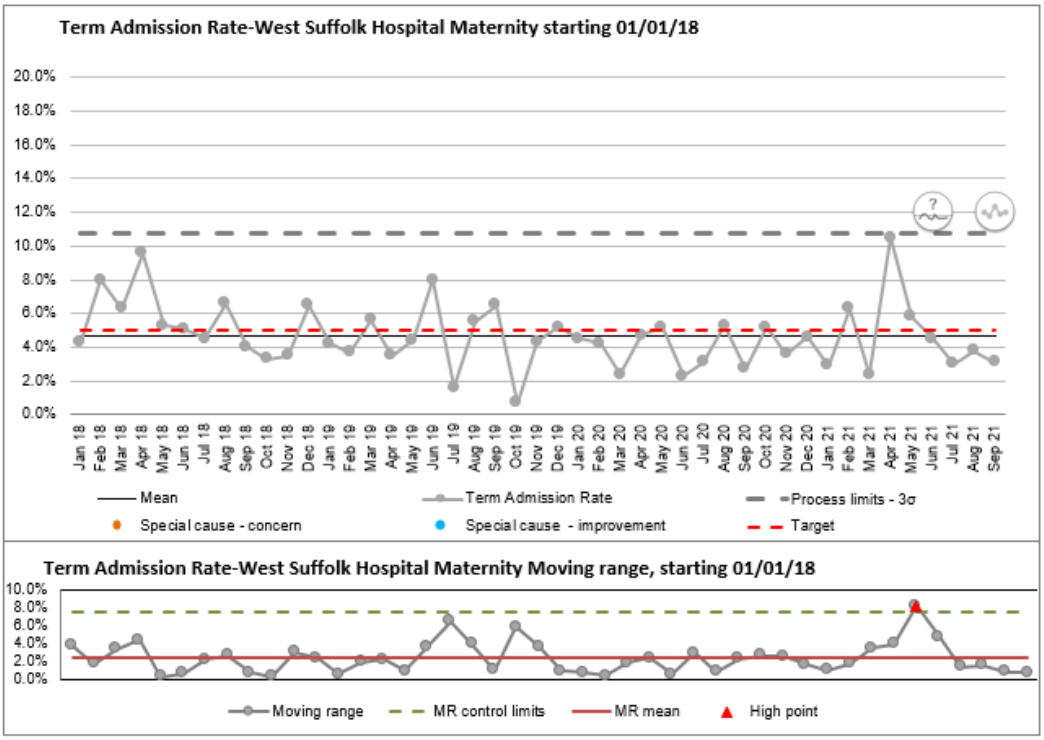
Term admission rates have settled again, after a higher than average rate in April and May this year. This appears to have been due to unavoidable variation, although an improvement theme was identified at the end of quarter 2: low admission temperatures for babies being admitted for a variety of reasons.

It was identified that babies who had been born in theatre were more likely to have a low admission temperature, and therefore a number of quality improvement actions were identified and completed – see section re quality improvement during this quarter.

Progress

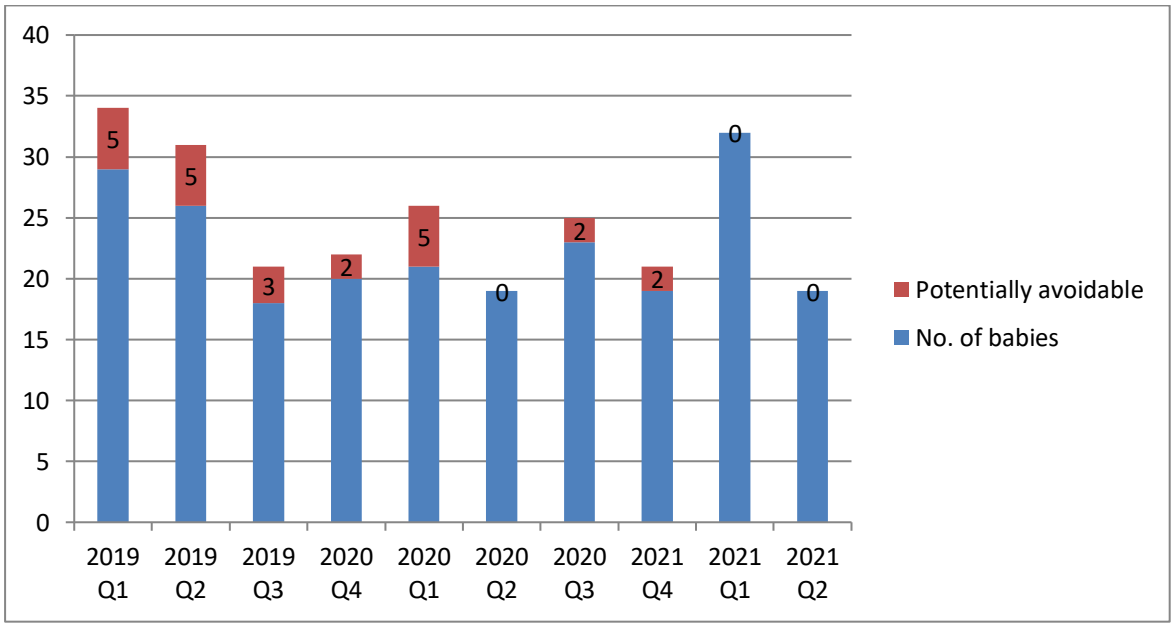


Overall progress since programme began (2018)



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, two 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

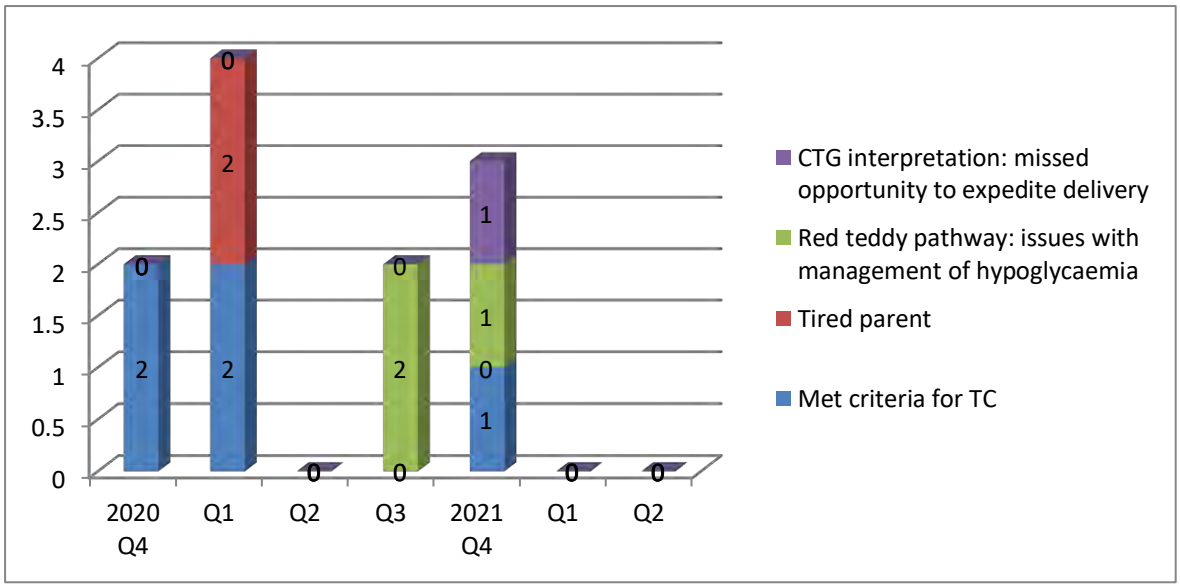
bay is not able to staffed by neonatal unit staff. Instead, nurses and nursery nurses visit the ward when observations are due, etc.

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. There were no avoidable admissions identified in this quarter.



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.

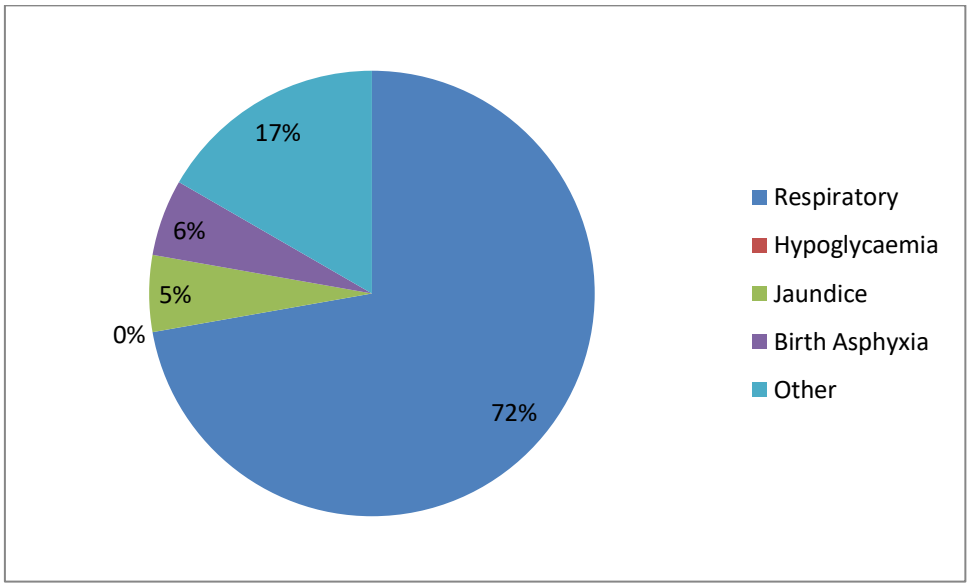
Learning is also often picked up and actioned even when it would not have reduced separation, but has the potential to improve care in other areas.

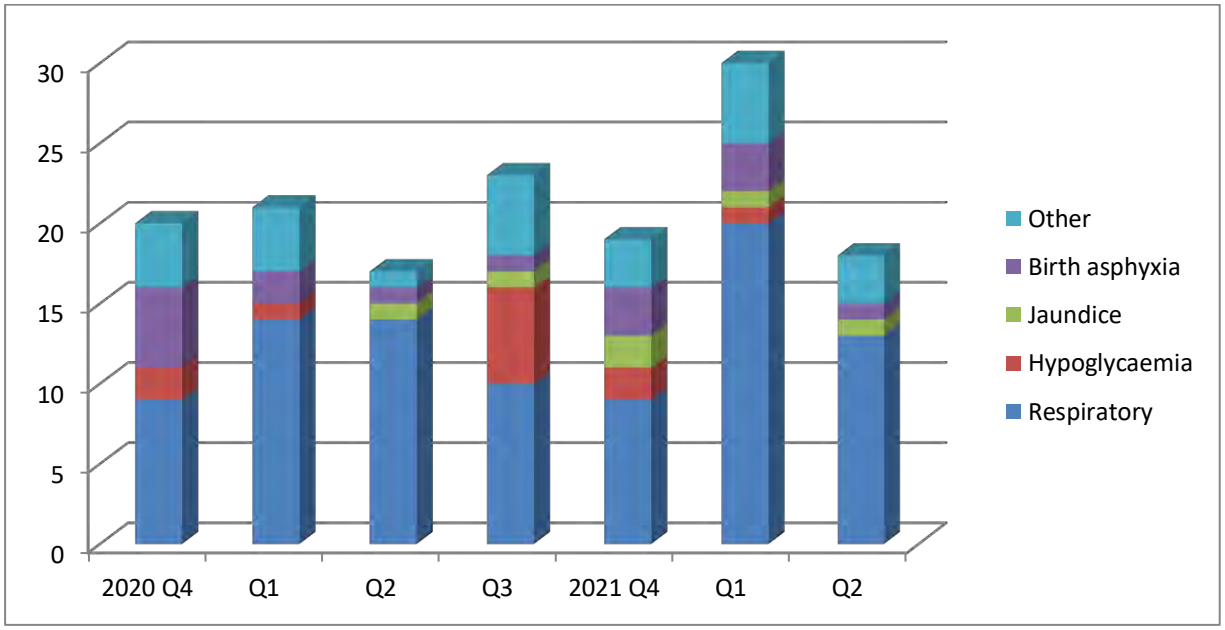
Please refer to the rolling action plan for details of work undertaken. In summary, there has been no recurrence of avoidable admissions in the areas previously identified (as shown in the table above). There was a particular drive to improve education and awareness of the

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 3 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 has steadily reduced.

Quality improvement in this quarter

A trend of babies being admitted with low temperatures (≤36.5°c) was first identified in May.

May 5/10 (50%)

June 1/7 (14%)

July 3/6 (50%)

In the above cases, low temperature was not the primary reason for the admission, however following a robust review of the notes this was identified and subsequent quality improvement plan initiated.

A number of actions were agreed and completed by the multi-disciplinary team. This included engagement with, and support from Theatres, Labour Suite and NNU teams

Action	Plan	Comments
Raise awareness among the NNU nursing team who check and record the obstetric theatre temperature daily re. changing the temperature if the theatre is too cool.	• Wise words • Discussion at handover	NNU Manager met with Theatre Team Lead to discuss the problems, and find out how to correctly set the temperature. It was reported that the theatre doors are frequently left open when the theatre is not in use, so steps were taken to remind all the thetare staff to keep the doors closed.
Raise awareness among the maternity team	• Take 5 – urgent message to all • Risky Business • Daily safety huddles • Share learning via email with senior midwives on Labour Suite (air conditioning in birth rooms). • Room temperature audit attempted (see comments)	As well as sharing the key messages, an audit was attempted to check the average room temperatures on Labout Suite. Unfortunately the week that this action was planned was extremely busy and the data collected could not be used to draw any meaningful conclusions. However, this exercise in itself helped to raise awareness among the team of Labour Suite Co-ordinators and was therefore another useful rool to raise awareness about appropriate birth room temperatures.
Raise awareness among the Theatre team	• Display poster next to air condition control unit in	Colourful, eye-catching posters were displayed in

	theatre (displaying correct temp range) • Share learning about theatre temperature with Theatre Team Lead to cascade to team.	theatre next to the air conditioning control panel. The theatre team lead expressed an interest immediately in supporting the team to make this improvement.
Raise awareness among Anaesthetists and Obstetricians to encourage a whole team responsibility / approach to this issue.	• Email to share learning with Anaesthetists and Obstetricians. • Discussed on daily MDT safety huddles	
Monitor progress	• Continue to record admission temperatures for term admissions as part of ongoing monthly reviews in order to monitor this closely.	Admission temperatures continue to be reviewed, and a significant improvement has resulted from these combined actions. In fact, in the months of August and September (and October) 0% of babies had a low admission temperature.

This evidence of positive improvement has been shared with all teams involved, and progress will continue to be monitored routinely as part of the ATAIN programme.

2.5. Infection prevention and control assurance framework

To Assure

Presented by Susan Wilkinson

Open Trust Board – 17 December 2021

Agenda item:	2.5			
Presented by:	Sue Wilkinson Exec Chief Nurse / Director of Infection Prevention & Control			
Prepared by:				
Date prepared:	29 November 2021			
Subject:	Review of COVID-19 Processes			
Purpose:	x	For information		For approval

Executive summary:

This document outlines the review processes that have been undertaken within the inpatient units* of the West Suffolk NHS Foundation Trust (WSFT) during the COVID-19 pandemic. It provides an overview of the common themes and recommendations that were detected during the review processes, and the actions that have resulted from these reviews. It draws on information from root cause analyses performed for ward outbreaks of COVID-19, reviews of deaths from COVID-19, reviews of complaints received by the Patient Experience team and audits conducted during the pandemic.

Fifteen COVID-19 outbreaks or clusters were declared on wards at WSFT between May 2020 and January 2021. Root cause analyses reports were conducted where applicable for each ward and key themes were identified in these root cause analyses. The actions from the root cause analyses have been combined into a "COVID-19 Outbreaks Combined Action Plan".

Please note Oxygen Stewardship is not included within the scope due to there being no specific concern over capacity at the Trust; lessons learned that could aid future pandemic planning will be reviewed as part of the Oxygen Management Group which reports to the Medical Gas Committee

**Review included Community beds in Newmarket Hospital and Glastonbury Court but not the wider Community settings.*

	Deliver for today	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
Trust priorities	✓	✓	✓
Trust ambitions			
Previously considered by	Executive Directors meeting, Infection prevention & Control committee and the Patient safety quality assurance panel (PSQAP)		
Risk and assurance			
Legislation, regulatory, equality, diversity and dignity implications			
Recommendation	The Board is asked to receive this report for information		

1.0 Purpose and scope of the review

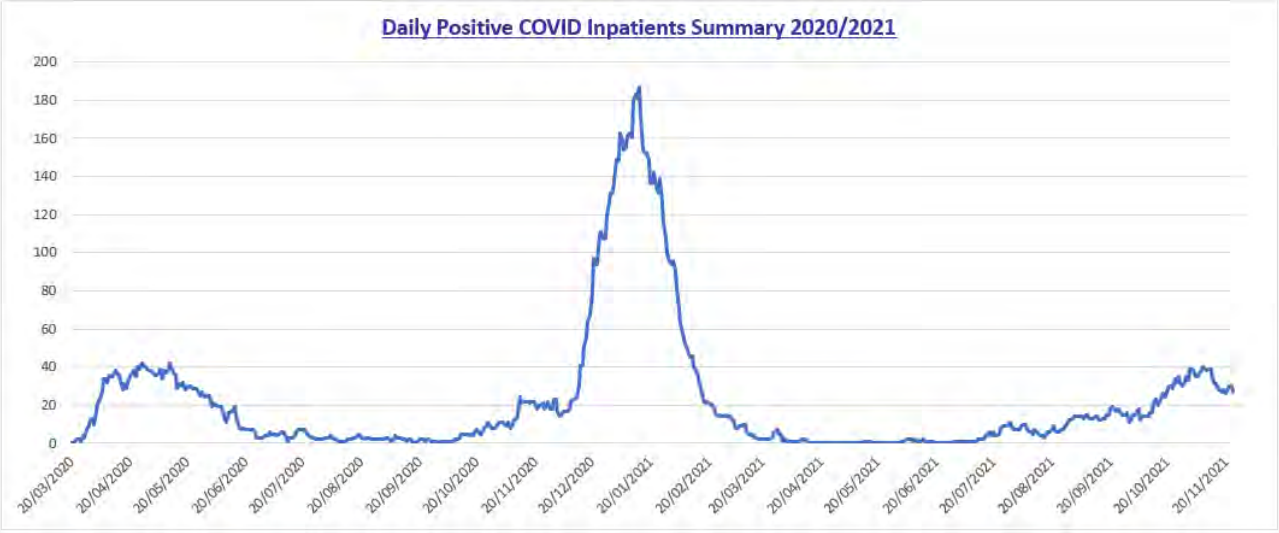
The purpose of this review is to outline:

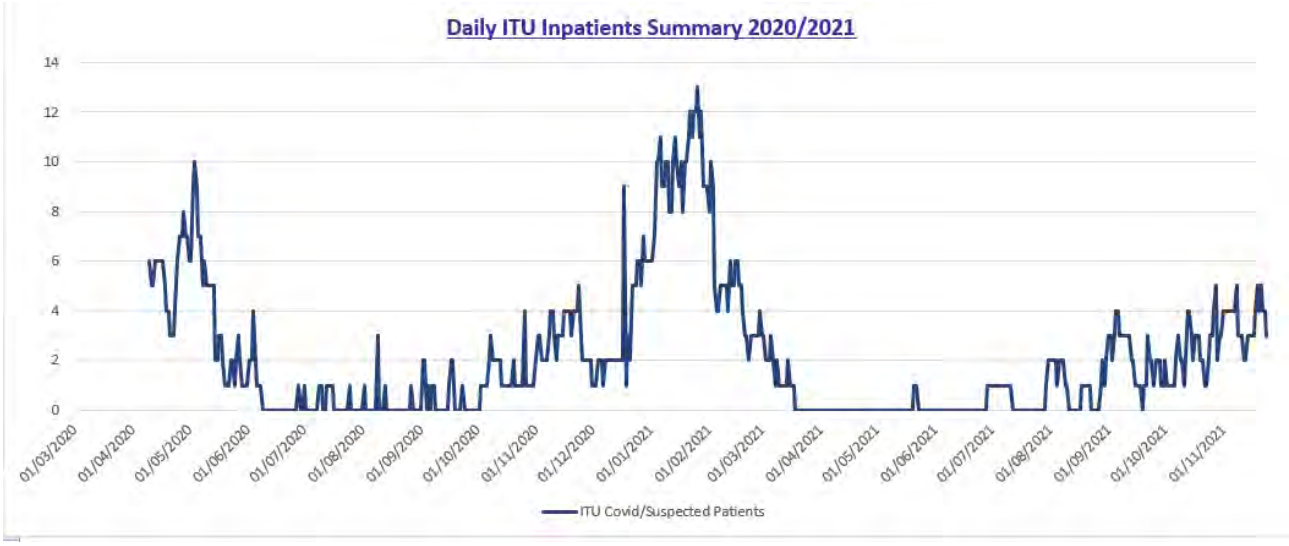
- The **process** that the West Suffolk NHS Foundation Trust (WSFT) took to review outbreaks of COVID-19 on wards at the trust, identifying contributory causes and identifying recommendations to prevent future outbreaks; reviewing deaths that occurred related to COVID-19, reviewing complaints related to COVID-19 and auditing clinical management of patients with COVID-19.
- The high-level themes and recommendations that were captured through these review processes.
- How the learning that has been captured during the pandemic has been shared internally across the trust and how it will be shared going forwards.

The report **is not** a review of clinical practice during the pandemic. Additionally, it **does not** compare clinical practice against national or trust policy at the time. Presenting details of individual root cause analyses; reviews of deaths; audit findings and reviews of complaints that the patient experience team received is beyond the scope of this review.

2.0 Background

The situation in March 2020 was one which developed quickly. Cases in the hospital were increasing, the country went into lock down and national guidance was being released and subject to various amendments requiring the Trust to respond and implement quickly. Throughout March and April 2020, the National and local picture was developing and the Trust was seeing increases in cases and admissions, and having to react to new and changing national guidance resulting in local decisions around service delivery. The charts below show the COVID-19 admissions since the start of the pandemic and the second graph demonstrates the ITU admissions with COVID-19 or suspected COVID-19.





As summer approached wave one started to decline and COVID-19 patients reduced and this level was maintained throughout the summer period however the increasing COVID-19 admissions of wave two became evident in the autumn and was to be much more significant than wave one.

3.0 Strategic decision making

In March 2020 as COVID-19 began to impact the UK, the Trust implemented a governance structure to respond to the incident; this structure is shown below.

The Core Resilience Team (CRT) was set up to manage and lead the trust planning around COVID-19. This included reviewing national guidance and legislation, which was then implemented by Tactical. To enable this various sub groups were in place which reviewed all the information and fed back to the CRT for coordination. These sub groups included an operational group, a clinical group, a resources group, a workforce group, community group and an ethical group. Each group had a formal structure and meeting rhythm and the chairs formed the CRT and provided feedback from the sub groups.

The operational and clinical sub groups were meeting daily and discussing the changing position and any new guidance along with the best way to react and implement across the Trust. An ethical group was developed to discuss the ethics behind these decisions to ensure patient safety was at the forefront of the decision-making process. This feedback led to CRT recommendation to the strategic meeting for decision making.

A decision model template was developed to present recommendations to strategic meeting to enable timely decisions to be taken with the relevant information available. Each decision was recorded in a central decision log.

4.0 COVID-19 ward outbreaks and clusters

In order to identify and define an outbreak or cluster within the trust, the national epidemiological definitions at the time were used[1].These definitions varied during the pandemic. Fifteen ward outbreaks or clusters were declared in the trust between May 2020 and January 2021 across the following wards: Respiratory Ward (F8 and G9 at the time), F3, F5, F7, F10, F12, G4, Renal Ward (G5), G3, G8, Rosemary Ward and Glastonbury Court (Kings Suite).

When a COVID-19 ward outbreak was declared, an Incident Management Team (IMT) meeting was convened and visiting restrictions were put in place, if they were not already in place. IMTs bring key partners together to investigate and manage an outbreak. Internal IMT partners often include: the Director of Infection Prevention and Control (DIPC); Infection Prevention and Control (IPC) team; Matron for the relevant department; Ward Manager; Microbiology; Public Health (PH), Patient Safety, Tactical and housekeeping. External IMT partners often include: West Suffolk Clinical Commissioning Group (CCG); NHS England; Public Health England (PHE) and Local Authority Public Health team. The IMT meets at regular intervals, as required, until the outbreak is declared over. During meeting regional national and organisational learning was shared

“Being open” conversations were undertaken with patients as they were moved or cohorted, explaining the purpose of the move and the status of whether the infection was deemed probable or definitely hospital acquired (see Glossary). Written duty of candour notification letters were sent to patients who had been identified as having a probable or definite hospital acquired COVID-19 infection. Where a patient had died and COVID-19 was listed on the death certificate, an open conversation was under taken by the medical examiners with the next of kin (NOK) of the deceased.

[1] COVID-19:epidemiological definitions of outbreaks and clusters in particular settings. Gov UK. Published 7th August 2020. Available at:https://www.gov.uk/government/publications/covid-19-epidemiological-definitions-of-outbreaks-and-clusters/covid-19-epidemiological-definitions-of-outbreaks-and-clusters-in-particular-settings#:~:text=Two%20or%20more%20test%2Dconfirmed%20or%20clinically%20suspected%20cases%20of,least%20one%20case%20(if%20a

5.0 Review processes and sharing learning

Review process for COVID-19 ward outbreaks and clusters

Each ward that had a COVID-19 outbreak was declared as a serious incident (SI) as per the SI framework (2015), meeting SI criteria on the basis of the disruption to provide adequate service. Other wards that had a cluster of cases also had an investigation. However, these were not reported externally on the Strategic Executive Information System (StEIS), as they did not meet SI criteria as the wards did not fully close. For both type of outbreak there was a requirement to perform an investigation.

The purpose of the root cause analysis (RCA) investigation was to identify key learning and use this information to significantly reduce the likelihood of future harm to patients. The objectives were:

- To establish the facts i.e. what happened (effect), to whom, when, where, how and why (root causes)
- To establish whether failings occurred in care or treatment
- To look for improvements rather than to apportion blame
- To establish how recurrence may be reduced or eliminated
- To formulate recommendations and an action plan
- To provide a report and record of the investigation process & outcome
- To provide a means of sharing learning from the incident
- To identify routes of sharing learning from the incident

The RCA reports were predominantly completed by the Trust Patient Safety Team, with input from the Infection Prevention and Control Team and Public Health team members in some cases. As part of the investigation a harm review for every patient who was resident on the affected wards was undertaken by the Infection Prevention team or Matron for the area. The purpose of this individual review was to ascertain if there were any individual cases which would meet SI criteria of patient harm. These reviews were collated alongside the ward outbreak reports. There were no cases which were escalated for further investigation.

The individual incident reports for the ward outbreaks were then discussed at the appropriate ward Governance meetings or divisional board meeting. The major harm/red incident reports (indicating that a ward closure had occurred) were sent to the Clinical Commissioning Group. Key actions and lessons learnt from COVID-19 ward outbreaks and clusters were presented to staff during a bi-weekly all staff briefing on the 2nd March 2021 and are presented in Table 1 in section 9.

A 'COVID-19 Outbreaks Combined Action plan' was developed by the Patient Safety team. This combines all of the actions from the ward outbreak/closure investigations and captures actions that had already been completed as part of the IMT response. The individual actions from each outbreak have been managed through Datix via the Managers and most are closed. After the Trust Executive Board meeting, this review will be shared with each division through the governance and board meetings, via the Patient Safety and Quality managers.

The process for reviewing any future outbreaks of COVID-19 within the trust is currently under review, following a new NHS England Patient Safety Incident Response Framework (PSIRF) framework2. The Patient Safety Team are working closely with the IPC team to review and refresh our HAI reporting and investigation pathways to ensure a timely and effective approach to investigation and consideration of investigation methods such as After Action Review (AAR) will be considered. This framework will be included in our PSIRP (Patient Safety Incident Response Plan) for 2022/23

[2] NHS England. Patient Safety Incident Response Framework. Available at: https://www.england.nhs.uk/patient-safety/incident-response-framework/

The development of an Infection Prevention and Control strategy for the Trust is currently underway.

6.0 Review process for COVID-19 deaths

The Learning from Deaths team are currently completing a review of all COVID-19 related deaths within the trust, providing an overall judgement of care (excellent, good, adequate, poor and very poor), to identify common themes and recommendations for improvement.

7.0 Review process: patient experience

The Patient Experience team shares the complaints that they have received with relevant staff and ask them to reflect on the feedback that has been received and provide a response. Once these have been received and medical records have been reviewed, a report based on the findings is produced. Most clinical staff recognise when there are areas for improvement or standards of care could have been improved. Often clinical staff will subsequently provide actions for their respective department or team, which are then included as part of the recommendations within the report, along with any recommendations identified from the complaint handler during the investigation. These will then be highlighted at the end of the report.

Once the investigation report has been completed, and a response or explanation to the complaint/concern has been provided and/or it has been identified where care or treatment could have been improved, the investigation report will be sent to the investigating staff with the findings and the recommendations that have been made. Once the report has been reviewed and signed by the Chief Executive, it is then sent to the complainant, all documents are uploaded to Datix and the recommendations are recorded on the 'Actions tab' within Datix.

If there have been any actions/recommendations from the complaint report, the Patient Experience team sends an Action Plan to investigating staff, heads of departments, service managers and Lead Consultants to ensure that the recommendations have been completed. When there are actions to change policies or processes, staff can update the action plan and attach evidence to reflect this. The team often meet with Senior Matrons to discuss any themes of complaints that are occurring, and to ensure that they can disseminate this information within their team. They also attend monthly divisional board meetings to discuss complaints that have been received the previous month and the outcomes and attend the monthly ward managers meetings to ensure that the themes and outstanding actions have been discussed.

The team has reviewed the themes that have occurred across the formal complaints related to COVID-19 (see Table 2). These complaints have been discussed with staff involved in the complaints, who acknowledged that communication could have been improved. However, the patient experience team also noted the clinical pressure that staff were under, particularly due to the volume of patients and constant adaptations to the methods of working throughout the pandemic.

8.0 COVID-19 clinical management and quality improvement projects

Multiple guidelines for the clinical management of patients with COVID-19 have been published throughout the pandemic. Audits were conducted to develop an understanding of how patients with COVID-19 were managed at WSFT, in light of these guidelines in the winter of 2020-21. See the Appendix for more information regarding these audits and a quality improvement (QI) project.

9.0 Key themes identified and actions taken

This section provides a high-level overview of the common themes of contributory causes identified in the root cause-analyses and key actions undertaken during the outbreak process. It does not contain all of the details of each individual root cause analysis report.

Table 1 provides a summary of the themes and actions arising from the root cause analyses of ward closures / outbreaks / clusters.

Table 2 provides the themes and recommendations from other sources including the complaints, audits and the learning from death reviews

Table 1: Summary of the themes and actions arising from the root cause analyses

Theme	Potential contributory factors identified in the root cause analyses	Actions undertaken during the outbreak management processes
Layout of wards and beds	• Less than 2 metre spacing between patients • Open plan environment	• Where possible, reduce bay capacity to four patients. • Installed COVID-19 curtains or screens where appropriate.
	• Challenges in social distancing for staff during breaks and in shared work areas	• On some wards the staff room was adapted to allow a maximum number of staff and the layout was reviewed to ensure that social distancing could be maintained. • Signs placed on the entry to staff room to remind staff about social distancing.
Transfer and movement of patients	• Potential transmission if patients were transferred to a ward before the COVID-19 swab had returned • Movement of patients due to clinical need • Movement of patients throughout the hospital	• Guidelines developed for patient moves and transfers within the trust to be minimised and only driven by essential clinical care, with a formal senior review and risk assessment prior to transfer and documentation of COVID-19 result. • Specialist areas within the trust should identify two patients who out of hours can be moved if required. These patients need to have a definite plan of care and a clear COVID-19 swab before movement. • A SOP was put in place for the clinical review of patients stepping down from COVID-19 wards.

Theme	Potential contributory factors identified in the root cause analyses	Actions undertaken during the outbreak management processes
Environmental contamination	• Frequently touched services as a source of potential contamination and transmission • Item sharing	• Increased environmental cleaning of frequently touched surfaces, including toilets and bathrooms. • Enhanced cleaning, up to three times a day, on dedicated COVID-19 wards. • Environmental audits completed. • Support from Infection Prevention team, Director of Infection Prevention and Control and the Tactical team. Regular visits to the ward from IPC team during an outbreak. • Patients discouraged from sharing their belongings with their fellow patients and are advised to remain within their bed spaces. • Communal belongings removed from shared staff room areas. • Aerosol Generating Procedures should be completed on two specific wards or on the Intensive Care Unit, wearing the correct PPE, within the correct environment and the procedure should be logged.
Personal Protective Equipment (PPE)	• Sub-optimal PPE use- mainly when a patient was wandering, at risk of falling or required rapid intervention and therefore staff were unable to don the appropriate full PPE in time to take care of the patient for the safety of the patient or other people (see also management of complex patients section)	• Advice to staff on sessional use of PPE, disposal and replacement of PPE. Posters on the donning and doffing of PPE. Resources for staff on the use of PPE on the Trust COVID-19 staff zone, including videos on donning/doffing of PPE. • PPE use included in staff wide briefing event. • Reminders given on PPE usage in daily briefings/bed meetings • Training delivered by IPC team on the dedicated COVID-19 wards. • Establishment of PPE advocates to provide PPE training and observe PPE use. • Regular PPE audits on dedicated COVID-19 wards and wards where an outbreak had been declared. • Enhanced training in the use of PPE for staff where sub-optimal PPE use had been identified. • Inpatients are asked to wear a surgical face mask when moving about shared areas, and if able and comfortable to do so, whilst sitting in bed.

Theme	Potential contributory factors identified in the root cause analyses	Actions undertaken during the outbreak management processes
Surveillance, testing and data information systems	• Delays in receiving the results of PCR swabs • Need to strengthen information streams to ensure that clusters and outbreaks are detected at the earliest stage	• Routine testing of patients for COVID-19 as per Trust policies. • Introduction of near patient, point of care testing. • Alerts in e-care to highlight when swabs are required. • Alerts on e-care for COVID-19 positive patients. • Any delays in receiving swab results should be escalated to the Tactical Command team. Escalate the lack of timely COVID-19 testing capacity to Regional and National leads. • Infection Prevention, Consultant microbiologist, Tactical and Bed flow teams are made aware of all cases of COVID-19 within the trust through the Tactical and Safety Huddle. • A Test and Trace system (with SOP) was developed to identify and manage contacts during an outbreak. Patient contacts should be tested every 72 hours during an outbreak. • A screening SOP for asymptomatic staff during an outbreak was developed. • The Trust encourages asymptomatic staff to take a lateral flow test twice a week.
Cohorting of patients and staff	• Cohorting of different contacts from separate bays into a single bay	• Guidelines developed for the cohorting of patients with a positive PCR result. • Guidelines developed for the management of patient contacts, discouraging the mixing of different patient cohorts from separate bays into single bays, where it is possible to do so. If it is not possible to do so due to operational pressures, a risk assessment should be completed and advice sought from Infection Control. • Staff should be encouraged to stay in specific areas to nurse allocated patients in set bays where it is possible to do so.

Theme	Potential contributory factors identified in the root cause analyses	Actions undertaken during the outbreak management processes
Management of complex patients	• Inadvertent contact of patients who were confused, wandering and/or non-compliant with others within the ward environment (also see PPE section of table)	• Recognition that patients with cognitive impairment might require additional supervision. Provide one-to-one care where it is possible to do so. Support available from clinical specialists if required. • Reminders to staff to be up-to date with dementia care training, challenging care and conflict resolution training. • Carefully consider the risks and benefits before moving any patient to another area for care which might not be beneficial for that patient.
Staff health and wellbeing		• A staff psychology support service was established in April 2020. • Staff health and wellbeing resources available on the staff intranet and are highlighted during the verbal all staff briefings and in the staff newsletters.

Table 2: Information from other sources

Theme	Key findings	Recommendations or actions taken
End of life care	Reviews into deaths occurring due to COVID-19, or when COVID-19 was a contributory factor in a death. Aspects that led to excellent care included: • Conversations with the patient and their family, including explaining decisions and holding difficult conversations. • Individualising care. • Timely recognition when a patient was deteriorating and contacting the Palliative Care team to start anticipatory medications and a syringe driver for symptom control. It is recognised that these themes are not necessarily specific to COVID-19.	Recommendations for improving end-of-life care in those cases where the care had been judged as 'poor' or 'very poor' included: • Ensuring that anticipatory medications are prescribed. • Early referrals are made to the palliative care team. • Minimising ward and bed moves for patients on an end-of-life pathway. • Fluid management reviews. • Individualising patient care and honouring their wishes regarding place of death where possible. • Ensuring that the patient and relatives are informed of end-of-life discussions. This learning will be shared with staff in a future Learning from Deaths bulletin
Communications	Communication was the most consistent theme across the complaints that the patient experience team received, including complaints where relatives felt that there was a lack of communication between departments or between the hospital staff and the family.	• A 'Keeping in Touch' service for patients and a dedicated clinical helpline was established in April 2020 to support relatives and next of kin, running seven days a week within the Patient Experience team. • A free video calling service for patients without their own digital devices is available, between 10am and 4pm Monday-Friday. • Staff were reminded to: o Provide timely updates on progress to relatives and ensure that the information provided to families/relatives is consistent. o Signpost families to the clinical helpline service. o Communicate discharge plans to families/relatives. o Ensure that Lasting Power of Attorneys (LPAs) are involved in the discussions about the patient's best interests. o Ensure that LPAs and/or Next of Kin are involved in Do not attempt cardiopulmonary resuscitation (DNACPR) decisions, if applicable, explaining the reasoning behind this. Training on LPAs was delivered to Junior Doctors.

10.0 Contributors

The following teams at West Suffolk NHS Foundation Trust contributed to this report: Director of Infection Prevention and Control and the Infection Prevention Control; Public Health; Patient Safety and Quality; Governance; Learning from Deaths; Patient Experience, Palliative Care and Microbiology. In addition, multiple junior doctors, consultants, members of the Information Technology and Clinical governance team led or contributed to the clinical audits/quality improvement projects.

11.0 Acronyms and glossary

AGP	Aerosol Generating Procedure
CO	Community-Onset- first positive specimen date less than or equal to 2 days after admission to trust.
HODHA	Hospital-Onset Definite Healthcare-Associated - first positive specimen date 15 days or more after admission to trust
HOPHA	Hospital-Onset Probable Healthcare-Associated- first positive specimen date 8-14 days after admission to trust.
HOIHA	Hospital-Onset Indeterminate Healthcare-Associated- first positive specimen date 3-7 days after admission to trust
IPC	Infection Prevention and Control
LFT/LFD	Lateral Flow Test/Lateral Flow Device
LfD	Learning from Deaths
LPA	Lasting Power of Attorney
PCR	Polymerase Chain Reaction
PPE	Personal Protective Equipment
PSIRF	Patient Safety Incident Response Framework
RCA	Root cause analysis
SI	Serious Incident
VTE	Venous Thromboembolism
WSFT	West Suffolk NHS Foundation Trust

Appendix 1 Board Assurance Framework

The Trust recognises the ongoing risk of COVID-19 and other healthcare acquired infections and the role of the Infection Prevention and Control (IPC) Team and Committee have in managing this risk.

The learning from these reviews and any future action will form part of the IPC ongoing work plan and the controls we have put into place will sit as part of the new risk register entry 'RR5204'.

Both of these will be overseen by the IPC Committee as set out within its terms of reference and will be described within the annual IPC report to the Trust Board.

Appendix 2: Clinical Management Audits and Quality Improvement projects

Four audits were conducted using data from the Winter-Spring of 2020-2022, assessing against the following guidelines:

- **Dexamethasone:** clinical practice was audited against the following guidance- "COVID-19 prescribing briefing: corticosteroids" NG159 published March 2020. This guidance has now been superseded by NICE guidance "COVID-19 rapid guideline: managing COVID-19" NG191, published February 2021.
- **Venous Thromboembolism prophylaxis:** The following guidance: CG1039093 "Thromboprophylaxis and Anticoagulation in COVID-19 infection," published in May 2020 was audited amongst COVID-19 patients. This guidance has now been superseded by another version published in February 2021.
- **Non-invasive ventilation:** The use of non-invasive ventilation (NIV) among COVID-19 patients was audited, using the following guidance CG10391-1 "NIV (non-invasive ventilation) inclusive of BiPAP and CPAP (HFNO can be considered) provision during COVID-19 Pandemic (inclusive of AGP)."
- **End-of-life care: a** manual audit of case notes was performed, assessing the proportion of patients who were referred to palliative care, had an end of life care plan, patients who were prescribed Morphine, Oxycodone and Midazolam and whether COVID-19 was on the death certificate.

For each audit, the data was extracted from E-care. However, ITU data was not available. The inclusion criteria for the audits were: dates ranging from 1/11/2020 to 28/2/2021 and inpatients with a positive PCR COVID-19 test. The detailed methodology, key findings and limitations for each audit were presented at the Medical Governance Group in August 2021.

The audit results showed that the use of Dexamethasone for eligible COVID-19 patients and the use of NIV among COVID-19 patients was done well , with recommendations to review the VTE prophylaxis guidance and EPARS (escalation plan and resuscitation status form) process in relation to NIV. The end-of-life care audits found that there was room for improvement in the use of the last days care plan and referral to the palliative care team. Recommendations were discussed at this meeting and actions taken for further review of guidelines as required.

A QI project was completed on the endocrinology ward, focused on the detection and investigation of hyperglycaemia in newly diagnosed COVID-19 patients, without pre-existing diabetes, who were commenced on Dexamethasone for COVID-19 pneumonitis. The baseline audit suggested that there could be improvement in the proportion of patients who had a HbA1c completed at baseline. Follow up of patients who had a high capillary blood glucose level was completed after discharge (at 3 to 6 months). Patients with newly diagnosed diabetes were referred to their GP and the project team is looking at onward support pathways for those in the pre-diabetic and diabetic ranges. These findings were presented during mandatory Foundation Year teaching, to highlight the significance of performing a baseline HbA1c on patients who do not previously have diabetes and are going to be commenced on Dexamethasone. The project team have been working with the e-care Information Technology team to automate HbA1c ordering on any patient where Dexamethasone is being ordered. This QI project has been expanded across the trust to perform the baseline audit across the whole hospital and the project team have reviewed pathways for HbA1c testing on admission.

12.0 Recommendation

The Board is asked to:

1. Note the review of the processes in place during the COVID-19 pandemic.

Board of Directors – 17 December 2021

Item:	2.5			
Presented by:	Sue Wilkinson Exec Chief Nurse / Director of Infection Prevention & Control			
Prepared by:	Rebecca Gibson – Head of Compliance & Effectiveness			
Date prepared:	December 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 IPC COVID-19 board assurance framework*. In addition, this month's report contains, our review of COVID -19 processes during all waves of the pandemic to date, methodology for reviews of outbreaks, risk register review and COVID-19 IPC dashboard:

1. **Review of COVID-19 processes** on the management of COVID-19. It should be noted that this paper describes inpatient services only and specifically excludes the work on oxygen management. (Appendix 1)
2. **Methodology of reviews:** At the time the trust was still subject to the serious incident framework (pre-PSIRF) and therefore ward closures were reported as serious incidents (SI) requiring a root cause analysis (RCA). Patients who definitely or probably contracted COVID-19 during their hospitalisation were not automatically considered as suffering harm because COVID-19 was defined as a naturally occurring disease. However, all patients were reviewed and any potential care omissions, which could have contributed to nosocomial infections were identified and addressed. All patients had a structured 'harm review' led by IPC and Matrons as part of the ward closure reports to ascertain if there were individual cases which needed to be escalated for further investigation. The learning identified at the time of the outbreaks was shared with ward staff, matrons and at ward governance meetings. It was also discussed and shared via core brief and divisional board/governance meetings as well as in the NMCC (nursing, midwifery and clinical council) and PGME (post graduate medical education).Now we are subject to PSIRF there will not be a need to undertake an RCA for future outbreaks and the patient safety team are working with the IPC team to review and refresh our healthcare associated infections (HAI) reporting and investigation pathways to ensure a timely and effective approach. This might, for example include an 'after action review' which has provided a very successful local model for learning in falls prevention. The learning from deaths team will continue to undertake SJRs for all nosocomial deaths which provides a structured process of escalation if poor care is identified. This approach will be discussed and agreed formally through the Patient Safety and Assurance Panel as per our governance framework.

The trust recognises the ongoing risk of COVID-19 and other healthcare acquired infections and the role the Infection prevention & control (IPC) team and committee have in managing this risk.

The learning from these reviews and any future actions will form part of the IPC ongoing work plan and the controls we have put into place will sit as part of the new Risk register entry 'RR5204'.

Both of these will be overseen by the IPC committee as set out within its terms of reference and will be described within the annual IPC report to the Trust Board.

3. **New Risk register entry RR5204:** Previously the IPC BAF specifically addressed the 10 key actions and self-assessment required relating to COVID-19 which was a regulatory requirement. We have through the Infection Prevention and Control committee now expanded this risk assessment to incorporate the IPC COVID specific BAF and to cover other risks associated with all healthcare associated infections and include community settings outside of healthcare premises. (Appendix 2)
4. **COVID-19 IPC Dashboard:** Note increases in COVID-19 incident reports, nosocomial infections and staffing sickness absence in the period October/November.

**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.

	Deliver for today	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
Trust priorities	x		
Trust ambitions	Deliver personal care	Deliver safe care x	Deliver joined-up care x	Support a healthy start	Support a healthy life	Support ageing well	Support all our staff x
Previously considered by	Infection prevention & control committee Executive Directors meeting Patient safety quality assurance panel (COVID-19 report only)		
Risk and assurance	As per attached assurance framework		
Legislation, regulatory, equality, diversity and dignity implications	NHSE		
Recommendation	Receive for assurance		

Dashboard

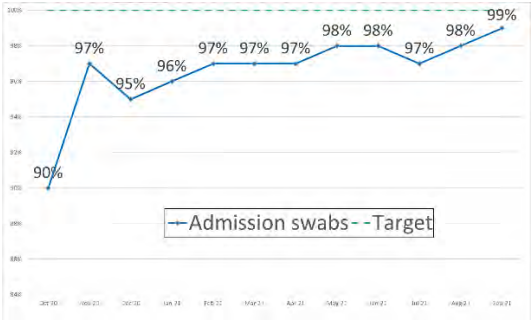
Measure	Time period reported	Data		
		Previous	Last period	This period
Nosocomial C19 (probable + definite)	Nov 21	44	86	76↓
Staff work-related C19 cases reported to RIDDOR	Oct 21	0	0	0 →
Incidents relating to C19 management	Nov 21	22	84	64 ↓
Admissions swabs within 24 hours of DTA	Oct 21	97%	98%	99% ↑
C19 clusters / outbreaks / ward closures	Nov 21	0	0	0 →
Staff sickness / absence due to C19	Oct 21	315	321	407 ↑

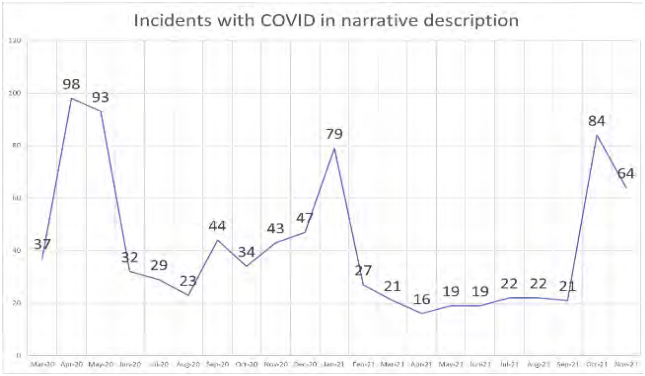
Associated charts / tables / narrative

C-19 admission swabs

The total number of patients swabbed in October remained very high with compliance of 98% of patients having a swab taken within 24 hours of the DTA and 99% in total.

14 patients (1%) did not have a record of having a swab taken in this episode.





The number of **incidents relating to C-19** recorded in October rose significantly and, although it fell in November remained at a level considerably higher than the eight previous months.

There were seven amber incidents reported in the two month period all relating to the F7 and G4 events.

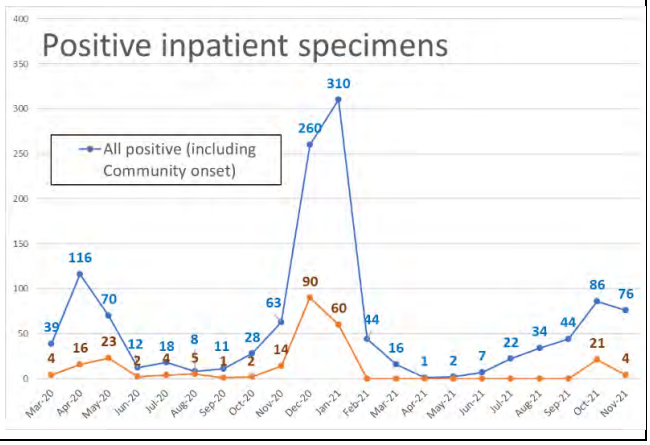
The most common (44 = 30% of total reported) incident type was *Mislabelled / unlabelled Microbiology specimen/forms* with Nursing or Midwifery staffing issues the next most common (20 = 14%)

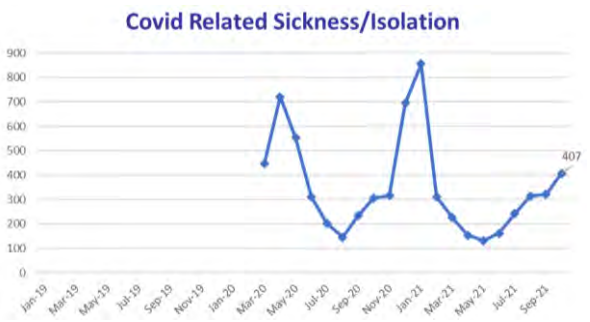
Nosocomial (Hospital-Onset) C-19

There were 22 cases identified in October; definite (15) and probable (7)

4 in November; definite (2) and probable (2). The number of community onset continued to rise but still remains well below the peak of last December-January.

The higher figures of nosocomial cases in October (compared to November and previous recent months) is associated with the F7 ward outbreak.





Sickness / isolation

Reported within the IQPR, this provides a count of our staff who have been off sick with a Covid related symptoms or required to isolate. This is a local metric to monitor the impact of Covid on our workforce.

In October 2021 there were 407 episodes recorded, an increase from September (321 episodes) a continuing upward trend now for the last five months.

Systems and processes are in place to ensure:

Key questions marked as WSFT Compliant

Ref	Key lines of enquiry	How would we evidence this?
1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users		
1.1	Infection risk is assessed at the front door and this is documented in patient notes	1. ED Signage and processes have been in place since January 2020. 2. Pre-surgical checklist in place 3. Maternity/EPAU - All women are asked the COVID symptom questions on the phone prior to admission. If the woman has any symptoms she is admitted to one of the Labour Suite single rooms. It is documented on a Triage form4, if not admitted via ED F14 woman are assessed over the phone and if any symptoms the site manger would be informed.
1.2	Patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	Previously reported as partially compliant now moved to full. Whiteboard amendment made to enable tracking and exception reporting for out-of-hours moves or >3 moves. Patient flow policy describes process.
1.3	Compliance with the national guidance around discharge or transfer of COVID- 19 positive patients	Documented local guidance. Evidence of updates from national guidance. Notes from strategic meeting. Daily staff COVID briefing.
1.4	All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	PPE training with available access to relevant PPE. Mask training records available. Stock levels of all COVID areas that are checked twice daily between 8am and 9am and then between 4pm and 5pm by Purchasing. Purchasing daily records of available PPE, including issues and stock levels
1.5	National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	Minutes of tactical command central repository and initiated through tactical command meeting. Guidance is reviewed by Tactical & Infection Prevention Team and changes communicated via Comms, updates provided to Matron's & Ward managers meetings as appropriate
1.6	Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	Report monthly to Board.
1.7	Risks are reflected in risk registers and the board assurance framework where appropriate	Completed risk register entry - 5204.
1.8	Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	IPC Manual Process for updating clinical guidelines as required RCA reports of other infections (e.g. Cdiff)

IPC BAF assurance - December 2021

Systems and processes are in place to ensure:

Ref	Key lines of enquiry	How would we evidence this?
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections		
2.1	Designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas.	All staff on COVID affected/designated areas were orientated and trained prior to accepting patients. Senior Nurse Leaders and the Infection Prevention Team conducted a multi-disciplinary meeting and training with staff prior to an area becoming 'COVID Affected'. Posters / information were available in clinical areas. IPC Visits to COVID -19 areas to provide support to staff. Many processes follow existing Infection Prevention guidance and policies. FFP3 mask fitting sessions provided and documented on ESR.
2.2	Designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to COVID-19 isolation or cohort areas.	Housekeeping training records. Can be subject to spot check audit.
2.3	Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance.	Policies / procedures in place which comply with national guidance via spot check audits.
2.4	Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance.	Cleaning records / audits demonstrate compliance with at least twice daily cleaning, more if required.
2.5	Attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas.	Cleaning records / audits demonstrate compliance with at least twice daily cleaning, more if required.
2.6	Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses.	Cleaning records demonstrate cleaning with chlorine base products as per national guidance.
2.7	Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products.	Adherence to manufacturers guidance. Assurance via spot check audits.
2.8	'Frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and contaminated with secretions, excretions or body fluids when known to be.	Cleaning records / audits demonstrate compliance with at least twice daily cleaning, more if required for high traffic areas.
2.9	Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily.	All undertaken by housekeeping (and when required clinical team) except staff's personal mobile phones and tablets subject to audit.

Systems and processes are in place to ensure:

Ref	Key lines of enquiry	How would we evidence this?
2.10	Rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily).	Cleaning records in conjunction with respective staff groups for appropriate timing of cleans.
2.11	Linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken.	All areas have alginate bags for infectious linen and staff are aware of the process to add an outer linen bag. Portering staff will not remove alginate bags alone, assurance via audit.
2.12	Single use items are used where possible and according to single use policy.	Single use items are purchased as a priority by the purchasing department as a standard for the Trust. Where a reusable item is required there is a process for establishing the protocol for this.
2.13	Reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance	Single use items are purchased as a priority by the purchasing department as a standard for the Trust. Where a reusable item is required there is a process for establishing the protocol for this.
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance		
3.1	Arrangements around antimicrobial stewardship are maintained	Wide ranging antimicrobial activity including; End of year CQUIN report, Antibiotic annual strategy, Electronic training packs for AMS + gentamicin + vancomycin - all of which as well as other antimicrobial guidance is available on the hospital formulary. AMS proposals have been written and awaiting Consultant Microbiologist approval, AMS Nurse champions, Pharmacist led AMS ward round, PCT – this will most likely adapt given the COVID pandemic, Urgent AMS and antimicrobial matters are discussed with a core group within AMG remotely for urgent approval. All antibiotic guidelines on the pink book are up to date. Antimicrobial considerations have been discussed in the COVID trust guideline. Microguide - all pink book guidelines are matched on Microguide. All changes to the above will be accompanied by appropriate comms to relevant practitioners. Some mandatory training sessions are going to be recorded for people to access from home. Reporting recommencing for Q2
3.2	Mandatory reporting requirements are adhered to and boards continue to maintain oversight	See 3.1
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion		
4.1	Implementation of national guidance on visiting patients in a care setting	Copy of guideline which has been developed in line with the changes to National Guideline on visiting. SOP publicised on Coronavirus banner of the Intranet

Systems and processes are in place to ensure:

Ref	Key lines of enquiry	How would we evidence this?
4.2	Areas in which suspected or confirmed COVID-19 patients are being treated are clearly marked with appropriate signage and have restricted access	Signage in place for the COVID areas with additional signage available should ward area allocation change in the future
4.3	Information and guidance on COVID-19 is available on all trust websites with easy read versions	On Trust website. This is continuously reviewed by Tactical supported by IPC.
4.4	Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	Transfer document eCare record
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people		
5.1	Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection, as per national guidance	Evidence of working processes in place – Lateral flow screening tool followed by SAMBA rapid swab. Clear signage. MAA isolation area operational for patients either suspected or confirmed to require isolation. Pathways currently under review with updated national guidance.
5.2	Mask usage is emphasized for suspected individuals	FRSM available and use encouraged for all patients regardless of COVID suspicion or status. Mask signage in place and masks available for all at all entrances to hospital buildings
5.3	Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff	Screens are placed on reception desks
5.4	For patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible	Previously reported as partially compliant now moved to full. Isolation achieved through cohorting on dedicated ward (or side room on specialty ward if required). Patient and Visitor Test and Trace SOP in place. Visiting currently suspended in the Trust
5.5	Patients with suspected COVID-19 are tested promptly	All suspected patients are tested promptly. The Trust can usually 'rapid' swab patients suspected to have Covid symptoms particularly if already within the inpatient setting and not previously identified as having symptoms. Clinical care records record the swab dates
5.6	Patients who test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced	Patients with suspected Covid are moved to single side room isolation until their COVID swab result is available. This can be a rapid swab to detect a positive result as early as possible. Bays are closed until the result is available and if positive, contacts are identified and tested every 72 hours for the duration of the isolation period, as per national guidance. Bed flow and clinical care records record this

Systems and processes are in place to ensure:

Ref	Key lines of enquiry	How would we evidence this?
5.7	Patients who attend for routine appointments and who display symptoms of COVID-19 are managed appropriately	Patients are asked if they have symptoms on arrival using screening questions and advised to return home and request a swab if the appointment is non-urgent and rebook. Patients are advised however, not to attend their appointment if they have COVID symptoms or who have tested positive in the last 14 days.
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection		
6.1	All staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	Each area has access to the guidance and posters are in place both demonstrating the correct processes, advising on top tips and links to the guidance. Areas were trained on a rolling programme when designated as Covid areas and received Presentation from Infection Prevention Team and Head of Nursing for Medicine to discuss COVID and the challenges that this posed. Question and answer sessions provided / FFP3 Mask Fitting / Donning and Doffing training and posters / RAG rating posters to establish individual area risks to support practice / Social distancing. Regular review of national guidance by Tactical and IPC. Individual staff risk assessments carried out as nationally required.
6.2	All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation, and on how to safely don and doff it	FFP3 Mask Fitting / Donning and Doffing training records As per 1.4
6.4	Appropriate arrangements are in place so that any reuse of PPE in line with the CAS alert is properly monitored and managed	Through policies and procedures
6.5	Any incidents relating to the re-use of PPE are monitored and appropriate action taken	Datix incident reporting system monitored for these incidents.
6.6	Adherence to PHE national guidance on the use of PPE is regularly audited	Weekly PPE audit as part of observation audits
6.7	Staff regularly undertake hand hygiene and observe standard infection control precautions	Audit data
6.8	Hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	Hand dryers in public toilets only. Estates have turned them off and erected 'Out of Order Notices'. Estates have put up hand towel dispensers and House Keepers will manage topping up paper towel dispensers.
6.9	Guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	Posters on hand hygiene are available in all toilets
6.10	Staff understand the requirements for uniform laundering where this is not provided on site	Uniform policy now being updated. Specific uniform policy for 'COVID' is available on the coronavirus banner on the intranet.

Systems and processes are in place to ensure:

Ref	Key lines of enquiry	How would we evidence this?
6.11	All staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance, if they or a member of their household displays any of the symptoms	Staff understand. Staff are individually risk assessed for return to work if they have been identified as a COVID contact.
7. Provide or secure adequate isolation facilities		
7.1	Provide or secure adequate isolation facilities	Within the limits of the estate areas are designated in order of greatest ability to comply with the guidance. F7, G9 & G10 are the acute wards with doors to bays. G9 & G10 have provision of air changes, G10 has bathroom facilities in the bays and the footprint of the bays are larger with 5 beds per bay instead of the 'standard' 6. Single rooms are prioritized according to the risk of the infection; the Infection prevention and control team review and advise on this. Side room occupancy lists are completed daily and circulated. Covid curtains are now installed in every adult ward. Limitations to isolation facilities are acknowledged in RR15 risk assessment.
7.2	Areas used to cohort patients with possible or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	SOP for designated cohorting arrangements. COVID 'suspected' patients are isolated in single side room isolation until confirmation of positive test or negative test with further clinical review.
7.3	Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	As per trust policies, however the lack of single side room isolation facilities limits who is isolated and has to be carried out with a risk-based approach. This risk has been acknowledged on the Trust risk register.
8. Secure adequate access to laboratory support as appropriate		
8.1	Testing is undertaken by competent and trained individuals	spot audit / training records
8.2	Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	Previously reported as partially compliant now moved to full. All admitted patients are swabbed at the point of admission either on ED, AAU or as part of PAU screening. The information team provide a daily report of patients that may not have been appropriately swabbed prior to admission.
8.3	Screening for other potential infections takes place	Screening for other organisms remains as per National Guidance and in line with the guidance issued to ensure sufficient laboratory time available for Covid-19 Some restriction of micro lab processing however this is in line with the RCOPath guidance
9. Have and adhere to policies designed for the individual's care and provider organisations that will help prevent and control infections		
9.1	Staff are supported in adhering to all IPC policies, including those for other alert organisms	Alert organisms are identified by the Laboratory and the Microbiologists and flagged to the Infection Prevention Nurses and entered onto the IPN lab queue for action. The electronic patient record includes Flag/alert for historic alert organisms. Out of hours the Microbiologists will action. Trust has obtained ICNET which will be used to allow alert organism tracking to be more robust.

Systems and processes are in place to ensure:

Ref	Key lines of enquiry	How would we evidence this?
9.2	Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	Timely review of the guidance by Tactical/IPC and implemented through strategic group.
9.3	All clinical waste related to confirmed or possible COVID-19 cases is handled, stored and managed in accordance with current national guidance	Orange stream infectious waste is the predominant waste stream for the Trust and therefore compliant
9.4	PPE stock is appropriately stored and accessible to staff who require it	Purchasing review all areas daily to ensure that PPE is in the correct store. Trust Resource Group meet weekly to oversee and Lead attends Tactical
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection		
10.1	Staff in 'at-risk' groups are identified and managed appropriately, including ensuring their physical and psychological wellbeing is supported	Central held copies of risk assessments and list of all staff to confirm RA have been done New process being set up (Rainbird - electronic version) will be centrally stored.
10.2	Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	FFP3 fit testing was organised and implemented by tactical, monitored via ESR.
10.3	Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance	Matron of the day records and monitors staff movement between areas across the organisation.
10.4	All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	All staff are made aware of social distancing guidance through Trust wide communications. Visual PPE audits in clinical areas. Risk assessments for offices and also work place assessments are all held with the Head of Health, safety and risk.
10.5	Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	Time Out and well-being hubs spaced out with chairs and tables.
10.6	Staff absence and wellbeing are monitored and staff who are self-isolating are supported and able to access testing	Interviews with staff and/or the teams supporting them can provide additional assurance. Clinical psychologist and team now fully recruited with extra staff in post (team structure available). HR monitoring / OH meet re long term absence (incl. but not specific to long Covid). Tactical are point of contact for those staff off with short term related illness. Long term self-isolating and support (managerial responsibility) Nationally available Lateral Flow kit PCR testing available LAMP testing available on request
10.7	Staff who test positive have adequate information and support to aid their recovery and return to work	See 10.6 Managerial and OH support always available if needed

IPC BAF assurance - December 2021

Systems and processes are in place to ensure:

Key questions marked as WSFT partially compliant

6.3	A record of staff training is maintained	Training records are kept for induction and mandatory training (both of which cover infection prevention) and the data is reported as a standard. FIT testing training records are captured on OLM All future training sessions will have attendance records taken. The system and management of these records will be confirmed.
2.14	Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission	No fans in use in any waiting areas and windows open where possible can be evidenced by audit. Not all areas have forced ventilation and therefore rely on natural ventilation via windows being open which has a balance of risk associated. Risk register entry being updated to reflect balance of risk.

2.6. Nursing staffing report

To Assure

Presented by Susan Wilkinson

Trust Board – 17 December 2021

Agenda item:	2.6			
Presented by:	Susan Wilkinson, Executive Chief Nurse			
Prepared by:	Daniel Spooner Deputy Chief Nurse			
Date prepared:	November 2021			
Subject:	Quality and Workforce Report & Dashboard – Nursing September & October 2021			
Purpose:	X	For information		For approval

Executive summary:

This paper reports on safe staffing fill rates and mitigations for inpatient areas for September and October 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
- Launch of Rapid Response pool
- Funding for international midwifery recruitment agreed

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:	- **N/A**
Risk and assurance:	-
Legislation, regulatory, equality, diversity and dignity implications	

Recommendation:

This paper is to provide overview of September and October's position about nursing staff levels 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 in September and October 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 both September and October 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 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%
Average fill rate for September 21	91%	92%	89%	107%
Average fill rate for October 21	88%	87%	87%	101%

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
- Overfill in Paediatrics and Neonatal due to continuation of winter staffing and planning for RSV surge

- Areas of concern G1, G3, G8

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 has increased since June 2021. Both RN and NA sickness is the highest it has been since Jan 2021.

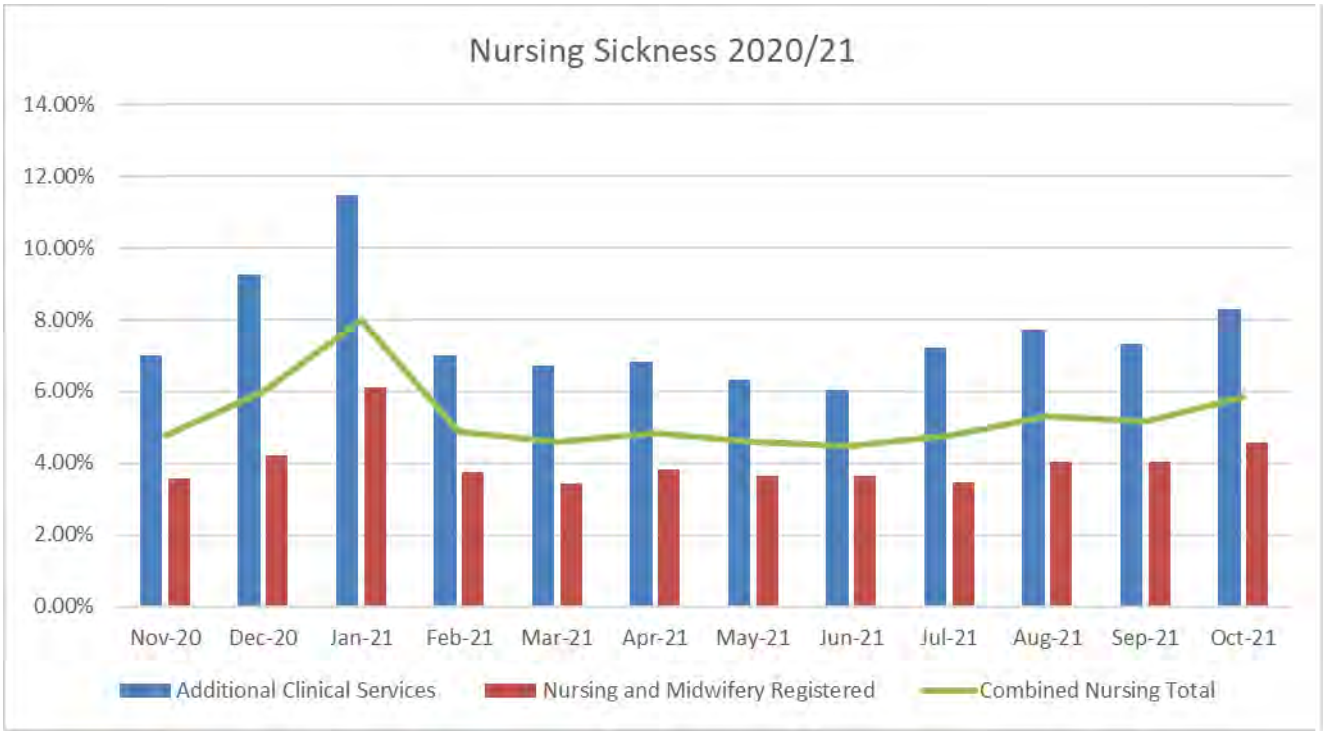


Chart 2.

	Mar 21	April 21	May 21	Jun-21	July-21	Aug-21	Sep-21	Oct-21
Unregistered staff (support workers)	6.71%	6.81%	6.32%	6.03%	6.88%	7.05%	7.53%	8.29
Registered Nurse/Midwives	3.43%	3.81%	3.70%	3.72%	3.51%	4.20%	4.28%	4.58
Combined Registered/Unregistered	**4.57%**	**4.85%**	**4.62%**	**4.53%**	**4.69%**	**5.19%**	**5.40%**	**5.85**

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). Staff isolation is still higher than in the summer months with additional short notice absences due to school children returning to school and either isolating or becoming positive, this has increased on last month. This is illustrated in chart 3.

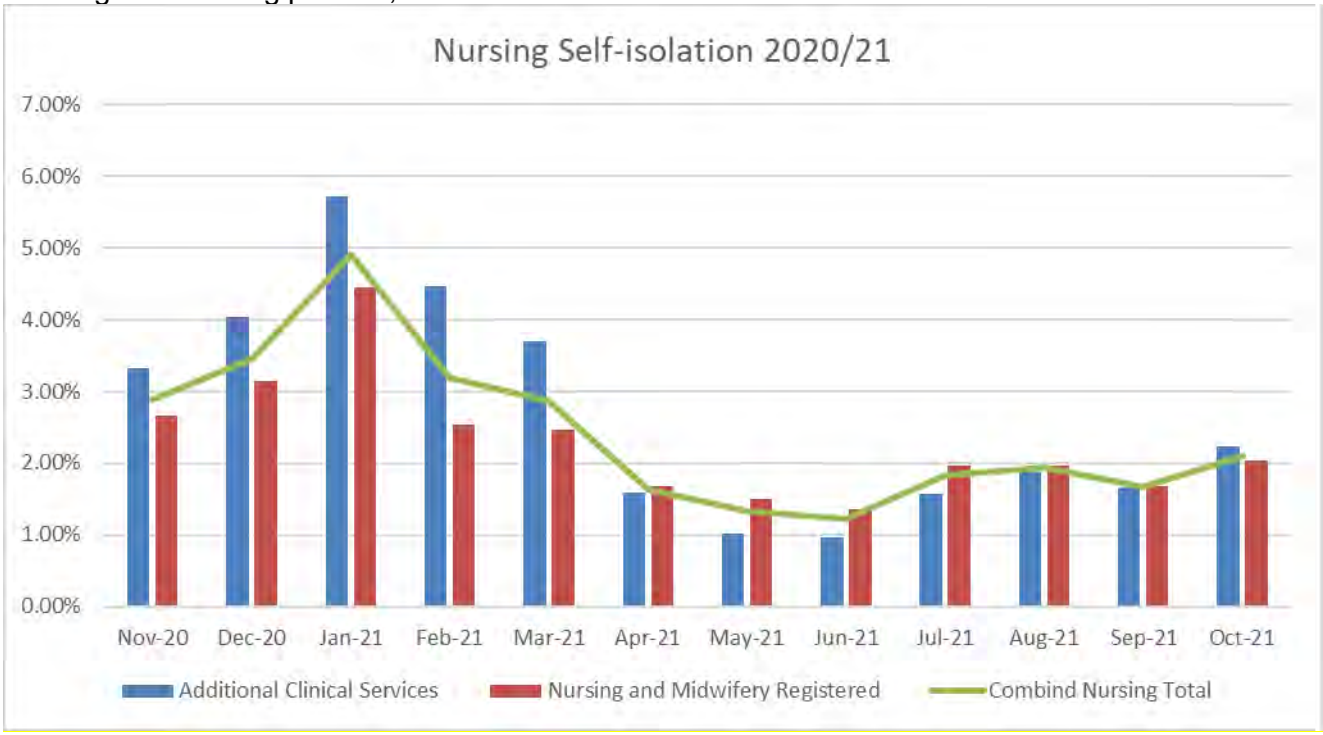


Chart 3

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):

- Inpatient RN/RM WTE vacancies is 111.1 WTE which is a significant increase from M5. This is driven by increase budgets in CCS, Continuity of Carer midwives and the F10 budget on line from M6. This equates to an additional 38.7wte.
- These uplifts have driven the inpatient RN vacancy rate from 11.9% to 15.4% and RM vacancy rate from 17% to 21.2%
- Total substantive numbers remain relatively static (Table 4b).
- Overall vacancy percentage for RNs (inpatient and all other areas) is 12.7%, an increase of 2% from previous reported month.

	Ward RNs	Sum of Actuals Period 2 (May)	Sum of Actuals Period 3 (June)	Sum of Actuals Period 4 (July)	Sum of Actuals Period 5 (Aug)	Sum of Actuals Period 6 (Sept)	Sum of Actuals Period 7 (Oct)	WTE VACANCY at period 7
RN/RM Substantive	Ward	609.4	603.1	602.0	605.9	616.4	611.1	111.1

	CV19 Costs	1.1	0.0	0.0	0.0	0.0	0.0	0.0
Total: RN Substantive		**610.5**	**603.1**	**602.0**	**605.9**	**616.4**	**611.1**	**111.1**

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

The chart below demonstrates the total RN establishment for the inpatient areas. 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

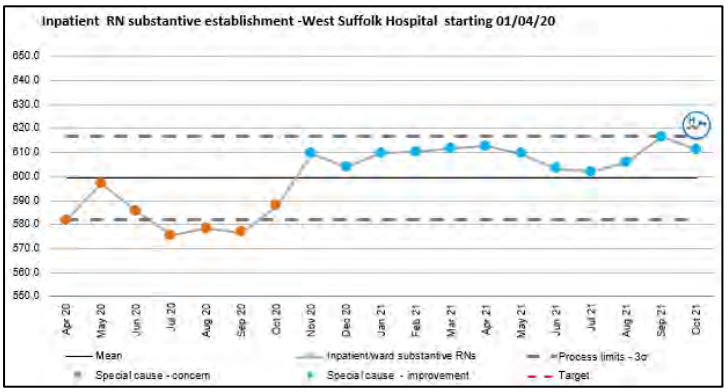


Chart 4a: SPC data adapted from finance ledger

Vacancies NAs (midwifery and Nursing combined):

- This month total NA vacancies has increased significantly to 11.3% (6.3% reported in August). This is driven by an increased establishment of 23.2 WTE for F10 (working within G10) that came on line in September. Actual WTE has only reduced by 5.4 WTE.
- Inpatient NA vacancies has increased to 4.2% to 10.6% for the reason described above

	Ward Nursing	Sum of Budget Period 2 (May)	Sum of Budget Period 3 (June)	Sum of Budget Period 4 (July)	Sum of Budget Period 5 (August)	Sum of Budget Period 6 (Sept)	Sum of Budget Period 7 (Oct)	WTE VACANCY at period 7
Nursing Unregistered Substantive	Ward	393.4	395.3	389.3	386.7	384.1	382.5	45.2
	CV19 Costs	4.3	0.0	0.0	0.0	00	0.0	0.0
Total: NA Substantive		**397.6**	**395.3**	**389.3**	**386.7**	**384.1**	**382.5**	**45.2**

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

Areas of challenge

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

- AAU continues with a large vacancy rate since the return of F10 staff to their newly budgeted ward. This is a slight improvement on month. The senior team have engaged with international recruitment leads and have secured four nurses in this pipeline

- Registered Midwives continue with a high vacancy rate exacerbated by additional budget applied to continuity of care budget. However substantive RM has increased by 5.4 WTE in month. Currently there are 5 midwives in the recruitment process with staggered start dates between November and February.
- F6 continues with high vacancy rate while waiting for recruitment pipeline. The ward has actively recruited and utilised both local and international recruitment and will be well established in Feb/March with a remaining vacancy of 0.72 WTE.
- G8 position has declined. The senior team are looking to increase skill mix by utilising vacancies to improve retention and aid staff development

To support the daily mitigation of risk and to reduce the number of times staff are moved to support other areas, which is known to cause anxiety, a rapid response pool (RRP) was launched in October. This is a temporary staffing pool with shifts that can be booked by staff that will be allocated on arrival to areas of most need. To reward this pre-emptive flexibility an enhanced hourly rate is offered. Early indication is that this is being met positively by staff both participating in the pool and from the wards receiving the support.

At the time of writing an enhanced bank rate for additional areas that require support is being scoped for December and into the winter period. This will be based on workforce level date to guide divisions to identify areas that would potentially benefit from short term incentives.

7. New Starters and Turnover

International Nurse Recruitment:

International recruitment (IR) continues and we are on track to deliver our target number by April 2022. From November 2021 the arrival of nurses is planned to increased from five to eight. Plans to increase this further in January and February to eleven is being realised as we work to increase classroom activity. Regular interviews are being conducted with the ward teams to ensure the pipeline continues.

- Five IR nurses arrived in September as planned
- Three IR nurses arrived in October. Two below plan. This was due to the limited provision of visas from the Philippines. This has now resolved. To compensate for this, 11 nurses will be arriving in November

New starters

	May	June	July	August	September*	October
Registered Nurses	13	9	12	17	36	14
Non-Registered	11	17	16	19	12	11

Table 6: Data from HR and attendance to WSH induction program
*two inductions ran this month

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

- In October 2021 fourteen RNs completed induction; of these; six were for acute services, five for pure bank and three midwives joined this cohort
- In October 2021, eleven NAs completed induction; of these ten NAs are for the acute Trust, one for bank services

Turnover

On a retrospective review of the last rolling twelve months, turnover for RNs has increased from to 8.52% which remains below the trust ambition of <10%. NA turnover has also increased from to 13.93% This will be reviewed in the recruitment and retention working groups to identify bespoke actions to be taken.

Turn Over 01/11/2020 - 31/10/2021								
Staff Group	Average Headcount	Avg FTE	Starters Headcount	Starters FTE	Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
Nursing and Midwifery Registered	1,286	1,110	116	87	118	95	9.18%	8.52%
Additional Clinical Services	564.50	474.77	189	165.71	75	66.15	13.29%	13.93%

Table 7.(data from workforce)

8. Quality Indicators

Falls

- September

The number of falls reported in September rose and this is also demonstrated in the falls per 1000 bed days. Within September the majority of the falls resulted in no harm however there were 17 with minor harm and 1 with moderate harm, which resulted in a -fractured pubic rami on F4.

During September the falls champion study day was held as well as falls awareness week. During falls awareness week the wards were provided with different topics to discuss at the daily ward huddle. Falls Awareness Posters were circulated to all wards.

- October

There was an increase in the number of falls reported in October compared to September. In October there were 15 falls reported with minor harm, 1 with moderate harm (distal radius fracture F3), and 2 with major harm (fractured neck of femur, G3 and G8). Learning from these falls has been identified through after-action reviews.

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.

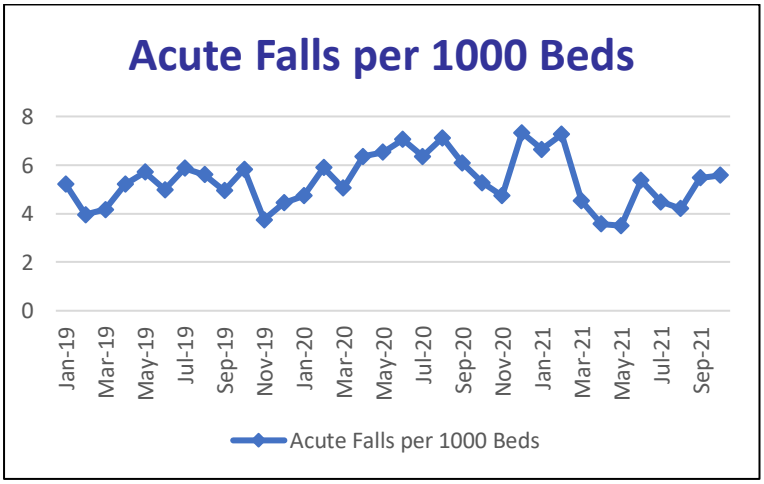


Chart 8

Pressure Ulcers

September and October saw a slight increase in pressure ulcers compared to the improvements seen in previous month. The team have had challenges with both staff and patients being moved around the Trust

due to both COVID 19 and repair works, this has led to challenged timely patient reviews and may have contributed to for these slightly high numbers.

The QI project and on F8 continues, the QI methodology has streamlined this project and aided the team's ability to perform a targeted approach to reduce pressure ulcers. The team have worked closely alongside the QI team and the F8 team, low incidence of HAPU have been observed in September and October which shows early signs of encouragement.

In October the TVN team raised awareness to highlight the new streamlined Skin and wound assessments on e-care, this involved a promotional stand and t-shirts to promote this initiative. Plans to recognise the national "*Stop the Pressure Day*" will be delivered in November where promotional stands within Time out and educational packages will be rolled out to wards.

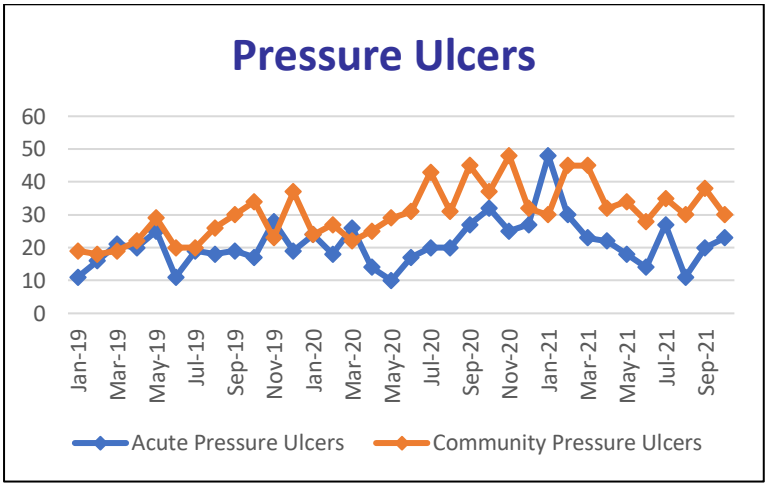


Chart 9a

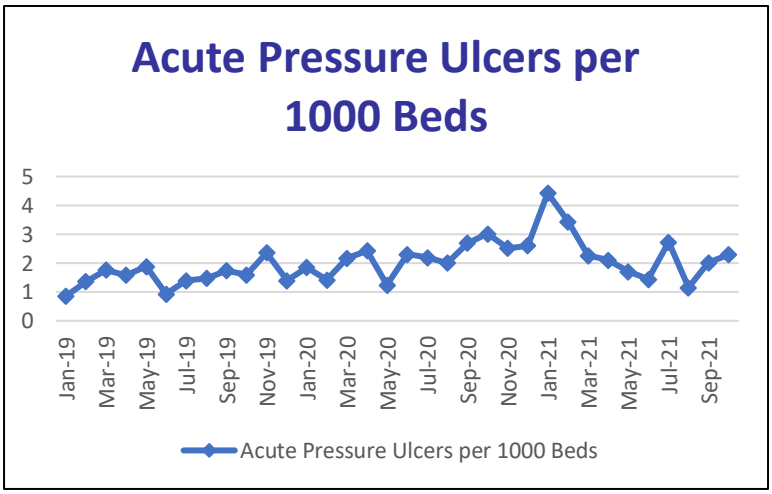


Chart 9b

9. Compliments and Complaints

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

The clinical helpline has seen an increase in use since August and in October saw an average of 114 calls a day to assist relatives who are unable to attend the wards to receive updates of the care of our patients. This is likely to increase in November as visiting restrictions have continued in response to rising community prevalence of CV19 infections.

Complaints have reduced for three consecutive months particularly reducing from A&E and gynaecology which is positive following the observed increases in both areas. Communication is still the most common reason for patient concerns.

	Compliments	Complaints
April 2021	26	15
May 2021	25	13
June 2021	31	19
July 2021	23	20
August 2021	17	19
September 2021	30	14
October 2021	15	10

Table 10

10. Adverse Staffing Incidences

Staffing incidences are captured on Datix with recognition of any red flag events that have occurred as per National Quality Board (NQB) definition (Appendix 4). Nursing staff are encouraged to complete a Datix as required so any resulting patient harm can be identified and reviewed.

- In September there were forty-nine 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.

- In October there were 40 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	Apr 21	May 21	June 21	July 21	Aug 21	Sep 21	Oct 21
Registered nursing shortfall of more than 8 hours or >25% of planned nursing hours	2	3	4	23	12	22	19
>30-minute delay in providing pain relief	0	1	0	4	7	3	2
Delay or omission of intention rounding	2	1	5	12	12	7	10
<2 RNs on a shift	3	5	1	1	2	10	6
Vital signs not recorded as indicated on care plan	1	2	1	0	0	5	3
Unplanned omissions in providing patient medication	0	0	0	1	0	2	0
Total	8	12	11	49	33	49	40

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 fifteen red flag events in September demonstrated in chart 12 below. No harm was recorded as in impact of these incidents.
- There were twenty-two red flag events in October demonstrated in chart 12 below. No harm was recorded as in impact of these incidents.

Chart 12a

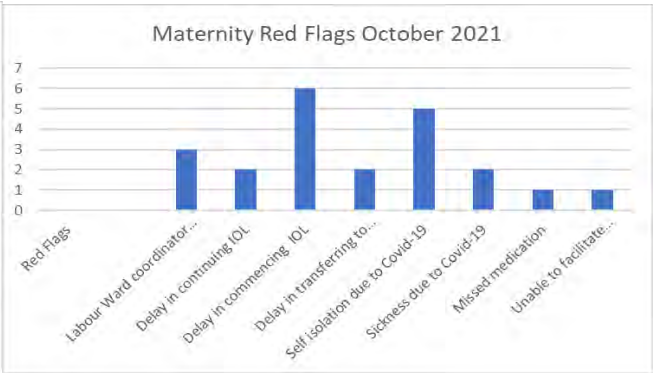


Chart 12b

Midwife to Birth ratio

Midwife to Birth ratio was 1:30 in September and 1:29.8 in October, this is higher than national average of 1:28 and Birthrate Plus recommendation of 1:27.7. Despite the increase in midwife to birth ratio which was also seen in previous month, 100% of 1:1 care provision has been achieved in both reported months.

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 September 85% compliance was achieved
- October 93% compliance was achieved

October shows slight improvement compared to the last three months however this is still below required target of 100% and is a result of an increased staffing absence due to Covid 19, staffing shortages. The escalation policy was activated and follow as required. A recruitment drive for further labour suite co-ordinators, band 5, 6 and adult RNs (to support F11) has been on-going however due to national shortages of midwives it is difficult to appoint into the vacancies available. The plans have been put in place at local/ regional and national level to address this.

Midwifery recruitment continues positively as mentioned in section 6. The service has been successful in receiving national funding to support an additional eight midwives which will be interview in December. These midwives would be estimated to arrive in in small cohorts from February 2022.

12. Summer Establishment review

In July 2021 the Safer Nursing Care Tool (SNCT) audit was completed on all inpatient wards. Following consolidation of the data, meetings with the ward team leaders where held with the Deputy Chief Nurse to review the audit output and provide professional judgement to individual ward outcomes. The validity of this review was affected on a number of wards moving from their original footprint to smaller bed bases. These

areas where not considered for any current change in establishment. A full breakdown of the audit output and recommendations can be found in appendix 5.

In summary

- 14 wards do not require any change to establishment
- AAU establishment meets the needs of the unit, however consistent use of escalation requiring additional staffing which may be considered in a permanent uplift in the future?
- G1 have opened additional inpatient capacity have increased their RN demand by 1WTE each day at cost. It is likely that this will be considered in budget setting in 2022/21
- F5 have changed activity from an elective focus to mix of elective and emergency step down. If the elective position remains unchanged they may require additional NA in day. Plan to review in next audit cycle
- F8 and G9 had no change to their establishment in the September 2020 review as both wards where being moved to a smaller footprint. On this review, the data suggests no change. Both these wards have the potential to have a sustained increase in acuity which may suggest an establishment change in the near future. These two wards will be of particular interest in the next round of audit scheduled for January 2022.
- F1 to run SNCT in December to capture winter activity peaks, not always seen in January.

13. 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.

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Appendix 1. Fill rates for inpatient areas (September 2021): Data adapted from Unify submission

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

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each day	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	932.5	889	1744	1588.2	1023.5	1000.5	1288	1165	95%	91%	98%	90%	794	2.4	3.5	5.8
Glastonbury Cour	694.5	705.5	1024.5	1023	690	681.5	525	519.5	102%	100%	99%	99%	511	2.7	3.0	5.7
AAU	2069.5	1851	2397.5	1779.5	1710	1484.5	1371.5	1519	89%	74%	87%	111%	761	4.4	4.3	8.7
Cardiac Centre	2838.5	2415.75	1205.5	1089.7833	1725	1418	667	632.5	85%	90%	82%	95%	632	6.1	2.7	8.8
G9	1380	1315	1380	1271	1369	1196.5	1035	1207.5	95%	92%	87%	117%	752	3.3	3.3	6.6
F12	540.5	625	345	206.5	690	510.5	345	254.5	116%	60%	74%	74%	240	4.7	1.9	6.7
F7	1732	1562.0833	1726	1436.5	1380	1207.916667	1708.5	1545	90%	83%	88%	90%	683	4.1	4.4	8.4
F9	1725	1547.75	1725	1563.75	1032.5	956.5	1379	1479	90%	91%	93%	107%	744	3.4	4.1	7.5
G1	1374	990	346.5	382.75	690	693.5	345	282.5	72%	110%	101%	82%	454	3.7	1.5	5.2
G3	1725	1430.1667	1697.5	1572.5	1035	1025.5	1035	1306.5	83%	93%	99%	126%	864	2.8	3.3	6.2
G4	1737.75	1591.25	1674.5	1629.25	1035	872	1380	1514.5	92%	97%	84%	110%	896	2.7	3.5	6.3
G8	2416.5	1797.1667	1775.5	1716.3333	1725	1414.25	1035	1192	74%	97%	82%	115%	615	5.2	4.7	10.0
F8	1380	1390.5	2069.5	1707.5	1034	879	1377.5	1365.5	101%	83%	85%	99%	723	3.1	4.3	7.4
Critical Care	2685.5	2394.6667	330	724	2748.5	2280.25	0	414.75	89%	219%	83%	N/A	388	12.0	2.9	15.0
F3	1725	1414	2063.5	1709.4167	1035	1021.5	1379.5	1318.5	82%	83%	99%	96%	732	3.3	4.1	7.5
F4	639.5	616.5	405.5	221.5	632.5	496	445	278	96%	55%	78%	62%	633	1.8	0.8	2.5
F5	1695.5	1336.1333	1376	1217.75	1035	886.5	1035	902.5	79%	88%	86%	87%	698	3.2	3.0	6.2
F6	1938.5	1481.5	1590	1537.75	1348.5	997.25	690	880	76%	97%	74%	128%	942	2.6	2.6	5.2
Neonatal Unit	984	1152.25	204	187.5	984	1092.5	120	108	117%	92%	111%	90%	116	19.4	2.5	21.9
F1	1175.5	1316.25	671.25	869.75	1035	1204.25	0	272	112%	130%	116%	100%	115	21.9	9.9	31.8
F14	572	943.5	302.5	536.5	708	709.6666667	0	234	165%	177%	100%	100%	106	15.6	7.3	22.9
F10	377.5	391.5	379.5	299	333.5	302.5	333.5	333.5	104%	79%	91%	100%	707	1.0	0.9	1.9
Total	31,961.25	28,764.97	26,053.75	23,970.73	24,665.50	22,028.08	17,161.00	18,390.75	**90%**	**92%**	**89%**	**107%**	**13106**	**3.9**	**3.3**	**7.2**

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NHS Foundation Trust

Appendix 1. Fill rates for inpatient areas (October 2021): Data adapted from Unify submission

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each day	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	963.25	888	1840	1442.5	1000.5	968	1253.5	1157	92%	78%	97%	92%	828	2.2	3.1	5.4
Glastonbury Cour	711	716	1069.5	1045	713	715	542.5	528.5	101%	98%	100%	97%	528	2.7	3.0	5.7
AAU	2118.5	1738	2457.5	1845	1771	1217.5	1426	1596	82%	75%	69%	112%	761	3.9	4.5	8.4
Cardiac Centre	2831.5	2344	1258	1120.25	1782.5	1460.5	695	703.5	83%	89%	82%	101%	632	6.0	2.9	8.9
G9	1419.33333	1355.5833	1420.5	1360.75	1420.5	1121.5	1069.5	1363.25	96%	96%	79%	127%	752	3.3	3.6	6.9
F12	556	619.5	356.5	313	713	568.5	356.5	304	111%	88%	80%	85%	240	5.0	2.6	7.5
F7	1778	1521.75	1737.5	1166	1426	1174.083333	1762.516667	1494	86%	67%	82%	85%	683	3.9	3.9	7.8
F9	1782.5	1432.5	1779	1495.5	1062.5	1030.666667	1426	1326.25	80%	84%	97%	93%	744	3.3	3.8	7.1
G1	1407.75	1016.75	356.5	338	713	702.5	356.5	240.483333	72%	95%	99%	67%	454	3.8	1.3	5.1
G3	1782.5	1407.4167	1767.5	1516.5	1069.5	1081	1060.5	1366	79%	86%	101%	129%	864	2.9	3.3	6.2
G4	1795.75	1548.75	1738.5	1703.25	1069.5	876	1425	1410	86%	98%	82%	99%	896	2.7	3.5	6.2
G8	2501.25	1842.6667	1844.5	1627.8333	1782.5	1357.25	1069.5	1150	74%	88%	76%	108%	615	5.2	4.5	9.7
F8	1426	1437	2149.5	1647	1069.5	920.5	1426	1387.25	101%	77%	86%	97%	723	3.3	4.2	7.5
Critical Care	2835	2565	334.5	382.83333	2852	2470.766667	0	153.5	90%	114%	87%	N/A	388	13.0	1.4	14.4
F3	1773	1415.5	2121.5	1797.25	1058	1034.5	1426	1295	80%	85%	98%	91%	732	3.3	4.2	7.6
F4	586.5	530	138	138	644	460	391	356.5	90%	100%	71%	91%	633	1.6	0.8	2.3
F5	1736.5	1417	1426	1092.5	1069.5	949	1065	906.25	82%	77%	89%	85%	698	3.4	2.9	6.3
F6	2011.5	1582.5	1616	1460.8333	1418.98333	1055	713	931.5	79%	90%	74%	131%	942	2.8	2.5	5.3
Neonatal Unit	1085	1212	132	139	1020	1062	180	182	112%	105%	104%	101%	116	19.6	2.8	22.4
F1	1203.75	1363.75	655.5	876.5	1069.5	1309.25	229	229.25	113%	134%	122%	100%	115	23.2	9.6	32.9
F14	628	1080.15	312	556	696	673	208	208.5	172%	178%	97%	100%	106	16.5	7.2	23.8
F10	1040	897	1096.5	701.5	793.5	691	1069.5	775.5	86%	64%	87%	100%	707	2.2	2.1	4.3
Total	32,932.58	29,033.82	26,510.50	23,063.50	25,420.98	22,206.52	18,081.02	18,288.73	**88%**	**87%**	**87%**	**101%**	**13157**	**4.0**	**3.3**	**7.3**

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NHS Foundation Trust

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

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	24.7	30.1	5.5	18.1	AAU	22.1	28.3	6.2	22.0
Accident & Emergency	67.0	77.3	10.2	13.3	Accident & Emergency	30.5	34.5	3.9	11.4
Cardiac Centre	35.9	40.7	4.8	11.8	Cardiac Centre	13.9	15.7	1.8	11.7
Glastonbury Court	12.0	11.7	-0.3	-2.2	Glastonbury Court	12.1	12.6	0.5	4.0
Critical Care Services	43.5	43.0	-0.5	-1.1	Critical Care Services	3.8	1.9	-1.9	-102.1
Day Surgery Wards	13.1	11.0	-2.1	-19.5	Day Surgery Wards	3.9	3.9	0.0	0.0
Gynae Ward (On F14)	13.1	14.1	0.9	6.8	Gynae Ward (On F14)	2.0	2.0	0.0	0.0
Neonatal Unit	18.7	20.6	1.9	9.3	Neonatal Unit	4.5	4.3	-0.2	-4.2
Rosemary ward	13.4	16.6	3.1	18.9	Rosemary ward	21.1	25.8	4.7	18.3
Recovery Unit	20.6	25.4	4.8	19.0	Recovery Unit	0.9	0.9	0.0	1.2
Ward F1 Paediatrics	21.7	22.3	0.6	2.7	Ward F1 Paediatrics	8.3	6.7	-1.5	-22.7
Ward F12	9.9	11.9	2.0	17.1	Ward F12	5.9	5.9	-0.1	-1.2
Ward F3	21.8	22.2	0.3	1.4	Ward F3	20.9	25.8	4.9	19.0
Ward F4	13.0	13.6	0.6	4.6	Ward F4	9.5	14.6	5.2	35.3
Ward F5	19.4	22.2	2.7	12.3	Ward F5	16.9	18.1	1.2	6.4
Ward F6	17.6	26.6	8.9	33.6	Ward F6	16.0	17.4	1.4	7.8
Ward F7 Short Stay	22.7	24.9	2.2	8.9	Ward F7 Short Stay	20.0	25.8	5.8	22.4
Ward F9	19.7	21.8	2.1	9.7	Ward F9	25.8	23.2	-2.7	-11.4
Ward G1 Hardwick Unit	26.2	30.6	4.4	14.3	Ward G1 Hardwick Unit	10.4	10.5	0.2	1.7
Ward G3	19.6	22.1	2.5	11.2	Ward G3	23.1	23.0	-0.1	-0.4
Ward G4	21.4	22.1	0.7	3.0	Ward G4	20.1	22.8	2.7	12.0
Ward G8	21.7	32.7	11.0	33.8	Ward G8	22.6	20.6	-2.0	-9.7
Renal Ward - F8	18.6	19.5	0.8	4.3	Renal Ward - F8	23.7	25.8	2.1	8.0
Ward F10	13.4	19.0	5.6	29.5	Ward F10	14.4	23.2	8.8	37.9
Respiratory Ward - G9	22.5	23.7	1.2	4.9	Respiratory Ward - G9	17.9	18.0	0.1	0.7
Total	551.3	625.5	74.1	11.9	Total	370.1	411.1	41.0	10.0
Hospital Midwifery	50.0	59.6	9.6	16.0	Hospital Midwifery	14.1	15.6	1.5	9.5
Continuity of Carer Midwifery	13.3	18.3	5.0	27.4	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	80.5	97.0	16.6	17.1	Total	17.9	19.4	1.5	7.5

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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	24.9	30.1	5.2	17.4	AAU	22.5	28.3	5.9	20.7
Accident & Emergency	65.8	77.3	11.4	14.8	Accident & Emergency	33.4	34.5	1.1	3.1
Cardiac Centre	34.8	40.7	5.9	14.4	Cardiac Centre	14.8	15.7	1.0	6.1
Glastonbury Court	12.0	11.7	-0.3	-2.8	Glastonbury Court	12.4	12.6	0.2	1.8
Critical Care Services*	41.2	50.0	8.9	17.7	Critical Care Services	2.8	1.9	-0.9	-48.9
Day Surgery Wards	12.6	11.0	-1.6	-14.4	Day Surgery Wards	3.9	3.9	0.0	0.0
Gynae Ward (On F14)	12.2	14.1	1.9	13.5	Gynae Ward (On F14)	2.0	2.0	0.0	0.0
Neonatal Unit	18.9	20.6	1.7	8.1	Neonatal Unit	5.0	4.3	-0.7	-15.9
Rosemary ward	13.2	16.6	3.4	20.4	Rosemary ward	20.3	25.8	5.5	21.2
Recovery Unit	22.5	25.4	2.9	11.5	Recovery Unit	0.9	0.9	0.0	1.2
Ward F1 Paediatrics	22.1	22.1	0.0	0.0	Ward F1 Paediatrics	7.1	6.7	-0.3	-5.0
Ward F12	9.6	11.9	2.3	19.4	Ward F12	5.5	5.9	0.3	5.5
Ward F3	19.6	22.2	2.6	11.7	Ward F3	22.8	25.8	3.0	11.8
Ward F4	13.1	13.6	0.6	4.2	Ward F4	8.7	14.6	6.0	40.7
Ward F5	19.0	22.2	3.1	14.1	Ward F5	17.0	18.1	1.1	6.1
Ward F6	16.1	26.6	10.5	39.6	Ward F6	19.2	17.4	-1.8	-10.4
Ward F7 Short Stay	23.5	24.9	1.4	5.8	Ward F7 Short Stay	20.4	25.8	5.4	20.8
Ward F9	17.9	21.8	3.9	18.0	Ward F9	24.8	23.2	-1.6	-7.0
Ward G1 Hardwick Unit	25.2	30.6	5.4	17.5	Ward G1 Hardwick Unit	10.7	10.5	-0.1	-1.2
Ward G3	19.3	22.1	2.8	12.5	Ward G3	21.2	23.0	1.7	7.6
Ward G4	22.4	22.1	-0.3	-1.4	Ward G4	17.9	22.8	4.9	21.4
Ward G8	21.1	32.7	11.6	35.4	Ward G8	22.2	20.6	-1.5	-7.5
Renal Ward - F8	18.4	19.5	1.0	5.3	Renal Ward - F8	22.3	25.8	3.4	13.4
Ward F10	13.4	19.0	5.6	29.5	Ward F10	14.8	23.2	8.4	36.4
Respiratory Ward - G9	21.9	23.7	1.8	7.6	Respiratory Ward - G9	17.4	18.0	0.6	3.3
Total	540.6	632.2	91.7	14.5	Total	369.7	411.1	41.4	10.1
Hospital Midwifery	50.1	58.9	8.8	14.9	Hospital Midwifery	12.8	15.6	2.8	17.8
Continuity of Carer Midwifery*	18.7	31.0	12.3	39.8	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	85.9	109.0	23.1	21.2	Total	16.6	19.4	2.8	14.3

*areas that have received an establishment uplift this month CCS (7wte) and Continuity of Carer (12.7wte)

Appendix 3:

Ward by Ward breakdown of Falls and Pressure ulcers September and October 2021

HAPU

Sep-21	Cat 2	Unstageable	Total
F1 - Ward	1	0	1
F5 - ward	1	0	1
G3 -	0	1	1
Gastro Ward	1	0	1
Rosemary Ward	1	0	1
AAU	1	0	1
F14 (Gynae - EPAU)	2	0	2
F3 - ward	2	0	2
G4 - ward	2	0	2
G8 - ward	2	0	2
Renal Ward	2	0	2
F7	4	1	5
Total	**19**	**2**	**21**

October 2021	Cat 2	Cat 3	Unstageable	Total
Cardiac Centre - Ward	1	0	0	1
F5 - ward	1	0	0	1
G8 - ward	1	0	0	1
Gastroenterology Ward	1	0	0	1
Glastonbury Court	0	0	1	1
Rosemary Ward	1	0	0	1
G3 - Endocrine and General Medicine	1	0	1	2
G4 - ward	2	0	0	2
Renal Ward	2	0	0	2
F3 - ward	2	1	0	3
F6 - ward	2	0	1	3
F7	6	0	1	7
Total	**20**	**1**	**4**	**25**

Falls

	None	Negligible	Minor	Moderate	Major	Total
Community Paediatric OT	0	0	1	0	0	1
Day Surgery Unit -	1	0	0	0	0	1
Eye Treatment Centre - Ward	1	0	0	0	0	1
F12 Isolation Ward	1	0	0	0	0	1
F14 (Gynae - EPAU)	1	0	0	0	0	1
F5 - ward	1	0	0	0	0	1
Glastonbury Court	1	0	0	0	0	1
Macmillan Unit	0	0	1	0	0	1
Respiratory Ward	1	0	0	0	0	1
F4 - ward	0	0	1	1	0	2
G1 - ward	2	0	0	0	0	2
Emergency Department	1	0	1	0	0	2
Gastroenterology Ward	2	0	1	0	0	3
Renal Ward	1	1	1	0	0	3
AAU	4	0	0	0	0	4
F6 - ward	4	0	1	0	0	5
Rosemary Ward	3	1	1	0	0	5
F3 - ward	3	0	3	0	0	6
G3 -	7	0	1	0	0	8
G4 - ward	9	0	2	0	0	11
G8 - ward	8	0	3	0	0	11
F7	10	1	0	0	0	11
Total	61	3	17	1	0	82

October 2021	None	Negligible	Minor	Moderate	Major	Total
Ambulatory Emergency Care (AEC)	1	0	0	0	0	1
Cardiac Centre - Diagnostics	1	0	0	0	0	1
Community Paediatric SLT	1	0	0	0	0	1
Critical Care Unit	1	0	0	0	0	1
F10	1	0	0	0	0	1
F4 - ward	1	0	0	0	0	1
General Corridors / Walkways	0	1	0	0	0	1
Macmillan Unit	1	0	0	0	0	1
Emergency Department	0	0	1	0	0	1
Major Assessment Area (MAA)	1	0	0	0	0	1
Physiotherapy Department	1	0	0	0	0	1
Respiratory Ward	1	1	0	0	0	2
Cardiac Centre - Ward	2	0	1	0	0	3
F12 Isolation Ward	2	0	1	0	0	3
F5 - ward	2	0	1	0	0	3
G1 - ward	3	0	0	0	0	3
G3 - Endocrine and General Medicine	1	0	1	0	1	3
Glastonbury Court	1	0	2	0	0	3
F3 - ward	4	0	0	1	0	5
G4 - ward	5	0	0	0	0	5
Gastroenterology Ward	3	0	2	0	0	5
Rosemary Ward	4	0	1	0	0	5
Acute Assessment unit (AAU)	4	0	1	0	0	5
G8 - ward	5	1	0	0	1	7
F7	6	0	1	0	0	7
F6 - ward	7	0	1	0	0	8
F8 - Renal Ward	7	1	1	0	0	9
Total	**66**	**4**	**14**	**1**	**2**	**87**

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.

Appendix 5: Data output from Summer 2021 SNCT

NHS West Suffolk NHS Foundation Trust

Wards	Split WTE		WTE	SNCT Audit Results						Variance SN(verses Current establishment	Decision / uplift/downlift / skill mix
	RN	NA		Sep-20		Feb-21		Jul-21			
				NHPDD	SNCT	NHPDD	SNCT	NHPDD	SNCT		
AAU	30.1	28.3	58.4	30.2	40.1	32.3	44.4	37.2	49.5	-8.9	Consider making escalation staffing permenant if no improvement
Cardiac	30.84	12.81	43.65	29.5	33.0	29.1	30.5	44.7	32.3	-11.3	No change
F12	11.9	5.9	17.8	9.6	10.2	9.9	10.4	9.2	9.7	-8.1	No change
F7	24.9	25.8	50.7	22.9	24.2	17.4	19.4	45.4	51.0	0.3	No change
F8	19.5	25.8	45.3	43.7	50.4	24.2	27.0	36.6	43.7	-1.6	No change but plans to change acuity of ward may mean uplift needed
G1	17.36	5.97	23.33	13.2	13.0	15.4	17.4	16.3	18.1	-5.2	Additional RN turns substantive in April with no additional changes
G3	22.1	23	45.1	45.9	35.8	26.5	27.8	43.7	48.6	3.5	No change
G4	22.1	22.8	44.9	39.4	43.9	20.9	22.0	40.1	43.2	-1.7	No changes
G5	21.8	23.2	45	40.4	42.3	32.6	34.0	43.7	49.4	4.4	No change
G8	32.7	20.6	53.3	37.3	43.0	37.2	42.1	57.5	50.7	-2.6	No change
G9	23.7	18	41.7	32.6	33.0	25.0	29.1	33.6	35.5	-6.2	No Change as low occupancy. Consider uplift in RN in next round due to NIV acuity
F3	22.2	25.8	48	42.5	46.4	29.1	31.8	41.3	46.9	-1.1	No change
F4	13.6	14.6	28.2	10.0	10.3	24.4	26.5	6.9	7.1	-21.1	No change
F5	22.2	18.1	40.3	36.1	33.7	36.8	38.7	36.3	37.8	-2.5	No change
F6	26.6	17.4	44	39.9	39.9	39.7	43.2	38.7	41.6	-2.4	No change
F14	13.1	2	15.1	6.7	5.7	6.8	5.8	11.7	10.2	-4.9	No change
F1	22.3	7.7	30	8.9	15.9	7.2	11.9	17.4	29.2	-0.8	No Change / December bespoke SNCT to cover peak times
Rosemary	16.6	25.8	42.4	24.4	27.8	25.0	29.1	31.0	37.8	-4.6	No change
Kingsuite	11.7	12.6	24.3	24.3	25.4	22.2	22.4	20.8	20.9	-3.4	No change

2.7. Quality and Learning Report

To Assure

Presented by Susan Wilkinson

Trust Open Board – 17 December 2021

Agenda item:	2.7			
Presented by:	Sue Wilkinson – Executive Chief Nurse			
Prepared by:	Rebecca Gibson – Head of Compliance & Effectiveness			
Date prepared:	November / December 2021			
Subject:	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 activities in the period since the last report. It includes the following sections.

Core (every report)

1: Learning from incidents

2: Quality & Safety dashboard

3: National patient safety updates

4: Learning from other sources:

4.1 Learning from deaths

4.2 Staff concerns

4.3 External concerns

4.4 Claims

4.5 Patient and public feedback

Theme (different every report)

5: External investigations / reviews of WSFT care

5.1 HSIB reports issued relating to the care of a WSFT patient

6: Quality assurance programme

Note: Future reports may contain one or more of the following: HSIB and other national best practice reports, quarterly incident analysis, clinical audit and QI, external quality assurance visits, 'Greatix' and a focus on one (or more) subject(s) within the PSIRP.

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 incident investigations

The two tables in Appendix 1 contain the learning from investigation / reports (patient safety incident investigations - PSIIs and patient safety reviews - PSRs) approved by the patient safety quality assurance panel (PSQAP). The full PSII reports are provided as an appendix to the closed board paper *Serious Incidents, Claims, Red complaints, Inquests and other external reviews of WSFT cases*.

Since the last Board report there have been four PSIIs and three PSRs approved at PSQAP.

- WSH-IR-71640: Retained urological stent
- WSH-IR-70727: New finding of Abdominal Aortic Aneurysm, not referred to vascular team.
- WSH-IR-68520: Subdural Haematoma post fall at home
- WSH-IR-72503: Patient who climbed out of an unrestricted window
- WSH-IR-68559: Alleged Assault
- WSH-IR-71710: Overdose of morphine during spinal anaesthesia for elective Caesarean section
- WSH-IR-74717: Discharge and subsequent readmission of patient with deteriorating renal function

Safety recommendations from PSIIs will be aggregated with other investigations and linked with appropriate improvement work/projects. The Action Oversight Group will be responsible for overseeing the follow-up of all the safety recommendations, either as standalone or via the specialist groups reporting frameworks in the new 3i committee structure.

2. Quality & Safety dashboard

(*being developed – this will include key KPIs and quality measures in future*)

There is a recently started trust project, led by Jodie Price (Performance Manager) with three main priorities: to review the IQPR board report, structure the role of Performance in the 3I structure and also the development of a Power BI dashboard. This project has been linked up to the wider development of an internal quality & safety dashboard and working with the CCG to develop an external quality & performance dashboard to minimise duplication and ensure consistency.

The Insight committee will receive updates on this development in its reporting schedule as part of its oversight of the CQC finding 7 "*The trust must take definitive steps to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant*"

3. National patient safety updates

Future iterations of this report may contain updates on the new patient safety syllabus, the replacement for the NRLS 'the national learning from patient safety events' system, the national patient safety specialists workplan, patient safety partners and other relevant national safety topics. Further information on all of these subjects can be found on NHS England's patient safety webpage https://www.england.nhs.uk/patient-safety/

3.1 Patient safety incident response framework (PSIRF) and the PSIRP (plan)

The Trust's PSIRP will be refreshed in Q4 with the following proposed timeline:

- Currently in progress – Quarterly analysis of in-year incidents to highlight key risks
- December 21
  - Divisional discussions of concern areas (including soft intelligence) led by triumvirate and divisional patient safety managers
  - Drugs & therapeutics group review of priority medication-based incident types
  - Review of key themes arising from complaints / PALS / claims / inquests / LfD
  - Consideration of wider ICS level risks for potential inclusion (through conversation with our CCG colleagues)

- January 22
  - Review of previous year's PSIRP key risks for inclusion or removal from PSIRP*
  - Senior Leadership team review of identified risks for inclusion in PSIRP (from all the above)
- February 22 – Board sign-off of final draft PSIRP
- April 2022 – Annual PSIRP (year 2) implemented

*Review of previous year's PSIRP key risks

Risk	How many PSIIs completed	What other reviews undertaken in year	Does subject warrant inclusion in the next year's PSIRP	(If removed from PSIRP) what ongoing systems are in place to manage the risk and oversee any planned improvements?

4. Learning from other sources

4.1 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: LfD data Q3 (19/20) – Q2 (20/21)

	Deaths	Deaths with an SJR* completed	SJRs classified as Poor / Very poor care	Deaths judged as >50% preventable**
Oct20-Dec20	286	44 (133 for SJR)	12	0
Jan21-Mar21	346	61 (197 for SJR)	8	0
Apr21-Jun21	202	27 (69 for SJR)	5	0
Jul21-Sep21	215	18 (59 for SJR)	6	0

** SJR - Structured Judgement Review **National reporting requirement*

Improvement plan

There is ongoing discussion relating to preventable deaths and how / where this data is captured and reported with the change to PSIRF. There is currently lack of assurance that a Hogan score is being recorded for every hospital death; Hogan scoring assists in identifying preventable deaths and learning opportunities. An audit of Hogan score completion will be available in December 2021 and will be included in the next board report. A review of data on preventable deaths (using other trust's quality accounts) is also underway to obtain some benchmarking data.

Learning from Deaths bulletin

A most recent issue was published and shared in September 2021. Feedback from staff is generally positive. The next issue will be published and shared in December 2021 with reference to Covid-19.

Summary Level Hospital Mortality Index (SHMI)

The LfD and information teams have worked to ensure the process when SHMI is reported as above the expected level this is quickly identified and is communicated to the relevant clinical director. Most recent SHMI above the expected level is fluid and electrolyte disorders. Expected deaths 25 actual deaths 35.

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

4.2 Staff concerns

A central database of all concerns raised by Trust staff through formal routes has been maintained with effect from January 2020 following the recommendations of our internal audit report on Freedom to Speak Up (FTSU). More information is available in the FTSUG reports to Trust Board.

Staff concerns raised 1st September 2021 to 31st October 2021 n = 20	
Route for raising concern	
Freedom to Speak Up Guardian	19
Senior Independent Director	0
Chief Executive	1
Anonymous phone line	0
Other e.g. NED other than SID	0
Concerns including element of patient safety/quality	14
Concerns including element of bullying and/or harassment	9
Detriment experienced i.e. staff experience detriment as a result of raising concern	1
Concerns raised anonymously	6

Staff group raising concerns		**Division of staff member raising concern**	
Not disclosed	5	Not disclosed	6
AHP	1	Medical	3
Medical	1	Surgical	4
Registered nursing and midwifery	8	Integrated services	2
HCA	3	Clinical support services	0
Administrative and clerical	1	Women and children	4
Maintenance and ancillary	0	Corporate	0
Manager	0	Estates and facilities	0
Senior leader	0	Bank/locum	1
Professional and technical	0		
Corporate services	0		
Other	1		

4.3 External concerns

The October board meeting requested that this report be updated to include external concerns. The organisation may receive concerns from external organisations such as the CQC which act as a third party referring concerns from service providers (e.g. social services or a care home) or from individuals (e.g. when cc'd into a complaint). There may also be on occasion a formal concern raised through the safeguarding referral process.

In the most recent six month period there have been a small number of both of these and (excluding complaint cc's which are addressed within 4.4) they have mostly related to concerns about potentially poor discharges.

4.4 Claims and litigation

The 2021 Claims scorecard has been issued by NHS Resolution for WSFT which includes all CNST claims received with an incident date between Apr 2011 and Mar 2021.

The GIRFT programme provides an opportunity to undertake a review of the cases that make up this data to identify opportunities for learning including a triangulation of learning from incidents, complaints or inquests linked to the claims.

	Nr		Value
General Surgery	1	£	4,625,000
Neurology	1	£	12,575,000
Obstetrics	2	£	25,650,000
Orthopaedic Surgery	1	£	1,930,314
Paediatrics	1	£	7,850,000
Psychiatry/ Mental Health	1	£	2,580,000
Radiology	1	£	1,310,000
Grand Total	8	£	56,520,314

	Nr	Value
None		

	Nr		Value
Anaesthesia	2	£	215,000
Community Medicine/ Public Health	1	£	298,599
Dentistry	1	£	18,564
Dermatology	2	£	1,847
District Nursing	2	£	45,031
Endocrinology	1	£	50,355
Haematology	1	£	138,000
Histopathology	1	£	82,000
Neurology	1	£	84,640
Non-Clinical Staff	1	£	64,382
Not Specified	1	£	4,916
Paediatrics	2	£	69,925
Pharmacy	1	£	11,300
Plastic Surgery	1	£	950
Psychiatry/ Mental Health	1	£	7,495
Renal Medicine	2	£	436,937
Respiratory Medicine/ Thoracic Medic	1	£	8,041
Rheumatology	1	£	16,051
Vascular Surgery	1	£	823,620
Grand Total	24	£	2,377,653

	Nr		Value
Cardiology	5	£	518,227
Emergency Medicine	36	£	3,097,921
Gastroenterology	4	£	728,567
General Medicine	15	£	1,870,881
General Surgery	17	£	845,566
Geriatric Medicine	3	£	5,973
Gynaecology	14	£	476,210
Intensive Care Medicine	4	£	429,871
Obstetrics	23	£	1,854,317
Oncology	8	£	496,159
Ophthalmology	5	£	1,006,471
Orthopaedic Surgery	35	£	2,274,409
Otorhinolaryngology/ ENT	8	£	143,320
Radiology	3	£	117,582
Surgical Speciality - Other	4	£	255,740
Urology	37	£	978,832
Grand Total	221	£	15,100,045

This process is currently ongoing and has identified only three claims with the potential for this further learning that were not classed as a serious incident at the time (2014-2015) and these are currently being evaluated by the Head of Legal services and the Head of Patient safety. This provides reassurance that the pro-active integrated approach to triangulation with incidents, complaints, inquests etc. is working well.

There are no obvious themes in the cases, the details of which will be reported to the Patient Quality & Safety Group as part of the regular Legal services report in January 2022

4.5 Patient and public feedback

Ten complaints responded to in Q2 were deemed to be upheld at the time of producing this report. Actions from these are set out in the table overleaf. 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
1948	Staff member's manner and attitude towards patient regarding wearing a face mask caused upset and distress to patient.	Staff member involved has reflected on patient's feedback regarding their manner. Complaint also shared during local governance meeting for wider team learning and reflection
2005	Patient's oxygen tube connected to flow metre was not turned on causing patient's saturations to drop to 60%	Has been shared with ward staff during daily safety huddle for reflection. Ward manager had reinforced the need for staff to ensure that they check that oxygen flow metre is on the correct rate when recording patient observations.
1960	Patient's mobile phone lost during admission.	PALS to work with ward managers and matrons to set up a working group to reduce the amount of lost property.
1944	Patient discharged with another patient's paperwork. Patient was not offered a shave and his medication locker was broken.	Internal incident raised regarding incorrect paperwork. Staff reminded that patients should be offered a shave on a daily basis. Staff reminded to escalate any broken medication lockers for repair as a priority.
1956	Patient found staff member to be rude towards her when she attended emergency department.	Staff involved with patient's care have reflected on feedback provided.
2006	Incorrect wording used in clinic letter which caused upset to patient.	Acknowledged that wording in clinic letter was incorrect and apology offered for upset caused. Staff will be more mindful of phrasing in the future.
1904	Delay in family seeing patient after they had died en route to hospital, correct procedures not followed by ambulance service and lack of understanding of appropriate procedure to follow within ED, when instructing ambulance crew where they should go.	Meeting held with Ambulance service to discuss complaint, the impact to the family and that correct procedures were not followed. Discussion during meeting ensured correct processes reiterated. Mortuary manager working with Ambulance service to ensure that correct process for when a patient dies on route to hospital is clear and that all staff at Ambulance service are aware of what steps to follow. Mortuary manager will be doing some education with staff in ED to raise awareness of appropriate procedures. Flow diagrams will be made available for ED staff and for Ambulance service for future reference.
1937	Overall lack of communication between staff and family which led to confusion about whether patient was NBM	SALT training with medical team to continue and team to ensure that these are conducted in a timely manner. Staff reminded to cancel ordered meals for patients who are deemed nil by mouth wherever possible and make sure signage in patient bed areas are checked before leaving any meals with patients. Pencil on F8 visitors list has been replaced with a pen to make it easier for visitors to complete the form. Wards asked to use individual sheets for visitors which are handed back to staff to prevent other visitors viewing information on any other person. Checking visitors list prior to contacting patient relatives highlighted to all staff. Staff reminded about 'hello my name is…' and to introduce themselves / anyone with them at beginning of conversation. Importance of mental capacity assessments and lasting power of attorney and legal duties to patients lacking capacity has been discussed and resulted in the production of a self-directed, reflective piece on mental capacity assessments and lasting power of attorney by one staff member with a request for training to be arranged for junior doctors 2-3 times a year for mental capacity, lasting power of attorney and duty of care to raises awareness. Ward manager has reminded ward staff that patients not receiving oral intake should receive mouth care regularly, this will be closely monitored by the senior team on the ward. Ward staff reminded to communicate with the registered nurse when taking decisions about a patient's care.
1972	Patient upset with the manner of a staff member when discussing choice for elective caesarean section.	Staff member has reflected on comments during telephone consultation and will be more mindful in future.
1903	Staff did not follow correct procedures to escalate an incident when patient reported she was sexually assaulted by another patient in the emergency department.	Cubicles 16 & 17 within ED not to be used for patients who have been admitted awaiting specialist team assessment. Head of security to arrange a flow chart and additional training regarding the correct policy on what to do if patients report an assault by another patient so that staff are aware of what steps need to be taken. Staff reminded about signposting patients to PALS is they wish to raise any concerns.

5. External investigations / reviews of WSFT care

5.1 HSIB reports issued since last Board report relating to the care of a WSFT patient

The table below 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 (every other meeting).

- WSH-IR 68725 - Early Neonatal Death - Final report receipt 22nd September

Safety Actions	Actions identified following review of HSIB report
The Trust to ensure that clinicians are supported to offer care that is in line with local and national guidance for gestational hypertension (NICE 2019).	Hypertension in Pregnancy Guideline has been updated to ensure robust guidance is available for the management of hypertension following receipt of this report. This guidance is in line with NICE guidance and was ratified 22/11/21
The Trust to support staff to recognise and escalate when a mother's observations are outside of the expected ranges.	Awaiting 2nd meeting, no representation from the ambulance service at the initial action planning meeting
The Trust to ensure there is a shared structured pre-alert tool used to facilitate effective communication between ambulance and the maternity service prior to arriving in hospital.	Pre-Alert tool now in place. This was a collaborative achievement between a senior midwife and an ambulance service representative. It will be trialled and amended following feedback. We have also introduced the ambulance tracking tool into maternity services. This enables the Senior Midwife and the Obstetrician to accurately plan for an impending arrival via ambulance, ensuring the team required is present on Labour Suite
The Trust to support staff to recognise a time critical obstetric emergency and the need for prioritising emergency transfer to the nearest maternity unit. This includes not staying on scene to insert an intravenous cannula, in line with national guidance	Awaiting 2nd meeting, no representation from the ambulance service at the initial action planning meeting Pre-alert tool provides the opportunity for the Senior Midwives and Obstetricians to use their skills and knowledge in supporting the ambulance Service in decision making
The Trust to ensure that there is adequate signage for the maternity departments throughout the hospital.	The issue regarding signage was resolved prior to the report being received. The HSIB representatives attended the hospital to undertake the patient journey and informed us of this risk. This was immediately addressed.

6. Quality Assurance

A meeting has taken place with the CCG quality and safety colleagues to agree a schedule of Quality assurance visits in 2022. This sought to determine the scope of a walkabout framework, understand what documents exist locally which would support framework and agree dates and subjects for review.

Subjects
Falls and frailty
End of life
Dementia
Pressure ulcers and Nutrition
Possibility for another if a risk becomes apparent in year either in addition or replacing one of the above

Process
Table-top / round table forum with provision of key documents
gap of time for documentation review
visit to acute site
visit to community

The visit methodology and report template will be similar to that used in the assurance visits in 2019 and 2020 for learning disabilities and medication security with external 'expert' partners / stakeholders invited to participate and will involve feedback under the headings of:

Risk and safety	Engagement & clinical care	Responsivity	Leadership, staffing and culture	Environment and IT	Communication

Appendix 1 - Outcome of investigation / reports (PSIIs and PSRs) issued since last report approved at Patient safety quality assurance panel

Table 1 - PSII reports.

Incident details	Learning points, involvement of patient / family
WSH-IR-71640 Retained urological stent	This investigation was undertaken with involvement of the patient whose experience is documented in the report. The main **findings** from the investigation were as follows: • A stent register is in place in Urology which is used by all Urology Consultants in the department. The stent register is monitored by the Urology Specialist Nurse on a monthly basis. The stent register and process for monitoring the register was reviewed and felt to be robust. • Currently no national stent register being used across the NHS and this has been identified in a national HSIB Investigation Report published in 2020. National Safety Recommendation was made to BAUS, the British Association of Urological Surgeons, in collaboration with other relevant specialties, to develop national standards which support electronic and paper-based systems for stent logging/tracking. • All patient records are now maintained electronically on e-Care unlike in 2013 when different electronic systems, and a combination of both paper and electronic systems, were in place. • There is a clear local process for follow up of patients who don't attend an appointment which was demonstrated as part of the investigation. There is also a Trust wide DNA process in place. • The service is actively reviewing its patient information leaflets on ureteric stents to align to recently published national guidance by BAUS. This was also a national recommendation by HSIB to BAUS in October 2020 to review its stent patient information leaflet. • A Stone MDT Meeting is in place which provides consultant oversight prior to, during and after lithotripsy treatment. This is another failsafe as part of the overall process for monitoring patients who are having ESWL as part of the management of their renal stones. **Immediate Safety Actions:** There were no immediate safety actions identified as part of the investigation into this incident. **Safety Recommendations:** Two safety recommendations were developed that are being taken forward by the Urology service. These are as follows: 1. Development of a local SOP to cover the procedure for tracking patients with ureteric stents and monitoring of the stent register. This process is already in place informally and the SOP will formalise this. The SOP is currently being developed and is being taken through the Urology governance processes. 2. Review of local patient information regarding stents and updating current information to align with recent national information published by BAUS. This is currently underway.
WSH-IR-70727 New finding of Abdominal Aortic Aneurysm, not referred to vascular team.	This investigation was undertaken with involvement of the patient's next of kin i.e. the patient's daughter. The main **findings** from the investigation were as follows: • Incidental finding of an abdominal aortic aneurysm was not referred to the vascular team for further investigation. • abdominal X-ray was requested and taken in line with IRMER regulations and the Trust's Radiological Imaging Reporting Guidance (Reporting Policy)', 2017 • Backlog in reporting of plain film X-rays for inpatients caused a five-week delay before the report was available • A shortage of radiologists is a continuing national issue and the risk remains on the Trust's Risk Register. • Radiologists are available to be contacted by a clinician who requires immediate or urgent radiologist input and that a review and report would be then be completed as a priority.

Incident details	Learning points, involvement of patient / family
	• Understanding of criteria for findings which imply the patient is at immediate risk of harm or that the patient may soon come to harm (requiring contact with the referrer) are not consistent across specialities • The code to trigger automatic referral to the vascular multi-disciplinary team meeting was not added to the X-ray report • The X-ray report had not been endorsed. This indicated that it had not been seen by a clinician. **Immediate Safety Actions:** A multi-speciality agreement must be reached regarding the criteria for which radiology consultants call the referring consultant to inform them of a finding which implies the patient is at immediate risk of harm or that the patient may soon come to harm. This is being taken forward by the Lead and the Head of Deteriorating Patients. **Safety Recommendations:** A standardised system for endorsement of results should be agreed and implemented across the Trust.
WSH-IR-68520 Subdural Haematoma post fall at home	This investigation was undertaken with involvement of the patient's next of kin i.e. her niece. The main **findings** from the investigation were as follows: • Information regarding a possible head injury and that a head CT had been requested was not successfully transferred to the T&O team. • The T&O team placed the patient onto a standard pathway for surgical repair of her hip fracture and this included standard venous thromboembolism (VTE) prophylaxis. • The ward staff were unaware of the head injury or head CT scan. • There is not consistent interpretation across specialities regarding the criteria for urgent communication of CT scan findings to the referrer. • ED followed up on imaging for patients who were still in the ED; not those who had been transferred to the care of other teams on the wards. • The eCare system did not clearly display the CT head report • The ward staff were not informed of the CT head finding or the neurosurgical advice after that had been obtained. **Immediate Safety Actions:** 1. A multi-speciality agreement must be reached regarding the criteria for which radiology consultants call the referring consultant to inform them of a finding which implies the patient is at immediate risk of harm or that the patient may soon come to harm. This is being taken forward by the Lead and the Head of Deteriorating Patients. 2. Clear documentation about tests, investigations or results requested but not yet completed must be easily available when a patient moves from one department/area/team to another. This is being explored in ED at consultant level. 3. Until the eCare updates are completed which will allow the national coding for CT scans to be visible, users must be advised which option to view radiology reports is the recommended option for clarity. This is being taken forward by the Lead and the Head of Deteriorating Patients. **Safety Recommendations:** 1. A clear process regarding how radiology images are followed up after a patient leaves the ED should be identified. This should comply with IRMER regulations and be a workable process within the environment. *2.* Review of the nurse to nurse handover when patients transfer from one team or department to another to ensure the key information is transferred with the patient.

Incident details	Learning points, involvement of patient / family
WSH-IR-72503 Patient who climbed out of an unrestricted window	This investigation was undertaken with involvement of the patient's next of kin i.e. the patient's mother. The main **findings** from the investigation were as follows: • Patient was initially triaged on e-Care as having had a fall rather than a self-harm incident, however narrative section on the triage form did include information on the patient's presenting mental health problem. • The Emergency Department was experiencing a high throughput of patients that day • The ED suffers from overheating and has a combination of restricted and unrestricted windows; the unrestricted windows open into an enclosed ground floor Courtyard area. • The Trust had assessed the risk of falls from poorly restricted windows (Risk Id 221) and that this risk was located on the Trust's risk register as a corporate Trust wide risk. • On the night of the incident the ward was experiencing high workload and was short an HCA • The current Trust's Procedure for the welfare and management of adult patients requires review and updating (Pathways for referral to PLS service and risk assessment tools for assessing the risk of self-harm) • Issues with the ward window restrictors had been reported and logged on the Estates task management system in February and March 2021, however the tasks had not been triaged, prioritised and allocated to a member of the team to check and repair as appropriate and remained on the system until June 2021. • As part of the process of review of Estates backlog tasks during June 2021, both tasks were deemed as no longer being required and therefore were removed from the helpdesk. **Immediate Safety Actions:** The following immediate actions were taken following the incident: 1. A full-site audit was undertaken by the Estates Maintenance team who established which areas required intervention regarding their window restrictors and all areas requiring attention were addressed. 2. Post this event, the process to manage both PPM and 'Defect' tasks was reviewed, clarified further and circulated to the team. All jobs put on the task management system in the preceding 24 hours are prioritised with team leader oversight. The team leader also undertakes a weekly review to check that jobs are triaged, prioritised and actioned correctly. 3. The Development Team have included window restrictor checks in the Clerk of Works duties when contractors hand an area back to the Trust; whilst this does not appear to have been the issue in Bay 2, this provides an additional assurance when handing an environment back to the service/ ward manager. 4. The ED Matron is progressing the work already started prior to this incident to review and update the initial ED mental health triage documentation on e-Care. 5. The Trust's Mental Health Procedure for the welfare and management of adult patients has been identified as being out of date and is currently under review. **Safety Recommendations:** Seven safety recommendations were developed that are being taken forward by the key leads for the subject areas. These are as follows: 1. Further improvements be made to content and documentation of the initial triage for patients presenting to the ED with a mental health problem. 2. The documentation of significant events in the ED, including post event monitoring of the patient, should be reflected in the patient's notes on e-Care and communicated via the handover process to the admitting ward team.

Incident details	Learning points, involvement of patient / family
	3. As part of the review of the Trust's Procedure for the welfare and management of adult patients with mental health problems, the pathways and timeliness of reviews by PLT are clarified and updated, especially for patients who present to the ED who are at high risk of self-harm. 4. In order to enable staff on the ward to assess the ongoing risk of self-harm/absconsion, a mental health risk assessment tool/toolkit be made available to staff via e-Care. 5. Implementation of the role of Building Officer in the Estates and Facilities Department who will have oversight of building-related compliance. 6. Development of an Estates local Standard Operating Procedure (SOP) for the management of window restrictors that includes the process for inspection and monitoring. 7. The Emergency Department undertakes a formal risk assessment of the likelihood of a vulnerable patient leaving the department through an unrestricted window, taking into account the risk of escape versus the risk of overheating in the department.

Table 2 - PSR reports.

Incident details	Learning
WSH-IR-68559 Alleged Assault	This incident was highlighted after a female patient made a formal complaint regarding an alleged sexual assault by a male patient while she was in the Emergency Department. The female patient was been in contact with the complaints team and the ED senior matron throughout the investigation and has received a copy of the investigation report. The main **findings** from the investigation were as follows: • Both female and male patient were in lower dependency cubicles awaiting review by the Psychiatric Liaison Service. These cubicles are partitioned by a wall and are open fronted with a curtain at the front for privacy. They provide limited observation access for staff members if patients are not continuously monitored. • The female patient had reported the incident to ED staff members at the time but it was not escalated to senior management. A staff member documented that this incident did not happen because the male patient was under constant observation, but this was incorrect. • The female patient had also reported the incident to Psychiatric Liaison staff during their review but it was not escalated to senior management. • Security and ED senior management were unaware of the incident until it was reported by the female patient in a formal complaint. Unfortunately this was after the 28-day CCTV retention period in line with GDPR, which meant the system had automatically deleted data from the day of the incident before it could be viewed. • The female patient reported the incident to the police approximately a week after it occurred. The police confirmed to the patient that they had telephoned ED reception and the Psychiatric Liaison Service. The police were reportedly informed that there was no male patient admitted for an assessment on the day of the incident. The ED reception team would not have had the IT access to provide this information to the police. This request was not escalated to ED senior management. **Safety Recommendations:** 1. All Emergency Department and specialist team staff must receive refresher training on the Safeguarding Adults at Risk of Abuse and Neglect PP(**)114 Policy, which includes the procedure of escalating incidents of alleged abuse to a member of senior management (i.e. Ward Manager/Matron/ Service Manager) or Trust Duty Manager (out of hours) for further action.

Incident details	Learning
	2. All confused and/or vulnerable patients that present to the Emergency Department must be assessed and monitored in line with Clinical Guidance: Observation of Patients: One to One CG10280-3 Section 2 and be guided by flow charts found in Appendix 1 and 2. 3. Trust senior staff must receive refresher training on Clinical Guidance: Observation of Patients: One to One CG10280-3. 4. Confused and/or vulnerable patients must remain within the main department and not placed in cubicles with limited observation access (15, 16, and 17) unless continuous monitoring can be put in place. 5. An environmental assessment should be undertaken of suitable areas for confused and/or vulnerable patients to be placed while in the department, which will produce a colour-coded floor plan risk map for staff awareness. 6. All Emergency Department staff must receive mental health refresher training, which must be under taken on an annual basis. This must also include reference to Trust Policy and Procedure for the welfare and management of adult patients with mental health problems (including both attempted or risk of suicide and/or deliberate self-harm) PP(**)361 7. Emergency Department reception staff to request police to provide requests for information in writing to unit manager and senior matron to provide an accurate response on behalf of the department. 8. Highlight inaccuracy of information provided to police by specialist team (part of Norfolk & Suffolk NHS Foundation Trust) regarding presence of male patient in the area at the time of the assault for reflection and action to improve process.
WSH-IR-71710 Overdose of morphine during spinal anaesthesia for an elective Caesarean section	This investigation was undertaken with involvement of the patient. The incident was also the subject of a Complaint. The main **findings** from the investigation were as follows: • The normal and preferred opiate that is used for obstetric spinal anaesthesia is diamorphine. There had been an ongoing national supply issue with the availability of diamorphine 5mg and 10mg resulting in the need to use an alternative opioid when diamorphine was not available. • Diamorphine was not available on the day of the planned procedure which meant that an alternative opioid, suitable for intrathecal use and preservative free, needed to be used. (Torbay and South Devon preparation morphine 1mg/ml). • Storage of morphine 10mg/ml and morphine 1mg/ml were stored in the same CD cupboard in theatre. • The morphine 1mg/ml ampoules do not stipulate on the ampoule that they are suitable for intrathecal use or are preservative free so other than the dose there were no immediate alerting or distinguishing features on the ampoule itself. • Lack of familiarity with alternatives to diamorphine at the time of the incident and supply issues with diamorphine had been intermittent problem. • Although the team checked the drug name, dose and expiry date, the process for checking and confirming that correct preparation of morphine was being used was not as robust as it could have been. **Immediate Safety Actions:** 1. Within a few hours of the incident the morphine 10mg/ml preparation was removed from the CD cupboard in theatre 5 and transferred to theatre 4 as it was identified that morphine 10mg/ml is rarely used in theatre 5, e.g. for general anaesthetic purposes. 2. More robust checking process implemented for the checking of opioids to include being specific regarding the morphine drug preparation required i.e. preservative free and suitable for intrathecal use. 3. Increased awareness of the issue and risks raised amongst anaesthetic, obstetric and theatre teams; issue discussed at theatre safety huddle. 4. Guideline was in place at the time of the incident that sets out the peri-operative management of patients receiving intrathecal morphine when diamorphine is unavailable. This is attached to the spinal trolley in theatre 5. A flowchart has also been developed by the Consultant Anaesthetist in the event of diamorphine unavailability and this is visible on the wall in theatre 5 above the spinal trolley.

Incident details	Learning
	Safety Recommendations: 1. Improved communication amongst the team at the time of requesting the drugs so that there is absolute clarity as to which preparation of morphine is required 2. Improvement in the process for checking the drugs prior to administration as part of the spinal procedure. As well as the drug name, concentration and expiry date the route should also be confirmed i.e. "*morphine 1mg/ml for intrathecal use"* 3. Continue to raise awareness amongst the multidisciplinary team of the supply issue with diamorphine and alternatives to its use in cases of lack of availability. Provide regular updates on the issue through existing communications channels including at huddles, in training sessions, local induction for new staff etc. 4. Ensure that shortages of diamorphine on the day are communicated through the huddles and team briefs. 5. Recirculate the Clinical Guideline "*Peri-operative management of patients receiving intrathecal morphine – when diamorphine is unavailable* " to the multidisciplinary team including anaesthetic, midwifery and theatre teams. 6. Timely completion of risk assessments for national drug supply issues to identify and mitigate against any potential risks.
WSH-IR-74717 Discharge and subsequent readmission of patient with deteriorating renal function	Verbal DoC undertaken at the time and opportunities to share the final report with the patient are being explored. **Findings:** • Patient keen to go home and looked and felt much better. However, had undergone significant surgeries and there was a chance condition may deteriorate following her discharge home. • The patient presented with symptoms of a recurrent cholangitis flare up on re-admission which were not present on the day of discharge and began to vomit with recurrent symptoms and this along with the sepsis would have contributed to the deterioration of renal function. • For patients who are discharged close to the weekend/over the weekend which clinicians have concerns about, there is nowhere for them to come in and be reviewed (due to Covid restrictions they cannot come to the ward and be seen). During the week they are able to be reviewed in SAU (Surgical Assessment Unit) however there is no surgical staffing option over the weekend. **Immediate Safety Action:** • (Patient's clinical care) Management and treatment of AKI and sepsis on readmission **Safety Recommendations** • Guidance surrounding AKI needs to be reviewed and shared with all clinical teams. Plan: AKI workstream group to revisit the AKI bundle • Plan to explore the possibility of using space in AEC for the surgical on call team to review patients of concern over the weekend.

10.30 am - Comfort Break - 10 minutes

3. FIRST FOR STAFF - CULTURE

3.1. Involvement Committee Report - November 2021

To Assure

Presented by Alan Rose

Chair's Key Issues

Part A

Originating Committee	**Involvement Committee**	**Date of Meeting**	**15 November 2021**
Chaired by	**Alan Rose**	**Lead Executive Director**	**Jeremy Over**

Item	**Details of Issue**	**For: Approval/ Escalation/Assurance**	**BAF/ Risk Register ref**	**Paper attached? ✓**
Introduction	We have attempted here to adapt the style of the Chair's Key Issues, to better reflect our purpose, which is establish the level of assurance we believe is in place for Board members as a whole on the involvement and engagement we have with our workforce, patients and system partners.	Approval.		
Governors	We welcomed the attendance of the Chair of the Governors' Member Engagement Committee (Florence Bevan), as part of enrichening our involvement with Governors and the communities we serve; also strengthening our assurance that the governor role at WSFT is involving and engaging others in order to provide effective representation.	Approval.		
Involvement Toolkit	Embedding of the fundamental principle to "involve" as part of a broader change management toolkit/methodology for the Trust.	Approval; to be developed.	BAF Risk 9	
CQC Annual Patient Experience Survey	The data is from quite a large sample and methodology robust. No very weak areas, but scope for WSFT to improve further across a large majority of measures which are rated "about the same" as other Trusts. "Keeping in Touch" service is a pocket of excellence. The Committee sought and received assurance that wards and departments are learning from the feedback and acting accordingly to make improvements, led and overseen by the "Patient Experience of Care Group". Team asked to ensure non-Ward areas such as Hospitality and Estates are involved in these actions. However, we feel ambitions should be raised where action is feasible and where it fits with our values and strategy.	Assurance – but asking the team: a) to identify a number of the (45) measures where we should be aspiring to excel. b) to gather more diversity of patient		

Originating Committee	Involvement Committee	Date of Meeting	15 November 2021
Chaired by	Alan Rose	Lead Executive Director	Jeremy Over

Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref	Paper attached? ✓
		inputs (survey is 98% "White").		
Equality, Diversity & Inclusion	Excellent data and analysis available and significant work progressing in this area; Some staff networks in place; discussion of Board/senior management composition and the workforce in general. Many actions underway as part of the People Plan and more focus on these issues than in the past. However, Board composition does not reflect the diversity of the wider workforce: gender, disability, ethnicity. Reiteration of the belief that appropriate diversity of thinking will improve decision-making and workforce engagement. Discussion of how best to take positive action. Disproportionate impact of bullying and harassment still an unresolved issue for those of protected characteristics – with further actions required to address.	Partial Assurance, but strong challenge escalated (to Board and Governors) to address Board and senior management (A4C 7-8-9) diversity through recruitment processes and leadership development.	BAF Risk 9	17/12/21 Board Paper
Freedom to Speak Up	Committee reviewed an updated version of the Board Freedom to Speak Up self-assessment toolkit. Discussion of progress on building a cadre of Freedom to Speak Up Champions across the workforce (53 nominations thus far). Training continues. Noted a specific need to attract more individuals into this Speak Up guardian-led service from across our medical workforce.	Partial Assurance, but Board asked to keep high level of openness on this topic and maximise learnings from Rapid Review.	BAF Risk 9	
Upcoming Meetings	Focus will be on involvement in the "Future System" and progress with the wide-ranging "People Plan"; The Committee is open to referrals of potential topics for us to consider assurance on. Post-meeting, Governors have asked for clarity on the network of specialty-specific patient support groups and how these fit with "VOICE" and other parts of the patient engagement processes.	Approval and invitation.		

Originating Committee		Involvement Committee	Date of Meeting		15 November 2021	
Chaired by		Alan Rose	Lead Executive Director		Jeremy Over	
Item	Details of Issue		For: Approval/ Escalation/Assurance	BAF/ Risk Register ref	Paper attached? ✓	
Date Completed and Forwarded to Trust Secretary			3 December 2021			

Part B

Receiving Committee		Board of Directors	Date of Meeting	17 December 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				

3.2. People & OD highlight report

To Assure

Presented by Jeremy Over

Board of Directors – 17 December 2021

Report Title:	Item 3.2 - People & OD Highlight Report
Executive Lead:	Jeremy Over, Executive Director of Workforce & Communications
Report Prepared by:	Members of the Workforce & Communications directorate
Previously Considered by:	N/A

For Approval	For Assurance	For Discussion	For Information
☐	☒	☐	☐

Executive Summary
Supplementary to the report arising from the November meeting of the Involvement Committee, the People & OD highlight report this month provides the Board with: • Notification and appreciation of our November Putting You First Award winner • An update on vaccination as a condition of redeployment (mandatory vaccination) • An update on recent Consultant appointments
Action Required of the Board
For discussion

Risk and assurance:	Research demonstrates that staff that feel more supported will provide better, higher quality and safer care for our patients.
Equality, Diversity and Inclusion:	The work described around mandatory vaccination will include an assessment of the impact on minority groups and by protected characteristic.
Sustainability:	N/A
Legal and regulatory context	Certain themes within the scope of this report may relate to legislation such as the Equality Act, and regulations such as freedom to speak up / protected disclosures.

Putting You First – November award

Prince Rowland Gregory, registered nurse
Nominated by Carry Beecroft on behalf of the diabetes inpatient nursing team

Prince Rowland Gregory independently and on his own initiative produced some amazing diabetes related artwork to display within the G3 ward area.

Nationally and internationally the percentage of people with all types of diabetes is increasing. The latest national inpatient diabetes audit (NaDiA) data found 1 in 5 inpatients had diabetes at the West Suffolk Hospital.

On G3, the WSH diabetes base ward, Prince's visual creativity depicts the way a patient with diabetes may be feeling when they have altered blood sugar levels. This innovative work has been shared and admired by his peers, ward patients and those visiting the diabetes ward. They are inspirational and captivating and have triggered conversations and raised the profile that this co-morbidity can lead to undesirable symptoms which are emphasised in the graphics.

As a diabetes inpatient nursing team, we would like to recognise Prince for his admirable achievement and taken that extra mile to contribute to diabetes awareness.

Vaccination as a condition of deployment (VCoD) – mandatory staff vaccination within healthcare settings in England

The Department of Health and Social Care (DHSC) has formally announced (9 November) that individuals undertaking CQC regulated activities in England must be fully vaccinated against COVID-19 no later than 1 April 2022 to protect patients, regardless of their employer, including secondary and primary care.

The government regulations are expected to come into effect from 1 April 2022, subject to parliamentary process. This means that unvaccinated individuals will need to have had their first dose by 3 February 2022, in order to have received their second dose by the 1 April 2022 deadline.

In recent days detailed implementation guidance has been issued which defines the scope of the requirement as follows:

"Workers who have face-to-face contact with patients and/or service users and who are deployed as part of CQC regulated activity."

We welcome the clarity provided the recently-issued guidance and have formed a multi-disciplinary implementation group. Whilst we have a high vaccination rate at West Suffolk there will be a small number of staff who have not yet taken up the vaccination. Furthermore the scope of the guidance ("workers") means that others – agency staff, students, volunteers for example), are also in scope.

We have started sharing what we know through staff briefings and will continue to do so, acknowledging the support that staff and managers will need in order to implement this with care across our organisation. Timescales are challenging, and there is a risk that this requirement will impact on staff availability, recruitment and retention.

Recent Consultant Appointments

Post: Consultant Colorectal and General Surgeon
Interview: 5 October 2021
Appointee: Mr Thomas Athisayarai
Start date: 6 October 2021

Current post: Fixed-term Consultant Surgeon: West Suffolk NHS FT
May 2020 to present

Previous Position:
July 2019 – May 2020
Trust Consultant General and Colorectal Surgery: West Suffolk NHS FT

Post: Consultant in Public Health Medicine
Interview: 18 November 2021
Appointee: Dr Anne Swift
Start date: 1 March 2022

Current post: Fixed-term Consultant in PH Medicine: West Suffolk NHS FT
December 2020 to present

Previous Position:
January 2016 to present
Director of Public Health teaching, University of Cambridge Clinical School

Post: Consultant in Intensive Care Medicine and Emergency Medicine
Interview: 2 December 2021
Appointee: Dr William Dean
Start date: 3 December 2021

Current post: Fixed-term Consultant Emergency Medicine and Intensive Care
West Suffolk NHS FT – September 2021 to present

Previous Position:
May 2021 – September 2021
Senior Clinical Fellow John Farnham Intensive Care, Cambridge University Hospitals

Post: Consultant in Neurology
Interview: 7 December 2021
Appointee: Dr Alexandre Costa
Start date: 8 December 2021

Current post: Fixed-term Consultant in Neurology: West Suffolk NHS FT
September 2021 to present

Previous Position:
April 2020 – August 2021
Fixed Term Consultant Stroke Medicine, Royal Derby Hospital

Post: Consultant in Neurology
Interview: 7 December 2021
Appointee: Dr Alexandre Costa
Start date: 8 December 2021

Current post: Fixed-term Consultant in Neurology: West Suffolk NHS FT
September 2021 to present

Previous Position:
April 2020 – August 2021
Fixed Term Consultant Stroke Medicine, Royal Derby Hospital

3.3. Medical revalidation annual report

To Note

Presented by Paul Molyneux

Trust Open Board meeting – 17 December 2021

Agenda item:	3.3			
Presented by:	Dr Katherine Rowe			
Prepared by:	Dr Katherine Rowe, Lorna Watson			
Date prepared:	December 2021			
Subject:	Appraisal and Revalidation update			
Purpose:	X	For information		For approval

Executive summary:

The previous appraisal and revalidation board report (25 June 2021) demonstrated a high level of incomplete and/or missed appraisals at West Suffolk Hospital for the appraisal year 20/21. A deep dive by the appraisal team demonstrated that data was entered incorrectly into the appraisal allocate software since its initial implementation at West Suffolk Hospital. This resulted in inaccurate reporting outputs. The data has since been corrected and demonstrated that there were a low number of incomplete and/or missed appraisals.

The 21/22 appraisal and revalidation developmental plan is underway, with some delays incurred due to the increased workload required to cleanse the allocate system from data errors and the increased number of revalidations in this appraisal year required due to cancellations by the GMC in the 2020/21 appraisal year.

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

Previously considered by:	*N/A*
Risk and assurance:	*N/A*
Legislation, regulatory, equality, diversity and dignity implications	*N/A*

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

1. Update on High Category 3 Appraisals (Incomplete and/or Missed) for 20/21 Appraisal Year

The previous appraisal and revalidation board report (25 June 2021) demonstrated a high level of incomplete and/or missed appraisals at West Suffolk Hospital (figure 1).

Figure 1. AO report presented to board June 2021

AO report

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

Figure 1 demonstrates that 219/475 appraisals were unapproved, incomplete, or missed (category 3) during the appraisal year 2019/2020. The category 3 rate was noted to be unusually high.

Following this, the appraisal team have completed a deep dive into the allocate system to confirm or refute these numbers.

Figure 2 demonstrates the figures confirmed by the appraisal team within the new template implemented by NHS England in July 2021.

Figure 2. Updated Appraisal Figures

Name of organisation:	West Suffolk Hospital
Total number of doctors with a prescribed connection as at 31 March 2021	319
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	111
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	23
Total number of agreed exceptions	185

Figure 2 demonstrates that 23 appraisals represent the previous unapproved, missed or incomplete appraisals (category 3). This large reduction is due to the following problems recognised with the inputting of data within the software:

1) Inaccurate inputting of data relating to appraisal status of doctors new to West Suffolk Hospital by individuals external to the appraisal team, with the default being recorded as missed.
2) Doctors being included incorrectly in the 2020/21 appraisal period when they had left WSH or because they were not due an appraisal within that period. These were recorded as missed appraisals by default.
3) Appraisal meeting dates changed from within the 2020/21 appraisal period and moved to within 2021/22 appraisal period to accommodate either appraisee or appraiser illness due to Covid-19. These should have been recorded as approved missed appraisals but were recorded as missed appraisals by default.
4) Appraisals due January-March 2020 (i.e., 2019/20 appraisal period) were delayed due to Covid-19. These appraisals were undertaken during the 2020/21 appraisal period but often not until after September 2020 when appraisals were restarted. 2020/21 appraisal should have been recorded as approved missed but were recorded as missed appraisals by default.
5) Many new doctors started at WSH in August 2020, their appraisal due dates were not set until after April 2021, but they appeared in the 2020/21 data as missed unapproved appraisals.

All of the above led to error in the data outputs of the software analytics function. The information has since been corrected by the appraisal team.

2. Progress Against 21/22 Development Plans

Development Plan	Update
1. Weekly review of overdue/missed appraisals	Not completed
2. Appraisal quality review	Not completed – to be actioned in Q4
3. Appraiser feedback from appraisees	Not completed – to be actioned in Q4
4. Formalised appraiser feedback	To be actioned following completion of tasks 3 and 4
5. Update Medical appraisal policy	Not completed – to be actioned in Q4
6. Update revalidation support group to ensure greater diversity	Completed, new members appointed
7. Turn on automated reminders via allocate	Completed
8. Ensuring AHP's are supported within appraisal and revalidation	Ongoing, allocate accounts set up, 1st appraisal completed
9. Increase training for appraisal	Training sessions ongoing

3. Other developments

1. Appraiser training initiated
2. 6 new appraisers appointed
3. Departmental budget concerns over appraiser funding

4. Identified hindrance to completion of development plans

The deep dive into the high category 3 rates resulted in an enormous time burden upon the appraisal team, however on the plus side this resulted in a greater understanding of the appraisal software and the importance of oversight into data entry, which was not apparent before the deep dive was conducted.

The national cancellation of appraisal and revalidations in 2020 and a more robust revalidation support group, has resulted in additional number of revalidations and an increased deferral rate. The latter has been addressed by increased appraisal and appraiser training.

3.4. Guardian of safe working report

To Assure

Presented by Paul Molyneux

Trust Board – 17 December 2021

Agenda item:	3.4			
Presented by:	Paul Molyneux, Medical Director			
Prepared by:	Francesca Crawley, Guardian of Safe Working			
Date prepared:	October 2021			
Subject:	Safe Staffing Guardian Report – Quarterly Report July – September 2020			
Purpose:	x	For information		For approval

Executive summary:

The report is compiled by the Guardian of Safe Working Hours (GOSW), a role appointed as part of the new contract. The purpose of the report is to provide evidence of safe rostering and compliance with the TCS, to highlight any difficulties which have arisen, and to explain how they are being addressed.

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

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

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

Recommendation: For the board to endorse the quarterly report

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QUARTERLY REPORT ON SAFE WORKING HOURS

DOCTORS AND DENTISTS IN TRAINING

1st July 2021 – 30th September 2021 Executive Summary

Introduction

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

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

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

Summary data

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

1. Exception reporting: 1st July – 30th September 2021

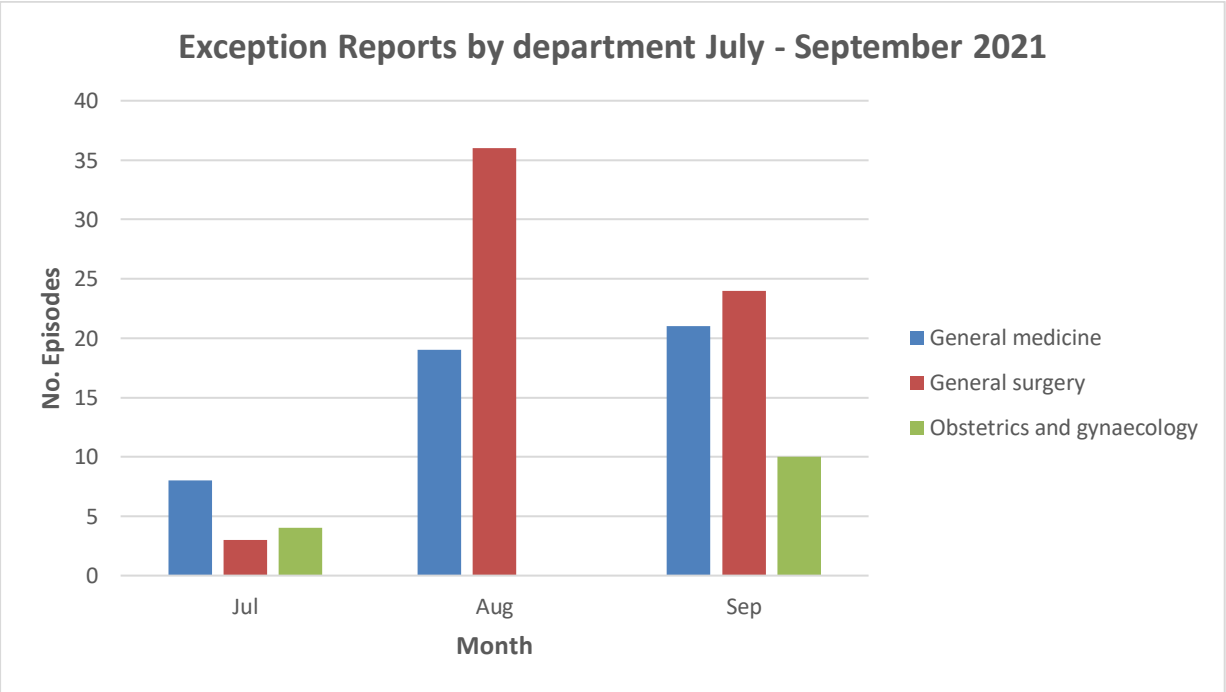
a) Exception reports (with regard to working hours)

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

the contractual obligation is also required. Details are sent to the Guardian and Clinical /Educational Supervisor.

Exception Reports by EXCEPTION TYPE						
Department	Grade	Pattern of Hours worked	Educational Opportunities or available Support	Support available during Service Commitments	Hours of Work	Total overtime hours claimed
Medicine	F1				27	43.25
	F2			1	8	14.25
	ST/CT		1	1	10	13.25
Surgery	F1				36	39.5
	F2				27	36.25
Women & Children	F2				1	1.5
	ST 1 - 7				13	8.5
Total			1	2	122	156.5

Exceptions reports by month and department



ER are likely to have risen a little across these three months as we moved out of the pandemic and in patient work has become busier and more varied/complex. The rise also reflects new doctors starting in August.

b) Work schedule reviews for period 1st July 2021 – 30th September 2021

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

No work schedule review requests were received during this period.

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

2) Immediate Safety Concerns: 1st July 2021 – 30th September 2021

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

There have been 2 ISCs raised in this period. One related to inadequate doctors covering the out of hours medicine and I have discussed this with the trainee involved and the service manager. A second related to OOH in obstetrics and gynaecology. WSFT is unusual in only having one junior on OOH. The ER related to the workload one night. The ER and the OOH cover is being discussed within the department, and I will raise this at the next GOSW/JDF meeting.

3) Locum Bookings: 1st July 2021 – 30th September 2021

TABLE 1: Shifts requested between 1st July 2021 – 30th September 2021 by 'reason requested'

Department	Maintain Minimum Numbers, Additional Beds/Clinics, Rota Compliance, Shadow Shift and Induction Cover	Leave (Annual, Carers, Maternity, Paternity, Study, Unpaid)	Sickness and Reduced Duties	Extra	COVID-19 Additional Dependency	COVID-19 Self-Isolation	Vacancy	Grand Total
Anaesthetics	16	1	8			2	13	**40**
Emergency Medicine	13	116	17	47			283	**476**
ENT	3		1					**4**
General Medicine	14	34	59	30		13	38	**188**
General Surgery	45	10	49	4		6		**114**
Obs & Gynae	11	3	17	1		1	5	**38**
Ophthalmology		6	2				2	**10**
Paediatrics	7		13	1		8	18	**47**
T&O	2	4	2				51	**59**
Theatre/Outpatients Schedule				9				**9**

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

Filled by NHS / Agency		
Department	**NHS**	**Agency**
Anaesthetics	40	
Emergency Medicine	376	100
ENT	4	
General Medicine	188	
General Surgery	114	
Obs & Gynae	38	
Ophthalmology	10	
Paediatrics	47	
T&O	42	17
Theatre/Outpatients Schedule	9	
Grand Total	**868**	**117**

4) Vacancies – 1st July 2021 – 30th September 2021

Department	Grade	July	August	September
Emergency Dept	ST3+	4.5	3.5	1.5
Emergency Dept	F2	0	1	1
Anaesthetics	Specialty Doctor	3	3	3
Anaesthetics	ST3+	0.4	0	0.2
Anaesthetics	CT1 – 2	0	1.25	1.25
ENT	ST1 - 2	0	0.2	0.2
Medicine	ST1 – 2	0	1	1
Medicine	ST3+	1.2	2	2
O&G	ST3+	2	0	0
O&G	ST1 – 2	0	0.4	0.4
T&O	ST3+	0	2	1
Paediatrics	ST1 – 3	1.4	1.4	0.5
Total		**12.5**	**15.75**	**12.05**

5) Fines – 1st July 2021 – 30th September 2021

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

- a breach of the 48-hour average working week across the reference period agreed for that placement in the work schedule
- a breach in the maximum 72-hour limit in any seven days

- the minimum 11 hours rest requirement between shifts has been reduced to fewer than 8 hours.

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

Matters Arising

- The new mess has opened. On behalf of all the juniors, I would like to thank the senior leadership team at the trust for their support for this.

- There is ongoing difficulty covering the out of hours rota. The rota coordinators are doing a very good job trying to cover these shifts, but this is not always successful.

- The surgical division has recruited extra juniors to support the out of hours cover. These doctors will start in December 2021. There is a regular survey looking at OOH support in surgery, which I continue to monitor. OOH cover in surgery remains on the risk register.

- ER has risen significantly in obstetrics and gynaecology, including one immediate safety concern (see above). The ER relate to OOH cover. The department is preparing a business case for more doctors to support the OOH rota.

- Supported Development time has been challenging as medical staffing and rota coordinators were not informed of various changes to this. We will discuss this at the GOSW/JFD meeting later this month and work with the relevant teams to rectify this.

- The national training survey has shown that WSFT is a red outlier for three areas (anaesthetics, geriatrics and surgery in foundation). The various clinical leads and college tutors have submitted improvement plans to HEE which the trust now needs to implement.

4. FIRST FOR THE FUTURE - STRATEGY

4.1. The Green Plan

To Approve

Presented by Craig Black

Trust Board – 17 December 2021

Agenda item:	4.1			
Presented by:	Chris Todd, Associate Director of Estates and Facilities			
Prepared by:	Clare Farrant, Travel and Sustainability Manager			
Date prepared:	October 2021			
Subject:	Green Plan			
Purpose:		For information	X	For approval

Executive summary:
To approve the Green Plan which replaces the Trust Board approved Sustainable Development Management Plan.

The Green Plan follows the latest guidance and includes requirements set out on the NHS Standard Contract and in the Delivering a Net Zero National Health Service document.

A Trust Board approved Green Plan must be submitted to the ICS by 14 January 2022

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

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

Previously considered by:	10 November 2021 – Scrutiny Committee Net Zero Steering Group, previously the Sustainable Development Steering Group
Risk and assurance:	
Legislation, regulatory, equality, diversity and dignity implications	2021/2022 NHS Standard Contract Delivering a Net Zero National Health October 2020 2021/22 NHS planning guidance

Recommendation:
Approve the Green Plan prior to submission to the December Trust Board meeting for final approval.

Putting you first

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Sustainability

Green Plan 2021- 2025

Putting you first

Contents

Foreword 3

Introduction 4

Drivers for change 5

What is sustainability? 6

Focus areas:

Workforce and system leadership 8
Sustainable models of care 10
Digital transformation 11
Travel and transport 12
Estates and facilities 14
Medicines 17
Supply chain and procurement 19
Food and nutrition 22
Adaptation 24

Foreword

Unchecked, West Suffolk NHS FT has the potential to cause harm to people's health and to our environment, even as we go about our business of helping people get better.

The NHS is one of the largest employers and users of resources in the world, and as such it has an environmental and social impact which, if unsupervised, can do a lot of damage. It is no exaggeration that climate change has been named the biggest global health threat of the 21st century. Even in west Suffolk, the way the Trust operates can have a negative effect, by contributing to air pollution, landfill, traffic danger and so on.

But let's turns this on its head: the preventative power that operating with attention to our environmental and social footprint offers is enormous. By buying food and other supplies close to home, we support the local economy. Our student volunteer programme, clinical shadowing and work experience programmes will restart in 2022, following a pause during the height of the pandemic. Through these programmes and our comprehensive apprenticeship and training programmes we improve the work and training prospects of young people and of our existing staff. By encouraging people to travel to our sites on foot, by bike or by public transport, we help them enjoy the massive benefits physical activity brings. In all these ways and more, we can have a positive impact on the wider determinants of health throughout our local, national and international communities. And as if that wasn't enough, it can also save the Trust money - meaning we can continue to invest every available penny in patient care.

A truly sustainable health system is defined as working within available resources, to protect and improve health, now and for future generations. We believe that description is not just compatible with the Trust's ambitions – **first for our patients, first for our staff and first for the future** – but that it underpins them.

This plan describes the action we will take. It will evolve over time as we achieve our goals and set ourselves even more ambitious targets.

We are committed to playing a leading role in securing a healthy and sustainable Suffolk.

Sheila Childerhouse, chair
Craig Black, acting chief executive officer
November 2021

Costello A et al. Managing the health effects of climate change. 2009 Lancet Commission on Health and Climate Change. Lancet. 2009; 373: 1693-73
Watts N et al. Health and climate change: policy responses to protect public health. 2015 Lancet Commission on Health and Climate Change. Lancet. 2015; 386: 1861-1914
The Sustainable Development Strategy for the NHS, Public Health and Social Care system 2014-2020.

Introduction

The West Suffolk NHS Foundation Trust (WSFT) provides hospital and some community healthcare services to people mainly in the west of Suffolk, and is an associate teaching hospital of the University of Cambridge.

The Trust serves a predominantly rural geographical area of roughly 600 square miles with a population of around 280,000. The main catchment area for the Trust extends to Thetford in the north, Sudbury in the south, Newmarket to the west and Stowmarket to the east. Whilst mainly serving the population of Suffolk, WSFT also provides care for parts of the neighbouring counties of Essex, Cambridgeshire and Norfolk.

As part of this we provide community services in the west of Suffolk, but also some specialist community services across the county. This includes the delivery of care in a variety of settings including people's own homes, care homes, community hospital inpatient units and clinics, day centres, schools, GP surgeries and health centres.

The Trust one of the largest employers in Suffolk, employing nearly 5,000 staff.

Our vision is to deliver the best quality and safest care for our community.

Our sustainable development mission statement is:

"West Suffolk NHS Foundation Trust will distinguish itself by making sustainability a part of all we do. In partnership with patients, staff and the local community, our plan captures the social, environmental and economic impact of our actions."

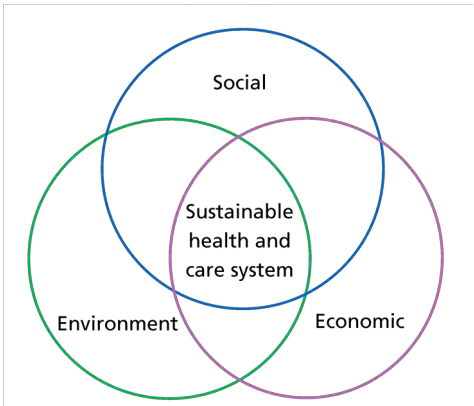
Drivers for change

- Legislative requirements
  - ⇒ Climate Change Act 2008
  - ⇒ Public Services (Social Values) Act 2012
  - ⇒ The Paris Agreement 2016
- Mandatory requirements
  - ⇒ Standard form contract requirements
- International guidance
- UK guidance

- Health specific requirements
  - ⇒ Delivering a net zero National Health Service
- Staff and public perception and expectation
  - ⇒ Raised expectations and social pressure linked to the Blue Planet documentaries
- COP26.

What is sustainability?

"Sustainable development is development that meets the needs of the present without compromising the ability of future generations to meet their own needs."
Brundtland Report 1987



The Climate Change Act (2008) gives the Government power to introduce measures to achieve carbon reduction and mitigate and adapt to climate change. It sets out legally binding targets to reduce Co2 emissions by at least 100% by 2050 against a 1990 baseline. All public sector organisations are required to develop and implement a plan to meet these targets.

"The NHS is committed to providing best value for taxpayers' money - it is committed to providing the most effective, fair and sustainable use of finite resources. Public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves."
NHS Constitution commitment no.6

For a Greener NHS was launched in January 2020 to build on the great work being done by trusts across the country, sharing ideas on how to reduce the impact on public health and the environment, save money and – eventually – go net carbon zero. **https://www.england.nhs.uk/greenernhs/**

The NHS has already significantly reduced carbon emissions, but through the 'For a Greener NHS' programme action will be accelerated.

Two clear and feasible targets emerge for the NHS net zero commitment, based on the scale of the challenge posed by climate change, current knowledge, and the interventions and assumptions that underpin this analysis:

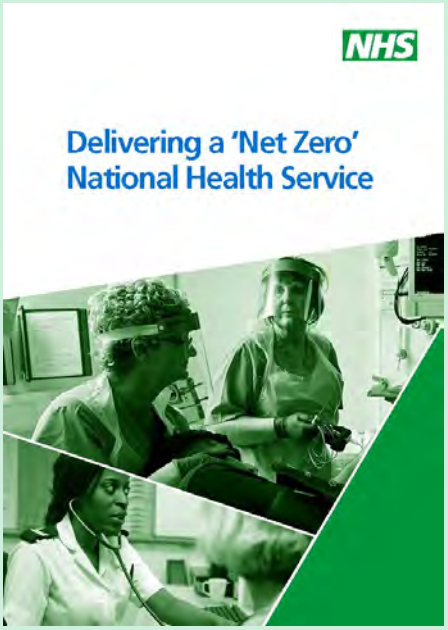
- for the **emissions we control directly** (the NHS Carbon Footprint), **net zero by 2040**, with an ambition to reach an 80% reduction by 2028 to 2032 from a 1990 baseline, equivalent to a 47% reduction from a 2019 baseline
- for the **emissions we can influence** (our NHS Carbon Footprint Plus), **net zero by 2045**, with an ambition to reach an 80% reduction by 2036 to 2039 from a 1990 baseline, equivalent to a 73% reduction from a 2019 baseline.

(Delivering a 'Net Zero' National Health Service October 2020)

Delivering a 'Net Zero' National Health Service (October 2020)

This report provides a detailed account of the NHS' modelling and analytics underpinning the latest NHS carbon footprint trajectories to net zero and the interventions required to achieve that ambition. It lays out the direction, scale and pace of change. It describes an iterative and adaptive approach which will periodically review progress and aims to increase the level of ambition over time.

https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2020/10/delivering-a-net-zero-national-health-service.pdf



The following interventions should be considered as a minimum that the Trust will have ensured by the end of 2021/2022:

2021/22 NHS Standard Contract

1. Every trust to ensure a board member is responsible for their net zero targets and their Green Plan. Similarly, every integrated care system (ICS) is asked to designate a board-level lead to oversee the development of their own Green Plan.
2. Every trust to purchase 100% renewable energy from April 2021, with supply contracts changing as soon as possible.
3. Every trust to reduce its use of Desflurane in surgery to less than 10% of its total volatile anaesthetic gas use, by volume.
4. Every ICS to develop plans for clinically-appropriate prescribing of lower carbon inhalers.

Delivering a Net Zero National Health Service

5. Ensure that, for new purchases and lease arrangements, systems and trusts solely purchase and lease cars that are ultra-low emissions vehicles (ULEVs) or zero emissions vehicles (ZEVs).
6. Develop a green travel plan to support active travel and public transport for staff, patients and visitors.

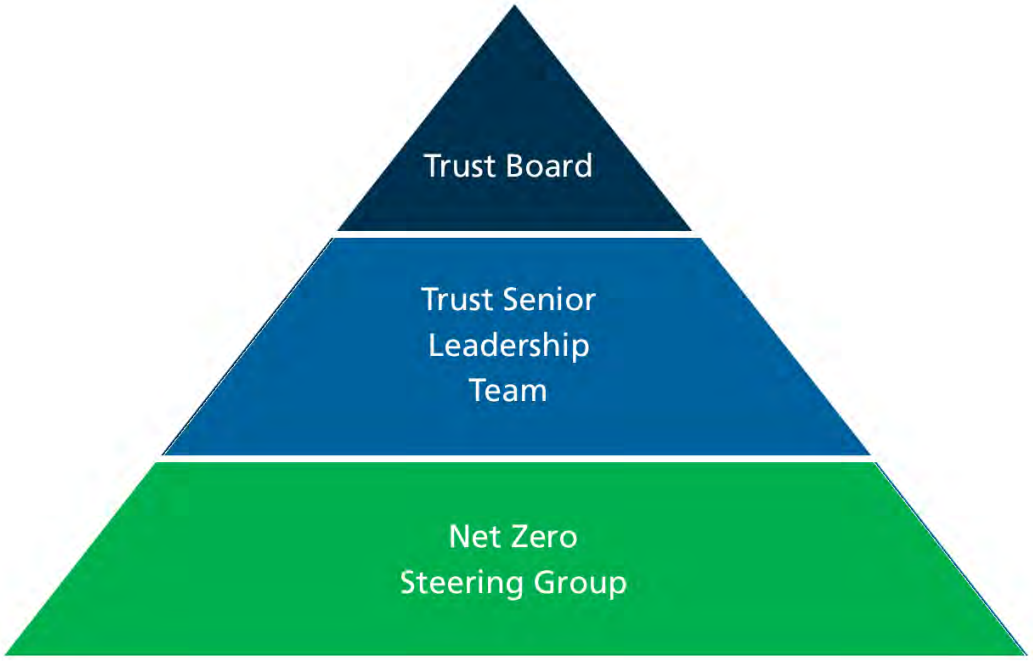
2021/22 NHS planning guidance

7. Where outpatient attendances are clinically necessary, at least 25% of outpatient activity should be delivered remotely, resulting in direct and tangible carbon reductions.

Workforce and system leadership

Leadership and governance

The Net Zero Steering Group (NZSG) is made up of representatives from across the Trust. It is responsible to the Trust Board through the Trust Senior Leadership Team for the delivery of plans designed to reduce the carbon footprint of the Trust to meet nationally set targets.



Co2e emissions across all utilities, water and waste streams are recorded and provide public disclosure of performance via the Department of Health in the Estates Returns Information Collection (ERIC). Energy consumption and CO2e emissions are benchmarked using ERIC data.

Progress towards completing Green Plan actions will be reported at the quarterly NZSG meetings and in the annual Sustainability Report. NHS data collections will be submitted quarterly or as appropriate.

NZSG membership

- Executive director of resources and deputy chief executive
- Deputy chief operating officer
- Associate director of estates and facilities
- Business analyst (finance)
- Head of procurement
- Catering and community facilities manager
- Deputy chief nurse
- Communications manager
- Travel and sustainability manager
- Estates energy and waste officer
- Emergency planning and resilience manager
- Capital projects manager
- Chief pharmacist.

Focus areas

The Trust is one of the largest employers in west Suffolk, employing nearly 5,000 staff. Developing the knowledge and expertise of our workforce around sustainable development is key to meeting the Trust net zero ambitions, which will benefit staff, patients and the wider community as well as the local environment.

FutureNHS Collaboration Platform

Trust staff involved with delivering net zero outcomes are encouraged to join the sustainability workspace on the FutureNHS Collaboration Platform and to access resources provided by the Greener NHS Team.

Pre-Covid the communications plan included monthly articles relating to progress in each section of the sustainable development management plan in the Green Zone section of the weekly staff newsletter. Communicating the details of the Green Plan with staff is essential to ensuring that actions and ambitions are realised. Communications from the national Greener NHS Team can also be shared in the Green Zone.

The Trust is part of the Integrated Care System (ICS) Sustainability Group, working with other NHS organisations to develop a regional plan and to share good practice.

The Trust continues to work with the East of England Regional Sustainability Network. The focus of the regional workstreams in 2021 are:

- Reducing plastics - working with Axion Ltd and PA Consulting on a project to identify the top 200 items used in hospitals and to identify ways that the waste associated with them can be reduced, and value retained and returned to the manufacturing supply chain
- Developing a carbon literate workforce - working with the Carbon Literacy Project to support them to develop training. This will be available free of charge to all public healthcare organisations.

The Trusts is also represented at:

- NHSEI exemplar catering group
- HEFMA
- Energy managers group
- National Performance Advisory Group (NPAG) waste management group
- NPAG car parking and sustainable transport network.

Membership of these groups allows the Trust to share and learn from examples of good practice across the NHS.

Focus areas

West Suffolk NHS Foundation Trust is a key **Anchor Institution** within the local community. Anchor Institutions refer to 'large, typically non-profit, public sector organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. Anchors get their name because they are unlikely to relocate, given their connection to the local population, and have a significant influence on the health and wellbeing of communities.' (1) The priorities outlined in this Green Plan strongly align to the key principles of Anchor Institutions, particularly those focusing on promoting environmental, economic and social sustainability.

(1) The NHS as an Anchor Institution. The Health Foundation. 2019. Available at:
https://www.health.org.uk/news-and-comment/charts-and-infographics/the-nhs-as-an-anchor-institution

Sustainable models of care

Sustainable models of community care are a focus for the range of community specialities within WSFT. Staff are currently planning or implementing a range of interventions which include :-

Implementation of a patient scheduling tool within community visit allocation. This software details patient geography and factors the most efficient route for staff travel. This negates the need for excess mileage covered. The tool also prevents duplication of visits and excess mileage so a sustainable approach can be a factor within the thousands of community visits completed yearly. We anticipate this will have a significant impact on the reduction of the teams carbon footprint moving forward.

Clinical staff can commence their journey to the patient home from their home address. This further reduces the office footprint. All community space employs a hotdesking approach which allows community teams to reduce their office environment floor capacity requirements with the subsequent environmental benefit.

Usage of digital technology has also been driven forward during the covid period. Team meeting and support are widely utilising this technology in community settings. This reduces the need to utilise transport in multiple situations.

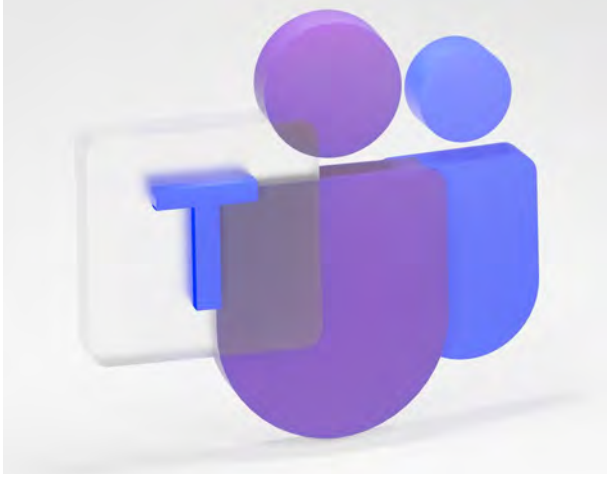
Patient Digital outreach into care homes and private homes is also implemented where possible and viable, again reducing teams footprint and enhancing sustainability.

Utilisation of medical supplies has also been a focus area with a focus on waste reduction. Agreed stock level checks are maintained at base and within patient homes to ensure excess stocks(dressings etc) are not held and potential for waste increased.

Digital transformation

The Trust is committed to aligning its digital programme to the green agenda and in particular supporting net zero ambitions. The understanding of exactly how much impact digital opportunities can have is developing and we are learning from national programmes and initiatives. Some examples of work that are already in train and how they support the net zero ambitions are given below. The digital team commits to working to the ethos of always considering the green impact of any digital initiatives and therefore we expect this list to expand as we move forward and as our learning and understanding of the opportunity matures.

- Move to low power thin client devices running a virtualised desktop will reduce overall power consumption
- Introduction of more cloud services where services are hosted off site in highly efficient and optimised data centres (Aiming for more than just net zero | Azure blog and updates | Microsoft Azure)
- Looking to reduce our carbon footprint through use of technologies that will mean the patient can be seen and/or monitored remotely. This will include telehealth, virtual consultations and continued implementation of Microsoft products (such as MS Teams) to support staff to work remotely and to avoid travelling to face-to-face meetings.
- Using technologies to support people's (patients and staff) health and wellbeing which in turn will support them to remain well and require fewer health services. These technologies will include educational programmes, patient portals and apps.
- As part of procurement, seeking assurance from providers on their sustainability approach.



Travel and transport

The Trust is committed to reducing the impacts of our travel and transport. We can improve local air quality and improve the health of our community by promoting active travel – to our staff and to the patients and public that use our services.

Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO2e) reductions. We support a culture for active travel to improve staff wellbeing and reduce sickness. Air pollution, accidents and noise all cause health problems for our local population, patients, staff and visitors and are caused by cars, as well as other forms of transport.

Travel Expenses Policy PP(19)367

http://staff.wsha.local/CMSdocuments/TrustPolicies/PDFs/351-400/PP(19)367-Travel-Expenses-Policy-v4-(2).pdf.

The Travel Plan is reviewed annually and the Trust encourages staff to take part in the annual Suffolk Travel Survey by publishing links and information in staff communications.

2021-2022 Trust lease vehicles

Ensure that, for new purchases and lease arrangements, the Trust solely purchases and leases cars that are ultra-low emissions vehicles (ULEVs) or zero emissions vehicles (ZEVs). There are 67 Trust lease pool vehicles which will be replaced with ULEVs or ZEVs over the next four years as they become due for renewal.

No idling

From April 2021 we will include a no engine idling requirement on patient transport contracts, including taxis and ambulances.

Taxi services contract August 2021 - July 2024: No Idling Policy

The incumbent contractor has a fleet of 76 cars, 64 private vehicles, 12 Hackney licensed cars and 25 specialist wheelchair cars. Of these, 20 vehicles are equipped with a manufacturer's anti-idling function, including all their electric and hybrid vehicles and most of their other newer vehicles. Two brand new fully electric vehicles have recently been added to the fleet.

Future plans involve replacing vehicles not equipped with an idling functionality. The contractor is also committed to purchasing more purely electric vehicles as their range increases and envisages only using hybrid and electric vehicles by the early 2030s, and aims to be fully electric well before 2035.

Focus areas

Electric vehicle charging points are available on site for staff and public use. There are three dual charge points providing charging for up to six vehicles, four x 7kw fast chargers and two x 22kw fast chargers.

- **2021– 2022** Feasibility study to increase number of EV charging points for Trust/private vehicles
- **2022-2023** Phase 1 of project to increase EV charging points
- **2023-2024** Phase 2 of project to increase EV charging points.

Fleet review 2022 –2023: arrange a fleet review with the Energy Saving Trust/Carbon Trust.

Business mileage data (Agenda for Change and junior doctors)

	Mileage	tCO2e*
2019-2020	574,593	160
2020-2021	402,668	111

2022-2023: Revisit grey fleet mileage reimbursement based on CO2 emissions of vehicles. Capture CO2 savings from new ways of working such as the increased use of remote appointments, using the Out Patient Transformation benefits calculator.

Estates and facilities

This section captures the reduction in energy consumption and the methodology for moving towards a Net Zero Carbon (NZC) position where possible within the confines of the existing estates and facilities infrastructure. In addition, we continue to work to reduce the impact of the organisation from a waste perspective to support both local and global emissions.

Energy

Despite an increase in the electricity consumed over the past five years of 30% (4,032,393kw/h 2015 -16; 5217,833kw/h 2020-21), we have seen a reduction in carbon emissions over the same period of 16%. This is largely due to the decarbonisation of the grid. We have seen a similar increase in gas consumed over the period. Both of these are as a result of two important factors:

1. Increase in site activity seeing areas occupied more frequently, specifically heavily serviced areas such as theatres and endoscopy
2. Hotter summers and colder winters with the need to temperature control.

The irony of point 2 being as a result of climate change and perpetuating is not lost on WSFT.

Partly in response to this, the Trust has moved to a 100% renewable electricity tariff as of 1 April 2021, to ensure that where we are using energy we do so from the most sustainable source economically available.

The Trust has a combined heat and power plant which utilises gas. As yet 'green' gas is not commercially viable or economically available.

The Trust is committed to continually improving its energy performance as outlined in the energy policy.

The Trust has undertaken a feasibility study into the decarbonisation of heating at Newmarket Community Hospital, which explored the possibility of air source heat pumps, solar PV and demand reduction options. This will go on to inform future projects at the hospital. The Trust will consider future decarbonisation grants or loan opportunities launched by the Government in conjunction with Salix.

The Trust has recently completed the installation of LED lighting at its West Suffolk Hospital (WSH) location. The Trust is committed to installing LED lightning in all new build projects and refurbishments going forward to reduce energy demand. This will be included within the WSH standard specification. Where products cannot be supplied with LED-type luminaires a low energy alterative will be agreed.

The Trust has a total of three solar PV systems across its West Suffolk Hospital site, with a recently installed 34KWP on the G10 project which will provide an estimated 28,592kWh per year. The Trust will consider solar PV on all future new builds across our estate. This will be achieved at the design phase, when a cost benefit analysis will be carried out. As part of this analysis a full review of alterative technology will be reviewed to establish the most efficient method of delivering a service, such as, lighting, power and HVAC.

The Trust will commit to quarterly energy efficiency communications with a view to promote sustainable energy efficiency behaviours Trust-wide.

Waste and the circular economy

The Trust is committed to applying the waste hierarchy in relation to waste management as outlined through our Waste Policy.

The following processes are currently in place within the Trust which seek to reuse products no longer required:

- Warp It reuse platform
- Partnerships with medical auction companies to sell on redundant medical equipment for reuse.

The Trust aims to increase the amount of medical equipment disposed of via auction companies over the duration of this Green Plan as per the waste hierarchy and circular economy principles.

The Trust seeks to segregate waste where reasonably possible to increase our recycling rate. We currently have the following recycling streams:

- Food
- Plastic
- Cooking oil
- Metal
- Paper
- WEEE
- Cardboard
- Glass
- Textiles
- Toners
- Batteries.

The Trust is in the process of introducing a pallet recycling stream which will provide a significant cost saving and reduce the carbon intensity of this stream. Where possible, pallets will be back hauled via the original delivery company.

Focus areas

The Trust aims for a recycling rate of 30% of total waste over the course of this Green Plan at the West Suffolk Hospital location.

Currently, the majority of healthcare waste produced is sent for incineration at high temperature. The Trust is in the process of ensuring that healthcare waste is segregated correctly by rolling out the offensive waste stream. This will allow us to eventually reduce the carbon emissions associated with soft healthcare waste disposal by making use of the alternative disposal option available for this stream.

Over the coming years, work will be carried out to reduce the amount of waste we produce and to explore the possibility for further reuse and closed loop recycling opportunities.

Green space and biodiversity

The Trust is committed to maintaining green space and biodiversity across its estate. The West Suffolk Hospital is fortunate to be positioned in a well-established location comprising of considerable areas of green space. The Trust currently undertakes a number of initiatives and maintenance tasks to maintain and improve the green space and biodiversity, such as:

- Bury in Bloom
- Maintaining wild tree belts
- Annual tree surveys
- Protection of hedge cutting during nesting seasons
- Protection of active badger sets on site
- Protection of active bat foraging corridors
- Site-wide ecology surveys
- Tree and root protection
- Wildlife habitat boxes
- Composting
- Inclusion of planting/ landscaping within capital developments.

WSFT is part of the NHS New Hospitals Programme, being made largely from a RAAC construction which is time-limited. As such, the opportunity to make long-term investment is limited.

Notwithstanding, approximately 25% of the estate will be retained as part of the New Hospital Programme (NHP) and there will be a clear focus on work to:

1. Develop a plan on how to provide heating through low temperature hot water (LTHW) and the transfer from plate heat exchangers to air source heat pumps
2. Establish the options for managing the flow of water temperature whilst using heat as the primary means of control in line with L8

Medicines

WSFT has utilised a number of strategies to reduce medication wastage and duplication of supply. The following processes are well established in the Trust:

- Reuse of patients' own medicines on admission
- One stop dispensing
- Avoidance of dispensing on discharge if patients have sufficient supply at home
- Return and reuse of stock and temporary stock items issued to clinical areas where storage conditions can be guaranteed.

Services that have been implemented more recently and are being embedded in clinical practice are:

- Medicines optimisation to avoid unnecessary polypharmacy, e.g. increased use of the Discharge Medication Service provided by community pharmacies
- Supporting virtual clinics through the provision of a home delivery service (or close to home dispensing and pick-up service) for medicines prescribed at the virtual appointment
- Homecare delivery of high cost drugs
- Reduction in pharmacy and medicines management staff travel by use of virtual meetings for off site meetings.

The pharmaceutical supply chain has taken some steps to reduce packaging waste. These actions include:

- Wholesalers delivering in reusable plastic totes (returned to supplier on next delivery) or recyclable cardboard boxes (recycled via Trust recycling waste stream)
- Bulk fluid delivery on reusable pallets (collected by the supplier on their next delivery).

Further action is required in the following areas:

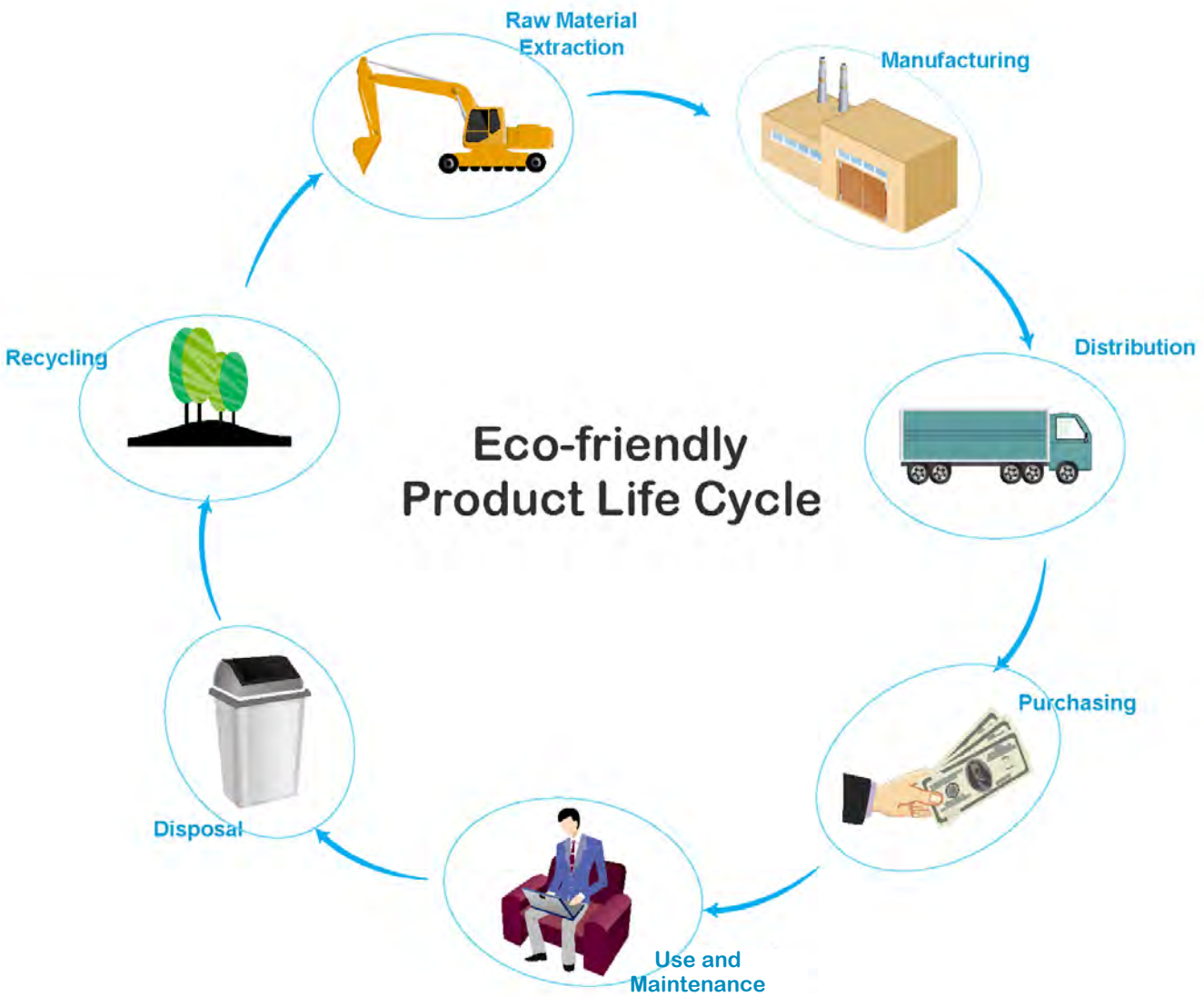
- Reduction in the use of aerosol inhalers and the use of inhaler recycling schemes. Unfortunately, the previous pharma sponsored GSK recycling scheme closed in 2020. The Trust respiratory and CCG/ICS respiratory formulary requires detailed review to ensure that appropriate patients are moved from aerosol inhalers to dry powder devices where possible. This will require the input of the specialist respiratory team in conjunction with agreement with the CCG prescribing leads

Focus areas

- Anaesthetic review of use of Desflurane. Aim for Trust usage of Desflurane to be less than 10% of Trust total of volatile anaesthetic (current Desflurane usage is between 10.7% and 11.4% of usage). In order to achieve the target reduction there will need to be active participation from the anaesthetic department to ensure that Desflurane use is minimised where possible. Scavenging devices may be required to further limit the effects of volatile anaesthetic gases on the environment
- Consideration of how the Trust can reduce its use of nitrous oxide gas or implement sustainable scavenging or catalytic destruction systems. This will require involvement from the anaesthetic and Trust facilities
- The pharmacy team currently uses a significant number of single use plastic bags to facilitate the safe and effective delivery of medicines to patients. In order to move to a more sustainable product, issues of cost pressure and difficulty in obtaining suitably robust large paper carrier bags to support moving from plastic dispensing bags to paper bags must be addressed.

Supply chain and procurement

The Trust recognises that the procurement of goods and services has a large impact on the Trust Green Plan and carbon footprint. The procurement department aims, where possible, to work closely with local suppliers and incorporate lifetime costing (see diagram below) and innovation into evaluation criteria, whilst still demonstrating value for money.



Focus areas

The Trust currently undertakes the following:

- Request all suppliers of large deliveries contracts with the local council for all domestic waste which is either zero to landfill or recycling
- Contracts for recycling of cooking oil, certain plastics, food waste, metal, wood and cardboard
- Has identified recycling champions in key areas around the Trust
- Ongoing contract with Warp It for the reallocation of non-clinical equipment across the Trust and community
- Contract with national auction house to reduce WEEE waste
- Confidential waste and paper waste recycling contract
- or projects take away all waste generated upon delivery of service/product
- A 5% evaluation around sustainability if relevant to the product being procured.

Focus areas

The aims over the next three years are:

- Build on our relationship with the local council to look at more areas of recycling such as tins, coffee grounds and glass
- Allocate points for staff to recycle in the smaller areas of the Trust
- Utilise Warp It with other providers such as the local council to expand on the reallocation of non-clinical equipment, reducing waste
- Work with fleet providers to move Trust vehicles to hybrid and electrical vehicles where and if the infrastructure allows
- Work in collaboration with the members of our Integrated Care System (ICS) to look at the carbon footprint across the region and scope more sustainable logistics operations
- Implement the pick and pack system in our theatres and day surgery unit to reduce waste in system and streamline stock ordering
- Incorporate the 10% evaluation criteria around social values which includes sustainability
- To work with suppliers to implement the Government's **'Taking Account of Carbon Reduction Plans'** (PPN 06/21) https://www.gov.uk/government/publications/procurement-policy-note-0621-taking-account-of-carbon-reduction-plans-in-the-procurement-of-major-government-contracts. From April 2023 all suppliers with new contracts for goods, services, and/or works with an anticipated contract value above £5 million per annum, will be required to publish a carbon reduction plan for their direct emissions. From April 2024, the NHS will expand this requirement for all new contracts, irrespective of value
- From April 2022 adopt the **Government's Social Value Model** (PPN 06/20) (see link above) where all NHS tenders must include a minimum of 10% scoring criteria in all procurements to assess how suppliers will contribute to the NHS' net zero targets and social value in contract delivery.

Food and nutrition

The Trust's in-house catering team offers a fresh cook plated meal service to patients and through two catering outlets to staff and visitors. This method of catering offers a lower waste output as routes to waste can be managed internally by the catering team. Areas of waste outside our direct control are jointly managed with the clinical teams alongside the dietetics department. Through the introduction of portion size and dietary analysis the department has reduced plate waste. However this could be improved further.

Of ultimate importance is the quality and nutritional value of the meals served and the department is continually working with others to improve this.

What do we want to achieve?

- We will achieve the NHS Plastics Pledge
- Continue to achieve and exceed the Government guidelines (e.g. Government Buying Standards)
- Maintain our external accreditation such as Food for Life (Soil Association) in regard to Red Tractor, dolphin-friendly and sustainable fish cities marks
- Continue to explore ways to reduce food waste with regard to unserved meals and from over-production
- Continue to reduce the use of processed foods and communicate the health and carbon benefits of diets with fewer of these
- Reduce the number of unserved meals, both for patients and overproduction within our catering outlets.

How will we achieve it?

- Review products available locally and increase use where possible
- Work with the health and wellbeing team.
- Source non-plastic alternatives to use that do not alter the safety and quality of food served
- Remove plastic cutlery from food outlets
- Review all catering contracts and work closely with the procurement department regarding supplies contracts
- Review food disposal systems appropriate for each site
- Ongoing unannounced food waste audits and working with individual wards to rectify any adverse trends
- Review menus to identify where alternatives to dairy products can be used
- Introduce more meat-free dishes and work with dietitians to review protein content of individual dishes
- Utilise resources such as the Eat Well plate to communicate clearly
- Work with wards to reduce unserved meals caused by discharges and uncommunicated movement of patients
- Work with the Nutritional Steering Group to identify ways of improving nutrition to patients and to asses portion sizes to best effect.

How will we measure it?

- Compliance with the NHS Hospital Food Review
- Ongoing compliance with the NHS Plastic Pledge
- Procurement reports on locally purchased produce
- Sales reports from food outlets
- Food waste reports.

Adaptation

Climate change brings new challenges to the Trust.

Examples in recent years include the effects of heatwaves, extreme temperatures and prolonged periods of cold, floods and droughts. Our Board approved plans address the potential need to adapt the delivery of the organisation's activities and infrastructure to climate change and adverse weather events. Events such as heatwaves, cold snaps and flooding are expected to increase as a result of climate change.

The Trust has a responsibility to ensure all current and future planning includes measures to address climate-induced hazards. The Trust's business continuity and emergency response plans for climate-induced incidents include such awareness, and the overarching command and control capability has a programme of training and exercising to reinforce this. In addition, all purchasing, transformation and improvement planning are to include the same requirement.

The existing works programme to deal with structural issues in the current hospital building are a challenge to adaptation planning for the near-future. Where we can, and judged against the greater risks we face, we will consider adaptation opportunities for current locations and systems. The future system planning for the new site (which includes the existing location) and services are being planned and developed concurrently. The Trust will therefore include adaptation for service resilience and business continuity as part of the future system, and proactively implement it as part of the design of the structure, services and capabilities. This adaptation will take into account such reports, specifications and requirements as are necessary, available and predicted at the key decision points.

Furthermore, Trust community service delivery locations, including Newmarket Community Hospital, are more likely to be susceptible to a wider range of climate impacts than the West Suffolk Hospital buildings and on-site services; this includes the movement of staff and patients. The planning requirements for off-site adaptation will also be included in the Trust's future plans and in any changes or improvements to off-site services.

We will:

1. By end of the financial year 2021/22, undertake iterative strategic Trust-wide risk assessments for current on- and off-site service delivery which takes account of current UK climate projections
2. As a result, and in the timescales necessary, define and implement coordinated tactical improvements to existing infrastructure and services
3. In accordance with the defined planning timeline, provide strategic objectives for future systems planning
4. Subsequently, proactively design operational resilience for the future hospital structure that will prevent re-design and nugatory infrastructure improvements at a later date. This will include:
    - Business continuity
    - Communications systems
    - Extreme weather impact prevention
    - Evacuation and lockdown
    - Fire prevention
    - Risk reduction
    - Efficiency in response resource use
    - Use of natural terrain and features for protection.

4.2. Future system board report

To inform

Presented by Craig Black

Public Board Meeting – 17th December 2021

Agenda item:	Future System Programme - Programme Directors Update			
Presented by:	Gary Norgate – Programme Director			
Prepared by:	Gary Norgate, Programme Director			
Date prepared:	01/12/2021			
Subject:	Update on the Future System Programme			
Purpose:	X	For information	X	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). Archaeological survey planning is underway and additional surveys, as required under recently updated legislation, are being undertaken to ensure the hydrology of the site and the impact of the proposed hospital are fully understood.
2. This additional survey work is expected to add c.2 months onto the date at which we submit our planning application, however, this activity is not on the project's critical path and will not therefore delay submission of the outline business case (December 2022).
3. Our Technical team have now closed a contract for the use of neighbouring fields during the construction of our new hospital.
4. Phase 3 Co-production workshops have been completed and have rationalised the schedule of accommodation to a point where the space required has reduced to c.85k sqm – from c.125k sqm. Key to this model are recommendations relating to maximising use partner assets (One public estate and diagnostic hubs), and ensuring we stick to the strategic principle of an acute hospital only doing that which an acute hospital can. Phase 4 of the clinical co-production process will now focus on the strategic, system-wide solutions aimed at transforming the way parties within the integrated care system collaborate and interact.
5. The outline schedule of accommodation upon which the outline business case will be based is on track for completion by 7th December.
6. The completion of this SOA will allow our architects to commence with the production of 1:200 plans while our finance workstream conducts the formal appraisal of our shortlisted options – including the construction and analysis of respective benefits.
7. The team hosted a senior delegation from the National Hospital Programme and NHSI/E. Following presentations of our clinical model and our planning application, delegates were given tours of both current and preferred sites. Feedback was universally positive and attendees were left in little doubt of the maturity, deliverability and need of our project.
8. At c.85k sqm, the proposed hospital is still likely to be at the upper-end of affordability. To explore this further, workshops with the national programme and our local partners are being established for January. That said, the team remain entirely confident of their co-produced SOA and will not, therefore, be making arbitrary changes to its volume or cost without a clear and

agreed understanding of the consequences.

9. The second phase of our pre-application public planning engagement has commenced with virtual and physical events at Mildenhall, Bury St Edmunds, Sudbury, Haverhill, Newmarket, Brandon, Thetford and Stowmarket. This work has been supplemented with presentations to a range of councillors and other stakeholders. The programme has, at the time of writing, several more weeks to run, however, initial indications are that our plans enjoy a broad degree of support.
10. Feedback from the national hospitals programme suggests the budget for developing business cases is significantly over committed. This could negatively impact the extent to which our request for the £7.9M required to support the development of our outline business case is fulfilled. That said, there is clear evidence that issues associated with RAAC infrastructure are widely appreciated and that such projects are viewed as a priority. We expect a concrete (forgive the pun) answer by mid-December.

Business Cases and Project Plan

I was delighted to welcome members of the national hospitals programme and our regional colleagues from NHSI/E to our proposed site at Hardwick Manor. Representatives spanned physical, commercial and clinical domains and we spent the day landing the following key points:

1) Our co-produced clinical design is extremely well thought out and has significant value to add to the national programme
2) We have a highly deliverable project
3) Our existing estate is facing, and presenting, significant challenges

Feedback was universally positive and the potential of the site was clear for all to see. The one note of caution came in the form of a statement that our proposed schedule of accommodation is, when we add in the volume of the retained estate, a little higher than the average being requested by other district general hospitals within the NHP. We discussed this point at our recent team meeting and are standing firm on the basis of our belief that our approach and conclusions are utterly defensible.

On a more positive point it was explained that the condition of the existing hospital along with; the deliverability of our plans, the fact that we own our proposed site and the demonstrable support we have from our system partners place us at the very front of the Phase 4 projects – a clear indication that we landed our points!!

In recent months I have been reporting a potential schedule of accommodation that would extend to 125k SQM. Such a hospital would be unaffordable from both capital and operational perspectives and, consequently, phase 3 of our clinical co-production has focussed on rationalising and de-duplicating this area, having agreed[1] several key innovations (see the Clinical Workstream update below for details), the SOA has reduced to c.85k sqm. This is an amazing outcome that has been co-achieved without impacting the integrity of the design, however, as mentioned previously, it remains at the upper edge of perceived affordability. With this in mind the team have discussed the potential of making arbitrary reductions to bring the size down, however, the unanimous preference, given our commitment to co-producing a clinically lead, data driven design, is to stick to our guns and to seek support for our preferred way forward. In order to test this support, we are planning two workshops for January:

Workshop #1, With our ICS partners – we need to be absolutely sure that they all understand the detail of our SOA and support the assumptions (particularly the growth assumptions / modelling) that underpin it. We would like to tease out objections such as “its fine to assume 3% annual growth – but we won’t be in a position to pay for that level of activity” etc.

Workshop #2, With NHP / NHSI/E – having gained regional / ICS support for our proposed SOA, we

[1] These ideas were presented at the last programme board and were subsequently supported by the WSFT executive team. The final recommendations will be put to the WSFT Board in December for formal ratification.

are proposing to present it to NHP in the same way we did in January 2020. We want to draw out the challenge of affordability and how our SOA compares to other DGH solutions within the NHP. I want NHP and NHSI/E to push us on our core assumptions and to indicate where centrally formulated guidance may compel us to trim certain aspects of our design.

In terms of progress against the overall project plan, our key highlights are:

Town and Country Planning – We remain on track to apply for outline planning consent in Spring 2022. Phase 2 of our public engagement in this process was launched successfully on 1st November. We had planned to submit our application for outline planning consent in January 2022, however, we are taking an opportunity to conduct further hydrology surveys to ensure we comply with the latest national planning framework requirements as well as taking additional time to explore the results of the fungi surveys. This extra work is likely to extend the submission date into March; however, this will not impact the overall programme milestone of submitting an OBC by close of 2022.

Rationalisation of SOA – Workshops considering options for rationalising, improving and de-duplicating our schedule of accommodation are complete and we remain on schedule for completing a schedule of accommodation by 7th December 2021. At this point we will have a firm view of the accommodation that will inform our physical design – we will also have a clear understanding of "the gap" in capacity that will need to be addressed collectively by our ICS.

Strategic System Solution – Once we have completed our SOA, work will begin in earnest as to how we will, as an integrated care system, work together to ensure the proposed hospital is sustainable and can keep pace with demand.

Outline Business Case – Funding for the development of our OBC should be announced within the following month, however, in the meantime work continues "at risk". We continue to forecast submission of an OBC by December 2022.

Estates Workstream

The main thrust of the Estates workstream continues to be the preparation of essential documentation for our planning application and the completion of our Environmental Impact Analysis. In these areas we have made the following strides:

1) Trenching for our archaeological surveys is about to commence. This represents another step towards truly understanding the intricacies of our preferred site and is another indication of the effort being put into preserving its integrity.
2) We have now completed negotiations with a neighbouring farm owner to secure a legally binding option to use his fields as a site compound and temporary access road for the duration of the construction phase. This agreement is extremely important for our planning application as it serves to allay the reasonably stated concerns that construction traffic would cause significant disruption to local traffic flows as well as creating significant noise and ecological pollution. Us of the land in this way will remove traffic from the local road infrastructure, reduce the number of journeys and reduce the complexity of the construction process, as such this agreement represents a significantly positive step.
3) Changes to the national planning framework have increased the emphasis placed upon understanding flood risk.[2] In the case of Hardwick Manor, the site is not at risk from rivers or coastal surge, however, at times of exceptional rainfall, waters are known to flow across the manor site. This flow has been traditionally dealt with by a single ditch / culvert, that runs behind the houses of Sharpe Road, however, the introduction of a new building could increase the impact of this run-off and consequently, we are taking additional time to model the potential impact and tune of sustainable drainage solution to ensure it is adequate. We are also keen to ensure we understand the impact that said drainage solution could have on the overall hydrology

[2] The legislation is largely designed to prevent housing estates being built on flood plains without adequate protection and drainage.

of the site and how our veteran trees might be impacted. This work is likely to add an additional 2 months to our planning cycle; however, this will not impact the overall critical path of our project.

4) Significant work has been conducted to understand parking and access needs for the new hospital. The result is a comprehensive plan for; improved ingress and egress, a more effective junction at the sites entrance, the potential for an alternative 'disaster recovery' route and a full parking strategy that, preferably removes the need for an ugly, expensive multi storey car park.

5) A detailed survey of Fungi on Hardwick Manor has identified 8 species of interest. Examples of these species have, in consultation with relevant experts, been carefully relocated in order to ensure they continue to flourish. That said, a risk remains that additional scarce species could be uncovered and that the site could become officially designated as a protected habitat[3].

6) Regardless of the fungi outcome, the project still faces challenges in terms of satisfying Suffolk Wildlife Trust that its plans to maintain / increase net diversity are sufficient. Various options for complying with the need to demonstrate a 10% net diversity gain are consequently being explored and negotiated.

Clinical / Digital Workstream

The clinical co-production team continue to drive work forward across the three service settings:

1. The hospital workstreams
2. The community workstream
3. The primary care workstream

Hospital workstreams: At the meeting of the programme board in October, members heard about 9 progressive trust-wide strategies that were being explored to make a significant difference to the schedule of accommodation. The group's comments were added to the options appraisal which was co-produced with hospital, community and primary care colleagues, the deputy directors, governors and Voice members and the clinical directors. The recommendations that were eventually fielded to the executive directors' panel, and their outcomes, are shown in the slides below.

[3] At the time of writing, 8 species of interest had been discovered, if the number were to increase to 19 or above, protective covenants could be triggered.

Ideas appraised and the recommendations made to executive directors

NHS West Suffolk NHS Foundation Trust

	Recommendation	Decision
Configure all services to run across 7 days a week, daytimes and evenings (21 sessions for sessional services)	Adopt **a minimum of 15 sessions per week** as the operating model for the OBC Conduct sensitivity analysis comparing 15, 19 and 21 sessions for workforce, finance and risks by end of March 2022 Revise the assumption upwards if safe, viable and affordable	✓
No new general adult inpatient beds	Adopt a strategy of **no new general adult inpatient beds** in the OBC, on the basis that a combination of prevention, proactive care, internal ways of working and system transformation will reduce demand for accommodation in the acute hospital. This does not deny the projected growth in demand or the collective challenge we will have meeting it	✗ **60 new beds agreed**
A large outpatient centre in the Western Way development	Plan to take space in the Western Way development for a self-contained outpatient centre Continue to work with the co-production groups to determine the most suitable services to be housed there This does not mean we will not also still need to secure improved ways of working, transformation and prevention in order to help attenuate growth in demand.	✓
Maximum use of elective hubs across the ICS	Adopt **maximum use of elective hubs across the ICS** as the operating model for the OBC Define "maximum use" with ICS and clinical leaders	✓

	Recommendation	Decision
"Abolish waiting"-no departmental waiting rooms, just a central café/waiting area and departmental receptions	Do not consolidate waiting areas further – stick with zonal hubs Good waiting management (digital alerts, wayfinding etc) will still be required to make zonal hubs work well.	✓
Working from home becoming routine, including for some of the clinical work which can be done remotely	Adopt **a flexible approach to routine working from home** as the operating model for the OBC, on the basis that is it explicitly not mandatory working from home. Find the right way to provide a compensating increase in team facilities to enable hybrid approaches, prevent isolation and encourage team cohesion.	✓ **With the red text added in**
Education to stay in the Drummond Centre (refurbished)	Education and training facilities to continue to be housed in the Drummond Centre. The Drummond Centre to be refurbished to create appropriate facilities for 21st century healthcare education and training.	✓
Day surgery to be housed in the Treatment Centre (refurbished /extended)	• Decision deferred to be part of holistic decision about use of retained estate	-
Sharing of ultrasound rooms	• Consolidate and share ultrasound facilities between departments / services where they are located on the same floor and it is clinically appropriate.	✓

The Day surgery topic subsequently returned to the executive panel on 19th November 2021 with a recommendation to:

- House the future day surgery department in the treatment centre, as long as the technical appraisal shows that it can be extended and refurbished in line with the co-produced service vision which was accepted.

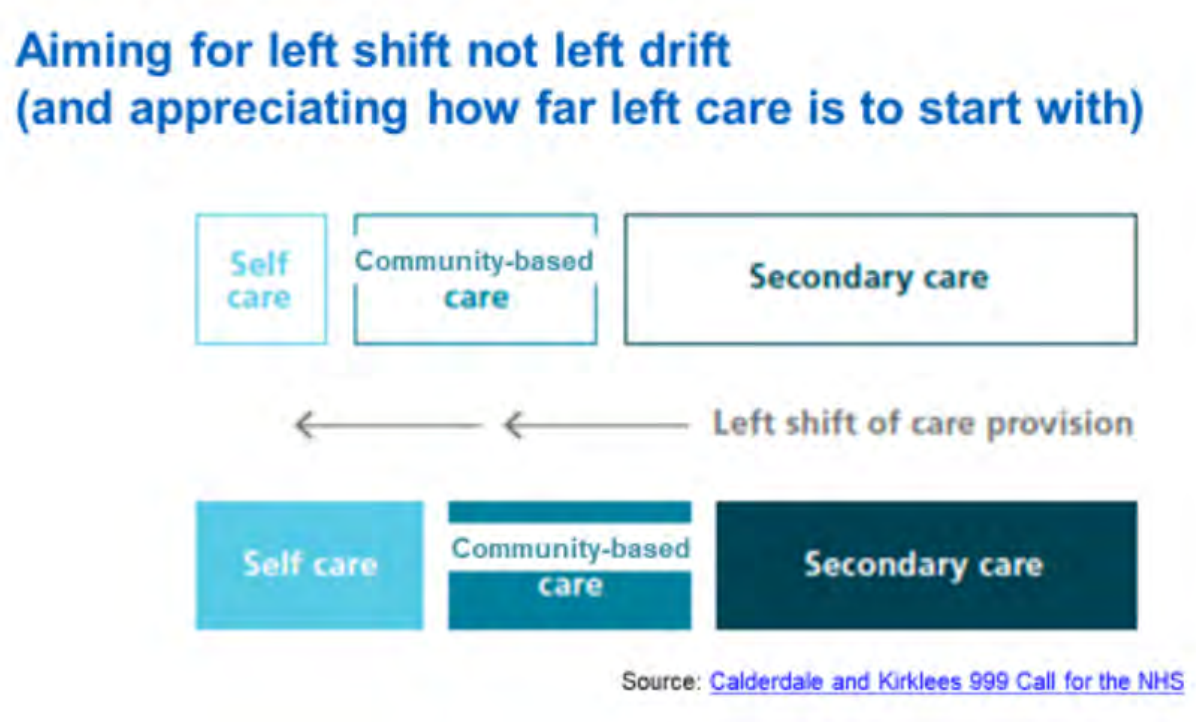
Further steps taken or in hand:

- The effect of 15 session weeks across all elective services and constraining the inpatient beds to +60 are being worked into the demand and capacity model across all elective services • Co-production activities are underway to shortlist services which would be well accommodated in Western Way, and to start to understand the design and enablers required.

- On the question of "maximum use" of elective hubs, the ICS provider collaborative group confirmed on 15th November that the quantum of elective care that could be provided in a hub equivalent in size to the one proposed at Newmarket could safely come out of the schedule of accommodation. Going beyond that in terms of "cold-site" elective capacity may well become the system ambition in the medium term, but at this point that was a level of commitment that the system could feel collective confidence in.
- The office accommodation requirements are being finalised and were presented to the executive directors for sense-checking on 26th November We are also appraising the options for housing services in the other retained buildings on Hardwick Lane (Quince House, the catering block, Macmillan centre, Rowan House), all of which will form the basis of the final recommended schedule confirmed on 7th December.

The WSFT Board is asked to note and ratify the recommendations above.

Community workstream
The community demand and capacity modelling are starting to generate results which are being validated by the community leads. This work has two purposes; firstly, to inform the number of acute beds that can be replaced by more community capacity; secondly and more importantly, to inform the amount of resource and what type of resource would be needed to create that community capacity. For example, the reduction in deaths in hospital to 30% releases 12 acute beds which can be reprioritised for other types of care; but the quantum of resource needed to support those 250 extra deaths at home each year needs to be described, and we need collective confidence it can be achieved. The modelling is drawing on both the local and national evidence bases and is extremely high quality. Throughout the community workstream there is a strong commitment to resisting the temptation simply to do more of the same; the goal is very much to change the way that services and communities work together to achieve a "left shift" in the locus of care (see graphic below). The community co-production groups continue to work up the new whole-system models for frailty, end of life care and discharge to optimise and assess with good engagement and this work will continue into and form the foundation of phase 4.



Primary care workstream
The primary care co-production leads are starting to conclude their initial exploration of community-based options for denosumab injections, termination of pregnancy and at-home point of care diagnostics and presented their recommendations to the peer review panel on 30th November. This learning exercise has been phenomenally valuable, both in exploring the opportunities for these services themselves but also in "practising the practice" of a different way of transforming services –

clinically-led, multi-agency and through co-production. A reflective debrief was held on 24th November and the formal learning from that will be presented at the next programme board meeting. The most advanced of the projects is denosumab injections; the GP Federation are interested in taking the service over and the co-production group are in the process of designing the care pathway that would enable safe and efficient shared care.

For each topic we are also gathering patient views through different engagement methods which will inform the eventual recommendations. Supporting both the community and primary care workstreams, an alliance project lead has now been recruited who will be embedded into the alliance team, managed by the deputy director of integration and who will coordinate the onward-work of taking any successful service changes through to delivery.

As good and inclusive as this work has been it is likely to leave us with a design that is still on the outer edges of affordability. This situation leaves us with two options – arbitrarily apply a percentage decrease across departmental floor space or defend the co-produced solution, regardless of its perceived affordability. The risk of the latter strategy is that the WSFT project is de-prioritised with the NHP, however, the recent visit by NHP leaders was seen to clearly establish our case for change and position us a very mature and deliverable project. In light of this we are recommending the following strategy:

We will continue to drive the process and observe our principle of co-production. By 7th December we will have our answer on what we need to build- this will be our position, regardless of 'affordability'. We will seek to test this position in roundtables with both our ICS colleagues (to gain clear support) and, then, NHP. These workshops are being planned for January. In parallel to the planning of the roundtables, we will continue with 1:200 designs.

Having completed the Phase 3 co-production workshops and identified the theoretical gap between that which we feel we can afford and that which we have concluded that we need (c. 10-15k sqm), the next phase of co-production will focus on working with our system partners to collectively decide how collaboration and different ways of working can bridge this gap.

In furtherance of our digital strategy, members of the clinical co-production and digital teams attended a digital showcase hosted by BT Plc. at their laboratories in Adastral Park.

Communications and Engagement

The second phase of the pre-application planning engagement launched, on schedule, on the 1 November as per the over-arching project plan.

As always, the team were keen to hear from as many people as possible so the website and online feedback form is compatible with screen readers. The online feedback form could also be translated into several languages at a flick of a switch. The hardcopy leaflet was available in easy read, large print, Portuguese, Polish and Russian and could be sent back at no cost using the freepost address or handed in at any event.

In order to make the events suitable for as many people as possible, the first hour of each event was sensory friendly with lights turned down, quieter and limited numbers.

We were also mindful of the shifts and working patterns that our staff are committed to. With this in mind, two face to face events were arranged for the Hardwick Lane and Newmarket Hospital sites. Originally this was for patients too but in light of the latest WSFT COVID visiting restrictions this was limited to just staff. Two online events were also held for staff at 12pm and 8pm considering the time of people's shifts. In total this reached 95 people.

A number of stakeholder briefings were held with local councillors including Councillor Soons, Councillor Stamp and Councillor Chung. Further briefings were delivered to Newmarket planning committee, Barrow parish council, the Thetford Planning Council and Bury resident's association.

Eight face to face events were delivered, two more than phase 1, following public feedback, and two

online events. These events were not purely for Bury St. Edmunds but expanded over West Suffolk and South Norfolk recognising our patient catchment area.

At the time of writing this paper, we have reached in total so far;

- 39,940 people online with 2,336 link clicks to our website, 105 likes and 69 shares across Facebook, Instagram and Twitter
- 4,000 hits to the planning engagement website (we received 7,000 in total in phase one).
- Received approx. 600 responses to our feedback form via the post, at events and online. In comparison, we have three weeks of our engagement to go and at the first round of pre-application planning engagement we received nearly 800 feedback forms in total.
- Media coverage in the BBC (online and drive time radio), Bury Free Press and East Anglian Daily Times.
- Spoken to more than 150 people at our face to face and online events. The Bury St. Edmunds event received 107 visitors alone compared to 60 in the first phase of pre-application planning engagement.

Over-arching feedback is broadly positive with concerns raised around, building height, traffic and car parking. Many individuals would like concrete plans for the elements however they do appear to understand that we are not in a position to confirm these as yet.

Clinical engagement
Earlier in the year the team carried out phase 2 of the clinical patient and staff engagement. This was via an online survey

In total 253 people responded. The feedback generated was predominately patients with 25% of responses from staff.

A number of areas were explored including remote appointments, the use of patient portal and where appointments should be held.

To provide a snapshot;

- 57% of the public didn't have a preference as to when their appointment was and subsequently 75% were happy to have an appointment in an evening or weekend, 62% were happy with either.
- A majority of the public said that their appointment had not been delivered using technology which was concurrent with staff feeling that they could make better use of it.
- Staff felt they needed better connectivity, equipment and improved wifi in order to make better use of technology.
- Patients, who did receive their appointment via video phone call or telephone felt the greatest benefits were less travelling time, the ability to have their carer present, more comfortable and more convenient.
- 88% of responders felt that mental health and social influences should be considered when treating an ailment.
- In terms of ward configuration 81% of the public who responded stated they would prefer to stay in a single room. This compared to 48% staff who preferred to treat patients in a single room.

The survey also detailed what would improve patient experience and what is expected of a 21st century facility as well as a breakdown of responses specific to each clinical area.

To supplement this work Community Engagement Group sessions were carried out for all workstreams (14 in total). 80 attended which averaged at 6 attendees per a session. This is not representative of the number of views captured for example one attendee spoke to 20 members prior to attending the meeting.

The recordings of all the sessions are available on the website in order to generate further feedback

from those unable to make the sessions over the summer.

Bespoke sessions were held with military personnel, those with learning disabilities and severe mental health requirements. The team also engaged with the homeless and rough sleeper audience and held bespoke meetings with a Stroke support group and Chronic pain support group.
The team would like to express their thanks to the governors who chose to attend the sessions.

Staff engagement
A marquee was set up at Hardwick Lane and a presence at Newmarket Hospital. The marquee depicted the journey so far including site selection, the preferred site and the clinical workshop process. There was the opportunity to provide anonymous feedback to be considered in the future design.

Stakeholder engagement
Visits to the Hardwick Manor site have been confirmed IN January and February for Ed Garrett, Nathalie Forrest (chief responsible officer of the national hospitals programme), Julian Kelly (CFO NHSI/E) and Jeff Buggle (CFO East of England NHSI/E).

Finance

A conclusion to our claim for funding the development of our OBC remains outstanding, however, I am assured that we should have a definitive answer by mid-December (the recent visit of NHP leaders was used as a means of stressing the need for this funding and feedback suggested the message had been well and truly landed).

In the mean time we continue to prepare for the commencement of our 1:200 designs and for the development of our economic and commercial cases. The work required to complete these cases should not be underestimated and Zoe has done a great job of establishing a series of work packages that will ensure we get the necessary data in time for a December submission of our OBC.
Two of the most critical inputs are described below:

The prediction of **activity and demand growth** is essential as it is the most significant determinant of space required within the schedule of accommodation. Helena, our clinical team and our health care planners have done an excellent job of calculating the sort of growth we can expect, however, the affordability of this growth (as real as it is) has to be pre-agreed with our commissioner partners who will be on the hook to pay for it! Hence significant work is planned to ensure this model and its affordability is unequivocally agreed.

As is often the case, “there is no such thing as a free lunch” and consequently our business case will need to demonstrate that the new and enhanced facilities of any new hospital can be leveraged to **reduce operational costs and improve efficiency**. We are therefore compelled to carefully construct a benefits plan that will cover internal cost improvements as well as societal benefits that stem from the investment – no small task!

In total there are 9 work packages spanning; activity growth, clinical service changes, new hospital benefits, equipment (non-digital), equipment (digital), capital cost, workforce model, estates & facilities cost changes and transition costs.

All in all, this has been a period in which significant progress has been made in the development of our schedule of accommodation, the positive national positioning of our project, the understanding of our preferred site and our engagement with our stakeholders and community.

By the time of the next Board meeting we will be in a position to provide:

- conclusions from our engagement exercise,
- a decision on the funding of our OBC
- a report on how our efforts to produce a system wide solution to activity growth has progressed

- conclusions from our environmental impact analysis and a firm date for the submission of our application for planning consent.

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

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

Previously considered by:	Future System Programme Board, WSFT Executive Panel.
Risk and assurance:	
Legislation, regulatory, equality, diversity and dignity implications	None

Recommendation: The WSFT Board are asked to ratify the co-produced recommendations described within the clinical and digital workstream update. These recommendations have previously been considered and agreed with the Future System Programme Board and the WSFT Executive Panel.

5. GOVERNANCE

5.1. BAF Summary

To Assure

Presented by Ann Alderton

Board of Directors – 17 December 2021

Report Title:	Item 5.1 - Board Assurance Framework
Executive Lead:	Ann Alderton, Interim Trust Secretary
Report Prepared by:	Ann Alderton, Interim Trust Secretary
Previously Considered by:	Board of Directors October 2021

For Approval	For Assurance	For Discussion	For Information
☐	☒	☐	☒

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.

The Board approved its risk appetite statement at the last meeting of the Board, following which the BAF risks were reviewed individually with the executive team during November 2021.

Action Required of the Board

a) To note the updated BAF and the increase in the risk score for Risk 2 (Emergency Capacity).
b) To consider whether Risk 4 (Digital Transformation) can be referred to the Insight Committee for de-escalation, on the basis that the current risk is within the Trust Board's agreed risk appetite and has achieved its target risk.
c) To support the merging of the CIP risk and financial sustainability risk. This will require a new risk assessment to be completed and reported back to the board in January.
d) Based on the BAF risks, controls and assurances consider topics for future Audit Committee 'deep dive' review or Board development

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.
Legal and regulatory context	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.

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.

Current Risk Profile

There has been an increase in the score for Risk 2 (Emergency Capacity) from Quarterly x Major = Red to Weekly x Major = Red.

All but one of the BAF risks are red. All of the red risks are outside the Trust Board's agreed risk appetite.

The amber risk relates to digital transformation. Assessed at Annual x Major = Amber, this has achieved its target risk and is within the Trust Board's agreed risk appetite.

Financial Risk Assessment – Request for Further Review

During the review of Risk 5 (CIPs) and Risk 6 (Financial Resource allocation), the Director of Resources considered that the identification and delivery of CIPs is a control to address the financial sustainability risk and not a separate risk in its own right. Combining the two risk assessments will give a more balanced evaluation of the current status of this risk, a more comprehensive identification of the gaps in control and remedial action required and will enable a realistic target risk to be established and worked towards. This work could not be completed in time for the production of this paper, but is in hand and will be concluded by the January 2022.

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.

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 [No change}
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 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	Weekly x Major = Red [Increased]
		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 [No change]
		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 [No change]
		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 [No change]
		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	Quarterly x Major = Red [No change]

Board Assurance Committee	Well-Led Key Lines of Enquiry	BAF Risks Assigned	Current Risk
Involvement	**Are the people who use the services, the public, staff and external partners engaged and involved to support high quality sustainable services?**	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 to leave WSFT	Quarterly x Major = Red [No change]
Core Resilience Team Red Risk Oversight Committee		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 [No change]
Future Systems Programme Board		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 [No change]

Appendix 2

Summary mitigating actions and gaps in assurance

	Residual Risk	Target Risk
1. Failure to maintain and further strengthen effective governance structures, systems and procedures over safety and quality, leading 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	Apr 22
Development programme for ward managers and matrons to support ward accreditation	SW	Apr 22
Align accreditation framework and KPIs with Nursing, midwifery and AHP strategy	SW	Apr 22
Co-produce nursing, midwifery and AHP strategy to meet current and future system needs (reflecting the updated Trust strategy - pending)	SW	Jan 22
Develop patient safety and learning strategy	LW	Apr 22
Quarterly review of the CQC Insight publication with actions to address outlying indicators overseen by Insight Committee	RG	Dec 21
IQPR refresh project (this will enable reinstatement of the previously listed control "IQPR including key quality indicators (including community) – reported to open board and also reported to Insight Committee. This supports timely identification, escalation and action to address issues of concern".	NC	Mar 22
Review 2021/22 Quality Priorities and develop 2022/23 quality priorities through the Improvement Committee with Board sign-off as part of the Annual Report/Quality Accounts	RG	Mar 22
Assurances		
• Organisational Framework for Governance approved by Board September 2021 • Serious incidents, complaints, claims and inquests report to board (every meeting) • Maternity reporting to Board and attendance of head of midwifery (every meeting) • Quality reporting to Board on key performance indicators e.g. infection prevention and control, maternity (every meeting) • Learning from Deaths report to board • Monthly breakdown of nurse staffing levels reported to board • 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 • Internal audit reporting: o Responsive internal audit programme linked to IPB assurance requirements (draft programme for 2021/22) o Risk Management - Reasonable Assurance (Nov 2020) o CQC Improvement Plan – Stage 1 Substantial Assurance (Nov 2020) o Data Quality – Paused Activity and Recovery Reasonable Assurance (Jan 2021) o Fit and Proper Persons - Partial Assurance (Jan 2021)		

	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	Weekly 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)	COO	Feb 22
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	Feb 22
Addition decant ward (G10)	COO	Completed Oct 21
Transformation initiatives: - review of home IV therapy to inform business case (Apr 21) - expansion of the virtual ward concept	COO	Feb 22
Review E-Zec contract performance when we return to more normal levels of outpatient activity	COO	Completed Nov 21
Review of space allocated to paediatrics and frailty within the ED footprint	COO	Completed Aug 21
Implement final versions of new ED access standard in line with national roll out	COO	Apr 22
System to approve community bed requirement and funding for additional community bed base	COO	Completed Sep 21
Submitted a range of bids for funding to support admission avoidance and improved hospital flow – funding schemes to be implemented	COO	Dec 21

Assurances

- Access and performance reporting arrangements to Board e.g. IQPR, operational report and transformation report (qrtly)
- 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
- 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)

	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
Theatre 1 recommissioned (delayed due to RAAC remediation and Covid)	COO / DoR	Feb 22
Shadow monitor against new 28-day standard – identify areas for improvement	COO	Completed Sep 21
Outpatient transformation programme with focus on digital and embedding of Covid learning – delivering benefits to key milestones. Advice and guidance virtual consultation PIFU	COO	Mar 22
Development of longer term contract for additional Orthopaedic capacity with the BMI	COO	Dec 21
Continue to progress opportunities to fund an elective hub at Newmarket	COO	Feb 22
Development of Ophthalmic injection suite	COO	Jan 22
Development of an additional clinical area within the JFDU	COO	Mar 22
Improve operational efficiency in line with the GIRFT HVLC	COO	Feb 22
Develop business case for community diagnostic hub at Newmarket	COO	Feb22
Assurances		

- Board reports and monitoring (every meeting)
- Weekly SNEE activity level review
- Cancer and diagnostics activity progress against trajectory (monthly)
- Internal audit reporting:
    - 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)

	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	Completed Dec 21
Delivery of Closed Loop blood request and administration	Guy Hooper	Apr 22
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	Dec 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) • Cyber Essential Plus audit report • Cyber security penetration test report • Data Security and Protection Toolkit assessment		

	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	Quarterly x Major = Red
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: o Risk Management - Reasonable Assurance (Nov 2020) o Data Quality – Paused Activity and Recovery Reasonable Assurance (Jan 2021) o COVID-19 Financial Governance & Key Financial Controls - Reasonable Assurance (Jul 2020)		

	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	Quarterly x Major = Red	Quarterly x Major = Red
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)		

	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
Development of next iteration of People Plan in support of the new WSFT strategy and reflecting national priorities	JO	Mar 22
Evaluation of additional staff support measures during pandemic and agreement of next steps	JO	Jan 22
Implementation of lessons learned from external review of whistleblowing matters	JO	Mar 22
Establish Mandatory staff vaccination implementation group and deliver action plan	JO	Apr 22
Assurances		
• Safer staffing - trust-wide establishment review approved by Board (Jan '21) • Approved WSFT people plan, with monthly reporting to Board • Vacancy levels – reported monthly • National staff survey – reported to board • Friends and family and staff recommender scores		

	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	Annual 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	Mar 23
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
Communication strategy for structural risk based on agreed remediation plan with clinical model to support capacity requirements (linked to Attain work)	C Black	ongoing
Assurances		
• Reporting to Board (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: o Civil Contingencies Act - Advisory (July 2020) o Risk Management - Reasonable Assurance (Nov 2020)		

	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	Ongoing
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	Ongoing
Outline Business Case submission	Craig Black	Oct 22
Assurances		
• FS Programme Board with NED membership meets monthly and reports to the Board of Directors • Monthly update to the board on progress with the project, providing detailed updates on all key stages of the programme		

5.2. Governance report

To inform

Presented by Ann Alderton

Board of Directors – 17 December 2021

Report Title:	Item 5.2 - Governance Report
Executive Lead:	Ann Alderton, Interim Trust Secretary
Report Prepared by:	Ann Alderton, Interim Trust Secretary
Previously Considered by:	N/A

For Approval	For Assurance	For Discussion	For Information
☒	☐	☐	☒

Executive Summary

This report summarises the main governance headlines for December 2021, as follows:

- Board Dates for 2022
- Agenda Items for the January Board meeting
- NHS Systems Oversight Framework Segmentation
- Use of Emergency Powers
- Senior Leadership Team report
- Board Effectiveness Review
- Dissolution of the Scrutiny Committee
- Use of Trust Seal

Action Required of the Board

To note the report and to approve the dissolution of the Scrutiny Committee

Legal and regulatory context	NHSE/I have assessed the Trust to be in Segment 3 of the NHS Systems Oversight Framework 2021/22 as a result of the CQC's assessment of the Trust's leadership. The Board Effectiveness review is one of the actions the Trust has taken to improve its position and meet regulators' expectations. The establishment of the Senior Leadership Team and dissolution of the Scrutiny Committee are also important actions to improve corporate governance.

Governance Report

1. 2022 Board Dates

From January 2022, the Board is moving to a bi-monthly cycle of meetings. Board meetings will be held in public and followed by a closed meeting for discussion and decision relating to confidential matters. During the months where the board will not be holding a formal meeting, board time will be set aside for board development and strategy workshops.

The Board dates for 2022 are as follows:

28 January
25 March
27 May
22 July
30 September
25 November

2. Agenda Items for the Next Meeting (Annex A)

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.

3. NHS Systems Oversight Framework Segmentation (Annex B)

On 15 November 2021, the Trust was notified by the regional office of NHSE/I that the Trust would be placed in Segment 3 under the NHS Systems Oversight Framework 2021/22 and given mandated support. There are four segments in the framework ranging from 1 (best performing) to 4 (worst performing). As the framework explains, any Trust which has been rated by the CQC as "Requires Improvement" overall and for "well-led" is placed in Segment 3. The Trust welcomes the offer of support and the opportunity to learn from the system and national expertise that this support offers.

4. Emergency Powers

The following decision was taken using emergency powers during October 2021 and is reported to this meeting for noting:

Revalidation – Annual Board Report and Statement of Compliance (Annex D)

This was approved by the Chair, Deputy Chief Executive and the non-executive directors on 26 October 2021. The report is included in the board papers under item 3.3

5. Senior Leadership Team

The Senior Leadership Team is a decision-making forum which provides strategic leadership for the organisation and is responsible for the implementation and delivery of the Trust's strategic direction, business plan and associated objectives, ensuring that a cohesive decision-making process and co-operative approach is applied to issues which have an impact across the organisation. The Team meet for the first time in November 2021 and will meet fortnightly.

As the team is in its formative stage, it has decided to defer approving its terms of reference until its agenda and forward plan becomes more established and its assurance and escalation links to

the Board and board committees mature, including future arrangements for divisional oversight. Its first meeting on 15 November focused on building compassionate and collaborative leadership and the values it wished to represent to the rest of the organisation. Other meetings focused on the Winter Plan and the Trust Strategy.

6. Board Effectiveness Review

It is a requirement of the well-led framework and the FT Code of Governance to undertake regular appraisals of the effectiveness of the Board of Directors, with an externally facilitated development review every 3-5 years, depending on circumstances. Following a number of recent board level changes, and recognising that the CQC had assessed the board as “requires improvement” for the well-led criteria, the Board selected Integrated Development Ltd as its partners for this review. Using on-line surveys, observations of board and committee meetings and individual interviews, Integrated Development Ltd presented reports of its findings to the board at a development day and workshop on 25 November. The workshop focused on the areas requiring the most improvement and the board will be working with Integrated Development Ltd on a Board Development plan with improvement and performance development in mind.

7. Dissolution of Scrutiny Committee (Annex C)

Following the establishment of a new Organisational Framework for Governance, it was agreed that the Scrutiny Committee be stood down. The duties of the committee as detailed in both the Scheme of Delegation and its Terms of Reference and their reallocation are listed in Annex C.

8. Use of Trust Seal

To note use of the Trust Seal, pursuant to Standing Order section 8. The Trust Seal was used on the following occasions:

Seal No. 149 – Option agreement between Christopher John Horace Brown and Rupert Jeremy Christopher Brown and WSFT relating to land on the west side of Horsecroft Road, Bury St Edmunds - Sealed by Helen Beck & Nicola Cottington, witnessed by Claire Peters-Finch (11 November 2021).

Seal No. 150 – West Suffolk Council and WSFT, lease relating to part of Brandon Leisure Centre, Church Road, Brandon, Suffolk, IP27 0JB - Sealed by Craig Black & Nick Macdonald, witnessed by Karen McHugh (22 November 2021).

Annex A: Scheduled draft agenda items for next meeting – 28 January 2022

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
Report from 3i Committees: Insight, Improvement & Involvement	✓		Written	Matrix	RD / AR / JC
Risk and governance report		✓	Written	Matrix	AA
First for Patients/Staff – Assurance and Culture					
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
First for the Future					
Digital Strategy	✓		Written		NM
Future system board report	✓	✓	Written	Matrix	CB
Strategic update, including Alliance, System Executive Group and Integrated Care System		✓	Written	Matrix	KV / CB
Governance					
Governance report, including - Agenda items for next meeting - Use of Trust's seal	✓		Written	Matrix	AA

- Senior Leadership Team report - Board 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: NHS Systems Oversight Framework Segmentation Letter

NHS England and NHS Improvement East of England
2 – 4 Victoria House
Capital Park
Fulbourn
Cambridge
CB21 5XB

Dear Craig,

The West Suffolk NHS Foundation Trust: NHS system oversight framework segmentation

As you will be aware, NHS England and NHS Improvement (NHSEI) recently consulted on the new NHS System Oversight Framework (SOF) 2021/22, which introduced a new approach to provide focused assistance to organisations and systems.

Following feedback from local leaders and others, this new SOF is now being implemented. The final SOF can be found here.

Following consideration by the NHSEI regional support group, it has been agreed that West Suffolk NHS FT should be placed into SOF segment 3 and mandated support.

What this means in practice is that the regional team will work collaboratively with you to undertake a diagnostic stocktake to identify the key drivers of the concerns that need to be resolved. Through this, we aim to better understand your support needs, reach agreement on clear and timely exit criteria.

We recognise and thank you for the efforts of you and your teams to provide the best quality care to our patients, including meeting and recovering from the additional challenges COVID-19 has posed. This decision is not a reflection of all those staff who have worked so tirelessly for patients this year in particular, but an opportunity for us all to work together to build better and more sustainable services for those patients for the future.

If you wish to discuss the above or any related issues in more detail, please contact Catherine Morgan in the first instance.

Yours sincerely

Catherine Morgan OBE
Regional Chief Nurse: East of England

Annex C: Reassignment of Scrutiny Committee Delegated Responsibilities

Delegated Responsibilities	Assigned to:
1. To recommend to the Board of Directors projects and developments to be considered for inclusion in the Committee's work programme. The Committee's work programme will be determined through an annual review, taking into account the annual review of the operational and strategic plans, and supported by ongoing review of the meeting agendas of the Committee and the Board of Directors.	This is an administrative duty which applies to the Board and its committees collectively. It is the Board's responsibility to establish appropriate governance for its major projects and developments.
2. To report to the Board any new projects or developments proposed for inclusion in the work programme during the year.	Major projects have their own governance arrangements, reporting to the Board of Directors directly
3. To ensure project management structures and processes are in place to ensure effective scrutiny of the projects within the Committee's work programme.	This is primarily an executive responsibility (Senior Leadership Team). Independent assurance over the project management arrangements for the Trust's major projects will fall within the Audit Committee's remit.
4. To review committee's work programme as a standing agenda item at each meeting and report this to the Board.	This is an administrative duty which ceases with the committee
5. To receive, review and recommend business cases when appropriate to the Board of Directors. All business cases of a level to require a Strategic Outline Cases (SOCs) will be considered by the Committee prior to presentation to the Board.	This is managed on a case by case basis, through the Senior Leadership Team and then the Board. Task and finish groups will be established for complex projects.
6. To secure the necessary Executive support to ensure the work programme is delivered and to: (a) Approve the scope of the projects and oversee their implementation (b) Approve the managers who will manage the project on its behalf and define their roles and responsibilities (c) Approve the project documentation (d) Approve the reporting arrangements, structure and frequency (e) Approve the sequence and timescale of the work (f) Identify resource implications to the Board of Directors (g) Agree any changes to a project's scope	These are executive responsibilities and are decided upon and approved by the responsible manager, the Executive Directors and/or the Senior Leadership Team.

Delegated Responsibilities	Assigned to:
(h) Initiate action to address any matters which are beyond the authority of other managers to resolve (i) Agree any arrangements for evaluation (j) Officially close the projects from the work programme	
7. For all significant projects, and in line with its own Financial Instructions, Department of Health and Social Care and NHS Improvement guidance as appropriate, the Committee will ensure that, if required, a third party is engaged to undertake a process of due diligence prior to any agreement on the transfer of services. This includes having an independent: (a) Assessment of the underlying financial position of services that WSFT may look to develop and/or take on; (b) Analysis and comment upon the assets and liabilities to be assumed; (c) Identification of internal control weaknesses including observations on systems and personnel; (d) Identification of transitional issues and potential assistance with post-transaction integration issues; (e) Identification of areas of risk (and opportunity) that may require specific protection (through warranties and indemnities) in any necessary agreements with other organisations.	This is undertaken by the board on a case-by-case basis, with separate task and finish groups set up for large major projects
Approval of Business Cases and investments up to a value of £250,000	Senior Leadership Team has authority to approve business cases and investments up to a value of £250,000

Classification: Official

Publications approval reference: B0614

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

Contents

Introduction:.....2
Designated Body Annual Board Report.....4
Section 1 – General:.....4
Section 2a – Effective Appraisal.....5
Section 2b – Appraisal Data.....7
Section 3 – Recommendations to the GMC.....7
Section 4 – Medical governance.....8
Section 5 – Employment Checks.....10
Section 6 – Summary of comments, and overall conclusion.....10
Section 7 – Statement of Compliance:.....11

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

Annual Organisational Audit (AOA):

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

Board Report template:

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2020 – 31 March 2021 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.[1] This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Statement of Compliance:

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

   Dr Nick Jenkins stepped down as responsible officer June 2021 – replaced by interim responsible officer (and interim medical director) Dr Paul Molyneux

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

   Yes

   Difficult year due to changeover of the longstanding appraisal and revalidation administrator in June 2021 – this has required investment in terms of time training new administrator from the appraisal team. Furthermore, transition from SARDS to allocate software has resulted in increased learning of the functionality of the software and correction of previously incorrectly inputted data.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

   Yes

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

   Yes – policy in place – will be reviewed and updated for the next appraisal year.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: no formal process – however new appraisal lead was the appraisal lead of a nearby trust, as such updated structure has been implemented – this includes updated SOP, terms of reference of revalidation support group and new membership of the RSG to support inclusive culture

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Yes – appraisal training via teams commenced October 2021

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

2020 model adopted – appraisal training commenced October 2021 as small TEAMS groups. 1:1 appraiser training commenced October 2021.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: n/a

Comments:

Action for next year:

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: yes, in place

Comments:

Action for next year: will be updated

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: currently insufficient appraisers – as such appraisers doing >6, recruitment process ongoing and new appraisers will be appointed

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Commenced for appraisal year 21/22

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Quarterly board reports

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	West Suffolk Hospital
Total number of doctors with a prescribed connection as at 31 March 2021	319
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	111
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	23
Total number of agreed exceptions	185

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Yes

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the

recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

yes

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

A huge amount of work has gone into ensuring the Organisation creates and sustains the right environment to support effective clinical governance for doctors. The Board actively encourages a culture of honesty, learning and improvement and this is borne out through our new Incident Reporting Process, Peer Support for Doctors, Freedom to Speak up Guardians and a much-improved approach to HR Processes and we will actively seek out organisational specific feedback from the 2021 NHS staff survey related to this. While there is no room for complacency, there is a relentless focus on the Board demonstrating the values that create an open and inclusive leadership style that facilitates good governance

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

As it stands, appraisal documentation focuses upon fitness to practise rather than fitness to perform, as such it includes rather limited performance data. However, governance information around complaints and incidents is included and reviewed upon all revalidation decisions for the doctor's entire scope of work. We plan to include a statement on conduct and performance from either the Clinical Lead or Clinical Director as part of the development of appraisal supporting information in the next appraisal year.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved

responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Yes

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

There is a system for reporting Doctors of Concern to Board on a regular basis. This does include numbers and type of concerns. However, as it stands, this does not currently include protected characteristics of Doctors. That said, the Trust does participate in the NHS Workforce Race Equality Standard Scheme, thereby receiving data that is built into our governance system The Trust will look to how we could directly include protected characteristics in its Board reporting framework in the next 12 months

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Yes

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

The Trust would find it difficult to provide direct evidence to support this standard as it stands. That said, there is strong representation from our BAME and LGBT Groups, that are fully supported by the board.

The Board will review its compliance with Principle 3 of the GMC Effective clinical Governance for the medical Profession as part of its development programme in the next 12 months, both to ensure compliance, but also to be able to evidence this

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Yes

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of actions since last Board report**
- **Much progress made in last 12 months, including appointment of a new lead appraiser with a designated PA allocation to fulfil the role. The move from SARD to Allocate has created real challenges in data management, but the new system is now firmly embedded**
- **It has been a uniquely challenging period for appraisal, with the transient suspension of the process during Covid, that created a situation whereby appraisal either took place or was deferred dependant on an arbitrary allocation of appraisal month.**
- **The move to reduce the requirement for Supporting Information is welcome, but risks potentially undermining some of the key benefits of appraisal in terms of providing assurance around fitness to practise across the individuals scope of work.**
- **The new focus on Clinical Governance is welcome, and has shone a light on the need to be able to demonstrate compliance with the Clinical Governance standards for doctors as laid out in the GMC Document. This is something the Board will devote time to addressing in the next 12 months, by benchmarking against the criteria and focussing on areas where it is currently more difficult to provide external assurance**

Section 7 – Statement of Compliance:

The Board of West Suffolk NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body:

Official name of designated body: **West Suffolk NHS Foundation Trust**

Name: SHEILA CHILDERHOUSE Signed: 

Role: CHAIR

Date: 26.10.21

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.

Publication approval reference: PAR614

5.3. West Suffolk NHS Foundation Trust Constitution

To Approve

Presented by Ann Alderton

Board of Directors – 17 December 2021

Report Title:	Item 5.3 - West Suffolk Hospital NHS Foundation Trust Constitution
Executive Lead:	Ann Alderton, Interim Trust Secretary
Report Prepared by:	Ann Alderton, Interim Trust Secretary
Previously Considered by:	Constitution Committee

For Approval	For Assurance	For Discussion	For Information
☒	☐	☐	☐

Executive Summary

All Foundation Trusts are required by law to have a Constitution. The Constitution provides details of how the Foundation Trust will operate, its membership area, the size and composition of its Council of Governors and its Board of Directors and other information relating to the governance of the organisation and the conduct of meetings. It is a public document which is available on the Trust's public website and on the NHSE/I Directory of Foundation Trusts. The Constitution can only be changed with the approval of both the Council of Governors and the Board of Directors.

The Constitution was previously reviewed in April 2021, to extend the membership area (Annex 1).

For this review, a Constitution Committee was established as a task and finish group, comprising three governors (public, staff and partner) and two Directors (one Executive Director and one Non-Executive Director.

The review focused on the Constitution itself, and any annexes affected by any proposed changes from that review. The review did not include Annex 4 – the model rules for elections, which are based on the latest template from NHS Providers and endorsed by the Department of Health and NHSI.
All of the narrative changes agreed by the committee are highlighted in yellow on the main body of the Constitution. Minor changes (page and paragraph numbers) and deletions are not shown due to the need to finalise page numbers but are listed in the table on the following page, which also explains the rationale for those changes.

Action Required of the Board

To approve the revised Constitution.

Equality, Diversity and Inclusion:	Change to Annex 5 to comply with the Equality Act
Legal and regulatory context	NHS Act 2006 Health and Social Care Act 2012

Page Ref	Section	Proposed Change	Rationale
6	Automatic Membership by Default	Insertion of sentence “This does not apply to staff who are eligible for membership under 7.2, who must make an application for membership”.	Automatic membership by default only works for staff who have a contract of employment and are on the payroll. The insertion recognises that individuals referred to under paragraph 7.2 (“Individuals who exercise functions for the purposes of the trust, otherwise than under a contract of employment”) will need to apply for membership
8	Council of Governors - tenure	Insertion of paragraph 12.8 A person may not stand for election as a Governor or be appointed as a Governor in accordance with clause 10 if their tenure as a governor was terminated following a breach of the Governors’ Code of Conduct or other rules relating to the governors or Council of Governors as determined by the Council of Governors	This prevents a governor who has previously breached the Governors’ Code of Conduct and removed from the Council of Governors from standing again for election.
11	Board of Directors - composition	Increase the numbers of Non-Executive Directors from 5 to “up to 7”. Increase the numbers of Executive Directors from 5 to “up to 7”.	The current number of non-executive directors is low, which means that the capacity of the current team is stretched. The Board limit of 5 executive directors means that the Executive Director of Workforce is not able to be a voting director. By using the term “up to”, this means that the Trust is not unconstitutional if the number of directors is below this number. The average board size in the NHS is 13 (1 Chair, 6 NEDs, 6 Execs). This allows the board to increase its size from 11 to 13, with flexibility of up to 15 without having to review the Constitution again.
Deletion	Board of Directors	Deletion of the following paragraphs 27 – Appointment of Initial Chairman and Initial Other Non-Executive Directors 29.3 – refers to the appointment of the initial Chief Executive 30 – Appointment and removal of Initial Chief Executive Deletion of reference to initial Non-Executive Directors in new paragraph 29.4	These clauses only applied on the date the Trust applied for Foundation status. This will not happen again and the Board of Directors no longer includes the Chair, Chief Executive and Non-Executive Directors who were in place at the time it became a Foundation Trust.
13	Board of Directors - Disqualification	Insertion of “a person who is a member of the Council of Governors”	Legal requirement under the NHS Act 2006
13	Board of Directors - Disqualification	**Insertion of new paragraphs** **29.7** A person who has been responsible for, been privy to, contributed to or facilitated any serious misconduct or	The Statutory Instrument relating to the Fit and Proper Persons requirement is scheduled to cease to have effect

Page Ref	Section	Proposed Change	Rationale
		mismanagement (whether unlawful or not) in the cause of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity **29.8** A person where disclosure revealed by a Disclosure and Barring Service check against such a person are such that it would be inappropriate for them to become or continue as a Director or would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute **29.10** A person is subject of a disqualification order made under the Company Directors Disqualification Act 1986 **29.11** A person who is the subject of an order under the Sexual Offences Act 2003 **29.12** A person who is included in any barred list established under the Safeguarding Vulnerable Groups Act 2006 **29.13** A person who has been been erased, removed or struck off by a direction from a register of professionals and has not subsequently had his qualification re-instated or suspension lifted.	after 31 March 2022 and will require another Statutory Instrument to continue the regulations. It is better, therefore, to list the requirements in the Statutory Instrument separately in the Constitution rather than use a reference which is about to become obsolete and cease to have effect in law. The Constitution still refers to the Fit and Proper Persons' Regulations in paragraph in paragraph 29.16 so that any modifications or re-enactment that adds to the list on the left is included in the criteria for disqualification, but listing the current requirements ensures that the disqualification criteria still stand even if the regulations become obsolete and are not modified or re-enacted. Paragraph 29.13 originally listed only "healthcare professionals" but the committee extended it to include other professional groups.
Page 17	Board of Directors – Remuneration and terms of office	Insert 35.3 On appointment, the duration of a term of office for a Non-Executive Director (including the Chair) shall be three (3) years. Subject to satisfactory appraisal, a Non-Executive Director (including the Chair) may be re-appointed by the Council of Governors for a further full term, normally service a maximum of six (6) years. Exceptionally, the Council of Governors may agree to extending the term of Office of a Non-Executive Director (including the Chair) by a further twelve (12) months in order to maintain continuity of knowledge and experience within the Board. 35.4 The maximum aggregate period of office of any Non-Executive Director shall not exceed seven (7) years, save that in the event that any Non-Executive Director takes office as Chair after they have been a Non-Executive Director for two (2) or more years, the maximum aggregate period of office for that Non-Executive Director shall not exceed nine (9) years	The terms of office were not included in the Constitution and have been added in. These are the current terms of office for West Suffolk Hospital NHS FT and reflect good practice in terms of independence.

Page Ref	Section	Proposed Change	Rationale
Page 19	Auditor	Insert 39.2 A person may only be appointed auditor if he (or the case of a firm, each of its members) is a member of one or more of the bodies referred to in Paragraph 23 (4) of Schedule 7 to the 2006 Act. 39.4 The auditor shall carry out its duties in accordance with Schedule 10 to the 2006 Act and in accordance with any directions given by Monitor on standards, procedures and techniques adopted	These inclusions are legal requirements and many FTs have included them in their Constitution
Page 20	Accounts	Amend heading to "Accounts and Records"	Clarification
Page 21	Accounts	Insert 39.6 In preparing its annual accounts or in preparing any accounts by virtue of paragraph 39.4 above, the Trust must comply with any directions given by Monitor with the approval of the Secretary of State as to: 39.6.1 The methods and principles according to which the annual accounts must be prepared: and/or 39.6.1 The content and form of the annual accounts 39.7 The Trust must: 39.7.1 Lay a copy of the annual accounts, and any report of the auditor on them, before Parliament; and 39.7.2 Send copies of the annual accounts, and any report of the auditor on them to Monitor within such a period as Monitor may direct	Inclusion of legal and other regulatory requirements relating to the accounts
Page 21	Annual Report, Forward Plans and non-NHS work	Paragraph 42.7 – slight amendment to the wording Instead of "A Trust which proposes to…may implement" Replace with "The Trust may implement a proposal…	Clarification, so that it is clear that the clause applies to West Suffolk NHS FT and not any Trust.
Page 23	Instruments	Add to paragraph 45.2 "as outlined in the Standing Orders for the Practice and Procedure of the Board of Director at Annex 8"	Clarification
Page 25	Interpretation and Definitions	After the definition of Monitor insert: "which, at the time of the preparation of this document operates as NHS Improvement"	Clarification. Monitor is still referred to by name in the 2006 Act and has therefore been kept as a reference in this document.
Page 78	Annex 5 Additional Provisions – Council of	Paragraph (f) amended to simplify the wording and to mirror paragraph 29.13 in the main Constitution Paragraph (g) deleted	(f) Clarification (g) No longer part of the model constitution (was originally in the main part of the model constitution used by Trusts prior

Page Ref	Section	Proposed Change	Rationale
	Governors	"he is incapable by reason of mental disorder, illness or injury of managing and/or administering his property and/or affairs;" Insert: "He has been previously removed as a Governor pursuant to paragraph 12.8 of this Constitution"	to 2012) and was removed following to the Equality Act 2010. For consistency it has now been removed from the Annex To prevent a governor previously dismissed through code of conduct breach from standing and being elected again.
Page 93	Annex 7 Governors' Standing Orders Lead Governor section	Removal of paragraphs 9.1 to 9.3 and replace with the following: 9.1 The Council of Governors shall appoint from their public governors a Lead Governor. Their role shall be: 9.1.1 To act as a conduit of communication between Monitor and Governors particularly in cases where it may not be appropriate to communicate through the normal channels and also where there is a real risk that a Trust is in significant breach of one or more conditions of its licence and Monitor has significant concerns about the leadership of a Trust. 9.1.2 To act as a conduit of communication between Monitor and Governors when individual Governors have concerns they wish to raise with Monitor. 9.1.3 To contact Monitor (NHSI/E) on behalf of Governors when there is concern 'that the process of appointment of the Chair or other members of the Board, or elections for Governors, or other material decisions may not have complied with a Trust's Constitution, or alternatively, whilst complying with the Constitution, may be inappropriate'. 9.1.4 To chair meetings of the Council of Governors in circumstances where it may not be considered appropriate for the Chair or another of the Non-Executive Directors to do so, for example when discussing the appointment/removal of the Chair. 9.1.5 The lead Governor should take steps to understand Monitor's role, the available guidance and the basis on which Monitor may take regulatory action. 9.2 The Council of Governors shall also appoint a Deputy Lead Governor from their public governors, who will	To provide a fuller description of the Lead Governor role and process for election of Lead Governor and Deputy Lead Governor. Role description taken from the FT Code of Governance

Page Ref	Section	Proposed Change	Rationale
		take up the role and responsibilities of the Lead Governor on a temporary basis, in the event the Lead Governor is absent for any reason. 9.3 The term of office for Lead Governor and Deputy Lead Governor is three years. The term of office may be extended in exceptional circumstances with the approval of the Council of Governors. 9.4 Those wishing to stand can nominate themselves. Those wishing to nominate another Governor should only do so with that person's permission. 9.5 The Trust Secretary will, every 3 years, request nominations for role of lead Governor and deputy lead Governor. 9.6 Subject to the number of candidates for the role the Trust Secretary will establish a confidential ballot mechanism to elect the lead Governor. 9.7 The lead Governor's contact details shall be provided to Monitor and updated as required.	
Page 114	Annex 10 – Further Provisions	Insert 4.1.3 The appointment of an Interim Chief Executive shall require the approval of the Council of Governors	Reminder of statutory duty
Page 114	Annex 10 – Further Provisions	Add after "gross misconduct" "or any other action deemed inappropriate"	The term "gross misconduct" is mainly used in the context of employment law but as this paragraph refers to a wider group of members of the Trust, the committee added "or any other action deemed inappropriate".
Page 114	Annex 10 – Further Provisions	Insert 6.4 The Board of Directors may not disqualify a governor from membership unless that governor has been removed from the Council of Governors by a resolution approved in accordance with Annex 6, paragraph 17.	The removal of a governor is a decision of the Council of Governors whereas the removal of a member is a decision of the Board of Directors. This clause ensures that the Board of Directors do not use their power to remove a member to remove a governor.

NHS
West Suffolk
NHS Foundation Trust

West Suffolk NHS Foundation Trust

Constitution

December 2021

TABLE OF CONTENTS

Paragraph *Page*

1. Name 4
2. Principal purpose 4
3. Other purposes and powers 4
4. Membership and constituencies 4
5. Application for membership 5
6. Public constituency 5
7. Staff constituency 5
8. Restriction on membership 6
9. Annual Members' Meeting 6
10. Council of Governors – composition 6
11. Council of Governors – election of governors 7
12. Council of Governors – tenure 7
13. Council of Governors – disqualification and removal 8
14. Council of Governors – Termination of tenure 8
15. Council of Governors – Vacancies 9
16. Council of Governors – duties of governors 9
17. Council of Governors – meeting of governors 9
18. Council of Governors – standing orders 10
19. Council of Governors – referral to the Panel 10
20. Council of Governors – conflicts of interest of governors 10
21. Council of Governors – travel expenses 10
22. Council of Governors – further provisions 10
23. Board of Directors – composition 10
24. Board of Directors – general duty 11
25. Board of Directors – qualification for appointment as non-executive 11
26. Board of Directors – appointment and removal etc 11
27. Board of Directors – appointment of deputy chairman 12
28. Board of Directors – appointment and removal etc 12
29. Board of Directors – disqualification 12
30. Board of Directors – meetings 13
31. Board of Directors – standing orders 13
32. Board of Directors – conflicts of interest of directors 14
33. Board of Directors – remuneration and terms of office 16
34. Registers 16
35. Registers – inspection and copies 17
36. Documents available for public inspection 18
37. Auditor 19
38. Audit committee 19
39. Annual accounts 20
40. Annual report and forward plans and non-NHS work 20
41. Presentation of the annual accounts and reports to the Governors and Members 21

Paragraph *Page*

42. Indemnity 21
43. Instruments 22
44. Amendment of the constitution 22
45. Mergers etc. and significant transactions 23
46. Interpretation and definitions 23

ANNEX 1 – THE PUBLIC CONSTITUENCIES 26
ANNEX 2 – THE STAFF CONSTITUENCY 27
ANNEX 3 – COMPOSITION OF COUNCIL OF GOVERNORS 28
ANNEX 4 – THE MODEL RULES FOR ELECTIONS 29
ANNEX 5 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS 78
ANNEX 6 – CODE OF CONDUCT FOR GOVERNORS 79
ANNEX 7 – STANDING ORDERS – COUNCIL OF GOVERNORS 82
ANNEX 8 – STANDING ORDERS – BOARD OF DIRECTORS 95
ANNEX 9 – STATEMENT OF TRUST PRINCIPLES 113
ANNEX 10 – FURTHER PROVISIONS 114

1. Name

The name of the foundation trust is West Suffolk NHS Foundation Trust (the trust).

2. Principal purpose

2.1 The principal purpose of the trust is the provision of goods and services for the purposes of the health service in England.

2.2 The trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3. Other purposes and powers

3.1 The trust may provide goods and services for any purposes related to:

3.1.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.1.2 the promotion and protection of public health.

3.2 The trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

3.3 The powers of the trust are set out in the 2006 Act.

3.4 All the powers of the trust shall be exercised by the Board of Directors on behalf of the trust.

3.5 Any of these powers may be delegated to a committee of Directors or to an Executive Director.

4. Membership and constituencies

The trust shall have members, each of whom shall be a member of one of the following constituencies:

4.1 the public constituencies or

4.2 the staff constituency

5. Application for membership

An individual who is eligible to become a Member of the trust may do so on application to the trust.

6. Public Constituency

6.1 An individual who lives in the area specified in Annex 1 as an area for a public constituency may become or continue as a Member of the trust.

6.2 Those individuals who live in the area specified for a public constituency are referred to collectively as the Public Constituency for that area.

6.3 The minimum number of Members in each Public Constituency is specified in Annex 1.

7. Staff Constituency

7.1 An individual who is employed by the trust under a contract of employment with the trust may become or continue as a member of the trust provided:

7.1.1 he is employed by the trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

7.1.2 he has been continuously employed by the trust under a contract of employment for at least 12 months.

7.2 Individuals who exercise functions for the purposes of the trust, otherwise than under a contract of employment with the trust, may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months. For clarity this does not include individuals who exercise functions for the purposes of the trust on a voluntary basis.

7.3 The Trust Secretary must have regard to Chapter 1 of Part 14 of the Employment Rights Act 1996 for the purposes of determining whether an individual has been continuously employed by the Trust, or has continuously exercised functions for the purposes of the Trust.

7.4 Those individuals who are eligible for membership of the trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

7.5 The minimum number of members in the Staff Constituency is specified in Annex 2.

Automatic membership by default – staff

7.6 An individual who is:

7.6.1 eligible to become a Member of the Staff Constituency, and

7.6.2 invited by the trust to become a Member of the Staff Constituency,

shall become a Member of the trust as a Member of the Staff Constituency without an application being made, unless he informs the trust that he does not wish to do so. This does not apply to staff who are eligible for membership under 7.2, who must make an application for membership.

8. Restriction on membership

8.1 An individual who is a Member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a Member of any other constituency or class.

8.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

8.3 An individual must be at least 16 years old to become a member of the trust.

8.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the trust are set out in Annex 10 – Further Provisions.

9. Annual Members' Meeting

9.1 The Trust shall hold an annual meeting of its members ('Annual Members' Meeting'). The Annual Members' Meeting shall be open to members of the public.

10. Council of Governors – composition

10.1 The trust is to have a Council of Governors, which shall comprise both elected and appointed Governors.

10.2 The composition of the Council of Governors is specified in Annex 3.

10.3 The aggregate number of public Governors is to be more than half the total membership of the Council of Governors.

10.4 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of Governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 3.

11. Council of Governors – election of governors

11.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Rules for Elections.

11.2 The Model Rules for Elections as published from time to time by the Department of Health form part of this Constitution. The Model Rules for Elections current at the date this constitution is approved are attached at Annex 4. Elections for elected members of the Council of Governors shall be conducted using the first past the post system. Thus, where appropriate, the alternative rules marked "FPP" (First Past the Post) should be used.

11.3 A subsequent variation of the Model Rules for Elections by the Department of Health shall not constitute a variation of the terms of this Constitution for the purposes of paragraph 46 of the Constitution (amendment of the constitution).

11.4 An election, if contested, shall be by secret ballot.

11.5 Where a vacancy arises for an elected Governor the trust may, instead of holding a by-election, fill the vacancy by appointing the highest polling unsuccessful candidate at the most recent election of governors for the constituency or class in respect of which the vacancy has arisen. Any person so appointed shall hold office for the unexpired term of office of the retiring Governor.

12. Council of Governors - tenure

12.1 An elected Governor may hold office for a period of up to 3 years.

12.2 An elected Governor shall cease to hold office if he ceases to be a member of the constituency or class by which he was elected.

12.3 Subject to Paragraph 12.4 below, an elected Governor shall be eligible for re-election at the end of his term.

12.4 An elected Governor may not hold office for longer than 9 years or be re-elected if, by virtue of this paragraph 12.4, he would not be able to remain in office for the full three year period.

12.5 An appointed Governor may hold office for a period of up to 3 years.

12.6 An appointed Governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him.

12.7 An appointed Governor shall be eligible for re-appointment at the end of his term, but may not hold office for more than nine years.

12.8 A person may not stand for election as a Governor or be appointed as a Governor in accordance with clause 10 if their tenure as a governor was terminated following a breach of the Governors' Code of Conduct.

13. Council of Governors – disqualification and removal

13.1 The following may not become or continue as a member of the Council of Governors:

13.1.1 a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

13.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

13.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

13.2 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

13.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 5.

14. Council of Governors – Termination of tenure

14.1 A Governor may resign from that office at any time during the term of that office by giving notice in writing to the Secretary to the trust.

14.2 If a Governor fails to attend any meeting of the Council of Governors, for a period of one year or three consecutive meetings (whichever is the shorter) his tenure of office is to be immediately terminated unless the other Governors agree by a majority vote that:

14.2.1 the absence was due to a reasonable cause; and

14.2.2 he will be able to start attending meetings of the Council of Governors again within such a period as they consider reasonable.

14.3 Where a person has been elected or appointed to be a Governor and he becomes disqualified for appointment under paragraph 13, he shall notify the Secretary in writing of such disqualification.

14.4 If it comes to the notice of the Secretary at the time of his appointment or later that the Governor is so disqualified, he shall immediately declare that the person in question is disqualified and notify him in writing to that effect.

14.5 Upon receipt of any such notification, that person's tenure of office, if any, shall be terminated and he shall cease to act as a governor.

15. Council of Governors – Vacancies

Where membership of the Council of Governors ceases, Public and Staff Governors shall be replaced in accordance with paragraph 11.5, and appointed Governors shall be replaced in accordance with processes agreed with their appointers.

16. Council of Governors – duties of governors

16.1 The general duties of the Council of Governors are –

16.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and

16.1.2 to represent the interests of the members of the trust as a whole and the interests of the public.

16.2 The Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

17. Council of Governors – meetings of governors

17.1 The Chairman of the trust (i.e. the Chairman of the Board of Directors, appointed in accordance with the provisions of paragraph 26.1 or paragraph 27.1 below) or, in his absence the Deputy Chairman (appointed in accordance with the provisions of paragraph 28 below), shall preside at meetings of the Council of Governors.

17.2 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons. The Chairman may also exclude any member of the public from a meeting of the Council of Governors if he is interfering with or preventing the proper conduct of the meeting.

17.3 For the purposes of obtaining information about the trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the trust's or Directors' performance), the Council of Governors may require one or more of the Directors to attend a meeting.

18. Council of Governors – standing orders

The standing orders for the practice and procedure of the Council of Governors, as may be varied from time to time in accordance with paragraph 46, are attached at Annex 7.

19. Council of Governors – referral to the Panel

19.1 In this paragraph, the Panel means a panel of persons appointed by Monitor to which a governor of an NHS foundation trust may refer a question as to whether the trust has failed or is failing—

19.1.1 to act in accordance with its Constitution, or

19.1.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

19.2 A Governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

20. Council of Governors - conflicts of interest of governors

If a Governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the Governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

21. Council of Governors – travel expenses

The trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the trust.

22. Council of Governors – further provisions

Further provisions with respect to the Council of Governors are set out in Annex 5 and Annex 10.

23. Board of Directors – composition

23.1 The trust is to have a Board of Directors, which shall comprise both Executive Directors and Non-Executive Directors.

23.2 The Board of Directors is to comprise:

23.2.1 a Non-Executive Chairman;

23.2.2 up to 7 other Non-Executive Directors; and

23.2.3 up to 7 Executive Directors.

23.3 One of the Executive Directors shall be the Chief Executive.

23.4 The Chief Executive shall be the Accounting Officer.

23.5 One of the Executive Directors shall be the Finance Director.

23.6 One of the Executive Directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

23.7 One of the Executive Directors is to be a registered nurse or a registered midwife.

24. Board of Directors – general duty

The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the trust so as to maximise the benefits for the members of the trust as a whole and for the public.

25. Board of Directors – qualification for appointment as a non-executive director

A person may be appointed as a Non-Executive Director only if –

25.1 he is a member of a Public Constituency, or

25.2 where any of the trust's hospitals includes a medical or dental school provided by a university, he exercises functions for the purposes of that university, and

25.3 he is not disqualified by virtue of paragraph 31 below.

26. Board of Directors – appointment and removal of chairman and other non-executive directors

26.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chairman of the trust and the other Non-Executive Directors.

26.2 Removal of the Chairman or another Non-Executive Director shall require the approval of three-quarters of the members of the Council of Governors.

27. Board of Directors – appointment of deputy chairman

The Council of Governors at a general meeting of the Council of Governors shall appoint one of the Non-Executive Directors as a Deputy Chairman.

28. Board of Directors - appointment and removal of the Chief Executive and other executive directors

28.1 The Non-Executive Directors shall appoint or remove the Chief Executive.

28.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

28.3 A committee consisting of the Chairman, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other Executive Directors.

29. Board of Directors – disqualification

The following may not become or continue as a member of the Board of Directors:

29.1 a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

29.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it.

29.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

29.4 a person who no longer satisfies paragraph 25.1 or 25.2 (if applicable).

29.5 a person who is a member of the Council of Governors

29.6 a person whose tenure of office as a chairman or as a member or director of a national health service body has been terminated on the grounds that his appointment is not in the interests of public service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest.

29.7 A person who has been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the cause of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

29.8 A person where disclosure revealed by a Disclosure and Barring Service check against such a person are such that it would be inappropriate for them to become or continue as a Director or would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute.

29.10 A person is subject of a disqualification order made under the Company Directors Disqualification Act 1986.

29.11 A person who is the subject of an order under the Sexual Offences Act 2003

29.12 A person who is included in any barred list established under the Safeguarding Vulnerable Groups Act 2006

29.13 A person who has been been erased, removed or struck off by a direction from a register of professionals and has not subsequently had his qualification re-instated or suspension lifted.

29.14 A person who has within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a national health service body.

29.15 A person who has failed to agree (or having agreed, fails) to abide by the value of the trust's principles as set out in Annex 9.

29.16 A person does not meet the criteria set out in Regulation 5(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Fit and Proper Persons' Regulations) (including any modification or re-enactment).

30. Board of Directors – meetings

30.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

30.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

31. Board of Directors – standing orders

The standing orders for the practice and procedure of the Board of Directors, as may be varied from time to time in accordance with paragraph 46, are attached at Annex 8.

32. Board of Directors - conflicts of interest of directors

32.1 The duties that a Director of the trust has by virtue of being a Director include in particular –

32.1.1 A duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the trust (a "Conflict").

32.1.2 A duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

32.2 The duty referred to in sub-paragraph 32.1.1 is not infringed if –

32.2.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

32.2.2 The matter has been authorised in accordance with the Constitution.

32.3 The duty referred to in sub-paragraph 32.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

32.4 In sub-paragraph 32.1.2, “third party” means a person other than –

32.4.1 The trust, or

32.4.2 A person acting on its behalf.

32.5 If a Director of the trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the trust, the Director must declare the nature and extent of that interest to the other Directors.

32.6 If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.

32.7 Any declaration required by this paragraph must be made before the trust enters into the transaction or arrangement.

32.8 This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.

32.9 A Director need not declare an interest –

32.9.1 If it cannot reasonably be regarded as likely to give rise to a conflict of interest;

32.9.2 If, or to the extent that, the Directors are already aware of it;

32.9.3 If, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered –

32.9.3.1 By a meeting of the Board of Directors, or

32.9.3.2 By a committee of the Directors appointed for the purpose under the Constitution.

32.10 A matter shall have been authorised for the purposes of paragraph 32.2.2 above if:

32.10.1 The Directors, in accordance with the requirements set out in this paragraph 32.10, authorise any matter or situation proposed to them by any Director which would, if not authorised, involve a Director (an "Interested Director") breaching his duty under paragraph 32.1.1 above to avoid Conflicts:

32.10.1.1 the matter in question shall have been proposed by any Director for consideration in the same way that any other matter may be proposed to the Directors under the provisions of this Constitution;

32.10.1.2 any requirement as to the quorum for consideration of the relevant matter is met without counting the Interested Director or any other Interest Director; and

32.10.1.3 the matter was agreed to without the Interested Director voting or would have been agreed to if the Interested Director's and any other Interested Director's vote had not been counted.

32.10.2 Any authorisation of a Conflict under this paragraph 32.10 may (whether at the time of giving the authorisation or subsequently):

32.10.2.1 extend to any actual or potential conflict of interest which may reasonably be expected to arise out of the Conflict so authorised;

32.10.2.2 provide that the Interested Director be excluded

from the receipt of documents and information and the participation in discussions (whether at meetings of the Directors or otherwise) related to the Conflict;

32.10.2.3 impose upon the Interested Director such other terms for the purposes of dealing with the Conflict as the Directors think fit;

32.10.2.4 provide that, where the Interested Director obtains, or has obtained (through his involvement in the Conflict and otherwise than through his position as a Director of the Trust) information that is confidential to a third party, he will not be obliged to disclose that information to the Board of Directors, or to use it in relation to the Trust's affairs where to do so would amount to a breach of that confidence; and

32.10.2.5 permit the Interested Director to absent himself from the discussion of matters relating to the Conflict at any meeting of the Directors and be excused from reviewing papers prepared by, or for, the Directors to the extent they relate to such matters.

32.11 Where the Directors authorise a Conflict, the Interested Director will be obliged to conduct himself in accordance with any terms imposed by the Directors in relation to the Conflict.

32.12 The Directors may revoke or vary such authorisation at any time, but this will not affect anything done by the Interested Director, prior to such revocation or variation in accordance with the terms of such authorisation.

32.13 A Director is not required, by reason of being a Director, to account to the Trust for any remuneration, profit or other benefit which he derives from or in connection with a relationship involving a Conflict which has been authorised by the Directors (subject in each case to any terms, limits or conditions attaching to that authorisation) and no contract shall be liable to be avoided on such grounds.

33 Board of Directors – remuneration and terms of office

33.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chairman and the other Non-Executive Directors.

33.2 The trust shall establish a committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors;

33.3 On appointment, the duration of a term of office for a Non-Executive Director (including the Chair) shall be three (3) years. Subject to satisfactory appraisal, a Non-Executive Director (including the Chair) may be re-appointed by the Council of Governors for a further full term, normally service a maximum of six (6) years. Exceptionally, the Council of Governors may agree to extending the term of Office of a Non-Executive Director (including the Chair) by a further twelve (12) months in order to maintain continuity of knowledge and experience within the Board.

33.4 The maximum aggregate period of office of any Non-Executive Director shall not exceed seven (7) years, save that in the event that any Non-Executive Director takes office as Chair after they have been a Non-Executive Director for two (2) or more years, the maximum aggregate period of office for that Non-Executive Director shall not exceed nine(9) years

34 Registers

The trust shall have:

34.1 a register of Members showing, in respect of each Member, the constituency to which he belongs and, where there are classes within it, the class to which he belongs;

34.2 a register of members of the Council of Governors;

34.3 a register of interests of Governors;

34.4 a register of Directors; and

34.5 a register of interests of the Directors.

35 Registers – inspection and copies

35.1 The trust shall make the registers specified in paragraph 36 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

35.2 The trust shall not make any part of its registers available for inspection by members of the public which shows details of any Member of the trust, if the Member so requests.

35.3 So far as the registers are required to be made available:

35.3.1 they are to be available for inspection free of charge at all reasonable times; and

35.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

35.4 If the person requesting a copy or extract is not a Member of the trust, the trust may impose a reasonable charge for doing so.

36 Documents available for public inspection

36.1 The trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

36.1.1 a copy of the current Constitution;

36.1.2 a copy of the latest annual accounts and any report of the auditor on them; and

36.1.3 a copy of the latest annual report;

36.2 The trust shall also make the following documents relating to a special administration of the trust available for inspection by members of the public free of charge at all reasonable times:

36.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.

36.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.

36.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.

36.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.

36.2.5 a copy of any statement provided under section 65F(administrator's draft report) of the 2006 Act.

36.2.6 a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA(Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.

36.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

36.2.8 a copy of any final report published under section 65I (administrator's final report),

36.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.

36.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

36.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

36.4 If the person requesting a copy or extract is not a member of the trust, the trust may impose a reasonable charge for doing so.

37 Auditor

37.1 The trust shall have an auditor.

37.2 A person may only be appointed auditor if he (or the case of a firm, each of its members) is a member of one or more of the bodies referred to in Paragraph 23 (4) of Schedule 7 to the 2006 Act.

37.3 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors.

37.4 The auditor shall carry out its duties in accordance with Schedule 10 to the 2006 Act and in accordance with any directions given by Monitor on standards, procedures and techniques adopted.

38 Audit committee

The trust shall establish a committee of Non-Executive Directors as an Audit Committee to perform such monitoring, reviewing and other functions as are appropriate.

39 Accounts and Records

39.1 The trust must keep proper accounts and proper records in relation to the accounts.

39.2 Monitor may with the approval of the Secretary of State give directions to the trust as to the content and form of its accounts.

39.3 The accounts are to be audited by the trust's auditor.

39.4 The trust shall prepare in respect of each financial year annual accounts in such form as Monitor may with the approval of the Secretary of State direct.

39.5 The functions of the trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

39.6 In preparing its annual accounts or in preparing any accounts by virtue of paragraph 39.4 above, the Trust must comply with any directions given by Monitor with the approval of the Secretary of State as to:

39.6.1 The methods and principles according to which the annual accounts must be prepared: and/or

39.6.2 The content and form of the annual accounts.

39.7 The Trust must:

39.7.1 Lay a copy of the annual accounts, and any report of the auditor on them, before Parliament; and

39.7.2 Send copies of the annual accounts, and any report of the auditor on them to Monitor within such a period as Monitor may direct

40 Annual report, forward plans and non-NHS work

40.1 The trust shall prepare an annual report and send it to Monitor.

40.2 The trust shall give information as to its forward planning in respect of each financial year to Monitor.

40.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the Directors.

40.4 In preparing the document, the Directors shall have regard to the views of the Council of Governors.

40.5 Each forward plan must include information about:

40.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the trust proposes to carry on, and

40.5.2 the income it expects to receive from doing so.

40.6 Where a forward plan contains a proposal that the trust carry on an activity of a kind mentioned in sub-paragraph 40.5.1 the Council of Governors must:

40.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfillment by the trust of its principal purpose or the performance of its other functions, and

40.6.2 notify the Directors of the trust of its determination.

40.7 The Trust may implement a proposal to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of health service in England the proposal only if more than half of the members of Council of Governors of the trust voting approve its implementation.

41 Presentation of the annual accounts and reports to the Governors and Members

41.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

41.1.1 the annual accounts

41.1.2 any report of the auditor on them

41.1.3 the annual report.

41.2 The documents shall also be presented to the Members of the trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

41.3 The trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 43.1 with the Annual Members' Meeting.

42 Indemnity

The Secretary of the trust and members of the Council of Governors and Board of Directors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, save where they have acted recklessly, and the trust may also take out and maintain at its own cost insurance against such risks, both for its own benefit and for the benefit of such persons.

43 Instruments

43.1 The trust shall have a seal.

43.2 The seal shall not be affixed except under the authority of the Board of Directors as outlined in the Standing Orders for the Practice and Procedure of the Board of Directors at Annex 8.

44 Amendment of the constitution

44.1 The trust may make amendments of its Constitution only if:

44.1.1 More than half of the members of the Council of Governors of the trust voting approve the amendments, and

44.1.2 More than half of the members of the Board of Directors of the trust voting approve the amendments.

44.2 Amendments made under paragraph 46.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act

44.3 Where an amendment is made to the Constitution in relation the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the trust):

44.3.1 At least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and

44.3.2 The trust must give the Members an opportunity to vote on whether they approve the amendment.

44.4 If more than half of the Members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the trust must take such steps as are necessary as a result.

44.5 Amendments by the trust of its Constitution are to be notified to Monitor. For the avoidance of doubt, Monitor's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

45 Mergers etc. and significant transactions

45.1 The trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

45.2 The trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the trust voting approve entering into the transaction.

45.3 "Significant transaction" means a transaction which meets the definition set out in Table 1 below:

Table 1: Significant transaction

Ratio	Description	Significant
Assets	The gross assets* subject to the transaction, divided by the gross assets of the trust	>25%
Income	The income attributable to assets or contract associated with the transaction, divided by the income of the trust	>25%
Consideration to total NHS foundation trust capital	The gross capital** of the company or business being acquired/divested, divided by the total capital*** of the trust following completion or the effects on the total capital of the trust resulting from a transaction	>25%

* Gross assets is the total of fixed assets and current assets

** Gross capital equals the market value of the target's shares and debt securities, plus the excess of current liabilities over current assets

*** Total capital of the foundation trust equals taxpayers' equity

46 Interpretation and definitions

Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this Constitution shall bear the same meaning as in the

National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

References to statutory provisions shall be deemed to include references to any provision amending, re-enacting or replacing them and to such provisions as amended from time to time.

Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

the 2006 Act is the National Health Service Act 2006.

the 2012 Act is the Health and Social Care Act 2012.

Accounting Officer means the Officer responsible and accountable for discharging the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act, which shall be the Chief Executive.

Adviser means a person formally appointed by resolution of the Council of Governors to advise the Council of Governors at meetings of the Council of Governors in an advisory and non-voting capacity.

Annual Members Meeting is defined in paragraph 9 of the constitution.

Audit Committee means a committee whose functions are concerned with the arrangements for providing the Board with an independent and objective review on its financial and risk systems, financial information and compliance with laws, guidance, and regulations governing the NHS and with the arrangements for the monitoring and improving the quality of healthcare for which the trust has responsibility.

Board of Directors ("the Board") means the Executive and Non-Executive Directors including the Chairman as constituted in accordance with the Constitution as the Board of Directors.

Chairman is the person appointed by the Council of Governors to lead the Council of Governors and Board of Directors and to ensure that they successfully discharge their overall responsibility for the trust as a whole. The expression "the Chairman of the trust" shall be deemed to include the Deputy Chairman of the trust if the Chairman is absent from the meeting or is otherwise unavailable.

Chief Executive means the accounting officer of the trust.

Committee members means in the context of a Committee persons formally appointed by the Council of Governors or Board of Directors to be members of the Committee.

Council of Governors means the elected and appointed Governors of the trust collectively as a body, as constituted in accordance with the Constitution.

Constitution means this constitution and all annexes to it.

Deputy Chairman means the Non Executive Director appointed by the Council of Governors to take on the Chairman duties if the Chairman is absent for any reason.

Director means a Member of the Board.

Executive Director means a Member of the Board who holds an executive office of the trust.

Finance Director means the Chief Financial Officer of the trust.

Governor means a person who is a member of the Council of Governors.

Licence issued by Monitor the Licence sets out a range of conditions that the Trust must meet.

Member means any person registered as a member of the trust, and authorised to vote in elections to select Governors.

Monitor is the body corporate known as Monitor, as provided by Section 61 of the 2012 Act, which, at the time of the preparation of this document operates as NHS Improvement.

Motion means a formal proposition to be discussed and voted on during the course of a meeting.

Non Executive Director means a member of the Board of Directors who is not an Executive Director of the trust.

Officer means employee of the trust or any other person holding a paid appointment or office with the trust.

Secretary means a person who may be appointed to act independently of the Council of Governors to provide advice on corporate governance issues to the Council of Governors, and the Chairman and monitor the trust's compliance with the law, Standing Orders and guidance of the Monitor.

SFIs means Standing Financial Instructions.

SOs mean Standing Orders.

Voluntary Organisation is a body, other than a public or local authority, the activities of which are not carried on for profit.

ANNEX 1 – THE PUBLIC CONSTITUENCIES

The trust shall have two Public Constituencies. The area of the Public Constituencies will be made up of the wards specified below and the minimum number of Members in each Public Constituency shall be 100.

A. Suffolk and bordering areas

Babergh:	All wards
Braintree:	Bumpstead, Hedingham and Maplestead, Stour Valley North, Stour Valley South, Upper Colne, Yeldham
Breckland:	Conifer, East Guiltcross, Harling and Heathlands, Mid Forest, Thetford-Abbey, Thetford-Castle, Thetford-Guildhall, Thetford-Saxon, Watton, Wayland, Weeting, West Guiltcross
East Cambridgeshire:	Bottisham, Burwell, Cheveley, Dullingham Villages, Fordham Villages, Isleham, Soham North, Soham South, The Swaffhams
Forest Heath:	All wards
Ipswich	All wards
King's Lynn and: West Norfolk	Denton
Mid Suffolk:	All wards
South Norfolk:	Bressingham and Burston, Diss and Roydon
St Edmundsbury:	All wards
Suffolk Coastal	All wards
Waveney	All wards

B. Rest of Norfolk, Cambidgeshire and Essex

All wards of Norfolk, Cambidgeshire and Essex excluding wards mentioned in the Public Constituency A (Suffolk and bordering areas) above.

ANNEX 2 – THE STAFF CONSTITUENCY

The Staff Constituency will comprise a single class. The minimum number of Members in the Staff Constituency shall be 100.

ANNEX 3 – COMPOSITION OF COUNCIL OF GOVERNORS

A. Elected Governors - public members	
(a) Suffolk and bordering wards	14
(b) Rest of Norfolk, Cambidgeshire and Essex	1
B. Elected Governors - staff members	5
C. Appointed Governors:	
(a) Local Authority Governors:	
i. Suffolk County Council	1
ii. St Edmundsbury Council in consultation with Babergh, Braintree, Breckland, East Cambridgeshire, Forest Heath, Ipswich, King's Lynn and West Norfolk, Mid Suffolk, South Norfolk, Suffolk Coastal and Waveney councils	1
(b) University of Cambridge Governor	1
(c) Other appointing organisations: (specified for the purposes of sub-paragraph 9(7) of Schedule 7 of the 2006 Act)	
i. Friends of West Suffolk Hospital	1
ii. West Suffolk CCG in consultation with local general practitioners and West Suffolk Alliance Partners	2
iii. University Campus Suffolk (UCS) in consultation with West Suffolk College	1
Or in each case such other organisations as may be the successors to their functions.	

ANNEX 4 –THE MODEL RULES FOR ELECTIONS

PART 1: INTERPRETATION

1. Interpretation

PART 2: TIMETABLE FOR ELECTION

2. Timetable
3. Computation of time

PART 3: RETURNING OFFICER

4. Returning officer
5. Staff
6. Expenditure
7. Duty of co-operation

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election
9. Nomination of candidates
10. Candidate's particulars
11. Declaration of interests
12. Declaration of eligibility
13. Signature of candidate
14. Decisions as to validity of nomination forms
15. Publication of statement of nominated candidates
16. Inspection of statement of nominated candidates and nomination forms
17. Withdrawal of candidates
18. Method of election

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot
20. The ballot paper
21. The declaration of identity (public and patient constituencies)

Action to be taken before the poll

22. List of eligible voters
23. Notice of poll
24. Issue of voting information by returning officer
25. Ballot paper envelope and covering envelope
26. E-voting systems

The poll

27. Eligibility to vote

28. Voting by persons who require assistance
29. Spoilt ballot papers and spoilt text message votes
30. Lost voting information
31. Issue of replacement voting information
32. ID declaration form for replacement ballot papers (public and patient constituencies)
33 Procedure for remote voting by internet
34. Procedure for remote voting by telephone
35. Procedure for remote voting by text message

Procedure for receipt of envelopes, internet votes, telephone vote and text message votes

36. Receipt of voting documents
37. Validity of votes
38. Declaration of identity but no ballot (public and patient constituency)
39. De-duplication of votes
40. Sealing of packets

PART 6: COUNTING THE VOTES

STV41. Interpretation of Part 6
42. Arrangements for counting of the votes
43. The count
STV44. Rejected ballot papers and rejected text voting records
FPP44. Rejected ballot papers and rejected text voting records
STV45. First stage
STV46. The quota
STV47 Transfer of votes
STV48. Supplementary provisions on transfer
STV49. Exclusion of candidates
STV50. Filling of last vacancies
STV51. Order of election of candidates
FPP51. Equality of votes

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections
STV52. Declaration of result for contested elections
53. Declaration of result for uncontested elections

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll
55. Delivery of documents
56. Forwarding of documents received after close of the poll
57. Retention and public inspection of documents
58. Application for inspection of certain documents relating to election

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate
STV59. Countermand or abandonment of poll on death of candidate

PART 10: ELECTION EXPENSES AND PUBLICITY

Expenses

60. Election expenses
61. Expenses and payments by candidates
62. Expenses incurred by other persons

Publicity

63. Publicity about election by the corporation
64. Information about candidates for inclusion with voting information
65. Meaning of “for the purposes of an election”

PART 11: QUESTIONING ELECTIONS AND IRREGULARITIES

66. Application to question an election

PART 12: MISCELLANEOUS

67. Secrecy
68. Prohibition of disclosure of vote
69. Disqualification
70. Delay in postal service through industrial action or unforeseen event

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this constitution;

"*council of governors*" means the council of governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

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8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the

return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and

(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,

(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as

required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

PART 5: CONTESTED ELECTIONS

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19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that he or she has not marked or returned any other voting information in the election, and

(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity

with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),

(b) the voter's voter ID number,

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate, (d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote and how to make a declaration of identity,

(vi) the date and time of the close of the poll, and

(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-

(i) the voter’s voter ID number;

(ii) the voter’s declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter’s vote,

(e) if the voter’s vote has been duly cast and recorded, provide the

voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter his or her voter ID number in order to be able to cast his or her vote; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(ii) the candidate or candidates for whom the voter has voted; and

(iii) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details

of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the

tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID

number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper “disqualified”,

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the "list of disqualified documents"); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and

(c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6: COUNTING THE VOTES

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark*" means a figure, an identifiable written word, or a mark such as "X",

"*non-transferable vote*" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule STV49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,
"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:

(i) the use of such software for the purpose of counting

votes in the relevant election, and

(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:

(iii) ballot papers that have been returned; and

(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or

preferences.

STV44.2 The returning officer is to endorse the word “rejected” on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word “rejected” on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word "rejected" on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words "rejected in part" on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,

(b) writing or mark by which voter could be identified, and

(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub-parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the

candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further

transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the

election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1,

(f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

PART 8: DISPOSAL OF DOCUMENTS

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54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with "rejected in part",

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers and the list of spoilt text message votes,

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that Monitor has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chairman of the corporation, and rules 57 and 58 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

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66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by Monitor.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as

soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

PART 12: MISCELLANEOUS

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67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other

proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 5 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

A person may not become or continue as a Governor of the trust if –

(a) he, in the case of a staff Governor or public Governor, ceases to be a Member of the constituency he represents;

(b) he, in the case of a appointed Governor, has his sponsorship withdrawn by their sponsoring organisation;

(c) he has within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a national health service body;

(d) his tenure of office as the chairman or as a member or director of a national health service body has been terminated on the grounds that his appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

(e) he is an Executive Director or Non-Executive Director of the trust, or a governor, non executive director, chairman, chief executive officer of an organisation the nature of whose business is to give rise to potential conflicts of interest of a personal or prejudicial nature to such a degree as to prevent the person from the proper exercise of their duties as a Governor of this Trust. This may include other NHS Foundation Trusts;

(f) he is a person who has been been erased, removed or struck off by a direction from a register of professionals and has not subsequently had his qualification re-instated or suspension lifted.

(g) he has been declared, by a sub-committee of the Council of Governors, to be a vexatious complainant;

(h) he has failed to agree (or having agreed, fails) to abide by the Code of Conduct for Governors as set out in Annex 6 and the value of the trust's Principles as set out in Annex 9; or

(i) He has been previously removed as a Governor pursuant to paragraph 12.8 of the this Constitution.

ANNEX 6 - CODE OF CONDUCT FOR GOVERNORS

Introduction

1 This Code seeks to outline appropriate conduct for Governor, and addresses both the requirements of office and their personal behaviour. Ideally any penalties for non-compliance would never need to be applied; however a Code is considered an essential guide for Governors, particularly those who are newly elected.

2 The Code seeks to expand on or complement the Constitution. Copies will be made available for the information of all Governors and for those considering seeking election to the Council of Governors.

Qualifications for office

3 Members of the Council of Governors must continue to comply with the qualifications required to hold elected office throughout their period of tenure as defined in the Constitution. The Secretary should be advised of any changes in circumstances, which disqualify the Governor from continuing in office. An example of this would be a public Governor becoming an employee of the trust, given that the number of employees sitting on the trust's elected bodies is limited.

Role and functions

4 Governors should:

a) adhere to the trust's values and supporting behaviours; rules and policies; and support its objectives, in particular those of retaining Foundation Trust status and developing a successful trust.

b) act in the best interests of the trust at all times.

c) contribute to the workings of their Council of Governors in order for it to fulfill its role and functions.

d) recognise that their role is a collective one. They exercise collective decision making in the meeting room, which is recorded in the minutes. Outside the meeting room a Governor has no more rights and privileges than any other member.

e) note that the functions allotted to the Council of Governors are not of a managerial nature.

Confidentiality

5 All Governors are required to respect the confidentiality of the information they are made privy to as a result of their membership of the Council of Governors.

Conflict of interests

6 Governors should act with the utmost integrity and objectivity and in the best interests of the trust in performing their duties. They should not use their position for personal advantage or seek to gain preferential treatment. Any Governor who has a material interest in a matter as defined by the Constitution, shall declare such interest to the Council of Governors and:

- shall not vote on any such matters.

- Shall not be present except with the permission of the Council of Governors in any discussion of the matter.

If in any doubt they should seek advice from the Secretary. It is important that conflicts of interest are addressed and are seen to be actioned in the interests of the trust and all individuals concerned.

7 Any Governor who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so be a majority of the remaining Governors.

Council of Governors meetings

8 Governors have a responsibility to attend meetings of the Council of Governors. When this is not possible they should submit an apology to the Secretary in advance of the meeting.

9 In accordance with the Constitution, absence from the Council of Governors meetings without good reason established to the satisfaction of the Council of Governors is grounds for disqualification. If a Governor fails to attend for a period of one year or three consecutive meetings (whichever is the shorter) of the Council of Governors, his tenure of office is to be immediately terminated unless the other Governors are satisfied that the absence was due to a reasonable cause and he will be able to start attending meetings of the trust again within such a period as they consider reasonable.

10 Governors are expected to attend for the duration of the meeting.

Personal conduct

11 Governors are required to adhere to the highest standards of conduct in the performance of their duties. In respect of their interaction with others, they are required to:

a) adhere to good practice in respect of the conduct of meetings and respect the views of their fellow elected governors

b) be mindful of conduct which could be deemed to be unfair or discriminatory and support inclusivity

c) treat the trust's executives and other employees with respect and in accordance with the trust's policy

d) recognise that the Council of Governors and management have a common purpose, i.e. promote the success of the trust, and adopt a team approach and support inclusivity

e) Governors should conduct themselves in such a manner as to reflect positively on the trust. When attending external meetings or any other events at which they are present, it is important for Governors to be ambassadors for the trust.

Accountability

12 Governors are accountable to the membership and should demonstrate this by attending Members' meetings and other key events, which provide opportunities to interface with their electorate in order to best understand their views.

Induction and development

13 Training is essential for Governors, in respect of the effective performance of their current role. Governors are required to adhere to the trust's policies in all respects and undertake identified training and develop to allow them to effectively undertake their role.

Visits to trust Premises

14 Where Governors wish to visit the premises of the trust in a formal capacity as opposed to individuals in a personal capacity, the Council of Governors should liaise with the Secretary to make the necessary arrangements.

Non-compliance with the Code of Conduct

15 Non-compliance with the Code may result in action being taken as follows:-

a) Where misconduct takes place, the Chairman shall be authorised to take such action as may be immediately required, including the exclusion of the person concerned from a meeting.

b) Where such misconduct is alleged, it shall be open to the Council of Governors to decide, by simple majority of those in attendance, to lay a formal charge of misconduct.

c) notifying the Governor in writing of the charge/s, detailing the specific behaviour, which is considered to be detrimental to the trust, and inviting and considering their response within a defined timescale.

d) inviting the Governor to address the Council of Governors in person if the matter cannot be resolved satisfactorily through correspondence;

e) deciding, by simple majority of those present and voting, whether to uphold the charge of conduct detrimental to the trust;

f) imposing such sanctions as shall be deemed appropriate. Such sanctions will range from the issuing of a written warning as to the member's future conduct and consequences, non-payment of expenses to the removal of the Governor from office.

16 A Governor may be removed from the Council of Governors for non-compliance with the Code of Conduct by a resolution approved by not less than two-thirds of the remaining Governors present and voting at a general meeting of the Council of Governors.

17 This Code of Conduct does not limit or invalidate the right of the Governors or the trust to act under the Constitution.

ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

1. INTERPRETATION

1.1 Save as otherwise permitted by law, at any meeting the Chairman of the trust shall be the final authority on the interpretation of Standing Orders (of which he should be advised by the Chief Executive or Secretary).

1.2 Any expression to which a meaning is given in the National Health Service Act 2006 ("2006 Act") or in the Constitution shall have the same meaning in these Standing Orders.

2. THE COUNCIL OF GOVERNORS

2.1 **Composition of the Council of Governors -** The composition of the Council of Governors shall be in accordance with the Constitution.

2.2 **Appointment of the Chairman and members –** The Chairman is appointed by the Council of Governors, as set out in the Constitution.

2.3 **Terms of Office of the Chairman and members-** The regulations setting out the period of tenure of office of the Chairman and members and for the termination or suspension of office of the Chairman and members are contained in the Constitution.

2.4 **Appointment and Powers of Deputy Chairman –** subject to Standing Order 2.5 below; members of the Council of Governors may appoint one of the Non- Executive Directors, to be Deputy Chairman for such period, not exceeding the remainder of his term as a Non-Executive Director of the trust, as they may specify on appointing him.

2.5 Any Non-Executive Director so appointed may at any time resign from the office of Deputy Chairman and the Council of Governors may thereupon appoint another Non Executive Director as Deputy Chairman in accordance with the provisions of Standing Order 2.4.

2.6 Where the Chairman of the trust has died or has ceased to hold office or where he has been unable to perform his duties as Chairman owing to illness or any other cause, the Deputy Chairman shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes his duties, as the case may be, and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform his duties, be taken to include references to the Deputy Chairman.

3. MEETINGS OF THE COUNCIL OF GOVERNORS

3.1 *Admission of the Public and the Press* – The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Council of Governors but shall be required to withdraw upon the Council of Governors (including a majority of the public Governors present at the meeting) resolving as follows:

"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"

3.2 The Chairman (or Deputy Chairman) shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Council of Governors (including a majority of the public Governors present at the meeting) resolving as follows:

"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Council of Governors to complete business without the presence of the public"

3.3 Nothing in these Standing Orders shall require the trust to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Council of Governors.

3.4 **Calling Meetings** – Meetings of the Council of Governors shall be held at such times and places as the Council of Governors may determine.

3.5 The Council of Governors will hold at least four meetings each year, one of which is the Annual Members Meeting.

3.6 The Chairman of the trust may call a meeting of the Council of Governors at any time. If the Chairman refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of members of the Council of Governors, has been presented to him or her, or if, without so refusing, the Chairman does not call a meeting within seven days after such requisition has been presented to him at the trust's headquarters, such one-third or more members may forthwith call a meeting.

3.7 **Notice of Meetings** - Before each meeting of the Council of Governors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chairman or by an officer authorised by the Chairman to sign on his behalf shall be delivered to every Governor, by e-mail to the valid email address or sent by post to the usual place of residence of each Governor, so as to be available to him at least five days before the meeting.

3.8 Want of service of the notice on any Governor shall not affect the validity of a meeting.

3.9 In the case of a meeting called by Governors in default of the Chairman, the notice shall be signed by those Governors and no business shall be transacted at the meeting other than that specified in the notice.

3.10 Agendas will be sent by post or e-mail to Governors five days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than three days before the meeting, save in emergency. A notice shall be presumed to have been served one day after posting or delivery of e-mail.

3.11 Before each meeting of the Council of Governors a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the trust's office at least three days before the meeting, save where the meeting is convened by electronic communication.

3.12 **Setting the Agenda** - The Council of Governors may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted. (Such matters may be identified within these Standing Orders or following subsequent resolution shall be listed in an Appendix to the Standing Orders).

3.13 A Governor desiring a matter to be included on an agenda shall make his request in writing to the Chairman at least 10 (ten) clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chairman.

3.14 **Petitions** - where a petition has been received by the trust the Chairman of the Council of Governors shall include the petition as an item for the agenda of the next Council of Governors meeting.

3.15 **Chairman of Meeting** - At any meeting of the Council of Governors, the Chairman, if present, shall preside. If the Chairman is absent from the meeting the Deputy Chairman, if there is one and he is present, shall preside. If the Chairman and Deputy Chairman are absent another Non Executive Director as the members present shall choose who shall preside.

3.16 If the Chairman is absent temporarily on the grounds of a declared conflict of interest the Deputy Chairman, if present, shall preside. If the Chairman and Deputy Chairman are disqualified from participating, such Governor from a Public Constituency as the Governors present shall choose by majority vote who shall preside.

3.17 **Meetings: electronic communication -** In this SO, "electronic communication" means a communication transmitted (whether from one person to another, from one device to another or from a person to a device or vice versa): (a) by means of an electronic communications network; or (b) by other means but while in an electronic form.

3.17.1 In the Chairman's absolute discretion, a meeting of the Council of Governors may be held by way electronic communication. A meeting of the Council of Governors held by way of electronic communication can be (a) held exclusively by electronic communication; or (b) where a select number of Governors are present at the meeting by way of electronic communication whilst the majority attending are physically present at the meeting of the Council of Governors.

3.17.2 A Governor in electronic communication with the Chairman and all other parties to a meeting of the Council of Governors or of a committee or sub-committee of the Governors shall be regarded for all purposes as personally attending such a meeting provided that, but only for so long as, at such a meeting he has the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication.

3.17.3 A meeting at which one or more of the Governors attends by way of electronic communication is deemed to be held at such a place as the Governors shall at the said meeting resolve. In the absence of such a resolution, the meeting shall be deemed to be held at the place (if any) where a majority of the Governors attending the meeting are physically present, or in default of such a majority, the place at which the Chairman of the meeting is physically present.

3.17.4 Meetings held in accordance with this SO are subject to SO 3.37 (Quorum). For such a meeting to be valid, a quorum must be present and maintained throughout the meeting.

3.17.5 The minutes of a meeting held in this way must state that it was held by electronic communication and that the Governors were all able to hear each other and were present throughout the meeting.

3.18 **Notices of Motion** – A member of the Council of Governors desiring to move or amend a Motion shall send a written notice thereof at least 10 (ten) clear days before the meeting to the Chairman, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any Motion being moved during the meeting, without notice on any business mentioned on the agenda.

3.19 **Withdrawal of Motion or Amendments –** A Motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and consent of the Chairman.

3.20 **Motion to Rescind a Resolution –** Notice of Motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who gives it and also the signature of four other Governors. When any such Motion has been disposed of by the Council of Governors, it shall not be competent for any Governor other than the Chairman to propose a Motion to the same effect within six months however the Chairman may do so if he considers it appropriate.

3.21 **Motions -** The mover of a Motion shall have a right of reply at the close of any discussion on the Motion or any amendment thereto.

3.22 When a Motion is under discussion or immediately prior to discussion it shall be open to a member to move:

- An amendment to the Motion,
- The adjournment of the discussion or the meeting
- That the meeting proceed to the next business (*)
- The appointment of an ad hoc committee to deal with a specific item of business
- That the Motion be now put (*)
- A Motion resolving to exclude the public (including the press).

* In the case of sub-paragraphs denoted by (*) above to ensure objectivity Motions may only be put by a member who has not previously taken part in the debate and who is eligible to vote.

No amendment to the Motion shall be admitted if, in the opinion of the Chairman of the meeting, the amendment negates the substance of the Motion.

3.23 **Chairman's Ruling** - Statements of members of the Council of Governors made at meetings of the Council of Governors shall be relevant to matter under discussion at the material time and the decision of the Chairman of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

3.24 **Voting -** every question at a meeting shall be determined by either a majority of the votes of the Governors present, qualified to vote on the issue and voting on the question unless the Constitution requires otherwise. In the case of the number of votes for and against a Motion being equal, the Chairman of the meeting, or the person presiding over that issue if the Chairman is absent, shall have a second or casting vote.

3.25 All questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined by oral expression or by a show of hands, unless at the discretion of the Chairman, a vote is held by postal or e-mail vote, or by way of written resolution. A paper ballot may also be used if a majority of the Governors present so request. At all times, no Governor may vote by proxy.

3.26 If at least one-third of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each governor voted or abstained.

3.27 If a Governor so requests, his or her vote shall be recorded by name upon any vote (other than by paper ballot).

3.28 In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

3.29 A person attending the Council of Governors to represent a Governor during a period of incapacity or temporary absence without formal appointment as a Governor may not exercise the voting rights of the Governor. A person's status when attending a meeting shall be recorded in the minutes.

3.30 **Written resolution** - at the discretion of the Chairman, the Chairman may specify in a notice of a meeting any matter which requires approval by a written resolution and such a matter may be approved in writing provided that at least three quarters of the Governors, and a majority of the elected Governors, approve the resolution in writing within the timescale imposed in such a notice.

3.31 **Special provisions relating to the Chairman exercising their discretion to call a postal or e-mail vote**

3.31.1 The Chairman's discretion to hold a postal or e-mail vote may be exercised at any time, and for any reason.

3.31.2 If the Chairman exercises their discretion to hold a postal or e-mail vote, then the Governors must vote by post or e-mail by sending their postal or e-mail vote back to the Trust Secretary or an employee of the trust holding a paid appointment or office within the trust who is administering and counting the postal or e-mail votes by the Deadline Date. For the avoidance of doubt, if the Chairman exercises their discretion to hold a postal or e-mail vote, this postal or e-mail vote will form the only method of voting and no meeting will be held.

3.31.3 An individual Governor may only cast one vote unless a second further vote is required owing to the previous vote not being passed. Once a postal or e-mail vote has been cast by a Governor, the vote cannot be revoked or altered in any way.

3.31.4 **Protocol for voting by post** - The Trust Secretary is to publish a notice of the postal vote stating:

3.31.4.1 the details of the Motion;

3.31.4.2 the date and time at which postal votes are required to be sent out to the Governors;

3.31.4.3 the address for return of postal votes including the date and time by which they must be received by the Trust Secretary ("**Deadline Date**"); and

3.31.4.4 the contact details of the Trust Secretary.

3.31.5 As soon as reasonable practicable on or after the publication of the notice of postal vote, the Trust Secretary is to deliver to, or send by post to the usual place of residence of every Governor, so as to be available to him at least 7 (seven) clear days before the Deadline Date, the following information:

3.31.5.1 a ballot paper and ballot paper envelope (ballot paper envelope must have clear instructions to the Governor printed on it, instructing the Governor to seal the ballot paper inside the envelope once the ballot paper has been marked);

3.31.5.2 an ID declaration form (if required);

3.31.5.3 information about the Motion to be voted on; and

3.31.5.4 a covering return envelope providing:

3.31.5.4.1 the address for the return of the ballot paper printed on it;

3.31.5.4.2 pre-paid postage for return to that address;

3.31.5.4.3 clear instructions, either printed on the covering return envelope or elsewhere, instructing the Governor to seal a completed ID declaration form (if required) and the ballot paper envelope, with the ballot paper sealed inside it and return to the Trust Secretary by the Deadline Date.

3.31.6 **Protocol for voting by e-mail** – The Trust Secretary is to email a notice of the email vote to the valid email address of every Governor stating:

3.31.6.1 The details of the Motion;

3.31.6.2 The date and time at which the e-mail votes are required to be sent out to the Governors;

3.31.6.3 The e-mail address for return of e-mail votes includes the date and time by which they must be received by the Trust Secretary; and

3.31.6.4 The contact details of the Trust Secretary.

3.31.7 As soon as is reasonably practicable on or after the e-mail of the notice of the e-mail vote, the Trust Secretary is to e-mail to the valid e-mail address of every Governor, so as to be available to him at least 7 (seven) clear days before the Deadline Date, the following information:

3.31.7.1 a ballot paper attachment in accessible electronic format with clear instructions as to how to cast their vote by e-mail;

3.31.7.2 an ID declaration form (if required);

3.31.7.3 information about the Motion; and

3.31.7.4 a covering email providing:

3.31.7.4.1 the e-mail address for return of the ballot paper;

3.31.7.4.2 clear instructions for the Governor as to how to return their e-mail vote to the Trust Secretary by the Deadline Date.

3.32 **Minutes -** The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

3.33 No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.34 Minutes shall be circulated in accordance with Governors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public as required by Code of Practice on Openness in the NHS.

3.35 **Variation and Amendment of Standing Orders –** will be undertaken in accordance with paragraph 46 of the Constitution.

3.36 **Record of Attendance –** the names of the Chairman and Governors present at the meeting shall be recorded in the minutes.

3.37 **Quorum –** No business shall be transacted at a meeting unless at least one third of the whole number of the Governors are present, the majority of whom are from a public constituency. If at any meeting there is no quorum within 30 minutes of the time fixed for the start of the meeting, the meeting shall stand adjourned for 7 days and upon reconvening, those present shall constitute a quorum.

3.38 If the Chairman or Governor has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see Standing Orders 6 or 7) he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. The meeting must then proceed to the next business.

4. ARRANGEMENTS FOR DELEGATION

4.1 **Committees –** The Council of Governors shall agree from time to time to the delegation of matters for consideration by committee, or sub-committees which it has formally constituted in accordance with the Constitution. The constitution and terms of reference of these committees or sub-committees and their specific powers shall be approved by the Council of Governors. Such committees and subcommittees shall be advisory only and not decision-making.

4.2 **Overriding Standing Orders –** If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Council of Governors for action or ratification. All members of the Council of Governors and staff have a duty to disclose any non-compliance with these Standing Orders to the Chairman as soon as possible.

5. COMMITTEES

5.1 Subject to any guidance or best practice advice as may be issued by Monitor, the Council of Governors may and, if directed by Monitor, shall appoint committees of the Council of Governors to assist it in the proper performance of its functions, consisting wholly or partly of the Chair, Governors, and others, including Advisers.

5.2 A committee appointed under Standing Order 5.1 may, subject to such directions as may be given by the Council of Governors, appoint sub-committees consisting wholly or partly of members of the committee.

5.3 These Standing Orders, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Council of Governors with the terms “Chairman” to be read as a reference to the Chairman of the committee, and the term “Governor” to be read as a reference to a member of the committee as the context permits. There is no requirement to hold meetings of committees, established by the Council of Governors in public.

5.4 Each such committee shall have such terms of reference and powers and be subject to such conditions as the Council of Governors shall decide and shall be in accordance with the 2006 Act, the Constitution, and any best practice advice and/or guidance issued by Monitor, but the Council of Governors shall not delegate to any committee any of the powers or responsibilities which are to be exercised by the Council of Governors at a formal meeting.

5.5 Where committees are authorised to establish sub-committees they may not delegate their powers to the sub-committee unless expressly authorised by the Council of Governors.

5.6 Any committee or sub-committee established under this Standing Order 5.1 may call upon outside advisers to assist them with their tasks including any Advisers, subject to the advance agreement of the Board of Directors.

5.7 The Council of Governors shall approve the appointments to each of the committees which it has formally constituted.

5.8 Where the Council of Governors is required to appoint persons to a committee to undertake statutory functions, and where such appointments are to operate independently of the Council of Governors, such appointments shall be made in

accordance with applicable statute and regulations and with best practice advice and/or guidance issued by Monitor.

5.9 Where the Council of Governors determines that persons who are neither Governors, nor Directors or Officers of the Trust, shall be appointed to a committee, the terms of such appointment shall be determined by the Council of Governors subject to the payment of travelling expenses and other allowances being in accordance with such sum as may be determined by the Board of Directors.

5.10 The Council of Governors may appoint members to serve on joint committees with the Board of Directors or committees of the Board of Directors on the request of the Chair.

5.11 The Secretary or his deputy will attend all meetings of the Committees in support of them.

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1 **Declaration of interests –** The Constitution and the trust's Code of Conduct requires Governors to declare interests which are relevant and material to the Council of Governors of which they are a member. All existing Governors should declare such interests. Any Governors appointed subsequently should do so on appointment.

6.2 Interests which should be regarded as "relevant and material" are:

6.2.1 Directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies).

6.2.2 Ownership, part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

6.2.3 Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.

6.2.4 A position of trust in a charity or Voluntary Organisation in the field of health and social care

6.2.5 Any connection with a voluntary or other organisation contracting for NHS services

6.2.6 To the extent not covered above, any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the NHS Foundation Trust, including but not limited to, lenders or banks.

6.2.7 Any other commercial interest in the decision before the meeting

6.3 At the time Governors' interests are declared, they should be recorded in the Council of Governors minutes. Any changes in interests should be declared at the next Council of Governors meeting following the change occurring.

6.4 Governors' directorships of companies likely or possibly seeking to do business with the trust should be published in the Council of Governors Annual Report. The information should be kept up to date for inclusion in succeeding annual reports.

6.5 During the course of a Council of Governors meeting, if a conflict of interest is established, the member concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

6.6 There is no requirement in the Code of Conduct for the interests of Governors' spouses or partners to be declared. However Standing Order 7 requires that the interest of members' spouses, if living together, in contracts should be declared. Therefore the interests of Governors' spouses and cohabiting partners should also be regarded as relevant.

6.7 If Governors have any doubt about the relevance of an interest, this should be discussed with the Chairman. Financial Reporting Standard No 8 (issued by the Accounting Standards Council) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

6.8 **Register of Interests –** The Secretary will ensure that a register of interests is established to record formally declarations of interests of members. In particular the register will include details of all directorships and other relevant and material interests which have been declared by both elected and appointed members.

6.9 These details will be kept up to date by means of an annual review of the register in which any changes to interests declared during the preceding twelve months will be incorporated.

6.10 The register will be available to the public and the Secretary will take reasonable steps to bring the existence of the register to the attention of the local population and to publicise arrangements for viewing it.

7. DISABILITY OF CHAIRMAN AND MEMBERS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

7.1 Subject to the following provisions of this Standing Orders, if the Chairman or a Governor has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the trust at which the contract or other matter is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

7.2 The Council of Governors may exclude the Chairman or a member of the Council of Governors from a meeting of the Council of Governors while any contract, proposed contract to other matter in which he has a pecuniary interest, is under consideration.

7.3 Any remuneration compensation or allowances payable to the Chairman or a member of the Council of Governors by virtue of the Constitution shall not be treated as a pecuniary interest for the purpose of this Standing Order.

7.4 For the purpose of this Standing Order the Chairman or a member of the Council of Governors shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

a. He, or a nominee of his, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

b. He is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

And in the case of married persons living together the interest of one spouse shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

7.5 The Chairman or a member shall not be treated as having a pecuniary interest in any contract, proposed contract or any other matter by reason only:

a. of his membership of a company or other body, if he has no beneficial interest in any securities of that company or other body; or

b. of an interest in any company, body or person with which he is connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a member in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

7.6 Where the Chairman or a member of the Council of Governors has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and the total nominal value of these securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company body, whichever is the less, and if the share capital is of more than one class, the total nominal value of shares of any one class in which he has beneficial interest does not exceed one-hundredth of the total issued share capital of that class, this Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to his duty to disclose his interest.

7.7 The Standing Order applies to a committee or sub-committee as it applies to the trust.

8. SENIOR INDEPENDENT DIRECTOR

8.1 The Council of Governors is entitled to be consulted by the Board of Directors on the appointment of the Trust's Senior Independent Director.

8.2 The role of the Senior Independent Director is as set out in the Trust's "Senior Independent Director Role Specification" as amended from time to time. For the avoidance of doubt the "Senior Independent Director Role Specification" does not form part of the Constitution.

9. LEAD GOVERNOR AND DEPUTY LEAD GOVERNOR

9.1 The Council of Governors shall appoint from their public governors a Lead Governor. Their role shall be:

a) To act as a conduit of communication between Monitor and Governors particularly in cases where it may not be appropriate to communicate through the normal channels and also where there is a real risk that a Trust is in significant breach of one or more conditions of its licence and Monitor has significant concerns about the leadership of a Trust.

b) To act as a conduit of communication between Monitor and Governors when individual Governors have concerns they wish to raise with Monitor.

c) To contact Monitor (NHSI/E) on behalf of Governors when there is concern 'that the process of appointment of the Chair or other members of the Board, or elections for Governors, or other material decisions may not have complied with a Trust's Constitution, or alternatively, whilst complying with the Constitution, may be inappropriate'.

d) To chair meetings of the Council of Governors in circumstances where it may not be considered appropriate for the Chair or another of the Non-Executive Directors to do so, for example when discussing the appointment/removal of the Chair.

e) The lead Governor should take steps to understand Monitor's role, the available guidance and the basis on which Monitor may take regulatory action.

9.2 The Council of Governors shall also appoint a Deputy Lead Governor from their public governors, who will take up the role and responsibilities of the Lead Governor on a temporary basis, in the event the Lead Governor is absent for any reason.

9.3 The term of office for Lead Governor and Deputy Lead Governor is three years. The term of office may be extended in exceptional circumstances with the approval of the Council of Governors. Governors cannot stand in their final term of office.

9.4 Those wishing to stand can nominate themselves. Those wishing to nominate another Governor should only do so with that person's permission.

9.5 The Trust Secretary will, every 3 years, request nominations for role of lead Governor and deputy lead Governor.

9.6 Subject to the number of candidates for the role the Trust Secretary will establish a confidential ballot mechanism to elect the lead Governor.

9.7 The lead Governor's contact details shall be provided to Monitor and updated as required.

ANNEX 8 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

SECTION A

INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

SECTION B – STANDING ORDERS

1. INTRODUCTION

2. THE BOARD

3. MEETINGS OF THE TRUST

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

5. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

7. DUTIES AND OBLIGATIONS OF DIRECTORS UNDER THE STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

SECTION A

1. INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

1.1 Save as otherwise permitted by law, at any meeting the Chairman of the trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive or Secretary to the Board).

1.2 All references in these Standing Orders to the masculine gender shall be read as equally applicable to the feminine gender and vice-versa.

SECTION B – STANDING ORDERS

1. INTRODUCTION

1.1 Statutory Framework

The trust is a public benefit corporation which was established under the 2006 Act on 1 March 2009.

1.1.1 The powers of the trust are set out in the 2006 Act subject to any restrictions in the Constitution or the License.

1.1.2 The Constitution requires the Board to adopt Standing Orders for the regulation of its proceedings and business. The trust must also adopt Standing Financial Instruction (SFIs) as an integral part of Standing Orders setting out the responsibility of individuals.

1.1.3 The trust will also be bound by such other statute, legal provisions and binding guidance from Monitor which governs the conduct of its affairs.

1.1.4 As a statutory body, the trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable.

1.2 Delegation of Powers

1.2.1 The powers of the trust shall be exercised by the Board of Directors on behalf of the trust.

1.2.2 Any of those powers may be delegated to a committee of Directors or to an Executive Director. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions (SO 5) the trust is given powers to "make arrangements for the exercise, on behalf of the trust of any of their functions by a committee or subcommittee, or by an Officer of the trust, in each case subject to such restrictions and conditions as the trust thinks fit. Delegated Powers are covered in a separate document (Reservation of Powers to the Board and Delegation of Powers). This document has effect as if incorporated into the Standing Orders. Delegated Powers are covered in a separate document entitled – 'Schedule of Matters reserved to the Board and Scheme of Delegation' and have effect as if incorporated into the Standing Orders and Standing Financial Instructions.

2. THE BOARD

2.1 Composition of the Board

The composition of the Board shall be in accordance with the Constitution.

2.2 Appointment and Powers of Deputy Chairman

2.2.1 In accordance with paragraph 28 of the Constitution and subject to Standing Order 2.2.2 below, the Council of Governors may appoint a Non Executive Director, to be Deputy Chairman, for such period, not exceeding the remainder of his term as a member of the Board, as they may specify on appointing him.

2.2.2 Any Non Executive Director so appointed may at any time resign from the office of Deputy Chairman by giving notice in writing to the Chairman (in the Chairman's capacity as Chairman of the Board and the Council of Governors). The Council of Governors may thereupon appoint another Non Executive Director as Chairman in accordance with the provisions of Standing Order 2.2.1.

2.2.3 Where the Chairman of the trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chairman owing to illness or any other cause, the Deputy Chairman shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes their duties, as the case may be; and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform those duties, be taken to include references to the Deputy Chairman.

2.3 Appointment and Powers of Senior Independent Director

2.3.1 Subject to Standing Order 2.3.2 below, the Board of Directors (in consultation with the Council of Governors) may appoint any Member of the Board, who is also a Non Executive Director, to be the Senior Independent Director, for such period, not exceeding the remainder of his term as a Member of the Board, as they may specify on appointing him. The Senior Independent Director shall perform the role set out in the Trust's "Senior Independent Director Role Description", as amended from time to time by resolution of the Board.

2.3.2 Any Non-Executive Director so appointed may at any time resign from the office of Senior Independent Director by giving notice in writing to the Chairman. The Chairman (in consultation with the other Non Executive Directors and the Council of Governors) may thereupon appoint another member of the Board as Senior Independent Director in accordance with the provisions of Standing Order 2.3.1.

2.4 Appointment and Powers of Deputy Chief Executive

The Chairman and Chief Executive may jointly appoint or remove one of the Executive Directors as the deputy chief Executive. The powers of the Deputy chief executive are defined in the Board's Scheme of Delegation.

2.5 Role of Directors

The Board will function as a corporate decision making body and Non Executive and Executive Directors will be full and equal Board members. Their role as members of the Board will be to consider the key strategic and managerial issues facing the trust in carrying out its statutory and other functions. In exercising these functions, the Board will consider guidance from Monitor "The NHS Foundation Trust Code of Governance" as amended from time to time.

2.6 Corporate role of the Board

2.6.1 All business conducted by the trust shall be conducted in the name of the trust.

2.6.2 All funds received in trust shall be held in the name of the trust as corporate trustee.

2.6.3 The powers of the trust established under statute subject to the License shall be exercised by the Board in private session except as otherwise provided for in Standing Order 3.

2.7 Schedule of Matters reserved to the Board and Scheme of Delegation

2.7.1 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the Board' and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to Officers and other bodies are contained in the Scheme of Delegation.

2.8 Lead Roles for Directors

2.8.1 The Chairman will ensure that the designation of Lead roles as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Board Director with responsibilities for Infection Control or Child Protection Services etc).

3. MEETINGS OF THE TRUST

3.1 Calling meetings

3.1.1 Meetings of the Board shall be held at regular intervals at such times and places as the Board may determine.

3.1.2 The Chairman may call a meeting of the Board at any time.

3.1.3 One third or more Directors of the Board may requisition a meeting in writing. If the Chairman refuses, or fails, to call a meeting within seven days of a requisition being presented, the Directors signing the requisition may forthwith call a meeting.

3.2 Notice of Meetings and the Business to be transacted

3.2.1 Before each meeting of the Board a written notice specifying the business proposed to be transacted shall be delivered to every Director, or sent by

post to the usual place of residence of each Director, so as to be available to Directors at least five days before the meeting. The notice shall be signed by the Chairman or by an Officer authorised by the Chairman to sign on their behalf. Want of service of such a notice on any Director shall not affect the validity of a meeting.

3.2.2 In the case of a meeting called by Directors in default of the Chairman calling the meeting, the notice shall be signed by those Directors.

3.2.3 No business shall be transacted at the meeting other than that specified on the agenda, or emergency Motions allowed under Standing Order 3.6.

3.2.4 A Director desiring a matter to be included on an agenda shall make his/her request in writing to the Chairman at least 15 days before the meeting. The request should include appropriate supporting information. Requests made less than 15 days before a meeting may be included on the agenda at the discretion of the Chairman.

3.2.5 In the event that a meeting of the Board is to be held in public pursuant to paragraph 3.17.1, a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the trust's principal offices at least three days before the meeting.

3.3 Agenda and Supporting Papers

3.3.1 The Agenda will be sent to Directors five days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than three days before the meeting, save in emergency.

3.4 Petitions

Where a petition has been received by the trust the Chairman shall include the petition as an item for the agenda of the next meeting.

3.5 Notice of Motion

3.5.1 Subject to the provision of Standing Orders 3.7 'Motions: Procedure at and during a meeting' and 3.8 'Motions to rescind a resolution', a Director of the Board wishing to move a Motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chairman.

3.5.2 The notice shall be delivered at least 10 clear days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any Motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

3.6 Emergency Motions

3.6.1 Subject to the agreement of the Chairman, and subject also to the provision of Standing Order 3.7 'Motions: Procedure at and during a meeting', a Director of the Board may give written notice of an emergency Motion after the issue of the notice of meeting and agenda, up to one hour before the

time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the trust Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chairman's decision to include the item shall be final.

3.7 Motions: Procedure at and during a meeting

3.7.1 Who may propose

A Motion may be proposed by the Chairman of the meeting or any Director present. It must also be seconded by another Director.

3.7.2 Contents of Motions

The Chairman may exclude from the debate at their discretion any such Motion of which notice was not given on the notice summoning the meeting other than a Motion relating to:

- the reception of a report;
- consideration of any item of business before the trust Board;
- the accuracy of minutes;
- that the Board proceed to next business;
- that the Board adjourn;
- that the question be now put.

3.7.3 Amendments to Motions

A Motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to Motions shall be moved relevant to the Motion, and shall not have the effect of negating the Motion before the Board.

If there are a number of amendments, they shall be considered one at a time. When a Motion has been amended, the amended Motion shall become the substantive Motion before the meeting, upon which any further amendment may be moved.

3.7.4 Rights of reply to Motions

a) Amendments

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original Motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

b) Substantive/original Motion

The Director who proposed the substantive Motion shall have a right of reply at the close of any debate on the Motion.

3.7.5 Withdrawing a Motion

A Motion, or an amendment to a Motion, may be withdrawn.

3.7.6 Motions once under debate

When a Motion is under debate, no Motion may be moved other than:

- an amendment to the Motion;
- the adjournment of the discussion, or the meeting;
- that the meeting proceed to the next business;
- that the question should be now put;
- the appointment of an 'ad hoc' committee to deal with a specific item of business;
- that Director be not further heard;

In those cases where the Motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a Director of the Board who has not taken part in the debate and who is eligible to vote.

If a Motion to proceed to the next business or that the question be now put, is carried, the Chairman should give the mover of the substantive Motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.8 Motion to Rescind a Resolution

3.8.1 Notice of Motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Director who gives it and also the signature of three other Directors, and before considering any such Motion of which notice shall have been given, the trust Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

3.8.2 When any such Motion has been dealt with by the trust Board it shall not be competent for any Director other than the Chairman to propose a Motion to the same effect within six months. This Standing Order shall not apply to Motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.9 Chairman of meeting

3.9.1 At any meeting of the trust Board the Chairman, if present, shall preside. If the Chairman is absent from the meeting, the Deputy Chairman (if the Board has appointed one), if present, shall preside.

3.9.2 If the Chairman and Deputy Chairman are absent, such Director (who is not also an Executive Director of the trust) as the Directors present shall choose shall preside.

3.10 Chairman's ruling

The decision of the Chairman of the meeting on questions of order, relevancy and regularity (including procedure on handling Motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

3.11 Quorum

3.11.1 No business shall be transacted at a meeting unless at least one-third of the whole number of the Chairman and Directors (including at least one Executive Director and one Non Executive Director) is present.

3.11.2 An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

3.11.3 If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see Standing Order 7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.12 Voting

3.12.1 Save as provided in Standing Orders 3.l3 - Suspension of Standing Orders and 3.l4 - Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of Directors present and voting on the question. In the case of an equal vote, the person presiding (i.e.: the Chairman of the meeting) shall have a second, and casting vote.

3.12.2 At the discretion of the Chairman all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chairman directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

3.12.3 If at least one third of the Directors present so request, the voting on any question may be recorded so as to show how each Director present voted or did not vote (except when conducted by paper ballot).

3.12.4 If a Director so requests, their vote shall be recorded by name.

3.12.5 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

3.12.6 A manager who has been formally appointed by the Board to act up for a Director during a period of incapacity or temporarily to fill a Director vacancy as an Acting Director or Interim Director under paragraph 4 and 5

respectively of Annex 10 of the constitution shall be entitled to exercise the voting rights of the Director.

3.12.7 A manager attending the Board meeting to represent a Director during a period of incapacity or temporary absence who is not an acting Director or an interim Director for the purposes of the Constitution may not exercise the voting rights of the Director. An Officer's status when attending a meeting shall be recorded in the minutes.

3.13 Suspension of Standing Orders

3.13.1 Except where this would contravene any provision in the Constitution, the License, any statutory provision, any binding guidance issued by Monitor, or the rules relating to the Quorum (Standing Order 3.11), any one or more of the Standing Orders may be waived at any meeting, provided that at least two-thirds of the whole number of the Directors are present (including at least one Executive Director and one Non Executive Director) and that at least two-thirds of those Directors present signify their agreement to such suspension. The reason for and decision to waive shall be recorded in the trust Board's minutes.

3.13.2 A separate record of matters discussed during the waiver of Standing Orders shall be made and shall be available to the Chairman and Directors of the trust.

3.13.3 The Audit Committee shall review every decision to suspend Standing Orders.

3.14 Variation and amendment of Standing Orders

3.14.1 These Standing Orders shall only be varied in accordance with paragraph 46 of the Constitution.

3.15 Record of Attendance

The names of the Chairman and Directors present at the meeting shall be recorded.

3.16 Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate.

3.17 Admission of public and the press

3.17.1 Board meetings shall be held in public but the whole or any part of a meeting may be held in private if the Board so resolves.

3.17.2 In that event members of the public and the press will be excluded from all or part of a Board meeting.

3.17.3 General disturbances

In the event that the public and press are admitted to all or part of a Board meeting pursuant to paragraph 3.17.1 and 3.17.2 above, the Chairman (or Deputy Chairman if one has been appointed) or the person presiding over the meeting shall give such directions as he thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the trust's business shall be conducted without interruption and disruption and, the public and/or press maybe required to withdraw from a Board meeting at any time and for any reason whatsoever.

3.17.4 Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the trust or Committee thereof. Such permission shall be granted only upon resolution of the trust.

3.18 Observers at trust meetings

The trust will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the trust Board's meetings and may change, alter or vary these terms and conditions as it deems fit.

3.19 Meetings: electronic communication

3.19.1 In this SO, "electronic communication" means a communication transmitted (whether from one person to another, from one device to another or from a person to a device or vice versa): (a) by means of an electronic communications network; or (b) by other means but while in an electronic form.

3.19.2 A Director in electronic communication with the Chairman and all other parties to a meeting of the Board of Directors or of a committee or sub-committee of the Directors shall be regarded for all purposes as personally attending such a meeting provided that, but only for so long as, at such a meeting he has the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication.

3.19.3 A meeting at which one or more of the Directors attends by way of electronic communication is deemed to be held at such a place as the Directors shall at the said meeting resolve. In the absence of such a resolution, the meeting shall be deemed to be held at the place (if any) where a majority of the Directors attending the meeting are physically present, or in default of such a majority, the place at which the Chairman of the meeting is physically present.

3.19.4 Meetings held in accordance with this SO are subject to SO 3.11 (Quorum). For such a meeting to be valid, a quorum must be present and maintained throughout the meeting.

3.19.5 The minutes of a meeting held in this way must state that it was held by electronic communication and that the Directors were all able to hear each other and were present throughout the meeting.

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1 Subject to the Constitution, the Board shall appoint committees of the Board, consisting wholly of Directors.

4.2 Appointment of Committees

Subject to the Constitution, the trust Board may appoint committees of the trust.

The trust shall determine the membership and terms of reference of committees and sub-committees and shall if it requires to, receive and consider reports of such committees.

4.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders and Standing Financial Instructions of the trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the trust. In which case the term “Chairman” is to be read as a reference to the Chairman of other committee as the context permits, and the term “member” is to be read as a reference to a member of other committee also as the context permits. (There is no requirement to hold meetings of committees established by the trust in public.)

4.4 Terms of Reference

Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation. Such terms of reference shall have effect as if incorporated into the Standing Orders.

4.5 Delegation of powers by Committees to Sub-Committees

Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board.

4.6 Approval of Appointments to Committees

The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither members nor Officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

4.7 Committees established by the trust Board

The committees and sub-committees established by the Board may vary from time to time as per operational requirements, legislation and best practice. Their terms of reference may be obtained from the Secretary to the trust.

4.8 The Board of Directors may appoint persons to serve as members on joint committees with the Council of Governors or committees of the Council of Governors on the request of the Chairman.

5. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

5.1 Delegation of Functions to Committees, Officers or other bodies

Subject to the Constitution and License and such guidance as may be given by Monitor, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee, sub-committee appointed by virtue of Standing Order 4, or by an Officer of the trust, in each case subject to such restrictions and conditions as the trust thinks fit.

5.2 Emergency Powers and urgent decisions

The powers which the Board has reserved to itself within these Standing Orders (see Standing Order 2.7) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman after having consulted at least two non-Executive Directors. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the trust Board for noting.

5.3 Delegation to Committees

The Board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or subcommittees, which it has formally constituted in accordance with the Constitution, the License, binding guidance issued by Monitor and the 2006 Act. The Constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board in respect of its sub-committees.

5.4 Delegation to Officers

5.4.1 Those functions of the trust which have not been retained as reserved by the Board or delegated to other committee or sub-committee or joint-committee shall be exercised on behalf of the trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate Officers to undertake the remaining functions for which he/she will still retain accountability to the trust.

5.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board.

5.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Finance Director to provide information and advise the Board in accordance with the Constitution, License and any statutory requirements, or provisions required by Monitor.

5.5 Schedule of Matters Reserved to the trust and Scheme of Delegation of powers

The arrangements made by the Board as set out in the "Scheme of Reservation and Delegation" of powers shall have effect as if incorporated in these Standing Orders.

5.6 Duty to report non-compliance with Standing Orders and Standing Financial Instructions

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All Directors of the trust Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

6.1 Policy statements: general principles

The trust Board will from time to time agree and approve Policy statements/ procedures which will apply to all or specific groups of staff employed by the trust. The decisions to approve such policies and procedures will be recorded in an appropriate trust Board minute and will be deemed where appropriate to be an integral part of the trust's Standing Orders and Standing Financial Instructions.

6.2 Specific Policy statements

Notwithstanding the application of Standing Order 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

- the Standards of Business Conduct policy for trust staff;
- the staff Disciplinary and Appeals Procedures adopted by the trust both of which shall have effect as if incorporated in these Standing Orders.

6.3 Standing Financial Instructions

Standing Financial Instructions adopted by the trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

6.4 Specific guidance

Notwithstanding the application of Standing Order 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other binding guidance issued by Monitor:

- Caldicott Principles 1997;
- Human Rights Act 2018;
- Freedom of Information Act 2000.

7. DUTIES AND OBLIGATIONS OF DIRECTORS UNDER THESE STANDING ORDERS

7.1 Declaration of Interests

7.1.1 Requirements for Declaring Interests and applicability to Board Directors

(a) All existing Board Directors should declare any relevant and material interests. Any Director appointed subsequently should do so on appointment.

7.1.2 Interests which are relevant and material

(a) Interests which should be regarded as "relevant and material" are defined under paragraph 34 of the Constitution.

(b) Any Director who comes to know that the trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in Standing Order 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Director shall declare his/her interest by giving notice in writing of such fact to the trust as soon as practicable.

7.1.3 Advice on Interests

If Board Directors have any doubt about the relevance of an interest, this should be discussed with the Chairman or with the Secretary.

Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.1.4 Recording of Interests in trust Board minutes

At the time Directors' interests are declared, they should be recorded in the trust Board minutes.

Any changes in interests should be declared at the next trust Board meeting following the change occurring and recorded in the minutes of that meeting.

7.1.5 Publication of declared interests in Annual Report

Board Directors' Directorships of companies likely or possibly seeking to do business with the NHS should be published in the trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

7.1.6 Conflicts of interest which arise during the course of a meeting

During the course of a Board meeting, if a conflict of interest is established, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

7.2 Register of Interests

7.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board or Committee Directors. In particular the Register will include details of all directorships and other relevant and material interests (as defined in SO 7.1.2) which have been declared by both executive and non-executive trust Board Directors.

7.2.2 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

7.2.3 The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

7.3 Exclusion of Chairman and Directors in proceedings on account of pecuniary interest

7.3.1 Definition of terms used in interpreting 'Pecuniary' interest

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

(a) "spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);

(b) "contract" shall include any proposed contract or other course of dealing.

(c) "Pecuniary interest"

Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:-

(i) he/she, or a nominee of his/her, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or

(ii) he/she is a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

(d) Exception to Pecuniary interests

A person shall not be regarded as having a pecuniary interest in any contract if:-

(i) neither he/she or any person connected with him/her has any beneficial interest in the securities of a company of which he/she or such person appears as a member, or

(ii) any interest that he/she or any person connected with him/her may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him/her in relation to considering or voting on that contract, or

(iii) those securities of any company in which he/she (or any person connected with him/her) has a beneficial interest do not exceed £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph (iii) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with Standing Order 7.1.2 (ii).

7.3.2 Exclusion in proceedings of the trust Board

(a) Subject to the following provisions of this Standing Order, if a Director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

(b) The Board may exclude a Director from a meeting of the Board while any contract, proposed contract or other matter in which he has a pecuniary interest is under consideration.

(c) Any remuneration, compensation or allowance payable to a Director.

(d) This Standing Order applies to a committee or subcommittee as it applies to the trust.

7.4 Standards of Business Conduct

7.4.1 Trust Policy

All trust staff and Directors must comply with the trust's Standards of Business Conduct Policy. This section of standing orders shall be read in conjunction with this document.

7.4.2 Interest of Officers in Contracts

(a) Any Officer or employee of the trust who comes to know that the trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO 7.3) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or trust's Secretary as soon as practicable.

(b) An Officer should also declare to the Chief Executive any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the trust.

(c) The trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

7.4.3 Canvassing of and Recommendations by Directors in Relation to Appointments

(a) Canvassing of Directors or of any Committee of the trust directly or indirectly for any appointment under the trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

(b) Directors shall not solicit for any person any appointment under the trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the trust.

7.4.4 Relatives of Directors or Officers

(a) Candidates for any staff appointment under the trust shall, when making an application, disclose in writing to the trust whether they are related to any Director or the holder of any office under the trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

(b) The Chairman and every Director and Officer of the trust shall disclose to the Board any relationship between himself and a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the trust Board any such disclosure made.

(c) On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the trust whether they are related to any other Director or holder of any office under the trust.

(d) Where the relationship to a Director/Officer of the Trust is disclosed, the Standing Order headed 'Disability of Chairman and Directors in proceedings on account of pecuniary interest' (Standing Order 7) shall apply.

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 Custody of Seal

The common seal of the trust shall be kept by the Chief Executive or a nominated Officer by him/her in a secure place.

8.2 Sealing of Documents

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two Directors or a Director and the Secretary duly authorised by the Board.

8.3 Register of Sealing

The Chief Executive shall keep a register in which he/she, or another manager of the Authority authorised by him/her, shall enter a record of the sealing of every document.

8.4 Signature of documents

Where any document will be a necessary step in legal proceedings on behalf of the trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

In land transactions, the signing of certain supporting documents will be delegated to Officers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

ANNEX 9 – STATEMENT OF TRUST PRINCIPLES

The West Suffolk NHS Foundation Trust will operate within a governance framework which reflects best practice within the NHS. In particular it will adopt the seven principles of public life, determined by the Nolan Report. It will also from time to time develop mission statements, corporate values, codes of conduct and other governance statements.

Nolan Principles: - the seven principles of public life

1. **Selflessness**: Holders of public office should take decisions solely in terms of the public interest. They should not do so to gain financial or other material benefit for themselves, their family or their friends.

2. **Integrity**: Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

3. **Objectivity**: In carrying out public business, including making public appointments, awarding contracts or recommending individuals for rewards and benefits, holders of public office should make choice on merit.

4. **Accountability**: Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

5. **Openness**: Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

6. **Honesty**: Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

7. **Leadership**: Holders of public office should promote and support these principles by leadership and example.

ANNEX 10 – FURTHER PROVISIONS

1. Trust Secretary

1.1 The trust shall have a Secretary who may be an employee. The Secretary may not be a Governor, or the Chief Executive or the Finance Director.

1.2 Minutes of every meeting of the Council of Governors and of every meeting of the Board of Directors are to be kept by the Secretary.

1.3 The Secretary is to be appointed and removed by the Chairman and Chief Executive acting jointly.

2. Vacancy of Governor or Director position

2.1 The validity of any act of the trust is not affected by any vacancy among the Directors or the Governors or by any defect in the appointment of any Director or governor.

3. Absent Director

3.1 If:

3.1.1 an Executive Director is temporarily unable to perform his/her duties due to illness or some other reason (the "Absent Director"); and

3.1.2 the Board of Directors agree that the duties of the Absent Director need to be carried out;

then the Chairman (if the Absent Director is the Chief Executive) or the Chief Executive (in any other case) may appoint an acting Director as an additional Director to carry out the Absent Director's duties temporarily.

3.2 For the purposes of paragraph 3.1 of this Annex, the number of Directors appointed under paragraph 23.2.3 of the Constitution shall be relaxed accordingly.

3.3 The acting Director will vacate office as soon as the Absent Director returns to office or, if earlier, the date on which the person entitled to appoint him under this paragraph notifies him that he is no longer to act as an acting Director.

3.4 The acting Director shall be an Executive Director for the purposes of the 2006 Act. He shall be responsible for his/her own acts and defaults and he shall not be deemed to be the agent of the Absent Director.

4. Vacant Positions

4.1 If:

4.1.1 an Executive Director post is vacant ("Vacant Position"); and

4.1.2 the Board of Directors agree that the Vacant Position needs to be filled by an interim postholder pending appointment of a permanent postholder, then the Chairman (if the Vacant Position is the Chief Executive) or the Chief

Executive (in any other case) may appoint a Director as an interim Director ("Interim Director") to fill the Vacant Position pending appointment of a permanent postholder.

4.1.3 The appointment of an interim Chief Executive shall require the approval of the Council of Governors

4.2 The Interim Director will vacate office on the appointment of a permanent postholder or, if earlier, the date on which the persons entitled to appoint him under this paragraph notifies him that he is no longer to act as an Interim Director.

4.3 The Interim Director shall be an Executive Director for the purposes of the 2006 Act.

5. Title of "Director"

5.1 The trust may confer on senior staff the title "Director" as an indication of their corporate responsibility within the trust but such persons will not be Directors of the trust for the purposes of the 2006 Act ("statutory Directors") unless their title includes the title "Chief" or "Executive" or "Non Executive Director" or "Chair" or "Chairman" and will not have the voting rights of statutory Directors or any power to bind the trust.

6. Disqualification of membership

6.1 An individual may not become or continue as a member of the Trust if:

6.1.1 the individual has been specifically excluded in writing from any of the Trust's premises or other facilities in whole or in part following a decision of the Board of Directors that such a course of action is necessary because, for example, the individual concerned has been violent, aggressive, has committed an act of gross misconduct or any other action deemed inappropriate; or

6.1.2 the Board of Directors considers that an individual has or is likely to cause harm or detriment to the Trust and after the Trust has consulted with or made reasonable efforts to consult with the individual about the concerns of the Board and the Board notifies the individual about his disqualification accordingly.

6.2 Notwithstanding anything contained in this Constitution, no person who ceases to be a member of the Trust pursuant to paragraph 6.1.1 or 6.1.2 above shall be re-admitted to membership except by a decision of the Board of Directors.

6.3 It is the responsibility of Members to ensure their eligibility and not the trust, but if the trust is on notice that a Member may be disqualified from membership, they shall carry out all reasonable enquiries to establish if this is the case.

6.4 The Board of Directors may not disqualify a governor from membership unless that governor has been removed from the Council of Governors by a resolution approved in accordance with Annex 6, paragraph 17.

7. Termination of membership

7.1 A member shall cease to be a member if that member:

7.1.1 resigns by notice to the Secretary or the Chief Executive;

7.1.2 ceases to fulfill the requirements of paragraph 6 or 7 of the Constitution;

7.1.3 is disqualified under any other provision of this constitution;

7.1.4 dies; or

7.1.5 the Council of Governors, having made reasonable enquiries, determines that the member no longer wishes to be a member or he ceases to be eligible as a member for whatever reason.

6. ITEMS FOR INFORMATION

6.1. Questions from Governors and the Public

To Note

Presented by Sheila Childerhouse

7. Any other business

To Note

8. Date of next meeting - 28 January 2022

To Note

Presented by Sheila Childerhouse

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 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