Board of Directors (In Public)

Schedule	Friday 26 February 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, 26 February 2021 at 9:15. The meeting will be held virtually via video conferencing
Organiser	Karen McHugh

Agenda

AGENDA
Presented by Sheila Childerhouse

Agenda Open Board 2021 02 26 Feb.docx

9:15 GENERAL BUSINESS
Presented by Sheila Childerhouse

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

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

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

NHS
West Suffolk
NHS Foundation Trust

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

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

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6. Minutes of the previous meeting
   To APPROVE the minutes of the meeting held on 29 January 2021
   For Approval - Presented by Sheila Childerhouse

   Item 6 - Open Board Minutes 2021 01 29 Jan Draft.docx

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

   Item 7 - Action sheet report.doc

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8. Patient/Staff story
   To RECEIVE for consideration and reflection
   For Report - Presented by Susan Wilkinson

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

   Item 9 - Chief Exec Report Feb 21 Dunn.docx

   Item 9 Annex - nhs-providers-otdb-dhsc-white-paper-final.pdf

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10:00 DELIVER FOR TODAY

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

    Item 10 - Operational Board update Feb 2021.doc

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11. Integrated quality and performance report
To APPROVE a report
For Approval - Presented by Helen Beck and Susan Wilkinson

Item 11 - IQPR Trust Board Report January 2021 v1.pdf

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

Item 12 - Finance and workforce board Cover sheet - M10.docx

Item 12 - Finance Report- January 2021 FINAL.docx

10:40 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

Comfort Break - 10 minutes

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

Item 13 - People OD highlight report Feb 2021.doc

Item 13 - People Plan tracker.pptx.ppt

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14. Quality, safety and improvement reports
To APPROVE the reports
Presented by Susan Wilkinson and Nick Jenkins

14.1. Maternity services quality & performance report
For Approval

Item 14.1 - Maternity Quality and performance report Feb 2021.docx

Item 14.1 Annex B - Neonatal nursing staffing report 1_12_20.docx

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14.2. Infection prevention and control assurance framework
For Approval

Item 14.2 - IPC assurance framework.docx

14.3. Nursing staffing report
For Approval

- Item 14.3 - Nurse staffing report - January 2021 Final.docx

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14.4. Improvement programme board report
For Approval

- Item 14.4 - Improvement Programme Board Report Feb 21 V2.docx
- Item 14.4 - IPB Appendix 7.pptx
- Item 14.4 Annex A - IPB 210208 Status Summary Action Plans OUT.xlsx

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14.5. Quality and learning report - Q3
For Approval

- Item 14.5 - Quality and Learning report - Feb 21.docx

11:40 BUILD A JOINED-UP FUTURE

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

- Item 15 - Future System public board report feb 2021 Summary.doc

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11:00 GOVERNANCE

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16. Governance report
To APPROVE the report, including subcommittee activities
For Approval - Presented by Richard Jones

- Item 16 - Governance report.doc
- Item 16 Annex B - NEDs responsibilities 2021 Feb DRAFT.doc

12:15 ITEMS FOR INFORMATION

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

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18. Date of next meeting
    To NOTE that the next meeting will be held on Friday, 26 March 2021 at 9:15am in West Suffolk Hospital
    For Reference - Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

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

AGENDA

Presented by Sheila Childerhouse

Board of Directors

A meeting of the Board of Directors will take place on **Friday, 26 February 2021 at 9:15**.
The meeting will be held virtually via video conferencing.

Sheila Childerhouse
Chair

Agenda (in Public)

9:15 GENERAL BUSINESS		
1.	**Resolution** The Trust Board is invited to adopt the following resolution: "That representatives of the press, and other members of the public, be excluded from the meeting having regard to the guidance from the Government regarding public gatherings."	Sheila Childerhouse
2.	**Apologies for absence** To note any apologies for the meeting and request that mobile phones are set to silent: Kate Vaughton	Sheila Childerhouse
3.	**Declaration of interests for items on the agenda** To note any declarations of interest for items on the agenda	Sheila Childerhouse
4.	**Questions from the public relating to matters on the agenda** (verbal) To receive questions from members of the public of information or clarification relating only to matters on the agenda	Sheila Childerhouse
5.	**Review of agenda** To agree any alterations to the timing of the agenda.	Sheila Childerhouse
6.	**Minutes of the previous meeting (attached)** To approve the minutes of the meeting held on 29 January 2021	Sheila Childerhouse
7.	**Matters arising action sheet (attached)** To accept updates on actions not covered elsewhere on the agenda	Sheila Childerhouse
8.	**Patient/Staff story** To receive for consideration and reflection	Sue Wilkinson
9.	**CEO report (attached)** To receive an introduction on current issues	Steve Dunn
10:00 DELIVER FOR TODAY		
10.	**Operational report (attached)** To approve the report	Helen Beck
11.	**Integrated quality and performance report (attached)** To approve a report	Sue Wilkinson / Helen Beck
12.	**Finance and workforce report (attached)** To approve report	Craig Black

10:40 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP		
	Comfort break – 10 minutes	
13.	**People and OD highlight report (attached)** To approve report	Jeremy Over
14.	**Quality, safety and improvement report** To approve reports: 14.1 Maternity services quality and performance report, including Ockenden report (attached) 14.2 Infection prevention and control assurance framework (attached) 14.3 Nurse staffing report (attached) 14.4 Improvement programme board report (attached) 14.5 Quality and learning report - Q3 (attached)	Sue Wilkinson / Nick Jenkins
11:40 BUILD A JOINED-UP FUTURE		
15.	**Future system board report (attached)** To approve report	Craig Black
12:00 GOVERNANCE		
16.	**Governance report (attached)** To approve report, including subcommittee activities	Richard Jones
12:15 ITEMS FOR INFORMATION		
17.	**Any other business** To consider any matters which, in the opinion of the Chair, should be considered as a matter of urgency	Sheila Childerhouse
18.	**Date of next meeting** To note that the next meeting will be held on Friday, 26 March 2021 at 9:15 am in West Suffolk Hospital	Sheila Childerhouse
RESOLUTION TO MOVE TO CLOSED SESSION		
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To AGREE any alterations to the timing of the agenda.

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6. Minutes of the previous meeting

To APPROVE the minutes of the meeting held on 29 January 2021

For Approval

Presented by Sheila Childerhouse

DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 29 JANUARY 2021 AT WEST SUFFOLK HOSPITAL
Via Microsoft Teams

COMMITTEE MEMBERS			
		Attendance	**Apologies**
Sheila Childerhouse	Chair	•	
Helen Beck	Chief Operating Officer	•	
Craig Black	Executive Director of Resources	•	
Richard Davies	Non Executive Director	•	
Steve Dunn	Chief Executive	•	
Angus Eaton	Non Executive Director	•	
Nick Jenkins	Executive Medical Director	•	
Rosemary Mason	Associate Non Executive Director	•	
Jeremy Over	Executive Director of Workforce and Communications	•	
Louisa Pepper	Non Executive Director	•	
Alan Rose	Non Executive Director	•	
David Wilkes	Non Executive Director	•	
Sue Wilkinson	Interim Executive Chief Nurse	•	
In attendance			
Helen Davies	Head of Communications		
Georgina Holmes	Trust Office Manager *(minutes)*		
Richard Jones	Trust Secretary		
Earnest Lea	Medical student		
Kate Vaughton	Director of Integration and Partnerships		

Action

GENERAL BUSINESS

21/001 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 governors and the public to observe the meeting.

The Chair welcomed everyone to the meeting, she also welcomed governors and members of the public who had joined via YouTube.

21/002 APOLOGIES FOR ABSENCE

There were no apologies for absence.

21/003 DECLARATION OF INTERESTS FOR ITEMS ON THE AGENDA

No declarations of interest were received.

20/004 QUESTIONS FROM THE PUBLIC RLEATING TO MATTERS ON THE AGENDA

Q The vaccination report in the board papers indicated that 80% of staff had taken up the opportunity to have a Covid vaccination. Could governors be assured that this would be addressed with the 20% who had not had a vaccination and could an update be provided on staff uptake of the flu vaccine?

A This would be picked up under agenda item 11, vaccination report.

Q Re wellbeing of staff; often staff themselves were the last to recognise that they were struggling. Could assurance be provided that line managers would act on this.

A An update would be provided under agenda item 14, people organisational development (OD) highlight report.

Q The infection report states that in December there were 50 probable, and 41 definite, hospital acquired Covid19 infections. Is it known how the number of patients becoming infected in West Suffolk hospital compare to numbers of nosocomial Covid19 infections in neighbouring Trusts?

Following the reported outbreaks of Covid19 infection, it is reported that specific actions were put in place in an effort to reduce transmission. It is now the end of January, is there any assurance that the number of nosocomial infections/outbreaks have fallen this month?

Were the patients infected in high risk categories? What was the outcome for these patients?

A This would be picked up under agenda item 15.2, infection prevention report.

21/005 REVIEW OF AGENDA

The agenda was reviewed and it was proposed to move agenda item 18, integration report to after agenda item 10, operational report, as this linked with the operational report and vaccination report.

21/006 MINUTES OF MEETING HELD ON 4 DECEMBER 2020

The minutes of the previous meeting were approved as a true and accurate record subject to the following amendment:

Item 246.1, page 11, answer to final question, reword final two sentences to read: “As a smaller unit this was very difficult and the Trust was in regular contact with three units in the region which it benchmarked against and shared learning with.”

21/007 MATTERS ARISING ACTION SHEET

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

21/008 STAFF STORY

- This was an account from a registered nurse working in ITU who wished to remain anonymous.
- It was very difficult to explain how things had changed during the pandemic, there were often instances where she felt anxious, frustrated and stressed, but there were also good moments when a patient got better.
- Working in PPE was difficult and restricting but staff were learning to manage.

- She often had overall responsibility for two or three very sick patients with different needs. Even if there was support from staff from other wards, this could be very physically draining and stressful.
- She always tried to make time for the families to ensure that they were updated about their loved ones. However, staff often had to break bad news over the phone which was upsetting.
- Although staff were very exposed and this also put their families at high risk, they gave the best possible care to their patients and provided as much support to family members as they could.
- The board reflected on what it must be like for staff working on the front line in PPE caring for patients.
- It was very important to recognise signs of stress and strain in staff and be pro-active in supporting them. The people and OD highlight report (agenda item 14) provided a detailed update on developments in the staff psychology support service and explained what was being done to pro-actively support staff in these circumstances.
- It was noted that the Chief Executive had received a letter from a family about the excellent care their relative had received whilst an inpatient at WSFT.

21/009 CHIEF EXECUTIVE'S REPORT

- The staff story and letter referred to above demonstrated that although staff were under immense pressure and working in very difficult circumstances they still continued to provide the best possible care.
- Since the board meeting on 4 December there had been a significant increase in the number of Covid cases in the community, ie eight times as many. At the start of December there were 16 Covid positive patients in the Trust, and this had peaked at 185.
- There had been an amazing organisational response from staff, despite the very high level of staff sickness. Staff were working in areas that they did not normally work in to support teams, both in the hospital and the community.
- It had been a very difficult time for staff and the organisation was committed to supporting them both now and in the future, as a result of Covid.
- He thanked everyone who had been involved in implementing the vaccination programme for all their hard work.
- A significant number had been reached with over 100,000 people having died due to Covid. Everyone had been touched either personally or professionally and it was important to remember this. He thanked everyone in the organisation for all they were doing, both in caring for patients and supporting one another.
- The lead governor had requested, on behalf of the governors, that the Chief Executive pass on their thanks to staff and acknowledge their ongoing hard work, particularly during this recent very challenging period.
- Despite the pressure that the organisation had been under during the pandemic, significant achievements and progress had been made in other areas, eg pathology would be applying for accreditation; improvement programme/CQC action plan; catering.

Q The NEDs wanted to make sure that they were able to triangulate assurance but there had been limited opportunities due to Covid and they had not been able to go into the hospital, although they had managed to join operational meetings. Was it possible to undertake virtual visits to wards so that they could gain a view of what was going on, as this would help them to provide assurance to governors etc in the future.?

A The executive team would consider how to facilitate this as it would be a way of seeking assurance and staff would welcome the opportunity to speak to members of the board.

ACTION: Consider how NEDs could undertake virtual ward visits. **J Over / R Jones**

Q NEDs wanted to be able to support the executive team and staff as much as possible. One of the areas for consideration was looking forward, eg the Trust's strategy. The team should not feel they had to deliver this very quickly but when and how would this start to be looked at in greater detail?

A The existing strategy was overdue and this was in the process of being reviewed. A draft was being worked on and governors had received a briefing on the initial thinking and how the ambitions might be changed and the number of priorities reduced to simplify the approach. The key question was the best time to publish this and it was important that it was launched at an appropriate time; this was likely to be spring or early summer depending on the Covid situation.

DELIVER FOR TODAY

21/010 OPERATIONAL REPORT

- Both operational and clinical teams in ITU were under immense pressure and working at the upper end of maximum surge capacity, but this was not unexpected.
- There were currently 115 Covid positive patients in the Trust and this number was reducing steadily which was positive news. However, this was still twice the number reached during the peak of the first wave.
- The rapid increase in cases had resulted in the cancellation of the non-urgent elective programme which had put the Trust further behind.
- Everything possible had been done to maintain the level of diagnostic activity, although there had been some reduction, particularly in higher risk diagnostics.
- The graphs on page 42 showed regional and local modelling, but there was a caveat that the data had been influenced by additional discharge capacity.
- Pages 43 and 44 provided details around community structures and the work undertaken by the transformation team and system as part of the emergency response. This was complex work and community teams had been working very hard.
- It was stressed that although pressures in the hospital were receding it was very important not be complacent, particularly in the community where pressures remained significant and high.

Q Was there a proposed timescale for the review of the community structures, recognising the current situation with Covid?

A This work had continued throughout Covid, although not as rapidly as it might have done. HR were supporting this work and there was a named contact within adult social care. Key staff who would be affected by the changes had been made aware of the outline plan and this had been received very positively.

Job descriptions and organisational structures were now being developed together with a more formal consultation document which it was anticipated would receive good support from the staff involved.

It was proposed to appoint to key senior posts and these individuals would work down through the rest of the organisations. The timescale for this should be available next month.

Q If herd immunity was achieved by July it was likely that there would then be a big pressure on recovery. However, there was a need to balance giving staff time to recover against the pressure to move forward with recovery. Had the executive team started to think about managing the conflicts that they would face?

A This had started to be considered by the executive team, as well as both regionally and nationally. It was not yet known what the approach to this would be, but conversations were taking place about the need to balance this with staff recovery. The Trust Executive Group (TEG) would be discussing this on Monday and seeking the views of the broader leadership team. Discussions were also taking place with the CCG and regional team. There was more of a realisation this time that different organisations nationally had been affected in different ways.

It was important to realise that in terms of recovery and getting back to were the organisation originally was would be a two to three-year piece of work. It would be very important to support staff through this period.

ACTION: consider how to support staff as move into the recovery period. — **H Beck / J Over**

Q Re the virtual ward, looking forward was there any potential post Covid to look at this more widely and whether it could interface with community services?

A The Trust would want to assess the effectiveness of all of the initiatives and where appropriate they would be embedded into future ways of working. The virtual ward would start slowly as a concept and it was important to take time to evaluate this initiative properly; however, it was the hoped that this would be a future way of working.

Q How big was it planned that the virtual ward would be and had the Trust liaised with other organisations about their experiences with this?

A The virtual ward was a very specific Covid virtual ward which was around managing people's respiratory conditions. As this was a new concept there was not a lot of experience in other organisations, however ESNEFT have some experience and the Trust was talking to them about this. WSFT's virtual ward would start next week with two patients and would then be slowly increased to ten patients if it went well.

If successful this would be looked at in the future as part of a wider transformation services.

Q Would long Covid support and rehabilitation be available to young adults and children?

A The number of young adults and children requiring this serviced would be small. However, the route into all of these programmes would be via normal services, ie GPs, paediatric services etc.

21/011 INTEGRATION REPORT

- Evaluation of initiatives would be a key piece of work in recovery and beyond.
- Since December the alliance had been meeting on a daily basis to look at the situation across the system and understand how it could keep the flow through the hospital and place patients in the right setting.

- Capacity in the community had also been increased to take Covid positive patients in a designated setting, ie care homes willing to take positive patients, and they had been very flexible about this.
- The alliance was also looking at how to increase keeping patients safe in their own homes rather than in a hospital setting. This report gave details of initiatives that had been developed to assist with this, eg looking at each case to provide personalised health care and keeping patients, family and carers in a safe place and providing outreach support.
- Partnerships across the system have been absolutely key and there had been a phenomenal response in terms of people being willing to change the way in which they previously worked.
- The vaccination programme had started with two primary care hubs opening on 14 December and a further four on 14 January, ie six in west Suffolk. Every part of the system had been involved in the delivery of this and each hub had been supported by an army of volunteers. 83% of people over 80 had now been vaccinated. Last Saturday all of the care homes had been completed and there was an ongoing process for this.

Q A number of organisations were discharging patients who could still be carrying Covid into care homes. This had resulted in national media coverage and the implication that they were not telling care homes that this was the case. What could be done with local media to ensure that they understood how this was being managed?

A WSFT was discharging patients into designated settings which had been set up for this purpose where there was any suggestion of Covid or that they may have been in contact with Covid. Non-Covid patients were not in the same setting and there was no mixing of different steams of patients, ie those who had had Covid, were recovering from Covid or had been in contact with someone with Covid.

Q Overnight care or support was crucial as part of the enhanced integrated neighbourhood team. Was there the capacity within this service to provide care at short notice when needed?

A This was a very difficult staffing cohort to fill and they had gone out for recruitment of enablement and care workers, as well as working with hospice colleagues around volunteers and linking with communities. Sometimes this was about providing support rather than a clinical need. If the system continued with these models, staffing models would look different in the future but this could offer career development for some people.

- A number of initiatives that had been implemented as a result of the Covid pandemic that would allow greater and faster transformation to the benefit of patients and their carers in the future.

21/012 VACCINATION REPORT

- The board thanked and commended everyone in the organisation who had been involved in implementing the vaccination programme for staff, particularly in managing the changing and uncertain situation with the provision of vaccine. A lot of very positive feedback had been received about the efficiency of the process.
- Today would be the busiest day for the vaccination team in Quince House, ie 650, and by the end of today they would have done 13,000-14,000 vaccines in 3½ weeks.
- In response to the question about the uptake of vaccine amongst staff and how the Trust would manage the 20% who had not had a vaccine there were a number of issues contributing to this.

- 69% of staff had had the flu vaccine and this was unlikely to increase. People could not have a flu vaccination seven days before their Covid vaccination, or between their Covid vaccinations, or seven days after their second vaccination.
- A significant number of staff had had Covid recently and it was not recommended that people had a vaccine within 28 days of having Covid. Therefore, there was a cohort of staff who could not yet have a vaccination but wanted one and there would be provision for this.
- There was also a group of staff who could not easily have the vaccine due to health issues and provision was being made for them to have a conversation with a senior doctor. To date all of these staff who had had a conversation had gone on to have a vaccine without any adverse reactions.
- There would also be people who were concerned about having the vaccine and the Trust was trying hard to address this through the executive team, weekly briefings and leaders across the organisation and other members of staff from diverse groups, ie Filipino, to support staff and encourage them to have the vaccine.

Q How did the Trust plan to manage front line staff who refused to have the vaccine?

A There would be a very small group of staff who did not want the vaccine and this was their right, as it was not currently compulsory. Neither flu or Covid vaccinations were on the mandatory list for front line staff. The Trust would continue to try to support and persuade these people and mitigate their fears.

Q How confident was the Trust that it would be able to get sufficient supplies of vaccine to be able to administer the second dose to everyone?

A The Trust had been assured that it would receive sufficient supplies of the second vaccines. The hub in Quince House would be pausing after next week; the allocation had been reduced for last week and for next week and it would not be receiving any more until it second vaccines were due.

21/013 INTEGRATED QUALITY AND PERFORMANCE REPORT

- For next month's report it was hoped to be able to indicate actual performance on charts, were possible.

ACTION: include actual figures on charts. **H Beck**

- There had been a reduction in demand in the emergency department and this was likely to continue in January, eg up to 100 less patients per day.
- The number of patients on the referral to treatment (RTT) waiting list at the end of December was 2442. Prior to the second Covid wave the medicines division was doing very well in recovering its position, however women & children and surgery were struggling due to the number of patients requiring surgical procedures.
- As at the time of producing this report there were 2206 patients who had waited over 52 weeks and this would be a significant challenged to recover.
- Incomplete 104 day waits were still a significant challenge. The standard for this was zero at the Trust was at this point prior to Covid but as of today there were 47 patients on cancer pathways. 43 had not had a diagnosis, 33 were in the colorectal group and the majority of the rest also required diagnosis through an endoscopy.
- Once diagnosed there were no delays at WSFT for patients needing cancer treatment, however it was noted that there were some delays for patients awaiting treatment at the tertiary centres and these patients remained on our tracking lists until treated.

- The Trust was trying to maintain diagnostic activity as much as possible and this would be a focus of recovery.

Q In order to provide assurance and identify whether WSFT was an outlier, was there an external benchmark that could be used to see whether or not the impact on RTT etc was consistent with other organisations?

A It was difficult to look at this in terms of size of waiting lists and backlogs, as every organisation had been impacted on and reacted differently. The region was now asking what mutual aid WSFT could supply to other organisations who not been able to treat cancer patients and in some cases emergency patients. This month WSFT was delivering more day cases and more activity than others in the region.

Some regional data was available looking at volumes of activity being delivered compared to pre-Covid. This was being looked at across the region and nationally.

ACTION: Consider how to benchmark against other organisations. **H Beck**

Q Was the Trust still using facilities at the BMI?

A WSFT was still using the BMI. As of next week, the three acute Trusts in the region had been given permission to take over 100% of capacity in local independent private sector organisations which would be funded nationally.

Q Was the reduction in emergency department attendances resulting in significant harm?

A It was too early to know what the outcome of this would be, however attendance levels were higher this time than before and there a been a lot of public messaging to encourage people to attend emergency departments if they needed to. There had also been more messaging around using NHS 111 for advice and guidance.

Q Was it possible to develop a measure of effectiveness of data in the community?

A This would be followed up.

ACTION: consider how to develop community effectiveness metrics. **H Beck**

21/014 FINANCE AND WORKFORCE REPORT

- The Trust continued to breakeven and would breakeven at the year end due to the mechanism put in place nationally around reimbursement by the Department of Health (DH) of expenditure within NHS organisations.
- The focus in the last couple of months had been on looking forward to next year. Trusts had recently heard that the mechanism in place this year would continue for quarter one of the next financial year but there was no detail for the rest of the year. Therefore, there was a significant degree of uncertainty on the financial situation moving forward.
- It was proposed to set the same budget for next year as this year but with a much smaller than usual cost improvement programme (CIP). However, this was problematic due to the uncertainty around the organisation's position/activity.
- Therefore, the CIP included in this year's budget would become the CIP for next year's budget with a proposal for an additional 1%.

- It was expected to achieve approximately 50% of this year's CIP. The original aim was to achieve the recurrent CIP for this year but this was unlikely and the shortfall would become a problem for next year which would be an issue for the organisation.
- David Wilkes had agreed with Craig Black that he would engage directly with the lead on CIP in the programme management office (PMO) and undertake a deep dive into how achieving the CIP for next year was being looked at.

ACTION: Outcome of review of CIP with PMO to be fed back to the board. **D Wilkes**

- The cash position remained good due to the support that all organisations received in month one of this year. This was expected to reverse in month 12 and then be reinstated in month one of the next financial year. However, the cash position was expected to remain good in March.
- The capital programme was currently behind plan and was likely to remain behind plan at the end of the financial year. Estates and IT were doing everything possible to try and minimise the under spend and the extent to which it was behind plan.

Q Although the capital plan was behind schedule, did the underspend take into account the funding for the new hospital?

A The Trust was on target to spend the funding for the new hospital. It was behind plan in other schemes which was mainly due to Covid.

Q Was the investment for the business cases that the board would be considering today factored into the numbers in the report?

A This had been factored into the capital plan for this year and also factored into the plan for next year. In terms of revenue the budget for next year would include the consequences of any business cases that had been approved. It was assumed that the board would approve the businesses cases today and this had been factored into next year's plan, as well as CIPs.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

21/015 PEOPLE AND ORGANISATIONAL DEVELOPMENT (OD) HIGHLIGHT REPORT

- The board congratulated the staff members who had been nominated for Putting You First awards for January, including Sara Rollo who was attending the meeting today to present the histopathology business case.
- In response to the governor's question about the importance of the role of line managers in recognising and supporting staff who were struggling, this was being addressed through WMTY 1: promote the value of great line management. Details of this were provided in the report.
- An update on the staff psychology support service and recruitment to the team was provided in this report, together with an update on appraisals, mandatory training, freedom to speak up and recruitment within the community, ie Debenhams.

Q When would the results and impact of some of the initiatives that have been introduced be seen?

A This information would be reflected in future reports to the board.

Q Recognising that Covid had made it difficult to fully implement and progress with the more detailed people plan and cultural plan, when would it be possible to produce a tracker for progress against key schemes?

A This was being developed within the team and should be ready to bring the board meeting next month.

Q It appeared from the FTSU report that there had been more instances of people speaking up, which was a good thing. Was this an increase?

A The FTSU data was a snap shot of the date, a more detailed report with trends and numbers would be presented to the board next month.

ACTION: provide detailed report of FTSU trends and numbers to next meeting. **J Over**

An increase in the number of cases brought to the FTSU guardians had been seen but these were not always FTSU cases, more a case of people wanting to get something of their chest. The Trust needed to continue to make staff aware of this service.

Q When would the results of the next staff engagement survey be received?

A The full results from the national staff survey should come to the board next month.

Q Given the pressures faced by staff and despite all the support being given was it anticipated that there would be an increase in people leaving the organisation?

A This was a concern due to the impact of the current situation and from various sources of data, both locally and nationally, there were individuals who were considering their career in the NHS. This also related to recovery and ensuring that individuals were given time to recover and made to feel that their employer understood what they had endured and the impact this could have both in the medium and long term.

As WSFT emerged from the pandemic it may need to be very flexible about the different roles that people could have in the organisation if they wished to move away from the front line, eg redeployment and retention of skilled and experienced individuals.

Q It was important that people did not feel persecuted for using the FTSU service and it was concerning that four people had responded 'I don't know' to the feedback question, 'given your experience, would you speak up again?' Was it know why this was?

A The FTSU guardians ask for feedback from people who engage with them but if a response was not received it was recorded as 'don't know'. Therefore, this did not necessarily mean that people would not speak up again.

- The excellent work that the communications team was doing with the wellbeing team was highlighted and a range of initiatives would be launched around wellbeing and awareness of wellbeing for staff.
- It was proposed that the board should receive a presentation on the staff psychology support service at a future meeting.

ACTION: schedule a presentation to the board on the staff psychology support service. **J Over / R Jones**

21/16 QUALITY SAFETY AND IMPROVEMENT REPORT

16.1 Maternity services quality and performance report, including Ockenden report

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

- The board were asked to note the maternity clinical and quality dashboard (annex B)
- The Trust's Maternity Quality and Safety Framework was still in the development stage and had been shared with the division. It was now waiting for review by the new clinical director who would be taking up their role next week. This would then be shared more widely.
- Further work was required on the patient safety incident response framework (PSIRF) and how this would fit with maternity incidents. A meeting had been arranged to finalise this.
- The Ockendon report on maternity care at the Shrewsbury and Telford Hospital NHS Trust had identified a number of themes, including seven immediate and essential actions.
- NHSE had produced an assurance assessment tool which included adherence with NICE guidance and processes, compliance with CNST safety and staffing.
- Annex A provided an overview of the themes from the Ockendon report and where WSFT rated itself against these, together with actions required. The areas where it was amber were explained and the actions had been incorporated in the Trust's improvement programme.
- Consultant led ward rounds; these had only been happening once so day, but as of last weekend a second ward round had been introduced. This would be audited as it could be a challenge due to staffing levels.
- Managing complex pregnancy; although each patient had a named consultant it was not always that consultant who looked after them. A more robust way of allocation had been introduced which meant that patients would be allocated to the correct consultant.
- Development of maternal medicine centres; regional centres were being set up and the Trust was committed to using them. It also had good relationships with external tertiary centres with monthly MDT meetings
- Risk assessments at every contact; risk assessments were undertaken but compliance was not 100%. Therefore, this had been discussed with staff to ensure that they were fully documented.
- Informed consent; although the Trust had information leaflets it did not currently publish guidelines etc on the website. Work was being undertaken with the communications team to address this.
- The Trust had been on track to be fully compliant in terms of external assurance, ie 90% of each staff group. However, due to Covid the anaesthetics and theatre teams had been redeployed but it was hoped that compliance would improve.
- It was proposed to update the maternity dashboard (annex B) and a meeting was taking place next week to agree the revised indicators.
- The quality dashboard showed a trajectory of improvement, on the whole, except for compliance with swab counts. The reason for this was unknown and was being addressed with staff.
- The CNST incentive scheme was embedded in the Ockendon report and WSFT hoped to be compliant with this. The only area highlighted related to PROMPT training and this would be the same the across every unit in the region due to Covid.
- There had been two serious incidents (SIs) one in November and one in December. These would be discussed in the closed board meeting.
- The board received the following reports and the key points were highlighted:

- Maternity Safety Highlight Report incorporating CNST Maternity incentive scheme (Annex C)
- UKOSS Covid report March/April 2020 (Annex D – CNST requirement)
- Paediatric Staffing report (Annex E – CNST requirement)
- ATAIN Programme report (Annex F – CNST requirement)

- The board commended Karen Newbury for all her work and achievements, particularly in relation to the Ockendon report.

16.2 Infection prevention and control assurance framework

- The dashboard continued to be developed and was work in progress.
- With regard to the question from a governor relating to nosocomial infections, the number of cases had increased significantly last month in correlation with high numbers in the community which had resulted in a number of outbreaks in the organisation.
- There was an incident management team meeting for every outbreak and these were attending by a number of external parties as well senior leaders, ie ward managers and matrons.
- Each case was declared a serious incident (SI) and was fully investigated, therefore each outbreak had been a through a full SI review.
- Currently two wards were closed due to an outbreak. These were admitted wards and it was likely that patients were already developing Covid as they came into hospital.
- As patients were identified as being positive they were moved into a positive Covid area, but unfortunately other patients in the bay would have been exposed.
- This was happening nationally in any organisation without a large number of side rooms.
- Learning from these incidents was being disseminated immediately without waiting for the results of the SI review, together with learning from other organisations how to manage this.
- The Trust was adhering to all infection prevention and control guidance and this was monitored on a regular basis.

16.3 Safe staffing guardian report

- Although exception reports had increased in December this could be taken as a positive as this was a mechanism for junior doctors to claim their over time and it was important that people reported their working hours and were paid appropriately.
- There were no fines in this period.
- This report highlighted the flexibility in which everyone had been working to provide the best possible care to patients in challenging circumstances.
- The feedback from the BMA was noted and the board complimented HR and the operational teams on their management of rotas.

16.4 Nursing establishment review

- Dan Spooner, deputy chief nurse, joined the meeting to present this report; he explained that this paper had been presented to the executive team and scrutiny committee.

- In September 2020 a trust wide inpatient nursing establishment review was undertaken throughout the organisation which was a significant piece of work for the nursing teams.
- The results were then triangulated with nursing sensitive indicators, eg pressure ulcers, falls etc, and meetings took place with all the teams to discuss the output.
- For 11 wards there was no change to the current establishment; for five wards it was proposed that there should be a small uplift, mainly at night, including a lower uplift for the stroke ward.
- The review also addressed the skill mix on a number of wards in favour of registered nurses (RNs).

Q The board was previously told that bay-based nursing would improve patient care as well as being more efficient. Was the reason that this was no showing any benefit because it had not been implemented properly?

A The rationale behind this was understandable, ie a nursing assistant (NA) in every bay. However, the challenge was that it had resulted in a reduction in RNs and when you reduced RNs patient safety declined as they were trained to mitigate risks and create care plans to address patients' needs. Therefore, the proposal was to move to a ratio of 60 RNs:40 NAs.

Q Could similar assurance be provided for community nursing?

A This would be helpful for community beds, however the tool that was used for the review of nursing in the acute setting did not allow for a community review. It was hoped that a similar tool would be developed for this. The community teams were currently working on a demand and capacity model which should provide further information.

Individuals were also being moved onto e-rostering to enable flexibility of staff and it had been agreed to purchase Malinko software which would enable the organisation to match capacity, demand and nurse staffing.

Q The graph in the IQPR showed a gradual increase in acuity, mainly due to Covid. Was this likely to be a long-term trend that would continue to affect staffing levels?

A This was likely to be the case as a number of patients had not been accessing health care during this period. Therefore, the review would be ongoing on a six monthly/seasonal basis in order to ensure staffing levels were in line with activity and acuity.

- The outcome of this review had been well received by the clinical directors and it provided for better partnership working between doctors and nurses. It was anticipated that the additional investment would be well received by all staff.
- The board considered this to be a very helpful and detailed report and regular reviews would enable them to be kept updated on nurse staffing levels and patient acuity.
- The board recognised and authorised the recommendations within this paper and supported the investment of £655,936 in nursing staffing. This would be factored into budget setting for 2021/22.

ACTION: provide an implementation plan for the investment in nursing staff. — **S Wilkinson**

16.5 **Nurse staffing report**

- It was noted that this report was for November and December.
- Fill rates had reduced significantly across the organisation in December compared to other months, although this was not a concern across the Trust as a whole.
- Appendix A showed that there was a lot of more amber and red indicators in individual wards. This was due to an increase in sickness absence, particularly within nursing assistants.
- Vacancy rates remained static and recruitment continued.
- There had been an increase in the number of complaints received in December (22) but there had also been an increase in compliments (44).
- Adverse staffing incidences were now being included in this report; although there had been an increase in December, there had been no reports of patient harm.
- A number of additional actions as a result of the second wave in Covid in December had been implemented to provide additional assurance and to further strengthen and support staff.
- The Nursing and Midwifery Council (NMC) had agreed to allow third year students to join the workforce for their last third year placements and approximately 20 students were likely to join WSFT has unregistered nurses which would be very welcome.

16.6 Improvement programme board report

- Despite Covid the improvement programme board meeting and senior responsible officer (SRO) meetings had continued to monitor progress against the CQC action plan and the improvement plan.

21/017 HISTOPATHOLOGY BUSINESS CASE

- Sarah Rollo, Deputy Manager, Cellular Pathology, joined the meeting to present this item.
- This business case had been presented to the pathology group and executive team. It provided information on the proposal to replace outdated equipment in the histopathology lab.
- This would facilitate delivery of a quality service, accreditation and recruitment and retention of staff.
- The presentation illustrated the problems experienced within pathology over the last ten years due to lack of investment which had resulted in the problems being seen today and the effect that this had had on staff.
- There was a real need for investment and a real ambition of staff to improve services and achieve accreditation.

Q Assuming the investment was made in the equipment and accreditation achieved, was there potential for third party contracts in the future?

A There would be the potential to bring other work in-house if necessary and also options to provide additional services. The Trust already did outsourced work from the BMI but for most other work this would depend on UKAS accreditation which would allow the lab to undertake work for third parties.

Q Would measures be put in place to track improvement in performance, ie better lead times etc?

A Turnover times were regularly monitored so the impact of investment in new equipment would be shown very quickly.

- The board approved the proposal for replacement of the outdate histopathology equipment as presented to the meeting today.

ACTION: schedule follow up review of the impact of the investment in pathology. **N Jenkins**

21/018 CAR PARKING TARIFF REPORT

- It was noted that the board had previously been made aware of this proposal and the following which had been considered and approved by the Scrutiny committee:

  - The proposal to put the tariff increases on hold until the March 2021 Trust Board meeting or until charges for staff are reinstated.
  - The implementation of free parking for some frequent out-patients and parents of children in hospital overnight in March 2021, in lieu of final government guidance.
  - To continue to follow Government guidance and provide free car parking to NHS staff for the duration of the coronavirus outbreak.

BUILD A JOINED-UP FUTURE

INTEGRATION REPORT (see item 21/011)

21/019 FUTURE SYSTEM BOARD REPORT

- The main activity around this had been the preparation of the strategic outline case (SOC) and a key meeting would be taking place on 5 February with the regional office and DH to agree the next steps in terms of the submission of this document.
- A lot of work was also continuing in relation to estates and process of clinical design.
- Annex A gave details of the Texas model and appropriately illustrated the process of co-production. WSFT was following this process.
- The board noted this report and the next steps in the process.

GOVERNANCE

21/020 GOVERNANCE REPORT

The board noted the contents of the report and:

- Approved delegated authority to the audit committee to review and approve the charitable funds annual report and accounts for 2019/20
- Approved the updated health, safety and welfare policy.

ITEMS FOR INFORMATION

21/021 ANY OTHER BUSINESS

There was no further business.

21/022 DATE OF NEXT MEETING

Friday 26 February 2021, 9.15am

RESOLUTION TO MOVE TO CLOSED SESSION

21/023 RESOLUTION

The Trust board agreed to adopt the following resolution:-
"That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" Section 1 (2), Public Bodies (Admission to Meetings) Act 1960

7. Matters arising action sheet

To ACCEPT updates on actions not covered elsewhere on the agenda

For Report

Presented by Sheila Childerhouse

Board of Directors – 26 February 2021

Agenda item:	7			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	19 February 2021			
Subject:	Matters arising action sheet			
Purpose:		For information	X	For approval

The attached details action agreed at previous Board meetings and includes ongoing and completed action points with a narrative description of the action taken and/or future plans as appropriate.

- Verbal updates will be provided for ongoing action as required.
- Where an action is reported as complete the action is assessed by the lead as finished and will be removed from future reports.

Actions are RAG rating as follows:

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

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

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

Previously considered by:	The Board received a monthly report of new, ongoing and closed actions.
Risk and assurance:	Failure effectively implement action agreed by the Board
Legislation, regulatory, equality, diversity and dignity implications	None

Recommendation:
The Board approves the action identified as complete to be removed from the report and notes plans for ongoing action.

Ongoing actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1912	Open	29/1/21	Item 9	Provide recommendation following consideration of necessary staff support and reset to enable them to meet the future operational challenge	Include in People plan report	JMO / HB	26/02/21	Green
1915	Open	29/1/21	Item 12	Community services leaders to recommend appropriate community effectiveness metrics for future reporting		HB	26/03/21	Green
1916	Open	29/1/21	Item 13	David Wilkes to feedback on assurance review of CIPs with programme management office (PMO)		DW	26/03/21	Green
1918	Open	29/1/21	Item 15.4	Provide an implementation plan for the nursing investment approved by the Board in January '21		SW	26/03/21	Green
1919	Open	29/1/21	Item 15.5	Provide analysis of staffing and nursing quality metrics performance over time	To be included in the nurse staffing report	SW	26/03/21	Green

Closed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1913	Open	29/1/21	Item 12	Include actual performance figures on charts (at least the final few data points)	Reflected in IQPR performance charts	CB	26/02/21	Complete
1914	Open	29/1/21	Item 12	Provide information on WSFT operational performance relative to other trusts (activity and backlogs)	Included in Operational/IQPR reports	HB	26/02/21	Complete
1917	Open	29/1/21	Item 14	Schedule for the Board to receive a review of the psychology support service offered to staff	Included in Board's forward plan for meeting on 30 July	JMO/RJ	26/02/21	Complete
1920	Open	29/1/21	Item 16	Schedule follow-up to review measures for histopathology service efficiency improvements as a result of investment agreed in January Board	Included in Board's forward plan for meeting on 1 October	NJ	26/02/21	Complete

8. Patient/Staff story

To RECEIVE for consideration and reflection

For Report

Presented by Susan Wilkinson

9. Chief Executive’s report

To RECEIVE an introduction on current issues

For Report

Presented by Stephen Dunn

Board of Directors – 26 February 2021

Agenda item:	9			
Presented by:	Steve Dunn, Chief Executive Officer			
Prepared by:	Steve Dunn, Chief Executive Officer			
Date prepared:	19 February 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

During January we experienced a significant increase in the number of **Covid-19 patients** to nearly four times the level that we experienced in the first peak. I am hugely relieved that, like the rest of the country, we are starting to see a sustained reduction in the number of Covid patients in the hospital. The situation remains very challenging and our staff are under enormous pressure, but let us hope we can start to take some steps towards normality. I want to repeat my big thank you for all that our amazing staff have been doing – last month we acknowledged not only how tough it's been but also how flexible and professional they have been in terms of delivering care and supporting colleagues and teams.

The impact of the pandemic on NHS waiting times has been widely reported and inevitably as Covid patient numbers reduce attention turns to ensuring access to care and treatment for our patients. But we must ensure that we support our staff as we focus on a reset plan for elective services. Plans for this will be considered as part of the people and operational reports on the Board agenda.

To improve our **communication with staff** in a rapidly changing situation, we have continued our weekly staff briefings on the pandemic, which provide an opportunity to hear from myself and other executive colleagues and enable staff to ask us questions and receive direct feedback. As I have told you these meetings, which have also been recorded and shared, hopefully have helped staff to keep informed about the current situation and plans. Every week more than 300 staff, board members and governors have joined these weekly briefings.

But while it is challenging at the moment there is light at the end of the tunnel. Over the last few weeks thousands of our staff and other local health and care providers have received the game-changing Covid-19 vaccination. Since kicking off our staff vaccination programme on 4 January, we have **vaccinated more than 15,000 priority staff** from the Trust and local NHS partner organisations. This has literally been a big shot in the arm for us all and a huge morale boost. I want to say thank you to everyone, including our volunteers, who have played a part in vaccinating staff. Nationally it appears that the vaccines have had a significant impact on the risk of serious illness. In the fourth week after the first dose, hospitalisations were reduced by 85% and 94% for the Pfizer and AstraZeneca jabs. Hopefully, with the announcement by the Prime Minister this week, we now have a four-step plan to release us from lockdown by 21 June.

While this is good news, I suspect Covid-19 is probably here to stay and we will need to continue to evolve how we respond to it and treat it. This is why it's great that patients with Covid-19 can now be treated in specialist facilities after the opening of our **new major assessment area** within our emergency department. The 10-bed facility features separate treatment rooms specifically designed to allow for isolation of patients with Covid-19 or other infectious conditions. The extension of the emergency department also includes a new dedicated resuscitation area and 'negative pressure' facilities to help make treatments that might involve the spread of aerosol droplets - which can spread Covid-19 and other diseases – safer. Since the start of the pandemic, patients with Covid or suspected Covid have been treated separately from other emergency department patients, but this the new area offers even greater protection for patients.

The new facility has been made possible by a £2.7m Government grant that has seen office and storage areas relocated elsewhere in the hospital. A second phase of improvements aimed at improving the transfer of patients arriving by ambulance is now underway. It will include space for up to eight patients, two treatment rooms, and changing and rest facilities for staff. This expanded facility is due to open in the summer. While we are seeing levels of Covid-19 in the community beginning to fall, we still have new patients arriving every day with this very serious disease. The space is fully flexible, so we can also safely use this extra assessment space for other patients attending our emergency department.

A new service known as the **Covid Virtual Ward (CVW)** has been set up in record time to assist the safe and supported discharge of adult West Suffolk Hospital patients with Covid-19. The CVW, is a joint initiative between our acute medical and operational colleagues, and our community chronic obstructive coronary disease (COPD) team. Patients will need to meet certain criteria to be referred to the CVW but in summary medical consultants can put forward those with an improving clinical trajectory (symptoms, function, oxygen saturation), and who have had no fever for 48 hours consecutively (without medication to reduce fever). Under the care of a respiratory consultant, patients will remain under hospital supervision whilst on the CVW.

All patients will be given a pulse oximeter to regularly measure their oxygen saturation, with our discharge planning team set to prepare patients in how to monitor themselves when at home. All patients will be required to record saturations and pulse rate three times a day. Our community COPD team will carry out required community assessments and daily telephone follow-ups to ensure their recovery continues to go well, with weekly patient reviews carried out by a multidisciplinary team including colleagues from emergency medicine, respiratory and COPD. I can't thank our teams, involved in helping to set this up, enough. It's obviously early days but hopefully we will start to see a positive impact as a result of the service, and the safe discharge of patients to their homes where they can fully recover from coronavirus in the comfort of their own surroundings.

Looking after our staff and their well being is a key priority as we emerge from the challenges of Covid-19. Last week, we organised a free **well-being week for staff called 'Love Yourself'**. Timed to coincide with Valentine's Day it encouraged staff to take some time out for themselves by inviting them to take part in a wide range of virtual activities designed to support their physical, mental and social wellbeing. The week saw an array of online events, which were supported by local Suffolk businesses, including a virtual wellbeing session with a local mental health trainer, learning how to cook some of the Time Out classics with the Trust's head chef and focusing on strength and flexibility in a Pilates session with a local Pilates coach. The week saw around 1,000 people joining in the virtual events. There has been positive feedback from those attending, with one staff member commenting "this is a fantastic idea for getting us to spend a little time on us" and the Trust's Clinical Consultant Psychologist, Emily Baker, saying the Communication's Team is providing "outstanding support". I am also delighted that we have also recently teamed up with our fellow Alliance partner Abbeycroft Leisure to offer a free 14 month pack offering all our staff free access to a range of physical activity sessions, services and activities.

We have also continued on our cultural journey and recently heard from Dr Megan Reitz about her research into '**speaking truth to power'** and how perceptions of power enable and silence others. Dr Reitz spoke at our '5 o'clock club' leadership event on 8 February, and then facilitated a workshop with the executive team. Megan's research is highly relevant to our focus on developing more of a listening and learning culture and fostering the right environment for people to speak up. Specific learning points from these sessions included:

- Speaking up is relational. The dynamics and differences in role, position and context of the individual speaking up, and the individual they are speaking up to, will dictate the environment within which it happens
- We are not as good at it as we think we are (speaking up or listening up). No one is likely to tell leaders they are "wrong"
- Those in senior roles typically hold an optimism bias about what it is really like in an organisation, which can lead to them existing in a 'bubble'
- Titles and labels signal how power is created and held; and thus, impact on perceptions around a differential in power
- Colleagues in an organisation can perceive that senior leaders have a 'list' – of those that they listen to and those that they don't. And therefore, act accordingly
- Senior leaders can immediately perceive speaking up as criticism, and thus act defensively.

The future ‘5 o’clock club’ programme also includes an interactive discussion with Dr Amar Shah, Chief Quality Officer, East London NHS Foundation Trust and national improvement lead for mental health on 1 March. The session will look at what it really takes to develop a culture of continuous improvement. If we are to develop a culture of continuous quality improvement we need to learn, when things go wrong, or an unexpected event occurs and avoid focusing on blame. In healthcare we call these patient safety incidents. At West Suffolk, these are recorded on Datix before being reviewed to help prevent any future incidents. We are fortunate to be an early adopter of the new national **Patient Safety Incident Response Framework**, which will update the way we respond to and investigate these safety incidents. We are currently involved in the national pilot run by NHS England together with regional partners and commissioners which we hope will be rolled out nationally when the pilot comes to an end. As part of introducing the new framework, the Trust's patient safety team is developing a Patient Safety Incident Response Plan which will help us identify the most significant patient safety risks, to ensure learning is put in place. Building a culture where everyone feels confident and safe to speak up and raise concerns is vital and of the utmost importance to us here at the Trust. James Barrett and Amanda Bennett, our Freedom to Speak Up Guardians are visiting (virtually) teams and departments to discuss how speaking up and listening to others can help your team reach its full potential, ensure patient safety and improve working environments.

The People Plan report to the Board outlines in more detail the work we are undertaking to ensure we engage with our staff, support them and continue to learn and improve. But recognising the **amazing work that our staff** do is also an important part of the support that Board’s leadership provides to our amazing people. I have highlighted some brilliant examples below, but also be in no doubt that across the whole team and across the acute and community settings our staff are going above and beyond to continue to delivery services at the most challenging of times.

That said I am so delighted that three members of our **midwifery team have been recognised for their outstanding work**. The annual awards are given out in memory of Hannah Seeley, an exemplary midwife who worked at West Suffolk Hospital and tragically passed away in a road traffic accident in 2012. The winners were nominated by colleagues across three inspirational award categories and were chosen based on the number of nominations they received. Although unable to hold the usual awards ceremony due to social distancing, the winners were presented with their trophies individually. The awards, which have been running since 2013, cover three categories:

- Midwife of the year - the winner was Jacqui Clarke, who has worked at the Trust since 1987, for her above and beyond care to both colleagues and mums. One of her colleagues said: "Jacqui is the midwife you always want to work a shift with. She is kind, caring, professional, supportive but also has a sense of humour and a listening ear for those times when you need it."
- Support worker of the year - Kimberley Morton-Smith, who joined the Trust in 2019, picked up the support worker of the year award. One of her colleagues nominated her for ‘friendly and approachable’ manner, and for being a fantastic asset to the team.
- Student midwife of the year - the student midwife of the year award was taken home by Frances Morter, who is in her third year of her placement. She was nominated for her ‘passion’ and ‘dedication’ she shows when caring for both mother and baby.

As I have said previously, 2020 was an incredibly challenging year, but our amazing maternity staff have pulled together as they always do and continue to make us so proud.

I am also delighted that Clinical skills manager, James Whatling, has been named one of three finalists in the **Vascular Access Nurse of the Year Award**, in the British Journal of Nursing (BJN) Awards 2021. This is a fantastic achievement and recognises the quality and innovative nature of the work he is doing.

Recently we heard about some of the **issues facing our community teams** and some of the things that they have been doing to help through the pandemic. We heard from Gylda Nunn, our integrated therapies manager, and Sharon Basson the community head of nursing who gave us an update on the incredible work that is being undertaken by community teams across the county. Gylda and Sharon for example spoke about the vital post-Covid-19 rehabilitation available to people who are still experiencing longer term effects of Covid post discharge from hospital. Many still need continued support to help them recover. We heard how our physios are able to help those with issues around breathlessness and dysfunctional breathing and our occupational therapists are able to provide cognitive treatment and fatigue management.

Our community teams take a real pride in serving our community. I have told you how lucky I was to shadow our Bury rural district nursing team at the tail end of last year and was bowled over by the determination and commitment of the individuals I met while I was with them. I want to say a big thank you to every member of our community teams for all your efforts throughout the pandemic. The work they do to help people recover when they leave hospital, and importantly the preventative work to ensure they don't have to come into hospital in the first instance, is incredible. We're so lucky to have them as a vital part of our Trust family.

Using digital platforms to care for patients has become a familiar part of health care, with professionals and patients alike becoming familiar with virtual consultations. Paediatric speech and language therapy lead Peta Cook explained that in the early days of the pandemic, her colleagues kept in touch with children and their families on the telephone. I've shared more of what Peta said at the end of my report. I would like to sincerely thank Peta for sharing her experience, what she and all our staff have done, and continue to do, is truly amazing.

I also want to congratulate Natalie Bailey who is taking on the newly-created role of **head of mental health**, having been the head of nursing for medicine for a year, after initially taking on the role for three months. With 27 years' experience, Natalie joined us from Norfolk and Suffolk NHS Trust and is a registered mental health nurse. The new post will see her working across the WSFT in both our hospitals and community services, with alliance partners and services across the wider system. Natalie believes this new post is a unique one outside the mental health trusts and provides a great opportunity for us to put a greater emphasis the quality, safety and effectiveness of care given to those patients with mental health problems.

I am delighted to say that a partnership of health and care providers, including West Suffolk NHS Foundation Trust, has been awarded a five-year contract to deliver an **early supported discharge service (ESD) for stroke patients** across Suffolk. The specialist service will provide up to six weeks of intensive stroke rehabilitation in patients' own homes following their discharge from an acute hospital, in turn helping them to regain their mobility and independence. It will be provided by the Suffolk Alliance, which is a partnership of our Trust, East Suffolk and North Essex NHS Foundation Trust, and Suffolk County Council, and supported by a variety of third sector partners. The contract was awarded following a competitive tendering process and begins on 1 April. The alliance will take responsibility for delivering the service from current provider Norfolk Community Health and Care NHS Trust. Work is now taking place to make sure the transition between providers runs smoothly so that patients will not notice any change in the care they receive when the new service goes live.

In addition to the items already highlighted, key areas of focus for the Trust's senior leadership team are reflected on the Board meeting agenda. Key items include the updated and evolving **integrated quality and performance report (IQPR)** and a report from the most recent improvement programme board, including a copy of the **Trust improvement plan** which highlights lots of progress which staff should be rightly pleased about, given all that is going on at the moment.

Finally, on 11 February 2021, the government published a **white paper** setting out a raft of proposed reforms to health and care. These are the most important set of reforms the NHS has had in a decade with many of the measures introduced through the Health and Social Care Act 2012 set to be abolished, with a broad move away from competition and internal markets and towards integration and collaboration between services.

Integrated care systems (ICSs) are to be established on a statutory footing through both an `NHS ICS board' (though this will also include representatives from local authorities) and an ICS health and care partnership. The ICS NHS body will be responsible for the day-to-day running of the ICS, NHS planning and allocation decisions. The partnership will bring together the NHS, local government and wider partners such as those in the voluntary sector to address the health, social care and public health needs of their system. A duty to collaborate will be created to promote collaboration across the healthcare, public health and social care system. This will apply to all partners within systems, including local authorities.

There will be new powers for the Secretary of State for Health and Social Care over the NHS and other arm's-length bodies (ALBs). Under the proposals, the Secretary of State will be able to intervene in service reconfiguration changes at any point without need for a referral from a local authority. The Department of Health and Social Care will also be able to reconfigure and transfer the functions of arm's-length bodies (including closing them down) without primary legislation. Certain new duties on the Secretary of State will also be introduced. This will include a statutory duty to publish a report in each parliament on workforce planning responsibilities across primary, secondary and community care, as well as sections of the workforce shared between health and social care (such as district nurses).

There will be significant changes to procurement. It is proposed that section 75 of the Health and Social Care Act 2012 (including the Procurement, Patient Choice and Competition Regulations 2013) will be repealed and replaced with a new procurement regime. However, it is important that we continue to work effectively with the independent and voluntary sector.

I have appended to my report a fuller briefing on the White Paper prepared by NHS Providers.

Integrated community paediatric service - small screen therapy is here to stay

From overcoming initial technical glitches in partnership with IT colleagues, to developing best practice and making the most of a new way of working, clinicians across the Trust accept and are pleased that these changes are here to stay.

The specialist teams in our integrated community paediatric service (ICPS) have done all they can to use the technologies on offer to maintain the services they provide for children and young people across Suffolk.

Paediatric speech and language therapy lead Peta Cook said that in the early days of the pandemic, her colleagues kept in touch with children and their families on the telephone. “As the schools closed we had no option,” she said. “We moved to Visionable by the late spring, but now we mostly use Microsoft Teams, which has proved to be easier,” she said.

“Digital care is here to stay,” affirmed Peta. “The future will definitely see a blended offer, with a mix of virtual and face to face consultation in a suitable clinic space. We can offer coaching, and demonstrate shaping and modelling to do with children on screen,” she said.

Coaching family members or carers who can support the young person is a vital part of the team’s work, and Peta said the parents enjoyed the chance to be even more involved with their care, particularly if their child was usually seen at school. “They welcomed being able to see the therapist on the screen, and if one parent is at work and one at home, or if there are other stakeholders, we can bring them together on screen.”

Peta said, “Some people respond better than others. Most of the older young people are great, for example those who are receiving therapy for stammering or voice difficulties. That age group is so used to virtual communication in their daily lives. With pre-school children it can be more difficult, as they don’t stay still in front of the camera, but it can still add value.”

The care Peta’s 85-strong team provides in normal times, with its focus on face to face therapy, could not be turned into an identical virtual offer. “The team looked at packages of care, what was available and what was suitable,” she said. “What we could offer depended on family circumstances - if people only have a phone screen it can be very hard. Digital poverty is a real challenge for many families who are already struggling.”

Peta said preparing for virtual therapy takes a lot of time, partly because with face to face therapy in a clinic everything the therapist needed, such as visual aids, was to hand. “In a virtual world, your cupboard is your PC, and you have to find your resources online while you are on screen with the child and the parent,” she said.

“All our teams are well aware that safeguarding is a major issue when you are not able to see a child face to face. If we have a concern we really want to see that child in person,” Peta said. Another challenge has been that it has not been possible to run the group therapy sessions that were a major element of the team’s work, and waiting lists have grown as a result.

The service cares for 4,000 children up to the age of 19, and therapists visit babies in hospital with feeding problems, so they can be known to the community team from their earliest days.

Looking to the future, the team plans to take the introductory workshops they run for parents to the Moodle platform. “Parents will be able to access virtual workshops on their role as therapy partners,” said Peta. “They used to have to attend in person on a weekday, but soon they will be

able to access it at any time as the sessions will be interactive and recorded. This will be much better for them, and we will work with them to find out what has gone well."

Technology has also allowed therapists to train colleagues and share best practice, for example in ways to engage children through a screen. "We can share resources and training on Teams, whereas people used to have to travel around the county. Our regional clinical excellence network is also running virtually, including small breakout sessions. It will be good to see colleagues face to face, but this certainly saves time when things are so pressured."

The team receives many messages of thanks from parents – this from December 2020 is typical: "We just wanted to say a massive thank you to you for all your help and support with our child! It has been a long process for us so to see the difference in him especially since our video calls with you means so much! From the bottom of my heart though thank you. Your positivity and approach with him has been amazing!"

on the day BRIEFING

NHS Providers

Integration and Innovation: working together to improve health and social care for all

The Department of Health and Social Care's legislative proposals for a Health and Care Bill

The Department of Health and Social Care (DHSC) has today published its White Paper, *"Integration and Innovation: working together to improve health and social care for all – Department of Health and Social Care's legislative proposals for a Health and Care Bill"*. This briefing summarises key content from the White Paper as well as NHS Providers' initial views and analysis of the proposals most affecting trusts.

Today's White Paper marks an evolution of the proposals for legislative change originally brought forward by NHS England and NHS Improvement (NHSE/I) in Autumn 2019 following an engagement process with key stakeholders including NHS Providers, and NHSE/I's subsequent recent engagement process on *Integrating Care* with regard to system working. As our briefing sets out, the White Paper covers considerable ground and includes a number of provisions not previously considered by the sector. We will be prioritising our engagement around the White Paper, and the subsequent Bill on your behalf. If you have any feedback on this briefing or the White Paper, please contact Cath Witcombe, Public Affairs Manager, catherine.witcombe@nhsproviders.org and Georgia Butterworth, Policy Advisor (Systems), georgia.butterworth@nhsproviders.org

Overall positioning

DHSC makes the case for the current legal framework to be improved to support the NHS recovery from the pandemic and to meet future challenges. Today's White Paper marks an evolution of the proposals for legislative change originally brought forward by NHS England and NHS Improvement (NHSE/I) in Autumn 2019 following an engagement process with key stakeholders including NHS Providers, and NHSE/I's subsequent recent engagement process on *Integrating Care* with regard to

system working. Overall the paper covers considerable ground and also includes a number of new provisions not included in NHSE/I's thinking which will require full engagement.

The DHSC emphasises the fact that it has sought to develop the legislative proposals with the whole health and care system in mind to realise the ambition of reducing inequalities and supporting people to live longer, healthier and more independent lives. The purpose of the legislation set out is to create an enabling framework for local partners to build upon existing partnerships at place and system levels, and to align services and decision making in the interests of local people. In addition to closer working at a local and system level, the White Paper refers to new, 'proportionate national legislative intervention on public health measures'. The three factors that frame the government's proposed approach are:

1. The importance of shared purpose within places and systems;
2. The recognition of variation – some of it warranted – of form and in the potential balance of responsibilities between places and the systems they are part of;
3. The reality of differential accountabilities, including the responsibility of local authorities to their elected members and the need for NHS bodies to be able to account for NHS spend and healthcare delivery and outcomes.

The government reiterates its intention to bring forward separate proposals on social care later this year.

Summary of NHS Providers Views

Overall, trust leaders will welcome DHSC's ambition to create a flexible, permissive legislative framework that aims to remove barriers to collaboration and enable more joined up care.

Trusts have been working with their system partners for several years in sustainability and transformation partnerships (STPs) and then integrated care systems (ICSs) to improve population health and achieve best use of resources. The proposals rightly aim to build on this strategic direction of travel and offer the flexibility to build on local progress. We also welcome confirmation that as expected the statutory basis of trusts and foundation trusts will remain 'broadly unchanged' as the key unit of delivery for acute, mental health, ambulance and community services. Trusts' role as the leaders and co leaders of system working, will continue to evolve in this new context.

In general, trust leaders also view the current fragmented commissioning arrangements, competition rules and procurement processes as sub-optimal, and support the aim to align the legislative framework with collaborative ways of working.

That said, the significance of any move to amend the legislative framework within which the NHS operates cannot be understated. The proposals in the White Paper to strengthen system working do build on a clear legacy but still amount to a significant structural, and cultural shift in ways of working within the health and care sector – at a time of unprecedented operational pressure.

The White Paper also sets out a number of proposals which seem to cumulatively amount to far-reaching powers for the secretary of state. This includes greater powers of direction over NHS England, and the potential for the secretary of state to intervene at an earlier stage in local service reconfigurations. We are actively engaged in discussions with the DHSC to understand the intent and practical application of these new proposed powers.

There is a lot of detail to get right in what is now a wide-ranging Bill. We urge DHSC and NHSE/I to set out clearly a list of regulations that need retaining or replacing, and an assessment of the potential costs, savings and patient benefits associated with legislative change of the scale proposed in the next phase of Bill development.

One key issue for further discussion is how quickly these legislative changes can be implemented, given the immediate operational pressures the NHS is currently facing, including COVID-19 hospitalisations, maintaining non-COVID care and delivering the vaccination programme – which will remain a significant undertaking over the next six months at least. Staff will then need time to recover before the NHS turns its attention to recovering elective care and other services, which again will last many months – if not years. NHS Providers will urge DHSC and NHSE/I to seriously consider the timing of these proposals.

The scope, scale and pace of these changes, in the middle of the pandemic, mean it is more important than ever to engage trusts and their system partners in the policy development and Bill drafting process. The proposed changes are complex and must be carefully worked through with the sector to avoid unintended consequences. The consensus created around NHSE/I's 2019 proposals was helpful in terms of getting overall support from the health and care sector, which is essential for successful implementation. We encourage DHSC to replicate this forum.

Proposals for legislation

Working together and supporting integration proposals

Establishing Integrated Care Systems

The government is proposing to implement NHSE/I's recommendations in their recent *Legislating for Integrated Care Systems* document and legislate for every part of England to be covered by an ICS. The statutory ICS will be comprised of an ICS NHS Body (subsuming CCG functions and several NHSE commissioning functions for specialised commissioning, primary care and other directly commissioned services) and a separate ICS Health and Care Partnership (together referred to as the ICS), to strengthen the decision-making authority of the system leadership and to embed accountability for system performance into the NHS accountability structure. This dual structure aims to recognise that there are two forms of integration required – both within the NHS and between the NHS and its partners, including local authorities. ICSs will be accountable for population health outcomes.

The ICS NHS body will be responsible for:

- Developing a plan to meet the health needs of the population within their defined geography;
- Developing a capital plan for the NHS providers within their health geography;
- Securing the provision of health services to meet the needs of the system population.

The ICS would have the ability to delegate functions to provider collaboratives and places (facilitated by proposals for joint committees).

To support the ambition for ICSs to improve population health outcomes and tackle health inequalities, the ICS Health and Care Partnership will bring together health, social care, public health (and potentially representatives from the wider public space where appropriate, such as social care/housing providers). This body will be responsible for developing a plan that addresses the wider health, public health, and social care needs of the system – the NHS ICS Body and local authorities will have to have regard to that plan when making decisions. The two parts of the ICS will be given the flexibility to develop processes and structures which work most effectively for them. The ICS Health and Care Partnership could also be used by NHS and local authority partners as a forum for agreeing co-ordinated action and alignment of funding on key issues, and this may be particularly useful in the early stages of ICS formation.

An ICS will be expected to work closely with health and wellbeing boards (HWB) and the NHS ICS Body will be required to have regard to the joint strategic needs assessments (JSNAs) and joint health and wellbeing strategies that are being produced at HWB level (and vice versa).

Importantly, NHS trusts and foundation trusts will remain "separate statutory bodies with their functions and duties broadly as they are in the current legislation". The ICS NHS body will not have the power to direct providers. NHS England will have the power to set financial allocations and financial objectives at system level. There will be a duty placed on the ICS NHS body to meet the system financial objectives which require financial balance to be delivered. NHS providers within the ICS will retain their current organisational financial statutory duties. The ICS NHS Body will not have the power to direct providers, and providers' relationships with the Care Quality Commission will remain unchanged. However this will also be supplemented by a new duty to compel providers to have regard to the system financial objectives so both providers and ICS NHS bodies are "mutually invested in achieving financial control at system level."

Duty to Collaborate

Alongside the creation of statutory ICSs, the government intends to introduce a new duty to promote collaboration across the healthcare, public health and social care system. This proposal will place a duty to collaborate on NHS organisations (both ICSs and providers) and local authorities. The secretary of state will have the ability to issue guidance as to what delivery of this duty means in practice. This proposal will replace the two existing statutory duties to cooperate.

Triple Aim

Trusts, ICSs and NHSE will be required to have regard to the 'Triple Aim' of better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources. This proposal aims to support collaboration in the best interest of the population and address the wider determinants of health.

Reserve power over foundation trusts capital spend limits

The government plans to implement NHSE/I's recommendation for a reserve power to set a legally binding capital spending (CDEL) limit on individual, named foundation trusts.

DHSC states that this will be used when "trusts are not working effectively to prioritise capital expenditure within their ICS, and risk breaching either system or national CDEL limits." DHSC adds that "this is not a general power to direct all foundation trusts on capital spending and is not intended

to erode foundation trust autonomy, but it is designed to be used in targeted ways to support the work of ICSs."

Joint committees

The government proposes accepting NHSE/I's recommendation to allow (1) CCGs/ICSs and NHS providers and (2) groups of NHS providers to create joint committees. Legislation does not currently allow these bodies to take joint decisions. Both types of joint committees could include representation from other bodies such as primary care networks, GP practices, local authorities or the voluntary sector.

Collaborative Commissioning

The government intends to implement NHSE/I's recommendation to change the legislation to remove barriers to working collaboratively and to make decision making and the pooling of budgets between CCGs and NHS England, across CCGs, and between CCGs and local authorities, more streamlined.

These proposals will:

- Give NHS England the ability to joint commission its direct commissioning functions with more than one ICS Board
- Allow ICSs to enter into collaborative arrangements to exercise their delegated functions "enabling a double-delegation"
- Allow groups of ICSs to use joint and lead commissioner arrangements to make decisions and pool funds across all their functions.
- Enable NHS England to delegate section 7A public health services, including to collaborative arrangements.
- Enable NHS England to delegate or transfer the commissioning of certain specialised services to ICSs singly or jointly, or for NHS England to jointly commission these services with ICSs if these functions are considered suitable for delegation or joint commissioning subject to certain safeguards. Specialised commissioning policy and service specifications will continue to be led at a national level ensuring patients have equal access to services across the country.

Joint Appointments

In line with NHSE/I's recommendation, the government is proposing to introduce a specific power for NHSE/I to issue guidance on joint appointments between NHS bodies; NHS bodies and local authorities; and NHS bodies and combined authorities.

Data Sharing

The forthcoming data strategy for health and care will set out a range of proposals to address cultural, behavioural and legislative barriers to data sharing and a more flexible legislative framework to improve data access and interoperability, including enabling the safe sharing of data in support of individual care, population health and the effective functioning of the system.

As part of this work, the government is exploring where achieving these objectives may require primary legislation, including proposals to require health and adult social care organisations to share anonymised information, introduce powers for secretary of state to require data from all registered adult social care providers, introduce a duty on NHS Digital to consider the benefits of data sharing when exercising its functions, and introduce a power for secretary of state to mandate standards for how data is collected and stored.

Patient Choice

As part of its package of changes to procurement policy, the government is proposing to repeal section 75 of the Health and Social Care Act 2012 including Procurement, Patient Choice and Competition Regulations 2013 and replace the powers in primary legislation under which they are made with a new provider selection regime. Under the new model, decision-making bodies (ICSs, providers, groups of providers etc) will be required to protect, promote and facilitate patient choice with respect to services or treatment.

The government also wants to clarify rules, circumstances and processes around the operation of Any Qualified Provider (AQP) and intend to take forward the NHS's recommended approach by retaining existing patient choice rights and protections and strengthening the process for AQP arrangements. The government says that it will also work closely with the NHS to reduce the health inequalities currently experienced in the area of choice, by helping to increase clarity and awareness of patient choice rights within systems and of the range of choices available.

NHSE/I published proposals for a new provider selection regime today, which are out for consultation until 7 April.

NHS Providers View

Placing ICS on a statutory footing

The new proposal for ICSs to be comprised of a wider health and care partnership to help tackle population health and health inequalities, as well as a more narrowly focused, statutory ICS NHS body, helpfully addresses our concerns that the multiple objectives of an ICS (as proposed in NHSE/I's *Integrating Care* paper) may not be compatible. However, this proposal does raise new questions about how the two bodies will work effectively together in practice and ensure system governance reduces bureaucracy rather than adds further complication. It is also unclear whether NHS trusts and foundation trusts will report into the ICS NHS body, and how in practice CCG operational commissioning functions will be subsumed into this and/or the wider partnership.

Legislation should allow flexibility for individual ICSs to determine how the NHS ICS Body is comprised, and we will review with members whether the current proposals for trust, local authority and general practice membership should be prescribed on the face of the Bill or whether this is unwelcome proscription. We are concerned that a complex playing field of ICSs, Integrated Care Partnerships / provider collaboratives, formal place level governance structures, trusts and foundation trusts and PCNs risks confusing accountabilities. As this proposal for ICSs is a combination of the two options that NHSE/I recently consulted on in the *Integrating Care* paper, and has not been subject to consultation itself, we will discuss the proposal and its implications with trust leaders and colleagues on DHSC and NHSE/I.

We welcome DHSC's recognition of the heterogeneity of ICSs/STPs, which has clearly influenced its legislative proposals. It may be that the implementation timetable for putting ICSs on a statutory footing in 2022 needs to be reconsidered or some other flexibility built into the legislation, such as a shadow form or deferred commencements, to ensure that all systems are ready before they take on statutory functions. Many trust leaders are concerned that while collaboration is essential to post-Covid restoration and recovery (for example, tackling waiting lists for elective care and other services), distracting legislative change could hinder the NHS in addressing its post-COVID challenges.

We particularly welcome the confirmation that NHS trusts and foundation trusts will retain their current functions and duties "broadly as they are in current legislation". However, we will need to closely scrutinise further detail to ensure the clarity around local accountabilities in the current legislation is maintained. For example, DHSC states that providers will retain their current organisational financial statutory duties but there will be an additional duty on providers to have

regard to the system financial objectives. We welcome further clarity about how these two duties will work in practice and what mechanism will be in place to manage any conflicting priorities. It is vital that proposed new statutory powers for ICSs avoid overlap and duplication with those of trusts and foundation trusts.

Proposed powers to direct FT capital expenditure

Trust leaders are clear that the NHS capital system needs urgent reform. However, the legislative proposals for a reserve power to set a legally binding capital limit (CDEL) on individual, named foundation trusts, does not address the root of the problem. The CDEL at a national level is too low for the NHS' capital investment needs, and the allocation system is inadequate.

In 2019, NHS Providers carefully negotiated a number of safeguards to restrict this proposal within the recommendations NHSE/I originally put forward. We are therefore extremely concerned that details on how the power would be used transparently are not included in the White Paper, as agreed in the 2019 recommendations. This includes a commitment for NHSE/I to explain why the capital limit is necessary, describe what steps it had taken to avoid requiring its use and publish any representations from the foundation trust. In September 2019, we stated our clear preference that NHSE/I's reasoning should be published in Parliament. Transparency must not be lost and we will be pushing for this to be explicitly reflected in the Bill.

Joint committees, collaborative commissioning and joint appointments

DHSC's proposals around joint committees, collaborative commissioning and guidance on joint appointments, all represent a significant shift in approach but may provide trusts and their partners with practical, voluntary steps in support of system working. While trust leaders support the reciprocal duty to collaborate on NHS organisations and local authorities, as well as the new Triple Aim, they emphasise that the enabling framework/environment and non-legislative factors will be more impactful than any duty (which arguably exists already in the duty to cooperate). We would welcome more clarity about the secretary of state's ability to issue guidance as to what delivery of this duty means in practice. *Data sharing*

We welcome the ambitions aimed at sharing data more effectively across the health and social care system, given the government's goal to reduce bureaucracy. We know that data requests and record management are often cited by staff as a bureaucratic burden which distracts from patient care. However, we would welcome further dialogue around some of the specific proposals to ensure that

they fully address the current problems associated with data sharing and management, including the ability of trusts to invest in technical infrastructure. We would also welcome further information and clarity in regard to the secretary of state' powers to mandate standards.

The White Paper emphasises the importance of maintaining patient choice, but it is unclear how this will play out in the current circumstances of reducing the backlog of elective care and other services. The restoration and recovery of services will take many months, if not years, and DHSC needs to consider whether and how patient choice will be applicable in this instance. We agree with the recognition from DHSC that integration provides an opportunity to strengthen patient voice and could build towards genuine co-production, but note that this may be best shaped at a local level.

Reducing bureaucracy

Competition

The government intends to take forward proposals to replace the principle of competition with collaboration in legislation, including:

- Remove the Competition and Market Authority (CMA) function to review mergers involving NHS foundation trusts. The CMA's jurisdiction in relation to transactions involving non-NHS bodies (for example between an NHS trust/foundation trust and private enterprise) and other health matters (for example, drug pricing) would be unchanged.
- Remove NHS Improvement's specific competition functions and its general duty to prevent anti-competitive behaviour
- Remove the need for NHS England to refer contested licence conditions or National Tariff provisions to the CMA.

Arranging healthcare services

The government proposes to remove current procurement rules which apply for NHS and public health commissioners when arranging healthcare services. Powers will be created to remove the commissioning of these services from the scope of the Public Contracts Regulations 2015, as well as repealing Section 75 of the Health and Social Care Act 2012 and the Procurement, Patient Choice and Competition Regulations 2013.

The government wishes to develop a new provider selection regime, which will provide a framework for NHS bodies and local authorities to follow when deciding who should provide healthcare service. This will allow commissioners more discretion over when to use procurement processes than at present. Voluntary and independent sector providers will continue to play an important role, but

where there is no value in running a competitive procurement process (e.g. A&E provision), services will be able to be arranged with the most appropriate provider.
A consultation on the provider selection regime has been launched by NHSE/I today and we will respond on your behalf

These reforms will only apply to the arrangement of healthcare services. This includes public health services, whether commissioned solely by a local authority or jointly by the local authority and NHS as part of a Section 75 agreement. The procurement of non-clinical services, such as professional services or clinical consumables, will remain subject to Cabinet Office public procurement rules.

National tariff

The government will take forward NHSE/I's proposals on the national tariff, amending legislation to "enable the national tariff to support the right financial framework for integration whilst maintaining the financial rigour and benchmarking that tariff offers." This includes:

- Where NHS England specifies a service in the national tariff, then the national price set for that service may be either a fixed amount or a price described as a formula
- NHS England could amend one or more provisions of the national tariff during the period which it has effect, with appropriate safeguards
- Remove the requirement for providers to apply to NHS Improvement for local modifications to tariff prices
- NHS England should be able to include provisions in the National Tariff on pricing of NHS public health services where exercising public health functions delegated by the secretary of state.

The government also plans to remove the need for NHS England to refer contested licence conditions or national tariff provisions to the CMA.

New Trusts

DHSC proposes a new power for secretary of state to create new trusts. This takes NHSE/I's original recommendation for a power to create new integrated trusts further. ICSs will be able to apply to the secretary of state to create a new trust. This decision will be subject to engagement and consultation, set out in guidance.

Removing Local Education Training Boards (LETBs)

The government is proposing to remove LETBs from statute in order to provide HEE with the flexibility to adapt its regional operating model over time.

NHS Providers View

Competition, procurement and tariff

There is strong support from trust leaders for the ambition to replace competition with collaboration as the principle driving improvement in the NHS. We support the intention to move away from competitive retendering and burdensome procurement processes, as well as the principle of CCGs and then ICSs being able to decide to continue with existing providers/make arrangements with the most suitable provider without having to go through a competitive procurement process. It will be important to ensure that the right principles are applied to a robust process, with appropriate safeguards, and local areas are supported to develop the strong relationships required to implement this new kind of commissioning. Non-NHS providers are important partners for trusts, particularly in the community sector, and their role and services need to be supported where this is working well for local systems and populations.

We understand that amendments to the legislation relating to [the national] tariff support the broad policy direction towards system finances, and we are particularly closely engaged with NHSE/I colleagues and members to help shape how that might operate. We will work with NHSE/I and DHSC to understand the provision to remove NHSI's involvement in requests for local price modifications. Likewise, we will work with NHSE/I and DHSC to understand the full implications of contested licence conditions or national tariff provisions no longer having to be referred to the CMA. Importantly, we are pleased that the DHSC intend to maintain the financial rigour and benchmarking that the tariff offers.

New trusts

We are concerned about the implications of secretary of state having a broad power to create new trusts, particularly given this power will sit alongside a number of other powers aimed offering the potential for central direction. This opens up the potential for political involvement at a local service delivery level, and without sufficient safeguards could destabilise a local health and care economy. Developments such as this, in our view, should be locally determined.

LETBs

Trust leaders support ICSs taking on additional workforce responsibilities that make sense for their local system. The removal of LETBs in statute will be one part of a wider move towards a new operating model for the workforce, and serves to formalise the current, positive direction of travel.

Ensuring accountability and enhancing public confidence proposals:

Merging NHS England, Monitor and the NHS Trust Development Authority and secretary of state powers of direction

In line with NHSE/I's recommendations, the government is proposing formally bringing NHS England and NHS Improvement together as one legal entity.

The newly merged NHS England will remain answerable to the secretary of state and parliament for all aspects of NHS performance, finance and care transformation. The government is also proposing to bring forward a proposal to give the secretary of state "appropriate intervention powers" over the newly formed NHS England. DHSC sees this proposal as maintaining clinical and day-to-day operational independence for the NHS, but reinforcing accountability and agility by allowing the secretary of state to formally direct NHS England. While DHSC acknowledges that most issues should be resolved within systems rather than at national level, there are occasions when national intervention and oversight is necessary, and these powers will ensure ministers are accountable for them.

These powers will not allow the secretary of state to direct local NHS organisations, directly nor will they allow the secretary of state to intervene in individual clinical decisions. They will not undermine NICE process and guidance for treatment and medicines.

The NHS Mandate

The government is proposing to replace the current legislative requirement to have a new mandate each year with a new requirement to always have a mandate in place, and for this mandate to be changed in-year. The document argues that this well help align with strategic developments and external events.

This proposal will remove the duty to set NHS England's capital and revenue resource limits in the mandate itself. Instead, these limits will continue to be set within the annual financial directions that

are routinely published, and which will, in future, also be laid in Parliament. The direction set in the mandate will also continue to be closely aligned to the capital and resource spending limits.

Additional consequential changes will also be made to the current legal provisions on integration (the Better Care Fund) which currently rely on the NHS mandate. These provisions will be recreated as a standalone power so that they will continue to meet the policy intention for the Better care fund even where mandates are not replaced annually.

Each new mandate will continue to be laid in parliament by the secretary of state. NHS mandate requirements will also continue to be underpinned by negative resolution regulations, providing further opportunity for parliament to engage with the content of the mandate. The existing duty for the secretary of state to consult NHS England, Healthwatch England, and any other persons they consider appropriate before setting objectives in a mandate, will also remain in place.

Reconfigurations intervention power

The government is proposing to broaden the scope for potential ministerial intervention in reconfigurations, allowing the secretary of state to intervene at any point of the reconfiguration process. Currently, the secretary of state is only able to intervene in service reconfigurations upon referral from a local authority, usually in difficult or complex cases. Under the new proposal, the secretary of state will be required to seek appropriate advice in advance of their decision, including in relation to value for money, and subsequently publish it in a transparent manner.

Guidance will be issued by DHSC on how this process will work as well as removing the current local authority referral process to avoid creating any conflicts of interest. DHSC expects the Independent Reconfiguration Panel, established in 2003 to be replaced by new arrangements.

It is not anticipated that this power be used frequently but where there are issues that ministers have concluded need to be pressed to a resolution, this will provide a means of doing so.

Arm's Length Bodies (ALB) Transfer of Functions

The government is proposing to create a power in primary legislation for the secretary of state to transfer functions to and from specified ALBs, and to abolish ALBs that 'become redundant'. This power will only be exercisable via a Statutory Instrument, approved by both houses of parliament, following formal consultation and consideration of any recommendations by parliamentary committees. This power aims to allow flexibility to adapt to changes in priorities and avoid complex

workarounds, as experienced between NHSE/I. DHSC states there is no immediate plan to use this power.

Removing Special Health Authorities (SpHAs) Time Limits

Currently, existing legislation sets an automatic expiry date on SpHAs (for example NHS Business Services Authority, NHS Blood and Transplant etc) which requires the government to formally extend their existence every three years. In order to reduce bureaucracy and cut administration costs, the government's proposal will remove the three-year time limit on all SpHAs (but only NHS Counter Fraud Authority is currently impacted).

Workforce Accountability

The DHSC is proposing to create a duty for secretary of state to publish a document, once every five years, and in collaboration with HEE and NHSE/I, which sets out roles and responsibilities for workforce planning and supply at national, regional and local level in England. This document would also cover sections of the workforce that are shared across health and social care.

NHS Providers View

Merger of NHSE and NHSI and proposed powers of intervention

We welcome the closer working of NHSE/I. However, we are concerned about the cumulative impact of the proposed enhanced powers of direction for the secretary of state over the newly merged NHSE. The clinical and operational independence of the NHS – free from political intervention – is an important cornerstone of our health and care system.

Viewed in the round alongside other proposals for the secretary of state to have powers to create new trusts and intervene at any stage in NHS service reconfigurations, these proposals risk an unjustified swing of power towards the centre at the cost of local accountability mechanisms. While we welcome DHSC's reassurance that secretary of state will not be involved in day-to-day operations and that these powers would be rarely deployed, there needs to be further discussion about whether such broad powers are necessary and proportionate. We will consult with trust leaders on these new secretary of state powers, and identify the risks and unintended consequences in these proposals.

In addition, new powers for secretary of state to transfer functions between ALBs and ultimately abolish them, represents a further significant centralisation of power in DHSC. It is encouraging that these powers could only be exercised via SI after formal consultation and approval from both houses

of parliament, but would encourage DHSC to provide safeguards to prevent Henry VIII clauses being used to circumvent due parliamentary process.

While there may be a logic in changing the length of the NHS mandate to respond to wider circumstances in-year, there is also a strong logic in maintaining the link between the strategic asks of the NHS to the annual NHS financial cycle.

We will seek to understand the detailed implications of removing the time limits on special health authorities before commenting further.

Workforce accountabilities

We and other stakeholders have called for further clarity around how workforce accountabilities are shared at national, regional and local level. It is encouraging that secretary of state will need to do so publicly, but we note that the key issue of workforce shortages and future supply to meet demand remains unaddressed in this White Paper.

Additional proposals to support social care, public health, and quality and safety

Social Care

ICSs and Adult Social Care

DHSC intends to create a more clearly defined role for social care within the structure of a statutory ICS NHS Board, to give adult social care a greater voice in NHS planning and allocation. ICS legislation will complement and reinvigorate place-based structures for integration between the NHS and social care, including through HWBs, the ICS health and care partnership and the Better Care Fund.

Improve the quality and availability of data across the health and social care sector

DHSC wants to gather data from social care providers (for local authority and privately funded care) to remedy gaps in available data and to better understand capacity and risk in the system. DHSC states that high quality data should be collected to "agreed high standards" and meet the needs of all users. It should be collected once to reduce reporting burdens and used intelligently to support commissioning and delivery of high-quality services.

A new assurance framework for social care

The government is proposing to introduce a new duty for CQC to assess local authorities' delivery of their adult social care duties. Linked to this new duty DHSC also proposes introducing a power for the secretary of state to intervene where, following assessment under the new CQC duty, it is considered that a local authority is failing to meet their duties. Any intervention by the secretary of state would be proportionate to the issues identified and taken as a final step in exceptional circumstances when help and support options have been exhausted.

The government aims to secure these provisions in primary legislation at a high-level, prior to working with government partners and the sector on detailed system design and practice.

Provide a power for the secretary of state to make payments directly to providers

The government proposes to allow the secretary of state to make direct payments to adult social care providers in England. The Bill will not prescribe in what circumstances the power can be used, or how this funding should be provided. Instead, this power will act as a legal foundation for future policy proposals

The type of payment will be determined on a case-by-case basis. However, this power will not be used to amend or replace the existing system of funding adult social care, where funding for state provision is provided via local authorities. It will only be used in exceptional circumstances. Discharge to assess.

The government will put in pace a legal framework for a 'Discharge to Assess' model, whereby NHS Continuing Healthcare (CHC) NHS Funded Nursing Care assessments and Care Act assessments can take place after an individual has been discharged from acute care. This will replace the existing legal requirement for all assessments to take place prior to discharge.

Discharge to assess will not change the thresholds of eligibility for CHC or support through the Care Act or increase financial burdens on local authorities. The system of discharge notices, and associated financial penalties, will also be removed by this legislation.

A standalone power for the Better care fund (BCF)

Currently the allocation of the BCF is tied to the NHS mandate. Given that the process for setting the mandate will be amended, the government proposes to create a standalone legislative power to support the Better Care Fund and separate it from the mandate setting process.

Public Health

Public Health power of direction

The government proposes to create a power for the secretary of state to require NHS England to discharge public health functions delegated by the secretary of state alongside the existing section 7A provisions.

Other public health measures

The government proposes to make changes to legislation to support its ambitions to halve childhood obesity by 2030, to reduce the number of adults living with obesity and to reduce health inequalities. These changes include strengthening labelling requirements and introducing further advertising restrictions to prohibit advertisements for products high in fat, sugar or salt (HFSS) being shown on TV before 9pm via this Bill. Depending on the outcome of a recent consultation, it is the intention of the government to take forward further online advertising restrictions in this legislation.

The government proposes to give the secretary of state the power to directly introduce, vary or terminate water fluoridation schemes.

NHS Providers View

Social care

Social care reform is long overdue. While the White Paper does not address the longstanding issues in the social care system, it does reiterate the government's intention to "bring forward separate proposals on social care reform this year". We agree that one policy paper or piece of legislation cannot address all the challenges facing health and social care, but would reiterate the importance of properly funding and reforming the social care system to ensure people get the care they need, and stem the tide of increased demand on the NHS due to unmet or under-met need.

The proposals state that adult social care will have a greater voice in NHS planning and allocation at the ICS NHS Board, leading to a more clearly defined role for social care within ICSs. However, it remains unclear how the proposals truly address the original ambitions of bringing health and social care closer together at ICS level. While pooled budgets and guidance on joint appointments at place level are welcome, as this is where the majority of service integration will take place, this does not fully address the wider strategic ambition of designing a more integrated health and social care system. We also note that the efficacy of HWBs still varies across the country, and would welcome more detail

on how DHSC, NHSE/I and local government partners will ensure that joining up health and social care remains a key priority.

While we support the ambition to improve social care outcomes and co-produce a strengthened assurance framework for adult social care, we are concerned that the new powers of national intervention in the adult social care system are being developed without due consideration of the sustainable funding, and system reform, required by local authorities to deliver improvements in care.

We fully support the current discharge to assess model, and suspension of NHS Continuing Healthcare (CHC) assessments during the first wave of the pandemic, as well as the subsequent policy decision to postpone such assessments until after six weeks of centrally funded discharge care. This is better for patients, as more time in a hospital bed can lead to mental and physical deterioration, and better for the system if patients are not waiting for an assessment for long-term care in an acute bed. The new legal framework proposed will require all NHS CHC and Care Act assessments to take place after an individual has been discharged from acute care. We are aware that primary legislation needs to be amended to embed these changes, but encourage DHSC to only legislate for the minimal changes required (I.e. remove CHC) and consider with the community sector whether the new policy can be delivered through guidance.

Public health

The proposal for secretary of state to have powers to direct NHSE to take on public health functions, alongside existing 7A provisions, raises questions about the future of the commissioning and provision of public health services. While the new provider selection regime appears to imply that some services (e.g. health improvement) will continue to be commissioned by local authorities, this new power suggests in future they may return to the NHS. Caution must be taken to avoid destabilising changes to public health services, and in the absence of a long term funding settlement for public health, changes to the way services are commissioned will not alone resolve longstanding issues with their funding and delivery. Regardless of where these responsibilities sit, full and sustainable funding is essential to secure the effectiveness of public health services.

Safety and Quality

Health Service Safety Investigations Body

The Health Service Safety Investigations (HSSI) Bill was introduced in October 2019. The government intends to bring provisions from the HSSI Bill into the Health and Care Bill.

The provisions propose establishing a new independent body, the Health Service Safety Investigations Body (HSSIB) to investigate incidents which have or may have implications for the safety of patients in the NHS. This body will be established as an executive non-departmental public body with powers to investigate the most serious patient safety risks to support system learning. HSSIB will continue the work of the Healthcare Safety Investigations Branch which became operational in April 2017 as part of NHS Improvement.

This proposal will:
• prohibit disclosure of information held by the HSSIB in connection with its investigatory function save in limited circumstances set out in the Bill. The aim is to create a 'safe space'.
• encourage the spread of a culture of learning within the NHS. To this end the HSSIB will provide advice, guidance and training to organisations.

The government plans to extend HSSIB's remit to cover healthcare provided in and by the independent sector. They are also introducing a power to enable the secretary of state for to require HSSIB to carry out certain investigations into particular qualifying incidents or groups of qualifying incidents. A regulation-making power allowing the secretary of state to set out additional circumstances when the prohibition on disclosure (safe space) does not apply will also be included.

Professional regulation

Proposals for professional regulation form part of a wider programme to create a more flexible and proportionate professional regulatory framework that is better able to protect patients and the public. The secretary of state will be enabled to make further reforms to ensure the professional regulation system delivers public protection in a modern and effective way.

The proposal includes, but is not limited to, the power to remove a profession from regulation, abolish an individual health and care professional regulator, and remove restrictions regarding the power to delegate functions through legislation.

It also includes the power to extend the scope of section 60 to include senior NHS managers and leaders, to enable them to be regulated in future. While there are no plans at this stage to statutorily regulate senior NHS managers and leaders, extending the scope of professions who can be regulated using the powers in Section 60 of the Health Act 1999 to include these groups would enable this to be brought forward in the future, if further measures are needed following those currently being

proposed by NHS England/Improvement to address the concerns raised in the 2019 Kark Review. However, the Kark review stopped short of recommending full statutory regulation and NHSI is currently considering how best to achieve this through non-statutory means.

Medical examiners

This proposal would see existing legislation amended to establish a statutory medical examiner system within the NHS for the purpose of scrutinising all deaths which do not involve a coroner.

This proposal will amend the Coroners and Justice Act 2009 to allow for NHS bodies, rather than local authorities, to appoint medical examiners.

Medicines and Healthcare products Regulatory Agency (MHRA) new national medicines registries

The White Paper includes proposals for the MHRA to develop and maintain publicly funded and operated medicine registries where there is a clear patient safety or other important clinical interest. The aim of this proposal is to ensure that patients and prescribers, as well as regulators and the NHS, are provided with the evidence they need to make informed decisions about the medicines they use, as current registries (created by authorised companies) have not always delivered the required evidence in reasonable timeframes. This proposal will also enable registries to identify and investigate potential non-compliance, so that additional action can be taken by regulators.

Hospital food standards

The Independent Review of NHS Hospital Food was published on the 26th October 2020. It recommended that NHS food and drink standards for patients, staff and visitors be put on a statutory footing. This is supported by the government and it is proposed to grant the secretary of state for powers to adopt secondary legislation that will implement the national standards for food across the NHS.

Reciprocal healthcare agreements with Rest of World countries

Proposed legislation will enable the government to implement more comprehensive reciprocal healthcare agreements with Rest of World countries subject to negotiations. Under the current legislation, the UK is limited to implementing such arrangements with the EU, EEA, EFTA blocs or their Member States.

The proposed legislation will introduce a reimbursement mechanism and data exchange.

The responsibility for paying healthcare charges will lie with governments, thus guaranteeing income for the NHS while eliminating most of the financial burden for the traveller.

NHS Providers View

We understand the motivation for DHSC to add a wide range of legislative measures to the Health and Care Bill, given this may be the only legislative window for the NHS in parliament. However, this makes for a wide-ranging Bill, rather than a cohesive, targeted set of legislative reform.

Professional regulation

We are concerned that the proposed secretary of state powers could mean senior NHS managers are subject to professional regulation in future. Statutory regulation of senior managers will not preclude the possibility that an individual with a good track record may make a bad decision or a mistake, nor can it prevent non-compliant behaviour. There is a danger that we place unrealistic expectations on what regulation can achieve, and when it fails to achieve this, we seek to regulate further rather than examine the drivers of poor leadership and put in place systems which support good governance.

HSSIB

NHS Providers welcomes the proposals to establish HSSIB as an independent body to investigate incidents that may have an implication for the safety of patients. This is an important opportunity to help develop a just culture in the NHS and a focus on learning. We have strongly supported the creation of HSSIB since it was announced, as its investigations fill an important gap in how the NHS learns from patient safety incidents, and we contributed to the Joint Committee's pre-legislative scrutiny work in support of HSSIB. However, the proposal for HSSIB to be established as an executive non-departmental public body, which means it will be accountable to parliament through its sponsoring DHSC ministers, does not appear to ensure its functional independence. The NHS' regulatory bodies are directly accountable to parliament, and the same arrangements should be in place for HSSIB.

Medical examiners

We welcome confirmation that the non-statutory phase of the medical examiner programme will continue for this coming year, however clarity will be needed on whether current arrangements up to March 2021 regarding reimbursement for the cost of medical examiner offices hosted at acute trusts will continue.

We welcome DHSC's commitment to exploring ways to enhance the role of CQC in reviewing system working, which is supported by trust leaders, but notice that there are no proposals to enhance CQC's remit at this stage. We look forward to working closely with CQC and NHSE/I on how ICSs will be held accountable for population health outcomes.

NHS Providers press statement

Commenting on the release of today's 'White Paper' with legislative proposals for a Health and Care Bill, the chief executive of NHS Providers, Chris Hopson, said:

"There is widespread agreement across the NHS on many of the proposals in this paper thanks to the work done by NHS England and NHS Improvement and the Health and Social Care Committee to draw up a set of agreed legislative proposals in 2019, a process to which NHS Providers contributed extensively. We are pleased to see that this work forms the bedrock of what is now being proposed.

"These proposals provide an important opportunity to speed up the move to integrate health and care at a local level, replace competition with collaboration and reform an unnecessarily rigid NHS approach to procurement.

"There is a lot of detail to get right in what is now a wide ranging bill. We are keen to understand the Government's intentions on some of the new proposals it has added such as the new powers for the secretary of state to direct NHS England, transfer powers between arms length bodies and intervene in local reconfigurations.

"It is also vital that the proposed new statutory powers for ICSs avoid overlap and duplication with the statutory powers of trusts and Foundation Trusts which the Government rightly says it will maintain as the key delivery mechanism for ambulance, community, hospital and mental health care services.

"We will also want to discuss how quickly these changes can be implemented given the operational pressures the NHS is currently facing.

"We look forward to working closely with the Government to get the detail of these proposals right and ensure they contribute to improvements in care for patients and service users".

Cath Witcombe, Public Affairs Manager, catherine.witcombe@nhsproviders.org
Georgia Butterworth, Policy Advisor (Systems), georgia.butterworth@nhsproviders.org

10:00 DELIVER FOR TODAY

10. Operational report

To APPROVE the report

For Approval

Presented by Helen Beck

Trust Board – 26th February 2021

Agenda item:	10			
Presented by:	Helen Beck, Executive Chief Operating Officer			
Prepared by:	Helen Beck, Executive Chief Operating Officer Alex Baldwin, Deputy Chief Operating Officer Antonia Wells, Lead cancer clinician and Consultant Upper GI surgeon			
Date prepared:	19 February 2021			
Subject:	Operational Update			
Purpose:	x	For information		For approval

Executive summary:

This paper provides an update on the key operational areas of work during the month. This includes; an update on current operational pressures and an initial plan for elective recovery. Further details around the recovery of endoscopy performance is included as this is an area of concern and significant focus for improvement.

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

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

Previously considered by:	Future planning meeting. Winter planning meeting
Risk and assurance:	Failure to provide quality care to patients who require admission to hospital. Reputational risks around failure to achieve required standards and targets.
Legislation, regulatory, equality, diversity and dignity implications	

Recommendation: The board is asked to note the content of the paper.

Operational update

Covid activity

Through February we have seen a significant reduction in COVID demand and at the time of writing we have 17 positive inpatients. Critical care admissions continue to be above average, in part due to providing mutual aid to other units, although we currently have sufficient capacity across the two units.

ED attendances and non COVID admissions continue to be below average, although we are starting to see admission peaks suggestive of a return to more normalised admissions. The reduction in COVID demand means we are now maintaining social distancing on positive and contact wards. Likewise, the Medical Assessment Area within ED is now open and has significantly improved our ability to keep patients isolated until their COVID status is known.

The most recent regional data corresponds to the decreasing demand experienced by the Trust although our actual demand decreased faster than projections and our residual demand is currently higher than forecast (17 patients in West Suffolk compared to a forecast plausible upper limit of 6). Longer-term modelling suggests that lower levels of demand will continue up to a likely consequence of opening up of lockdown in early to mid-March with reduction then dependent on the degree to which social distancing is relaxed.

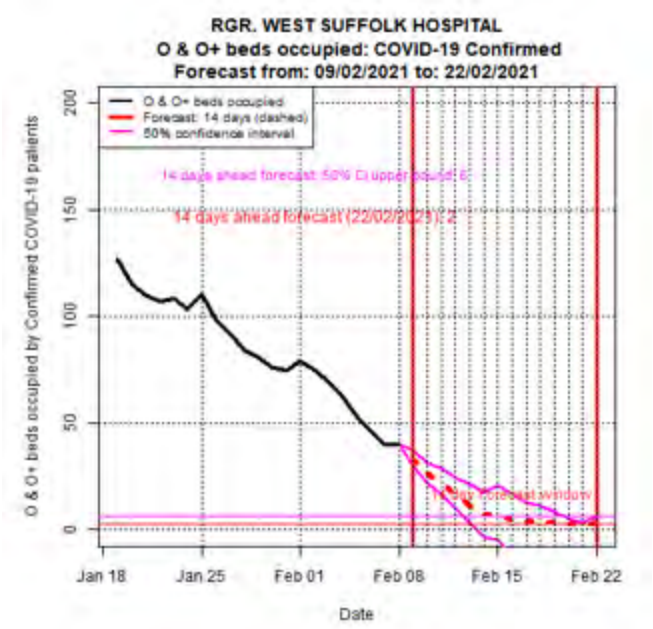


Table 1: Cambridge Judge Business School WSFT forecast, 9 February 2021.

As demand has decreased naturally attention has started to switch to elective recovery. Local guidance remains to maintain services for P1 and P2 patients. We continue to maintain high priority diagnostics in endoscopy, CRT and MRI and we also continue to have access to 100% of BMI staffed capacity. Albeit limited, this will continue until 14 March. Relative operational performance data is provided in appendix 1 but in summary we are delivering a comparative volume of activity, relative to other organisations, across all points of delivery.

Current instruction is to prepare for resumption of P3 activity but not to commence at present. However so far, we have received no national direction so there is a risk that this will arrive late and overturn local plans as happened at the end of the first wave.

Throughout all planning conversations the regional team and trust are very clear on the need to support staff recovery prior to restoring full levels of activity. Discussions have commenced and will inform what good looks like at team and specialty level, recognition given to the fact that individuals have experienced the pandemic differently.

Recovery will have three phases. Stabilise (current phase), recuperate and reset. It may be expected that the Trust is fully operational by 1st May (potentially earlier) but this will coincide with the theatre decant programme. Our current thinking is that there is a window of opportunity to commence some P3 work early to mitigate the planned shutdown later in the spring. We are likely, therefore, to request permission to commence P3 activity in early March. Finally, it is likely that the focus of performance management will move away from 18 weeks to a more clinical and activity focussed approach and we will need to consider what metrics are used in the IQPR as this becomes clearer.

Detailed recovery and RAAC decant operational plans are in development and will be presented to the scrutiny committee on 10 March.

Cancer Performance

The COVID situation has significantly impacted on the ability of the Trust to deliver against the range of cancer performance standards. Whilst there is no delay in treating patients once a diagnosis of cancer is confirmed there are currently long delays in a number of the diagnostic pathways, which are impacting the 2WW,62 day and 104-day performance standards. For reference in December 2ww performance was 72% (standard 93%), 62-day performance was 69.4% (standard 85%) and we have 47 patients waiting over 104 days (standard 0).

The most significant delay is the endoscopy service which is impacting mainly colorectal and upper GI pathways due to a cessation of all non-emergency endoscopy during the first wave of COVID in line with national guidance. 36 of the 104-day waits are in these two specialties and 2ww performance is 29.5% and 30.8% respectively.

Good progress was made during November and December and the Trust was on track to recover listing rapid access endoscopy patients within 2 weeks by end of January, however the recent spike in COVID cases has impacted on this as staff were required to be redeployed to support critical care. From 1st March these staff will return to enable us to fully open the endoscopy unit and the recovery trajectory is currently being revised in line with current increased demand and staff returning from ITU in March.
The Endoscopy service has been under pressure for some time pre COVID and has therefore been a focus for the new lead consultant for cancer Antonia Wells, who was appointed in Autumn 2020 with an additional PA allocation funded by the ICS cancer programme. In order to support the recovery of endoscopy and deliver sustainable improvements post COVID the following range measures/ new initiatives have been implemented.

1. Administration and booking processes

    - Additional administration staff and swabbing staff recruited to maximise list utilisation
    - Johnson & Johnson COVID recovery team commence 22nd February to support admin review and streamline booking process to increase performance
    - Endoscopy IT system, new system purchased to facilitate easier booking process along-with benefits to clinicians of results within e-care (Medilogik)
    - Patient cancellations due to COVID concern, patients receive letter around isolation process to provide reassurance, patients called at front end of process to agree date/self-isolation

2. Endoscopy Capacity
    - Outsourcing/ Insourcing providing 6 sessions per week

- Trans-nasal endoscopy service developed with first scopes completed prior to 2nd COVID surge. In mid-March this service will transfer to Joanna Finn Unit increasing capacity within main endoscopy unit by providing alternative location for gastroscopies
- Trans-nasal ENT service started in Joanna Finn unit, reduces head and neck 2WW delay and avoids strain on theatre capacity
- Cytosponge service started, initially delayed because of 2nd COVID surge (due to start mid-January) but first patients had their procedure last week. This protects some of our overdue Barretts surveillance patients, keeping them safe when endoscopy is not currently possible. They will then have their surveillance endoscopy in a year if cytosponge negative by which point endoscopy capacity should have increased.

3. CT colonoscopy

- Large backlog from previous surge
- Increased number of lists per week, including at the weekend facilitated by mobile CT scanner on site
- Additional nursing resource deployed to increase number of patient procedures done on list back up to pre-COVID capacity (performing pre-assessment and cannulas by nurses)
- Rate limiting step is number of trained CTC radiographers, 2 more currently are in training but takes time to become independent
- Current rate if no external capacity available (currently exploring Nuffield) then recovered to 2ww by start of April

4. Colon capsule endoscopy

- This will take offer a subset of patients (typically younger/fitter) an option other than colonoscopy
- Funding obtained to train 4 people (2 nurses and 2 Consultants), rate limiting step is training – approx. 6 weeks to become accredited.
- Service to be established in parallel to training, ensuring that once we have trained clinicians can go live

5. Straight to test colorectal service

- Some staffing challenges due to COVID shielding
- We have seen increased numbers of referrals due to patients with delayed presentation from COVID or secondary to more GP referrals as more difficult to assess during pandemic
- Incomplete referrals cause issues with effective triage, this is being tackled alongside primary care to improve quality and appropriateness of referral
- Time delays with patients not keen to attend hospital for investigation during COVID/wish to wait for first vaccine/do not want investigation

Clinical review of ED standards.

The national consultation of the clinical review of emergency care standards has now completed and it is anticipated that the report and recommendations will be published by the end of March/ beginning of April 2021. It is understood that over 80% of respondents supported the idea of a system bundle of metrics. These are expected to include: ambulance conveyance rates, ambulance handover times, ED time to initial assessment, ready for ward times, admitted and non-admitted mean times. A full update of the recommendations and implications for WSFT will be provided to the board in due course.

Community Update

Good progress is being made with the revised management structures for community services with the post of “Integrated Director of Health and Adult Social Care (West)” in the recruitment phase. Those affected by the restructure are all aware and the consultation process has started this week.

The range of initiatives designed to increase visibility of activity and demand across our community teams is proceeding as planned, with Newmarket teams now live on Healthroster and all community teams scheduled to follow by the beginning of April. This will in turn support the deployment of the Malinko activity scheduling software from the beginning of May. The Benson solution is already indicating good potential for us to be able to review skill mix and team productivity and assess differences between teams. This will support regular staffing and skill mix reviews in the community teams in line with those regularly presented to the board for acute teams.

The long-awaited implementation of increased 7-day services in our community teams is scheduled for full roll out in May. Currently services are operating 6 days per week through additional voluntary sessions. The CCG are aware that additional funding will be required to ensure 7-day enhanced provision is sustainable.

Recommendation

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

Appendix1: EOE activity report 31 01 21.

Source: SUS, Monthly Diagnostics (DM01) and Weekly Activity Return (WAR) *Data in this table has not been adjusted.*				Daycases						Ordinary electives					
				4 Week Average (Final data)			Latest week (Provisional)			4 Week Average (Final data)			Latest week (Provisional)		
Prov code	Provider Name	Region	STP	Same weeks last year	4 weeks ending: 31 Jan 2021	as a % of last year	Same week last year	w/e 07 Feb 2021	as a % of last year	Same weeks last year	4 weeks ending: 31 Jan 2021	as a % of last year	Same week last year	w/e 07 Feb 2021	as a % of last year
RC9	Bedfordshire Hospitals NHS Foundation	East of England	Bedfordshire, Luton and Milton Keynes	1,395	652	47%	1,423	677	48%	145	54	37%	158	62	39%
RGT	Cambridge University Hospitals NHS Fou	East of England	Cambridgeshire and Peterborough ST	1,697	965	57%	1,660	966	58%	274	98	36%	289	130	45%
RWH	East and North Hertfordshire NHS Trust	East of England	Hertfordshire and West Essex STP	1,349	870	64%	1,339	819	61%	131	61	46%	141	60	43%
RDE	East Suffolk and North Essex NHS Found	East of England	Suffolk and North East Essex STP	1,951	1,109	57%	1,977	1,096	55%	226	70	31%	243	66	27%
RGP	James Paget University Hospitals NHS F	East of England	Norfolk and Waveney Health & Care P	639	312	49%	658	348	53%	52	24	46%	57	32	56%
RAJ	Mid and South Essex NHS Foundation Tr	East of England	Mid and South Essex STP	2,300	1,174	51%	2,438	1,427	59%	384	75	20%	405	108	27%
RD8	Milton Keynes University Hospital NHS Fo	East of England	Bedfordshire, Luton and Milton Keynes	596	418	70%	561	399	71%	64	31	48%	66	27	41%
RM1	Norfolk and Norwich University Hospitals	East of England	Norfolk and Waveney Health & Care P	1,888	1,074	57%	1,934	1,063	55%	220	51	23%	226	46	20%
RGN	North West Anglia NHS Foundation Trust	East of England	Cambridgeshire and Peterborough ST	1,111	737	66%	1,079	782	72%	106	37	35%	116	30	26%
RGM	Royal Papworth Hospital NHS Foundatio	East of England	Cambridgeshire and Peterborough ST	207	60	29%	218	294	135%	160	39	24%	179	154	86%
RQW	The Princess Alexandra Hospital NHS Tr	East of England	Hertfordshire and West Essex STP	476	251	53%	508	295	58%	70	12	17%	79	18	23%
RCX	The Queen Elizabeth Hospital, King's Lyn	East of England	Norfolk and Waveney Health & Care P	880	270	31%	806	254	32%	68	8	11%	70	5	7%
RWG	West Hertfordshire Hospitals NHS Trust	East of England	Hertfordshire and West Essex STP	884	406	46%	899	470	52%	122	53	43%	134	58	43%
RGR	West Suffolk NHS Foundation Trust	East of England	Suffolk and North East Essex STP	572	292	51%	629	357	57%	68	26	38%	73	21	29%

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

				First Outpatients						Follow-up Outpatients						CT Scans					
				4 Week Average (Final data)			Latest week (Provisional)			4 Week Average (Final data)			Latest week (Provisional)			4 Week Average (Final data)			Latest week (Provisional)		
Prov code	Provider Name	Region	STP	Same weeks last year	4 weeks ending: 31 Jan 2021	as a % of last year	Same week last year	w/e 07 Feb 2021	as a % of last year	Same weeks last year	4 weeks ending: 31 Jan 2021	as a % of last year	Same week last year	w/e 07 Feb 2021	as a % of last year	Estimated same weeks last year	4 weeks ending: 31 Jan 2021	as a % of last year	Estimated same weeks last year	w/e 07 Feb 2021	as a % of last year
RC9	Bedfordshire Hospitals NHS Foundation	East of England	Bedfordshire, Luton and Milton Keynes	3,984	2,737	69%	4,412	2,730	62%	7,669	5,592	73%	7,662	5,991	78%	1,317	1,060	80%	1,447	1,086	75%
RGT	Cambridge University Hospitals NHS Fou	East of England	Cambridgeshire and Peterborough ST	5,953	3,793	64%	5,886	3,804	65%	7,415	6,596	89%	7,472	6,668	89%	889	1,067	120%	894	976	109%
RWH	East and North Hertfordshire NHS Trust	East of England	Hertfordshire and West Essex STP	3,781	3,028	80%	3,874	2,993	77%	7,326	6,833	93%	7,299	6,567	90%	1,152	717	62%	1,194	767	64%
RDE	East Suffolk and North Essex NHS Found	East of England	Suffolk and North East Essex STP	4,858	3,725	77%	4,967	3,756	76%	9,861	6,658	68%	9,911	6,707	68%	1,713	1,213	71%	1,684	1,246	74%
RGP	James Paget University Hospitals NHS F	East of England	Norfolk and Waveney Health & Care P	1,470	1,022	70%	1,552	1,139	73%	2,805	2,073	74%	2,702	2,359	87%	604	507	84%	587	558	95%
RAJ	Mid and South Essex NHS Foundation Tr	East of England	Mid and South Essex STP	6,956	5,323	77%	6,891	4,468	65%	13,703	11,086	81%	13,564	10,635	78%	3,107	2,520	81%	3,252	2,636	81%
RD8	Milton Keynes University Hospital NHS Fo	East of England	Bedfordshire, Luton and Milton Keynes	3,377	1,304	39%	3,549	1,511	43%	2,669	2,173	81%	2,639	2,139	81%	211	196	93%	202	0	0%
RM1	Norfolk and Norwich University Hospitals	East of England	Norfolk and Waveney Health & Care P	4,294	2,681	62%	4,443	2,539	57%	9,405	7,627	81%	9,409	7,191	76%	1,704	1,170	69%	1,657	1,198	72%
RGN	North West Anglia NHS Foundation Trust	East of England	Cambridgeshire and Peterborough ST	3,250	1,485	46%	3,338	1,561	47%	6,194	2,909	47%	6,014	2,531	42%	0	1,546	n/a	0	1,637	n/a
RGM	Royal Papworth Hospital NHS Foundatio	East of England	Cambridgeshire and Peterborough ST	214	184	86%	184	173	94%	577	452	78%	599	397	66%	87	156	179%	95	156	164%
RQW	The Princess Alexandra Hospital NHS Tr	East of England	Hertfordshire and West Essex STP	2,104	1,458	69%	2,114	1,509	71%	2,846	2,657	93%	3,021	3,402	113%	992	536	54%	1,002	565	56%
RCX	The Queen Elizabeth Hospital, King's Lyn	East of England	Norfolk and Waveney Health & Care P	1,488	1,008	68%	1,488	962	65%	3,596	2,576	72%	3,439	2,588	75%	499	418	84%	500	420	84%
RWG	West Hertfordshire Hospitals NHS Trust	East of England	Hertfordshire and West Essex STP	3,449	2,161	63%	3,493	2,144	61%	4,939	3,685	75%	4,739	3,362	71%	632	741	117%	669	717	107%
RGR	West Suffolk NHS Foundation Trust	East of England	Suffolk and North East Essex STP	1,956	1,333	68%	2,024	1,448	72%	4,726	3,118	66%	4,970	3,028	61%	536	499	93%	566	452	80%

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

				MRI Scans						Colonoscopies						Flexible-sigmoidoscopies					
				4 Week Average (Final data)			Latest week (Provisional)			4 Week Average (Final data)			Latest week (Provisional)			4 Week Average (Final data)			Latest week (Provisional)		
Prov code	Provider Name	Region	STP	Estimated same weeks last year	4 weeks ending: 31 Jan 2021	as a % of last year	Estimated same weeks last year	w/e 07 Feb 2021	as a % of last year	Estimated same weeks last year	4 weeks ending: 31 Jan 2021	as a % of last year	Estimated same weeks last year	w/e 07 Feb 2021	as a % of last year	Estimated same weeks last year	4 weeks ending: 31 Jan 2021	as a % of last year	Estimated same weeks last year	w/e 07 Feb 2021	as a % of last year
RC9	Bedfordshire Hospitals NHS Foundation	East of England	Bedfordshire, Luton and Milton Keynes	824	466	57%	918	475	52%	69	79	114%	91	83	91%	81	32	40%	108	29	27%
RGT	Cambridge University Hospitals NHS Fou	East of England	Cambridgeshire and Peterborough ST	664	550	83%	678	582	86%	138	38	28%	135	40	30%	28	9	30%	31	6	19%
RWH	East and North Hertfordshire NHS Trust	East of England	Hertfordshire and West Essex STP	572	404	71%	556	429	77%	84	47	56%	85	48	56%	29	15	51%	33	9	27%
RDE	East Suffolk and North Essex NHS Found	East of England	Suffolk and North East Essex STP	750	546	73%	814	562	69%	152	25	16%	171	60	35%	46	9	18%	58	10	17%
RGP	James Paget University Hospitals NHS F	East of England	Norfolk and Waveney Health & Care P	357	279	78%	334	293	88%	30	27	89%	34	27	79%	60	15	25%	54	26	48%
RAJ	Mid and South Essex NHS Foundation Tr	East of England	Mid and South Essex STP	1,263	988	78%	1,317	1,033	78%	148	113	76%	170	173	102%	70	33	47%	77	52	68%
RD8	Milton Keynes University Hospital NHS Fo	East of England	Bedfordshire, Luton and Milton Keynes	142	114	80%	136	93	68%	15	0	2%	22	140	636%	6	0	0%	12	0	0%
RM1	Norfolk and Norwich University Hospitals	East of England	Norfolk and Waveney Health & Care P	708	1,083	153%	740	1,114	151%	182	118	65%	181	68	38%	173	35	20%	175	45	26%
RGN	North West Anglia NHS Foundation Trust	East of England	Cambridgeshire and Peterborough ST	0	456	n/a	0	575	n/a	0	101	n/a	0	67	n/a	0	45	n/a	0	40	n/a
RGM	Royal Papworth Hospital NHS Foundatio	East of England	Cambridgeshire and Peterborough ST	50	56	112%	60	62	103%	0	0	n/a	0	0	n/a	0	0	n/a	0	0	n/a
RQW	The Princess Alexandra Hospital NHS Tr	East of England	Hertfordshire and West Essex STP	362	218	60%	336	195	58%	34	24	71%	18	0	0%	10	6	63%	5	0	0%
RCX	The Queen Elizabeth Hospital, King's Lyn	East of England	Norfolk and Waveney Health & Care P	202	112	55%	216	96	44%	53	15	29%	44	24	55%	20	5	26%	22	10	45%
RWG	West Hertfordshire Hospitals NHS Trust	East of England	Hertfordshire and West Essex STP	327	239	73%	302	197	65%	4	90	2250%	1	94	9400%	13	40	306%	5	43	860%
RGR	West Suffolk NHS Foundation Trust	East of England	Suffolk and North East Essex STP	294	214	73%	321	183	57%	57	47	83%	69	28	41%	43	23	52%	44	17	39%

11. Integrated quality and performance report

To APPROVE a report

For Approval

Presented by Helen Beck and Susan Wilkinson

Trust Board Report

Agenda Item:	11			
Presented By:	Helen Beck & Sue Wilkinson			
Prepared By:	Information Team			
Date Prepared:	Feb-21			
Subject:	Performance Report			
Purpose:	**X**	**For Information**		**For Approval**

Executive Summary:

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

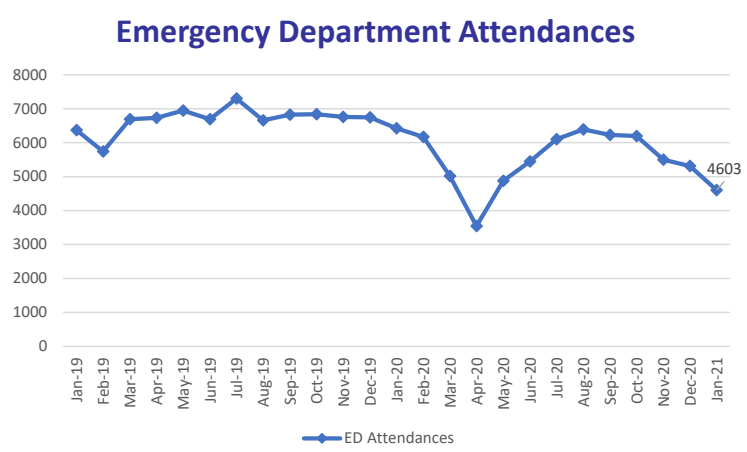
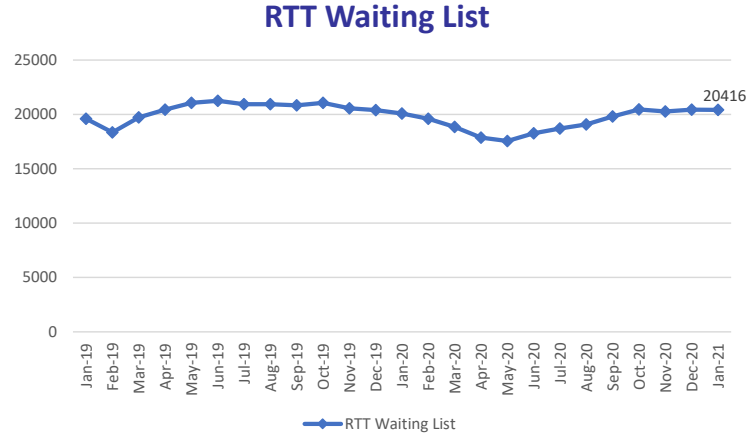
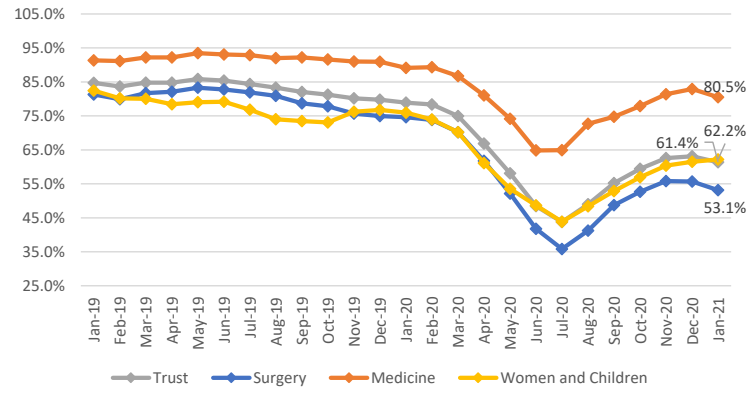
Trust Priorities [Please indicate Trust priorities relevant to the subject of the report]	**Delivery for Today**	**Invest in Quality, Staff and Clinical Leadership**	**Build a Joined-up Future**
	X		

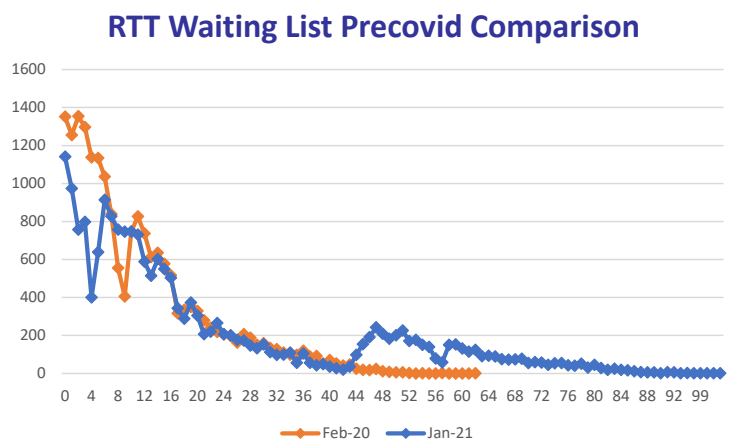
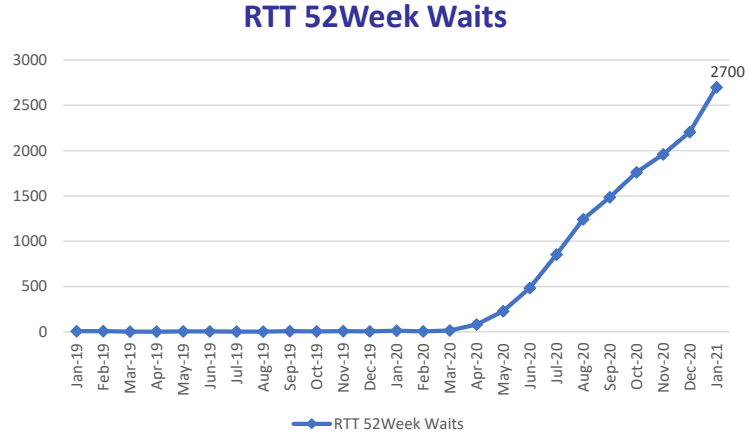
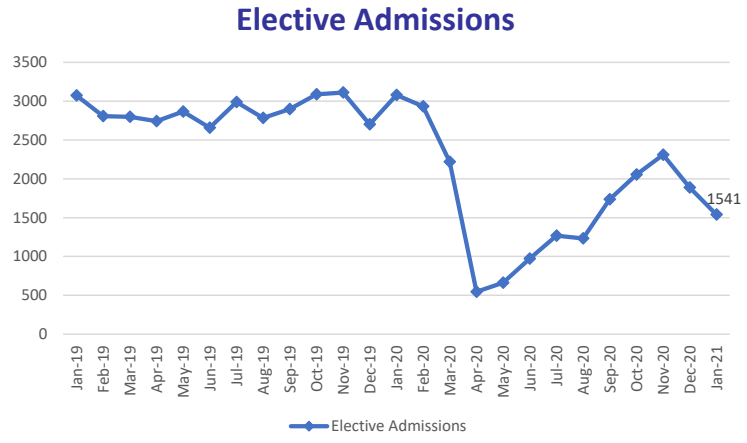
Trust Ambitions [Please indicate ambitions relevant to the subject of the report]	Deliver personal care	Deliver safe care	Deliver joined-up care	Support a healthy start	Support a healthy life	Support ageing well	Support all our staff
		X	**X**				**X**

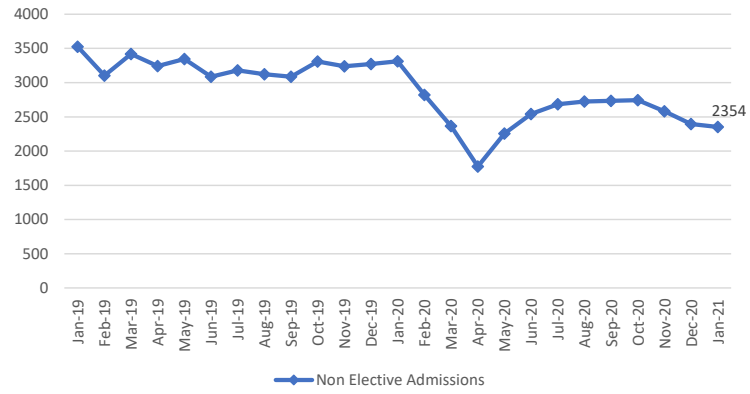
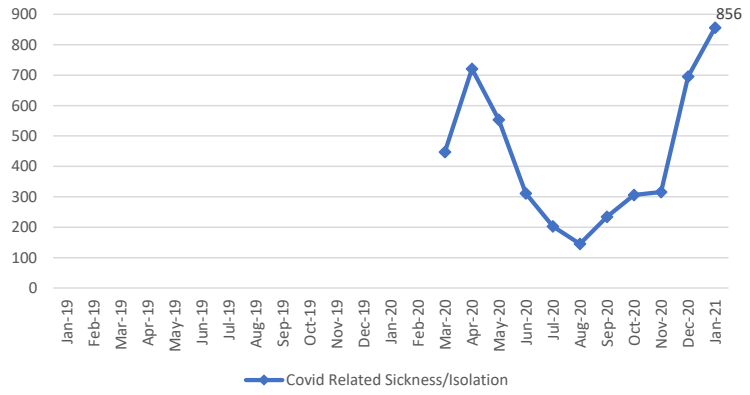
Previously Considered by:	
Risk and Assurance:	
Legislation, Regulatory, Equality, Diversity and Dignity Implications	

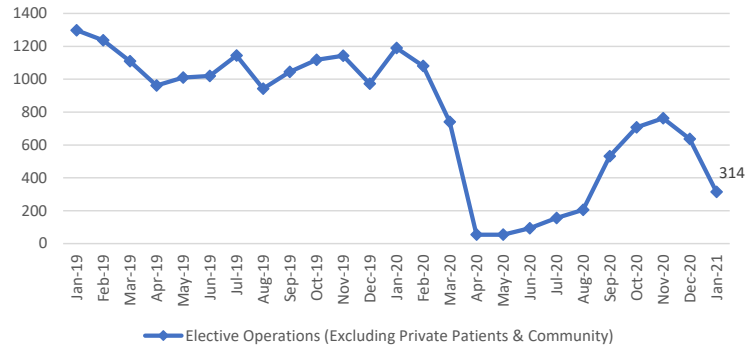
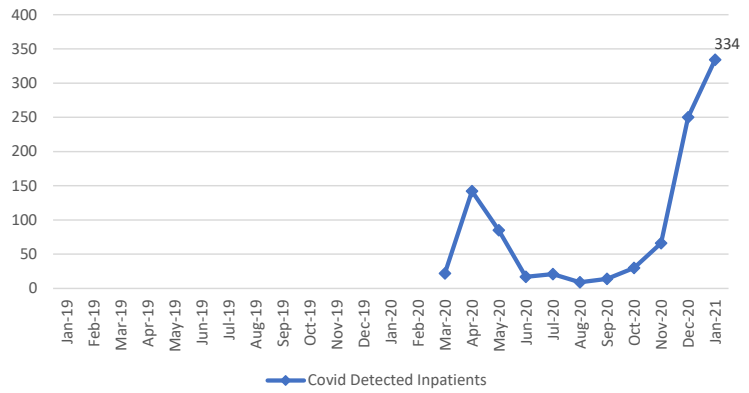
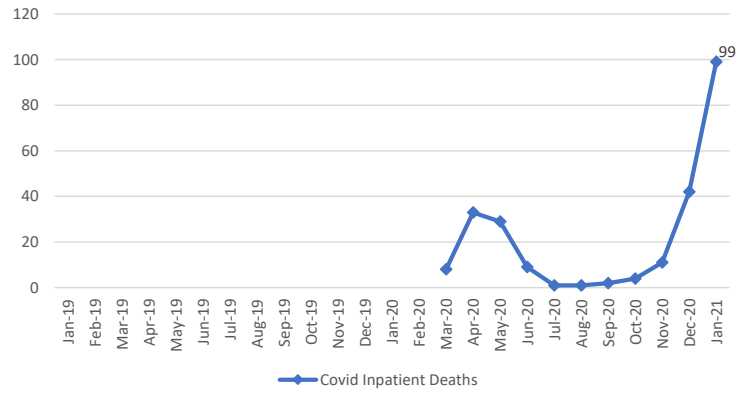
Recommendation:

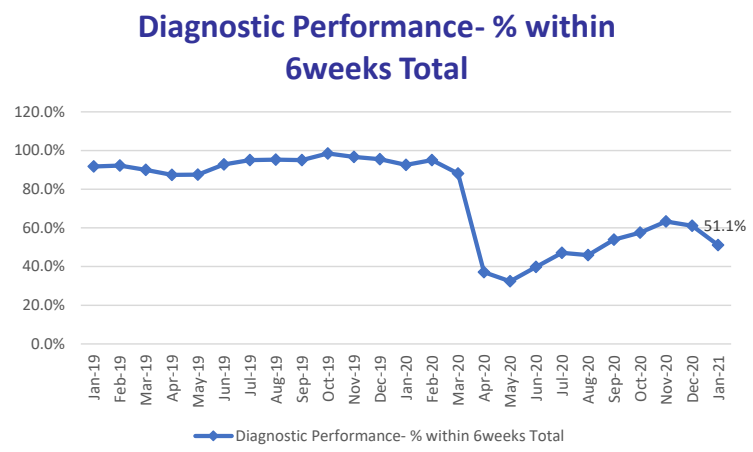
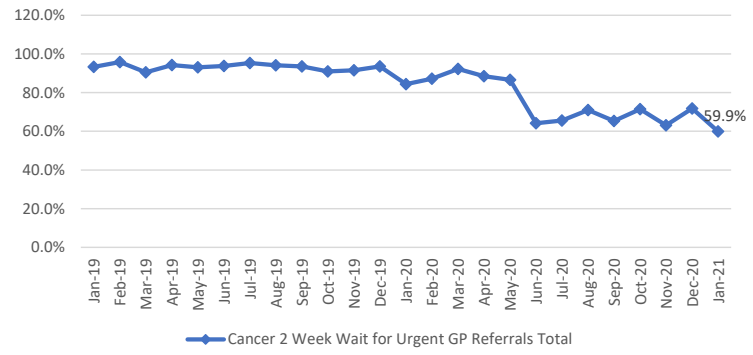
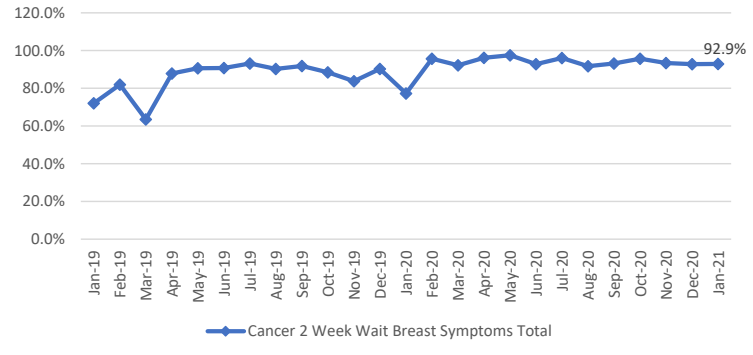
That Board note the report.

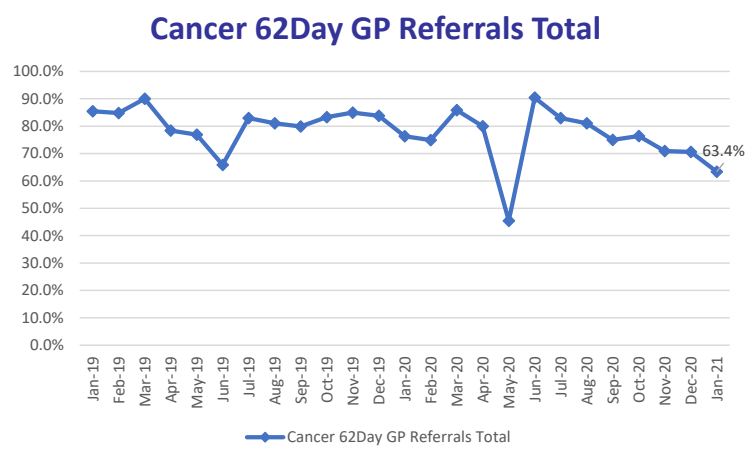
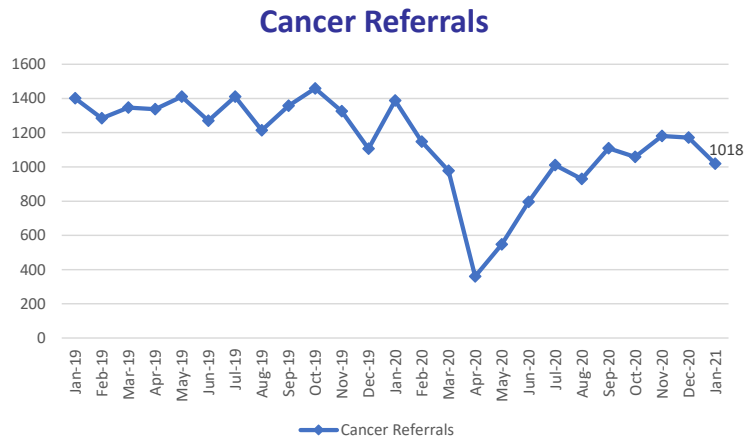
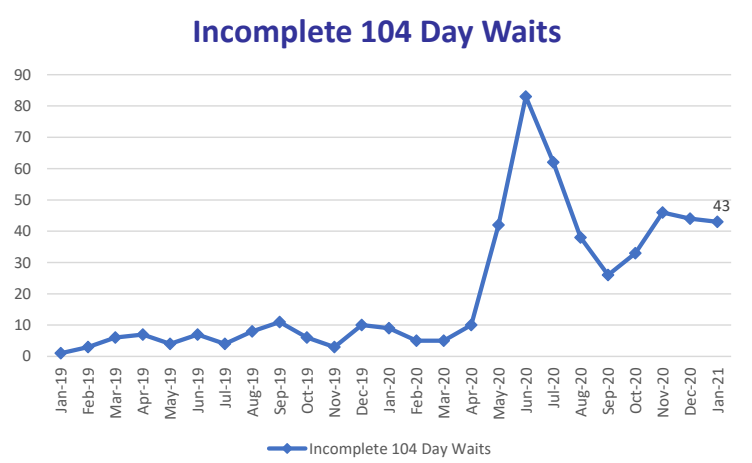
Board Report KPIs	Narratives
	There were 4603 attendances to ED in January 2021, compared with 6246 attendances in January 2020. This is a reduction of 1643 attendances. Lockdown and social distancing/ wearing of masks reducing the transmission of other illnesses and the occurrences of injuries.
A count of the arrivals at the Emergency Department. This metric has no national target but is key to understanding demand for non elective services.	
	Overall waiting list size maintained for the last 4 months although we have not treated so many patients in January referrals in have been lower in some services.
A count of the patients on the waiting list for treatment.	
	RTT compliance has dipped slightly across each division as expected as a reflection of all routine diagnostics, surgery and many outpatients being cancelled throughout January.
% of patients on incomplete RTT pathways	

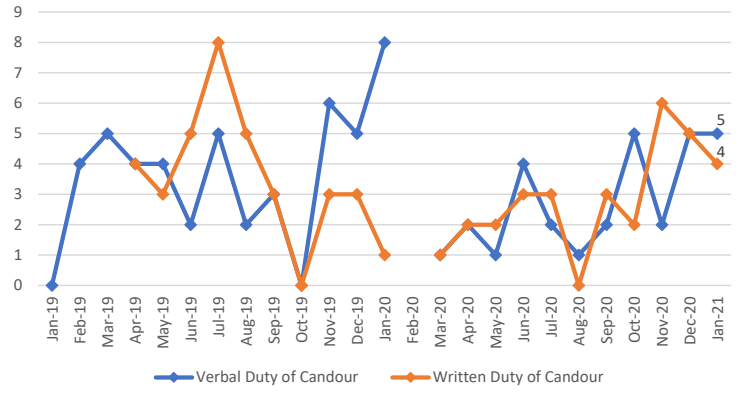
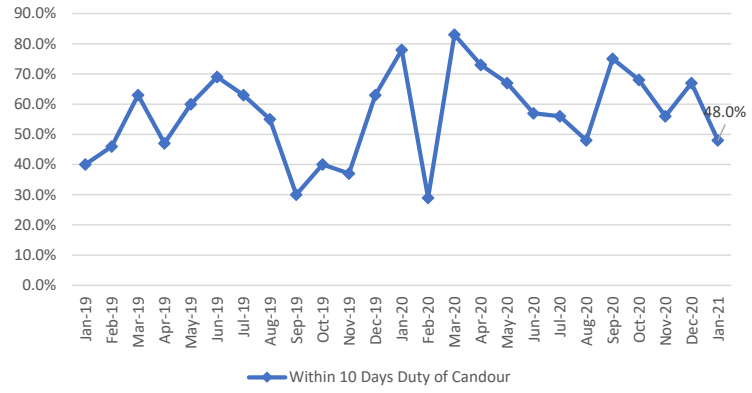
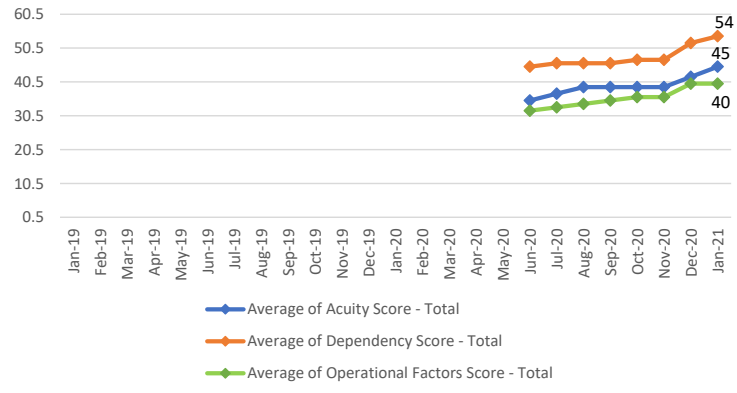
Board Report KPIs	Narratives
	As we have seen in previous months the waiting list 'tail' is significantly longer due to the restrictions in surgery as a direct impact of Covid-19 and the need to treat patients with the highest clinical priority. The waiting list shape has changed and we can see the dip at around the 42 week mark which was when referrals dropped off during the first wave of the pandemic.
A year on year comparison of the number of patients waiting for treatment.	
	Continued increase in the number of patients over 52 weeks. This is expected to continue to grow whilst we are not in a position to operate on routine surgical patients. The focus on treating patients in clinical priority order is likely to impact the recovery of this position for some considerable time.
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.	
	As expected elective admissions have significantly reduced during January as a result of ceasing routine elective surgery and diagnostics.
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.	

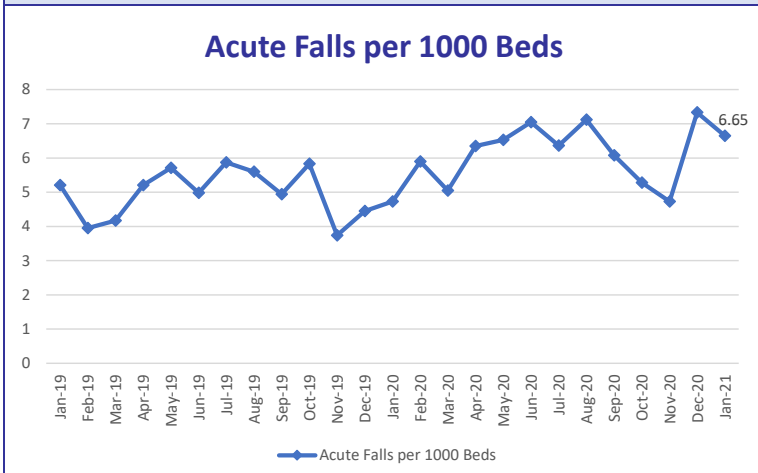
Board Report KPIs	Narratives
Non Elective Admissions 	There were 2345 Non-elective admissions in January 21 compared to 3312 in January 20, which represents a decrease of 967 non-elective admissions in month. This decrease correlates with the second wave of Covid and also the reduction in attendances to ED.
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.	
Staff Sickness 	The Trust's 12 month cumulative (rolling) absence figure as at the end of January 2021 was 3.9%, identical to the previous month. The in-month absence figure for January 2021 was 8.2%, a spike attributable to covid related sickness and self isolation. We can therefore expect the 12-month rolling average to increase over the coming 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.	
Covid Related Sickness/Isolation 	This chart illustrates the number of sickness episodes related to COVID-19. In January 2021 there were 856 episodes recorded which is an increase on December 2020 which was 695 episodes.
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.	

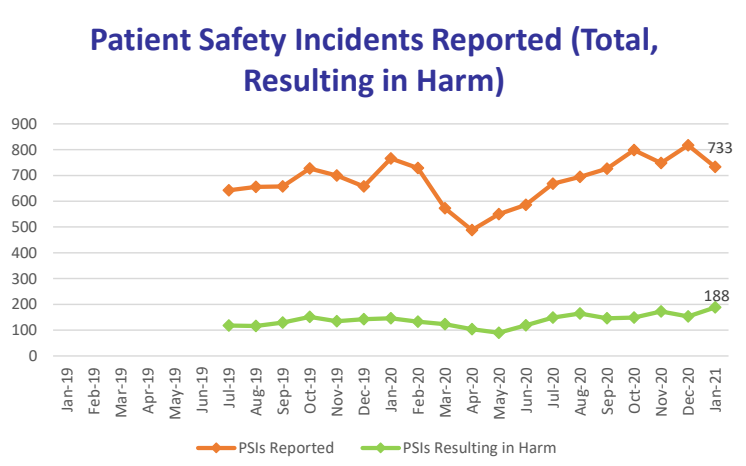
Board Report KPIs	Narratives
Elective Operations (Excluding Private Patients & Community)  This is a count of the number of operations that were carried out. This is a local measure to monitor our productivity and recovery from Covid.	As expected elective admissions have significantly reduced during January as a result of ceasing routine elective surgery. We have managed to maintain our planned cancer admissions for treatment throughout this period.
Covid Detected Inpatients  This is a count of the number of patients admitted to the hospital who tested positive for Covid. This is a local measure to understand the local impact of Covid. This number is reported daily as part of national daily reporting requirements.	There were 334 individual patients admitted during January, who had their first diagnosis of Covid-19. In January the highest number of Covid positive inpatients residing in the trust on any one day was 187, which was on 14th January.
Covid Inpatient Deaths  A count of the number of patients who have died within 28 days of 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.	There were 99 patients who died within 28 days of a positive Covid result, in January. These figures are as published by NHSE.

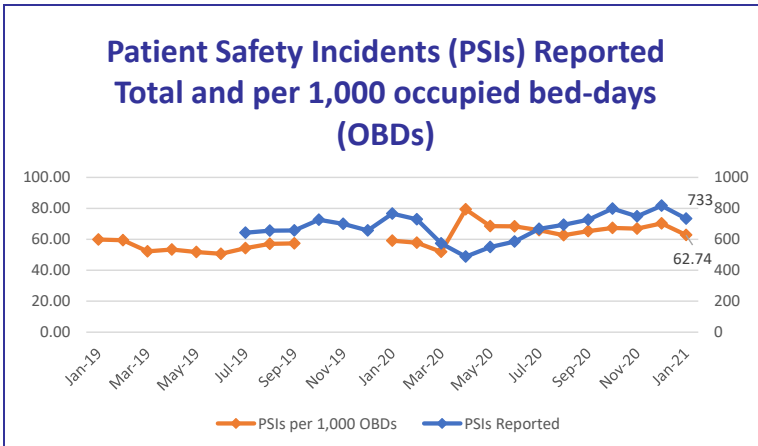
Board Report KPIs	Narratives
	Following steady growth in the percentage compliance with DMO1 during the summer months as the trust implemented it's plans for recovery following Covid Wave 1, we have unfortunately seen a decline again in performance over the last 2 months. During this time routine activity onsite has been suspended due to significant Covid related activity and as a measure to ensure the safety of both patients and staff. This has resulted in a deteriorating position against the DMO1 however modalities are developing plans for the safe reintroduction of routine activity in the coming weeks.
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 reduced in January, predominantly due to patients attending over 2 weeks for endoscopy diagnostics for upper and lower GI. Slightly higher numbers of referrals in Breast and Urology added pressure to the 2 Week Wait standard. Recovery trajectory for 2 Week Wait endoscopy is being developed.
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.	
	Standard achieved despite very high numbers of referrals.
This metric is a sub set of the national 2 week wait metric and measures those GP referrals specifically with breast symptoms. The target is the same as the overall 2 week wait of 93% of patients to be seen within 2 weeks.	

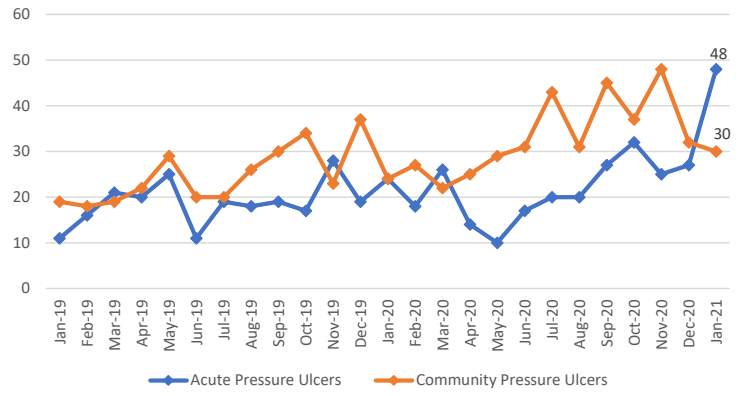
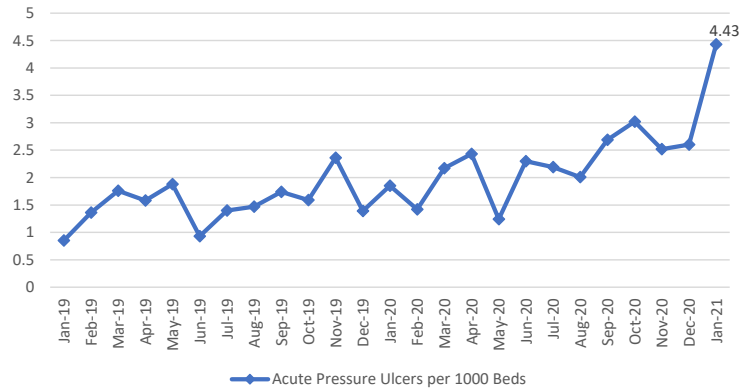
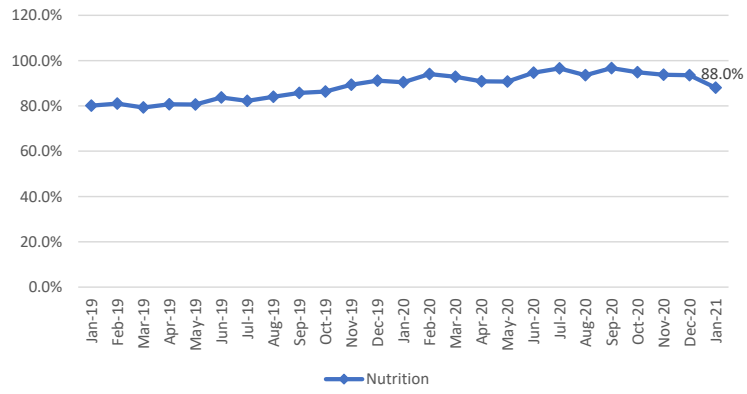
Board Report KPIs	Narratives
	Significant reduction in performance as expected due to treating patients who had been delayed for diagnostics. Once patients are diagnosed they are still being treated quickly but the backlog in endoscopy particularly, contributed to 11 of the 19 patients treated over 62 days. RCA's and harm reviews will be completed for these patients
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.	
	Reduction in referrals across some tumour sites in January, potentially in line with national lockdown and seasonal referrals trends (Skin particularly).
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).	
	Overall patients over 104 has reduced, but this continues to remain high for the Trust. Most of this is a direct impact of covid-19 and diagnostic delays. Although there are a small number of patients awaiting treatment at tertiary referral centres who have been delayed due to covid critical care requirements.
A count of the number of patients who have waited longer that 104 days for treatment for cancer from GP referral. This is a national standard and is expected to be 0.	

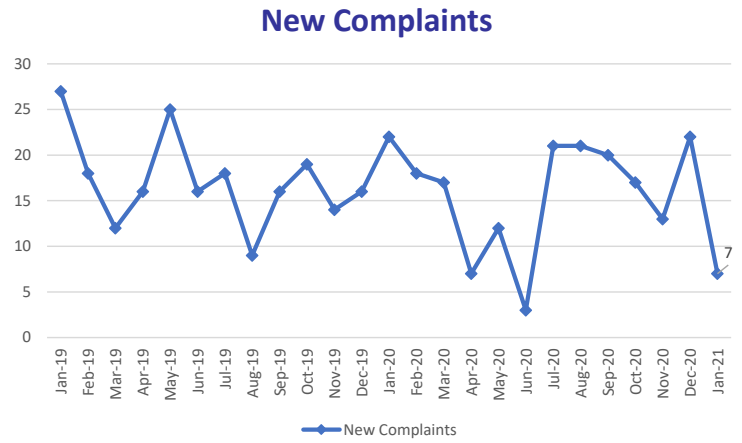
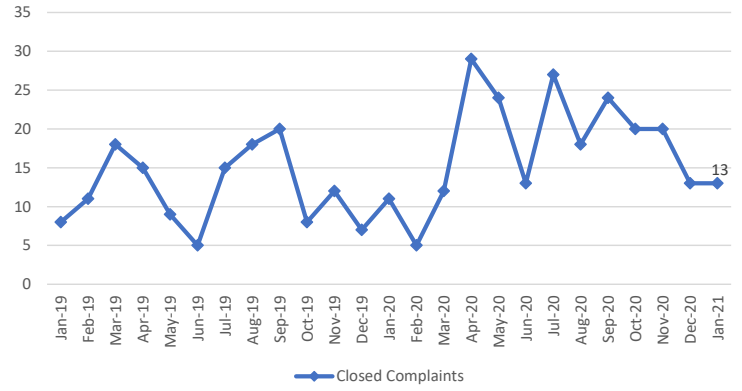
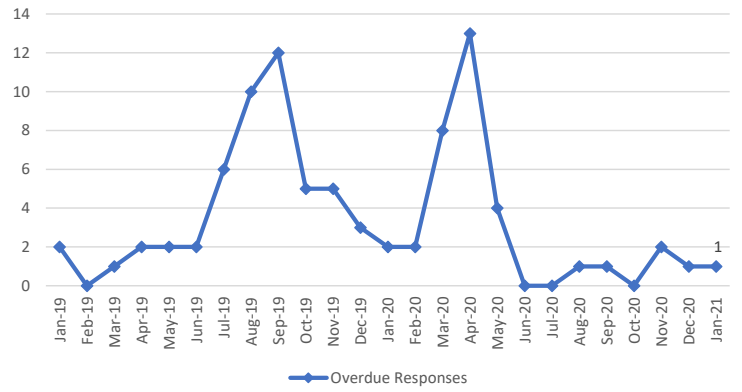
Board Report KPIs	Narratives
Duty of Candour  This is a count of the number of verbal and written duty of candour overdue for the reporting month (and earlier) as at the date of report issue	The timeliness indicator demonstrates a wide variance in performance as might be expected when a small denominator indicator is reported as a percentage. One of the wider aspects of the new PSIRF (Patient Safety Incident Response Framework) project will be a more targeted review of Duty of Candour to see why some incident types can be harder to achieve a timely Duty of Candour conversation and what support can be put into place to enable this. This Duty of Candour project is planned for March/April. The first step of this will be to consider the example of 'healthcare acquired' C. difficile (often following antibiotics) seeking the input of medical staff via discussion at pre-existing forums.
Within 10 Days Duty of Candour  The percentage of cases reported in that month where verbal duty of candour was completed within the nationally required 10 working day timeframe.	
Acuity 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.	January 2021 has seen a further increase in dependency and acuity levels from the proceeding months which is reflective of the surge in Covid 19 cases during this period. Many inpatient areas have seen high numbers of acutely unwell patients, many resulting in end of life. These measures also correlate with the increased oxygen demand seen in January. Overall, this position is indicative of the pressure the clinical teams have been experiencing during a period of high absence levels due to sickness and isolation. It is also important to acknowledge these markers do not include Critical Care which has doubled its capacity and acuity during January.

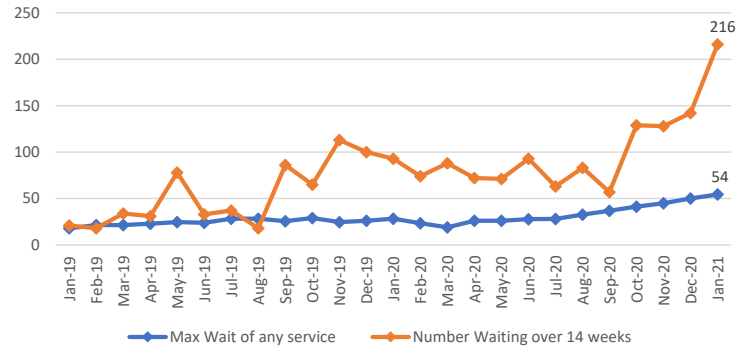
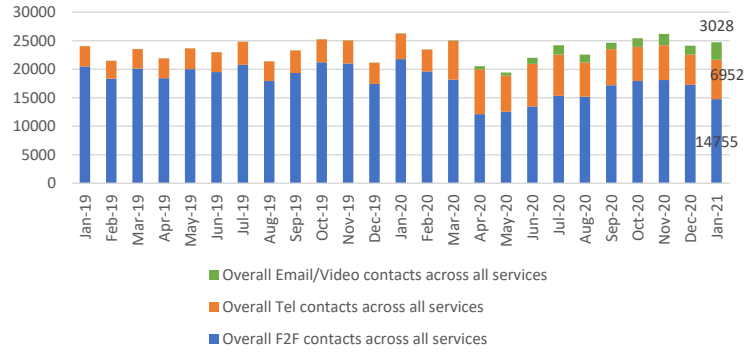
Board Report KPIs	Narratives
	The number of falls reported in January remained at the higher level seen in December although there was a reduction when expressed in terms of falls per 1,000 bed days. Whilst high compared to recent months, this is still within normal reporting limits of the longer-term reporting patterns. Within January; 48 falls resulted in no harm and this makes up the majority of the increased numbers in the month however there were also 22 with minor harm and two with moderate harm. There were some repeat fallers (n=7) most falling twice and one three times in the reporting month. Falls with Moderate harm will be investigated through the new PSIRF (Patient Safety Incident Response Framework) framework. Falls meeting held and chaired by the new Head of Nursing (Medicine) who proposed that the group identify 3 priorities to focus on this coming year, and demonstrate how these link with national and local requirements. From this develop a work plan with key work streams. Highlighting areas and opportunities for collaboration and cross working with other groups e.g. dementia, pharmacy/medication review, Education etc. The terms of reference and membership will also be reviewed to ensure the group is inclusive.
A measure of the number of falls in the acute hospital measured per 1000 bed days. Community falls are excluded from this metric.	

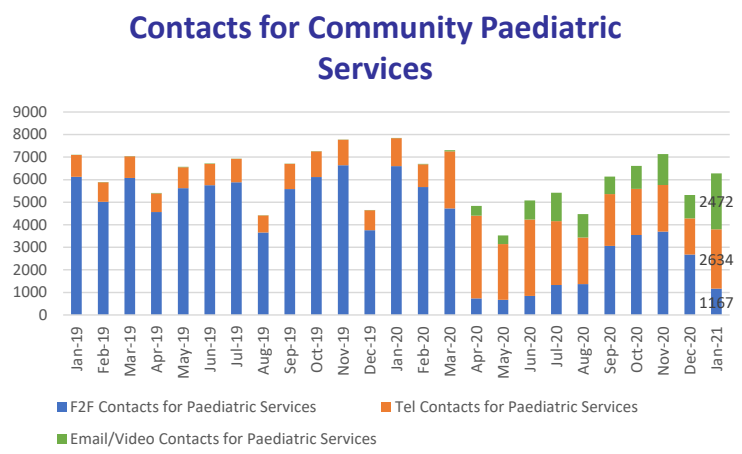
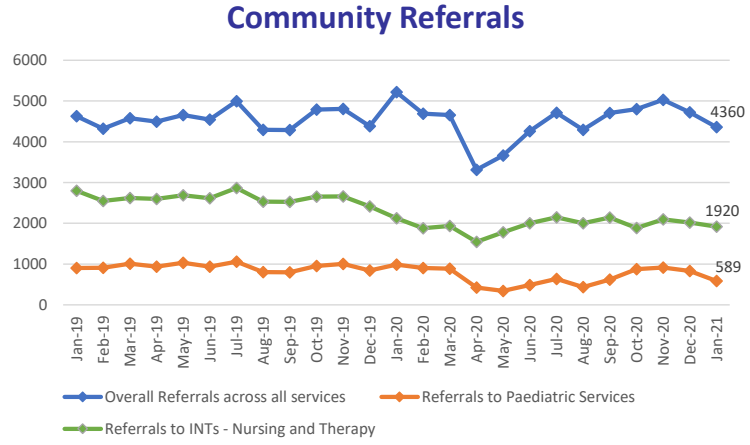
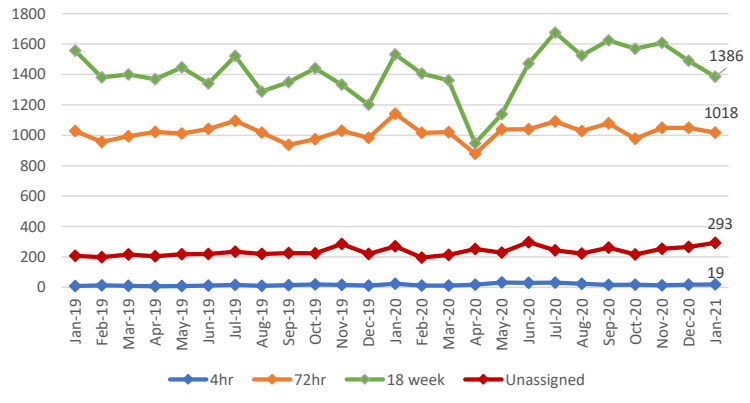
	The number of patient safety incidents reported in January fell compared to December but remained comparable to previous months. The number of incidents resulting in harm increased and was noticeably higher than in previous months. A drill-down into incident categories showed that the increase in the numbers of pressure ulcers (PUs) and falls were the main contributor to increased harm. More details on Pressure Ulcers and Falls are contained in the specific sections of the Board Report.
A count of the number of patient safety incidents reported in total and those resulting in harm	

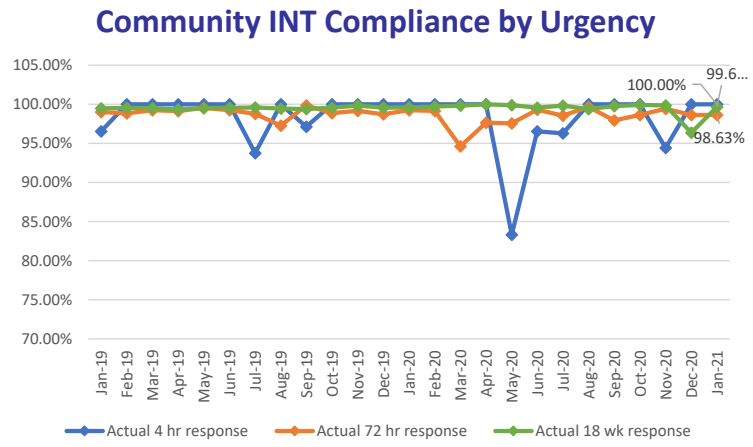
	The incidents reported per 1,000 bed days fell in January but remains within the normal limits of the recent 12 months.
The number of patient safety incidents reported as a percentage of occupied bed days to measure reporting rates	

Board Report KPIs	Narratives
Pressure Ulcers  A count of the number of recorded new pressure ulcers across the Trust. This metric will include those recorded in the acute hospital and community settings	The number of pressure ulcers reported as an organisation rose dramatically during January with increases in Cat 2 and Unstageable pressure ulcers. Whilst Community maintained its reporting position, the most concerning increases were seen across acute areas, particularly Medicine and Critical Care. Our staffing position through January remained challenging with higher than average staff absence levels, this may have impacted upon the ability of our teams to undertake preventative measures such as regular repositioning, the number of very sick/frail patients may also have been a factor; G4, G5, F7 and F8 all supported the care of Covid patients during this period. All reported CCU pressure ulcers were device related, a number of patients being nursed in the prone position. Teams continue to receive support via learning opportunities from the Tissue Viability Team (also significantly affected by absence) and a short-term secondment opportunity is to be advertised to support the analysis of data/trends underpinning the causes of pressure ulcer incidence.
Acute Pressure Ulcers per 1000 Beds  A measure of the number of pressure ulcers in the acute hospital measured per 1000 bed days. Community inpatient pressure ulcers are excluded from this metric.	
Nutrition  % of patients with a Malnutrition Universal Screening Tool (Adults)/Paediatric Yorkhill Malnutrition Score (Children) assessment completed within 24 hours of admission	There has been a decrease in compliance in completing nutrition assessments within 24 hours in January from 94% in December 2020 to 88% in January 2021. The decline in performance is mainly noted on the areas which have been converted to Covid wards and is indicative of these areas accepting direct admissions from the Emergency Department (ED), as opposed to transferring from the Acute Assessment Unit (AAU). This change in process, coupled with staff shortages due to sickness and high acuity, has resulted in delays in completing the assessments. It is acknowledged that of all patients discharged in January, 98% had a nutritional assessment completed, offering some assurance that patients were being assessed during this period, despite not meeting the expected timeframe. This will be an area of focus for Senior Matrons and Ward Managers in the coming months to ensure assessments are completed on time and appropriate plans of care are put in place.

Board Report KPIs	Narratives
	A surprising decrease in formal complaints overall for January and the lowest received since June 2020. Difficult to find a trend with so few complaints however the main subjects are still around communication with relatives. Obstetrics and Gynaecology increased with 2 complaints received in January, compared to 0 in December. A&E had a decrease from 3 complaints in December down to 0 complaints in January.
New formal complaints received and accepted, this counts both West Suffolk Hospital and Community	
	A reduced amount of complaints closed within January due to the keeping in touch team needed more attention due to low staffing levels and increased demand and therefore additional time was spent ensuring this service resumed full capacity. 2/3 members of the complaints team had been helping out full time on this service.
Formal complaints signed off by the CEO, this counts both West Suffolk Hospital and Community	
	1 complaint was resolved out of timescale. This was due to a delay in the trust office and we have apologised to the complainant for the slight delay which was overdue by a matter of days. We have however resolved all outstanding backlog complaints that were overdue and have ensured complainants have been kept up to date with any delays and or extensions.
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.	There has been an increase in the number of services with patients waiting over 18 weeks from 2 to 4. At the end of January, the 4 services were: Paed SLT, Paed Clinical Psychology, Wheelchairs and Environmental. The maximum wait for each of these services are 54.43 weeks (increased from 50), 19.71 weeks (from 16.43), 26.29 weeks (decreased from 27.86) and 24.43 weeks (increased from 14.43) respectively. 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.
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 January was 95.32% with the lowest individual service being Wheelchairs at 84.38%.
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 although the ratio of face to face and other means of contact (telephone, video and email) has altered. The INTs activity is still based in face to face but some other services have moved to telephone contacts successfully. As expected the activity has picked up again after the Christmas break.

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 has picked up again after the Christmas break.
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 have returned to pre-COVID numbers.
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, in particular the Green referrals have increased and stabilised above pre-Covid numbers.
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
 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)	All response thresholds were met in January.

12. Finance and workforce report

To ACCEPT the report

For Report

Presented by Craig Black

Board of Directors – 26 February 2021

Agenda item:	12			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	19th February 2021			
Subject:	Finance and Workforce Board Report – January 2021			
Purpose:		For information	x	For approval

Executive summary:

The reported I&E for January is breakeven. We expect funding to match any COVID related pressures and therefore forecast that we will break even at the year end. This will include receiving all FRF and MRET funding associated with meeting the Financial Improvement Trajectory (FIT).

Discussions over COVID related funding are ongoing and whilst there is uncertainty over COVID related expenditure and associated income our income and expenditure plan remains unchanged.

We have developed the budget for 2021-22 with a draft budget proposing a deficit of £10.5m. However, there is significant uncertainty over income and the funding of COVID related costs and so this budget is heavily contingent on a number of assumptions. As a result the budget may be updated as this becomes clear.

We anticipate setting a CIP of 1%. In addition to this were there to be any recurrent shortfall in the 20-21 CIP this would add to the requirement in 21-22.

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

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

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

Recommendation:
The Board is asked to review this report.

West Suffolk NHS
NHS Foundation Trust

FINANCE AND WORKFORCE REPORT
January 2021 (Month 10)

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

Financial Summary

I&E Position YTD	£0m	break-even
Variance against Plan YTD	£0m	on-plan
Movement in month against plan	£0m	on-plan
EBITDA position YTD	£30.8m	adverse
EBITDA margin YTD	15%	adverse
Total PSF Received	£41m	
Cash at bank	£27.1m	

Executive Summary

- The forecast position for the year is to break even.
- We anticipate receiving funding associated with any further COVID related costs.
- This position will include receiving all FRF and MRET funding associated with meeting the Financial Improvement Trajectory (FIT)
- Our focus is on our underlying income and expenditure position in readiness for 2021-22

Key Risks in 2020-21

- Costs and income associated with revised activity plan
- Costs associated with increased capacity pressures relating to COVID-19, RAAC planks and winter pressures
- Delivery of £8.7m CIP programme

SUMMARY INCOME AND EXPENDITURE ACCOUNT - January 2021	January 2021 Budget £m	January 2021 Actual £m	January 2021 Variance F/(A) £m	Year to date Budget £m	Year to date Actual £m	Year to date Variance F/(A) £m	Year end forecast Budget £m	Year end forecast Actual £m	Year end forecast Variance F/(A) £m
NHS Contract Income	18.0	18.3	0.3	184.5	179.8	(4.7)	220.4	216.0	(4.4)
Other Income	3.0	3.1	0.2	29.6	28.1	(1.5)	35.5	31.3	(4.2)
Total Income	**20.9**	**21.4**	**0.4**	**214.1**	**207.9**	**(6.2)**	**255.9**	**247.3**	**(8.6)**
Pay Costs	16.2	16.6	(0.3)	160.4	166.3	(5.9)	202.1	202.6	(0.5)
Non-pay Costs	7.4	7.5	(0.1)	79.3	72.4	6.9	84.9	81.0	3.9
Operating Expenditure	**23.7**	**24.1**	**(0.4)**	**239.7**	**238.7**	**1.0**	**287.0**	**283.6**	**3.4**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA excl STF	**(2.7)**	**(2.7)**	**0.0**	**(25.6)**	**(30.8)**	**(5.1)**	**(31.1)**	**(36.3)**	**(5.2)**
Depreciation	0.7	0.6	0.1	6.7	5.9	0.9	8.1	7.0	1.1
Finance costs	0.3	0.4	(0.1)	3.3	4.3	(1.1)	3.9	5.2	(1.3)
SURPLUS/(DEFICIT)	**(3.7)**	**(3.7)**	**(0.0)**	**(35.6)**	**(41.0)**	**(5.4)**	**(43.1)**	**(48.5)**	**(5.4)**
Provider Sustainability Funding (PSF)									
PSF / FRF/ MRET/ Top Up	3.7	3.7	0.0	35.6	41.0	5.4	43.1	48.5	5.4
SURPLUS/(DEFICIT) incl PSF	**(0.0)**	**(0.0)**	**0.0**	**(0.0)**	**(0.0)**	**0.0**	**(0.0)**	**0.0**	**0.0**

FINANCE AND WORKFORCE REPORT – January 2021

Contents:

Key:

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

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

FINANCE AND WORKFORCE REPORT – January 2021

Income and Expenditure Summary as at January 2021

The reported I&E for January is break even (YTD break even position). Due to COVID-19 we are receiving top up payments that includes MRET and FRF. This ensures we break even YTD. The 'top up' element is £22.6m YTD.

During September we submitted a revised activity plan. However, discussions over COVID related funding are ongoing and whilst there is uncertainty over COVID related expenditure and associated income our income and expenditure plan remains unchanged. We therefore forecast to break even at year end.

2021-22 Budgets

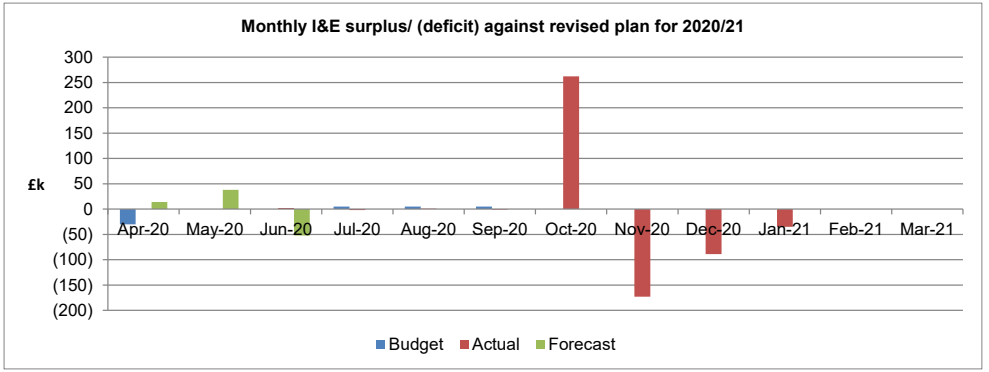
We have developed the budget for 2021-22 with a draft budget proposing a deficit of £10.5m.

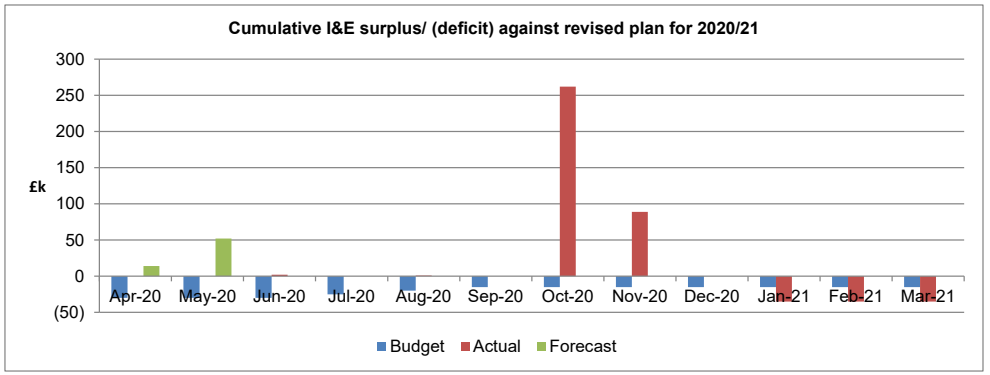
However, there is significant uncertainty over income and the funding of COVID related costs and so this budget is heavily contingent on a number of assumptions. As a result the budget may be updated as this becomes clear.

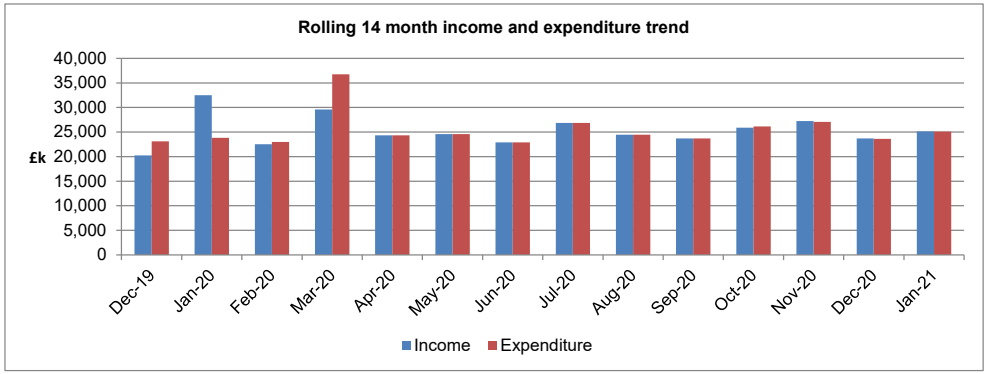
We anticipate setting a CIP of 1%. In addition to this were there to be any recurrent shortfall in the 20-21 CIP this would add to the requirement in 21-22.

Summary of I&E indicators

Income and Expenditure	Plan/ Target £000'	Actual/ Forecast £000'	Variance to plan (adv)/ fav £000'	Direction of travel (variance)	RAG (report on red)
In month surplus/ (deficit)	(0)	(0)	0	⇔	Green
YTD surplus/ (deficit)	(0)	(0)	0	⇔	Green
Forecast surplus/ (deficit)	(0)	(0)	(0)	⇔	Green
EBITDA (excl top-up) YTD	(3,737)	(3,737)	(0)	⇓	Green
EBITDA %	(17.9%)	(17.5%)	0.4%	⇑	Green
Clinical Income YTD	(194,532)	(189,080)	(5,453)	⇓	Red
Non-Clinical Income YTD	(55,165)	(59,832)	4,666	⇑	Green
Pay YTD	160,448	166,315	(5,866)	⇑	Red
Non-Pay YTD	89,247	82,589	6,659	⇓	Green
CIP Target YTD	7,288	3,765	(3,523)	⇑	Red







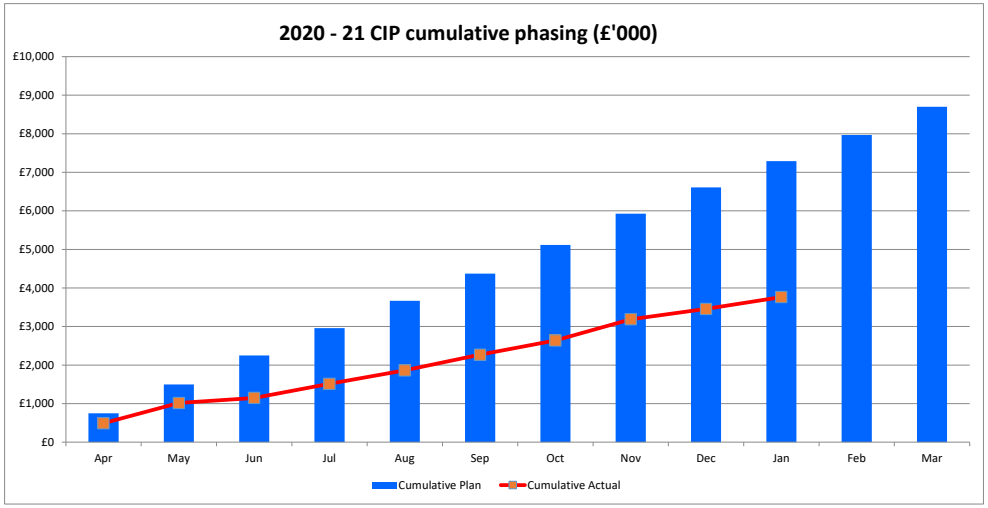
Cost Improvement Programme (CIP) 2020-21

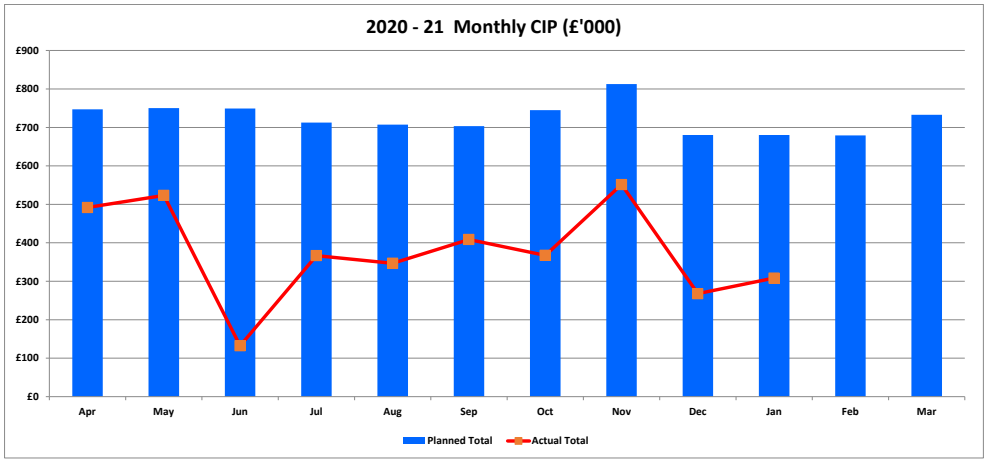
In order to deliver the Trust's control target in 2020-21 we need to deliver a CIP of £8.7m (3.4%). The plan for the year to January is £7.3m (83.8% of the annual plan) and we achieved £3.8m (43.3%). This represents a shortfall of £3,524k.

The CIP forecast is to achieve £4.1m by year end which is a shortfall of £4.6m.

Recurring/Non Recurring	2020-21 Annual Plan	Plan YTD	Actual YTD
	£'000	£'000	£'000
Recurring			
Outpatients	254	197	46
Procurement	492	410	427
Activity growth	200	167	167
Additional sessions	363	303	60
Community Equipment Service	510	425	282
Drugs	367	305	301
Estates and Facilities	187	165	90
Other	949	822	868
Other Income	493	410	143
Pay controls	327	263	162
Service Review	16	16	16
Staffing Review	819	647	566
Theatre Efficiency	302	252	-
Contract Review	50	42	4
Workforce	-	-	-
Consultant staffing	-	-	-
Agency	-	-	-
Unidentified CIP	975	805	-
Recurring Total	**6,304**	**5,228**	**3,131**
Non-Recurring			
Pay controls	580	505	502
Other	1,810	1,549	125
Estates and Facilities	6	6	6
Non-Recurring Total	**2,396**	**2,060**	**633**
Total CIP	**8,700**	**7,288**	**3,765**

Division	Divisional Target £'000	YTD Var £'000	Unidentified plan £ YTD	Unidentified plan £ year
Medicine	2,555	(1,759)	213	255
Surgery	2,029	(692)	169	203
W&C/CSS	1,847	(255)	0	0
Community	1,422	(430)	104	125
E&F	516	(323)	161	202
Corporates	331	(64)	159	191
Stretch	0	0	0	0
Total	**8,700**	**(3,524)**	**805**	**975**

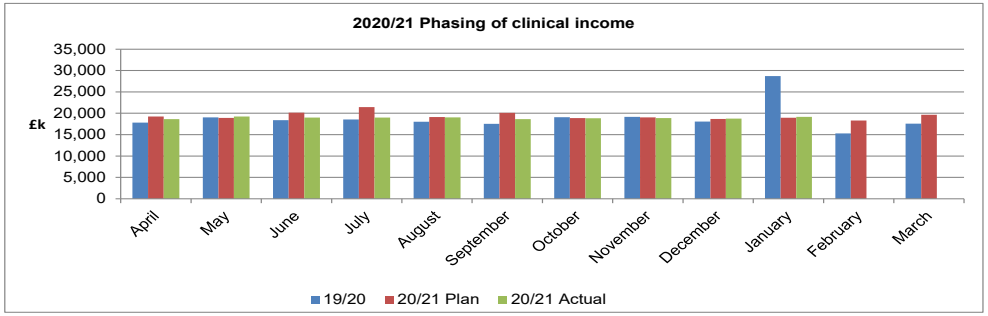




FINANCE AND WORKFORCE REPORT – January 2021

Income Analysis

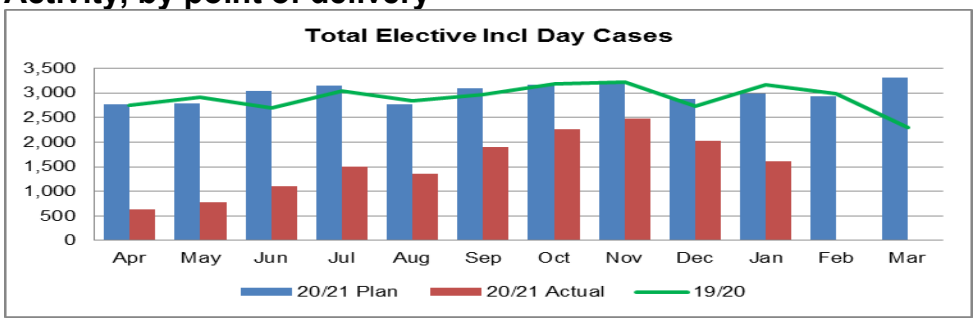
The chart below demonstrates the phasing of all clinical income plan for 2020-21, including Community Services. This phasing is in line with phasing of activity.

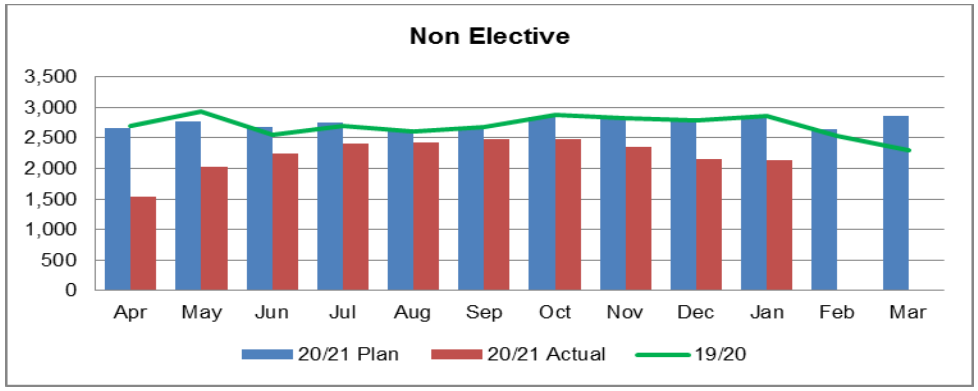


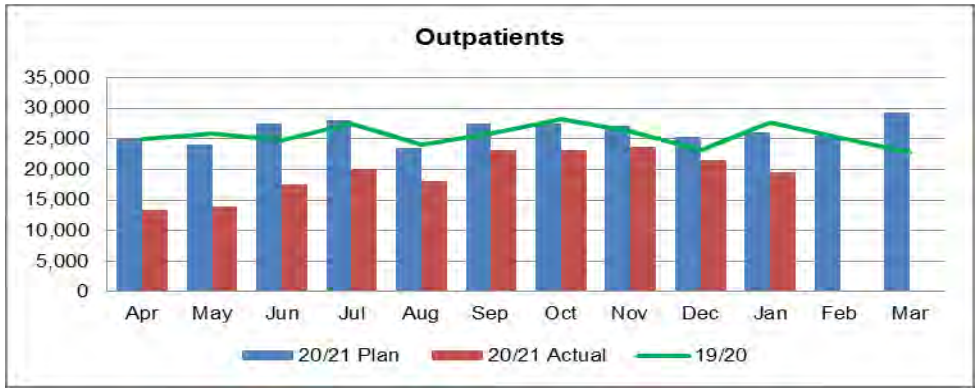
The income position was slightly ahead of plan for January. The income was based on the national agreed block payments as set out by NHS England, these were put in place to give Providers assured income during the coronavirus period.

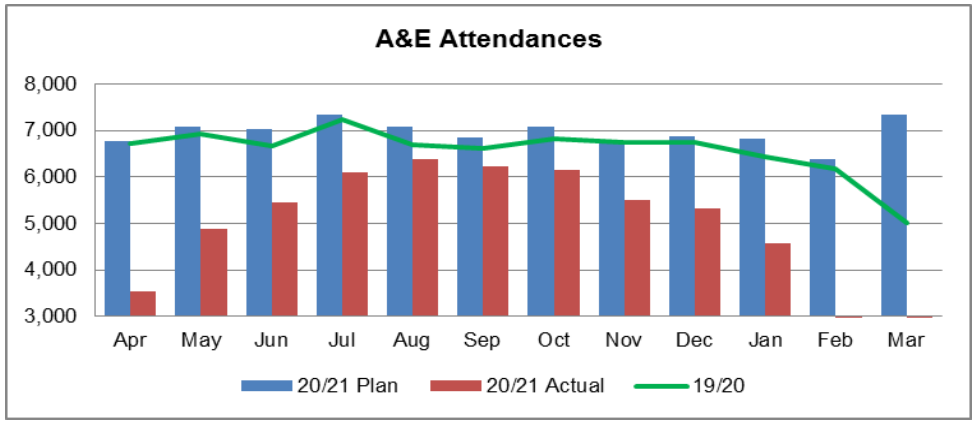
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	1,001	729	(272)	10,204	8,369	(1,835)
Other Services	1,905	5,313	3,407	27,434	51,431	23,997
CQUIN	185	148	(37)	1,809	1,455	(355)
Elective	2,797	1,146	(1,651)	28,685	14,207	(14,479)
Non Elective	7,061	7,092	31	65,656	65,201	(455)
Emergency Threshold Adjustment	(383)	(383)	0	(3,460)	(3,460)	0
Outpatients	3,155	1,972	(1,183)	31,782	20,237	(11,544)
Community	2,988	2,988	0	29,880	29,880	0
Total	**18,709**	**19,004**	**295**	**191,991**	**187,320**	**(4,671)**

Activity, by point of delivery



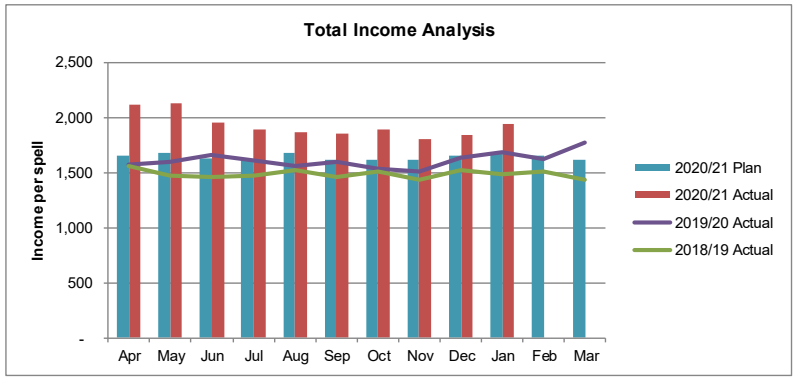


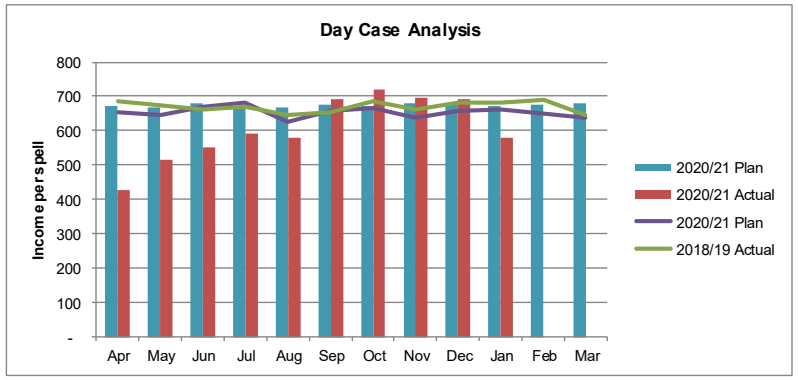


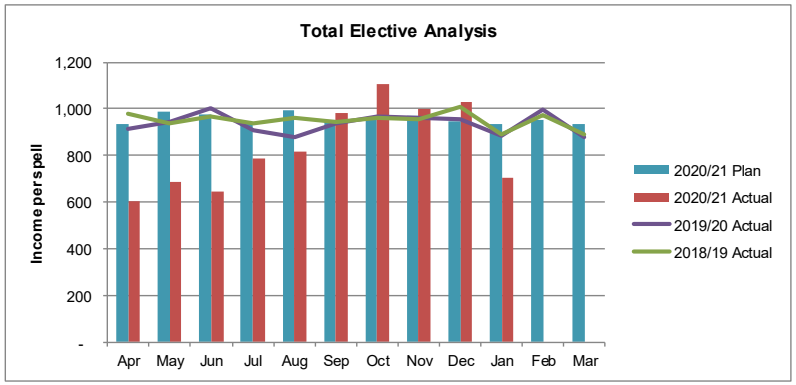


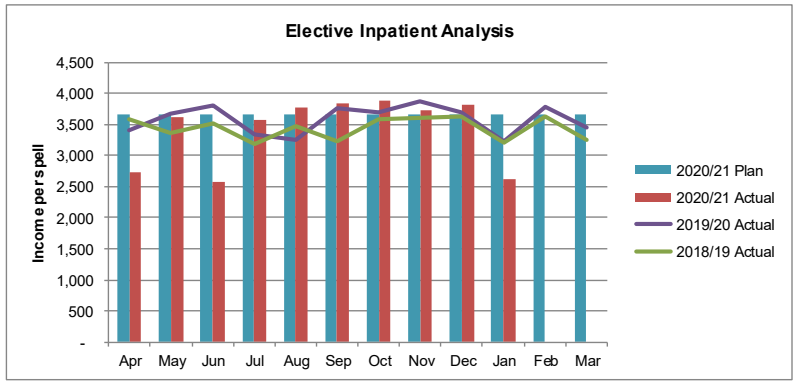
FINANCE AND WORKFORCE REPORT – January 2021

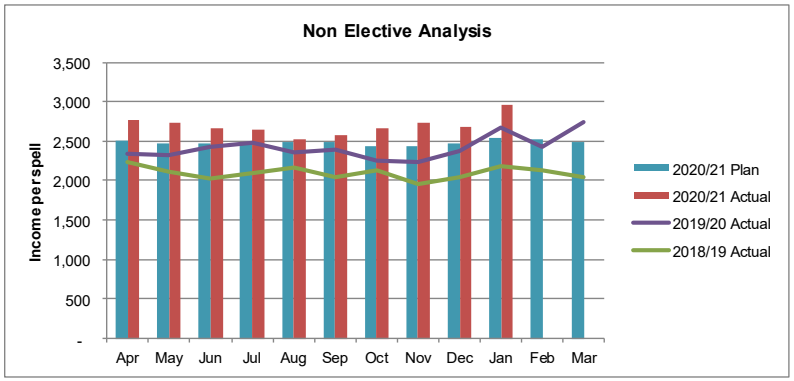
Trends and Analysis

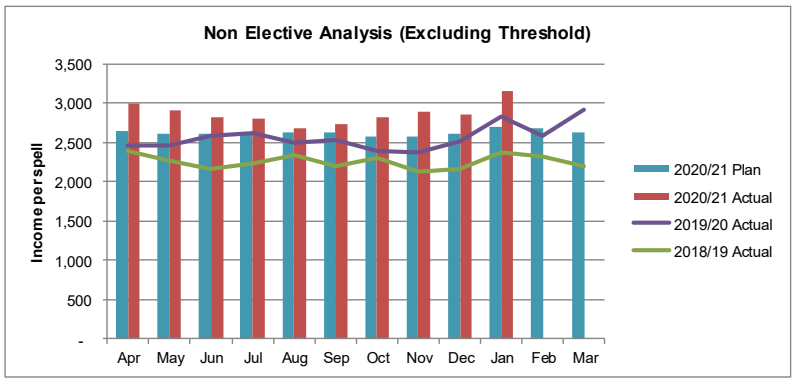










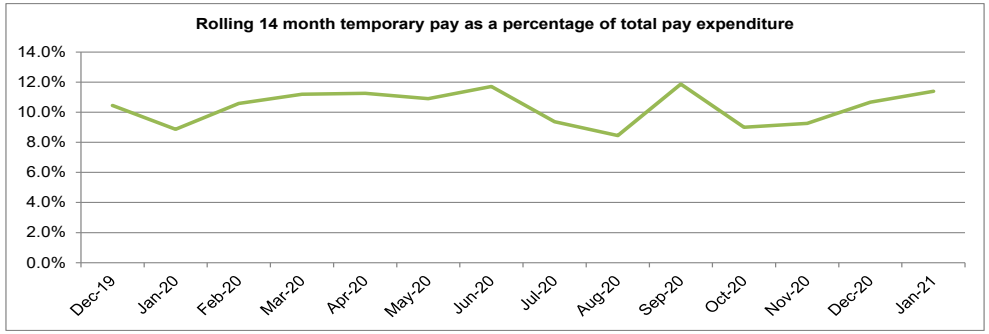


FINANCE AND WORKFORCE REPORT – January 2021

Workforce

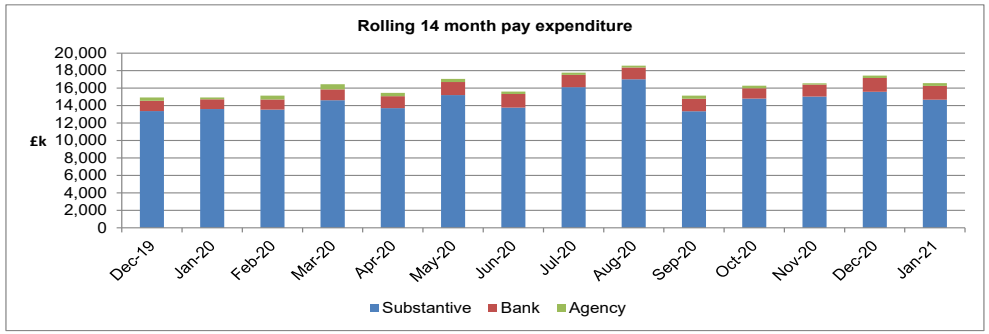
Monthly Expenditure (£)				
As at January 2021	Jan-21	Dec-20	Jan-20	YTD
	£000's	£000's	£000's	£000's
Budgeted Costs in-month	16,241	16,577	14,555	160,448
Substantive Staff	14,671	15,565	13,598	149,128
Medical Agency Staff	167	153	55	1,656
Medical Locum Staff	395	351	350	3,195
Additional Medical Sessions	212	251	125	2,614
Nursing Agency Staff	101	70	88	671
Nursing Bank Staff	465	516	353	4,367
Other Agency Staff	55	62	65	521
Other Bank Staff	241	239	161	2,140
Overtime	141	130	54	1,162
On Call	109	87	72	861
Total Temporary Expenditure	1,886	1,859	1,323	17,187
Total Expenditure on Pay	16,557	17,424	14,921	166,315
Variance (F/(A))	(316)	(847)	(366)	(5,866)
Temp. Staff Costs as % of Total Pay	11.4%	10.7%	8.9%	10.3%
memo: Total Agency Spend in-month	323	285	208	2,848

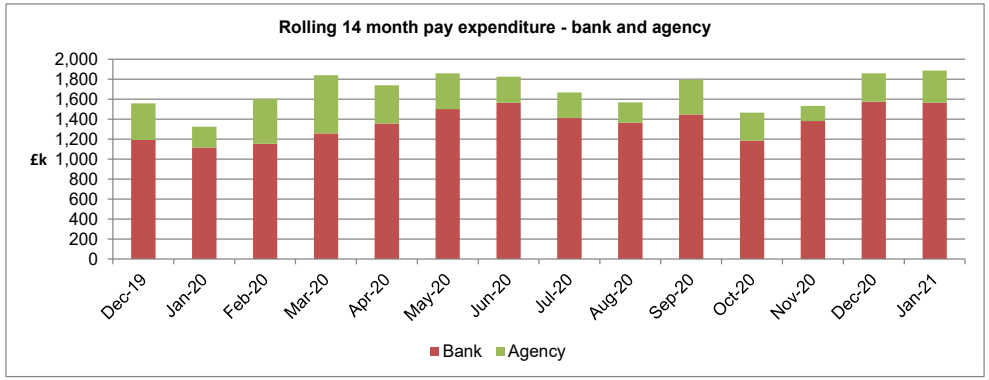
Monthly WTE				
As at January 2021	Jan-21	Dec-20	Jan-20	YTD
	£000's	£000's	£000's	£000's
Budgeted WTE in-month	4,228.2	4,190.7	3,894.4	42,454.9
Substantive Staff	3,933.0	3,922.8	3,658.0	38,097.9
Medical Agency Staff	17.9	10.6	5.0	154.6
Medical Locum Staff	33.9	26.5	29.7	279.3
Additional Medical Sessions	1.3	7.5	5.3	47.0
Nursing Agency Staff	18.0	16.4	12.6	135.7
Nursing Bank Staff	137.8	153.1	103.9	1,305.7
Other Agency Staff	18.1	15.1	14.7	109.6
Other Bank Staff	91.8	89.5	63.5	844.0
Overtime	36.1	30.3	11.5	304.6
On Call	9.8	5.2	6.4	67.2
Total Temporary WTE	364.7	354.2	252.7	3,247.9
Total WTE	4,297.7	4,277.0	3,910.7	41,345.8
Variance (F/(A))	(69.5)	(86.3)	(16.2)	1,109.1
Temp. Staff WTE as % of Total WTE	8.5%	8.3%	6.5%	7.9%
memo: Total Agency WTE in-month	54.0	42.1	32.3	400.0

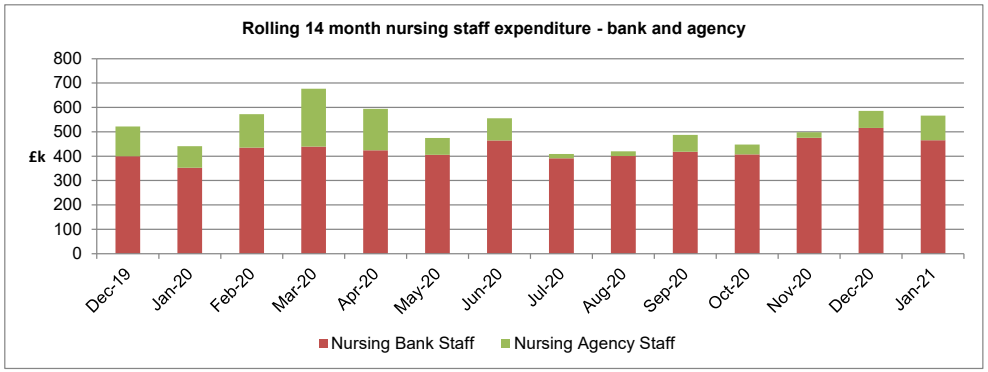


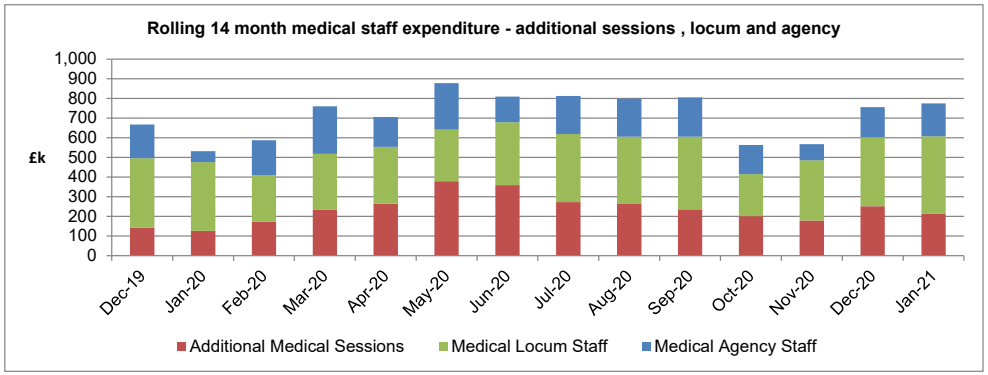
Pay Trends and Analysis

During January the Trust overspent by £316k on pay (£5.9m overspent YTD). This includes all COVID related pay costs.

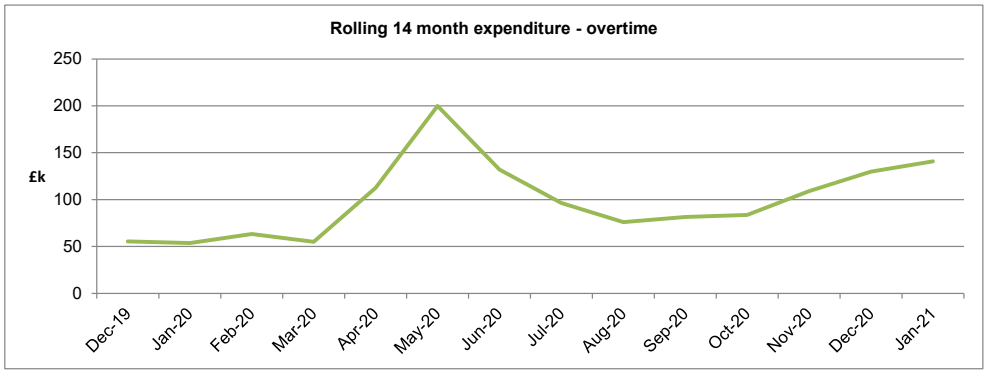








Expenditure on Additional Sessions was £212k in January (£251k in December)



FINANCE AND WORKFORCE REPORT – January 2021

Income and Expenditure Summary by Division

	Current Month			Year to date		
	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)
MEDICINE	£k	£k	£k	£k	£k	£k
Total Income	(7,802)	(5,851)	(1,951)	(74,706)	(61,781)	(12,925)
Pay Costs	4,409	4,782	(373)	42,787	48,090	(5,303)
Non-pay Costs	1,475	1,665	(190)	15,697	16,226	(529)
Operating Expenditure	**5,884**	**6,447**	**(564)**	**58,484**	**64,316**	**(5,832)**
SURPLUS / (DEFICIT)	**1,919**	**(596)**	**(2,515)**	**16,222**	**(2,536)**	**(18,757)**
SURGERY						
Total Income	(5,497)	(4,535)	(962)	(54,503)	(37,426)	(17,077)
Pay Costs	3,405	3,252	153	34,077	35,931	(1,854)
Non-pay Costs	1,499	899	600	11,491	9,065	2,426
Operating Expenditure	**4,904**	**4,151**	**754**	**45,568**	**44,996**	**572**
SURPLUS / (DEFICIT)	**593**	**384**	**(209)**	**8,935**	**(7,570)**	**(16,505)**
WOMENS AND CHILDRENS						
Total Income	(1,928)	(1,423)	(505)	(19,706)	(16,696)	(3,010)
Pay Costs	1,459	1,368	90	14,387	14,333	54
Non-pay Costs	165	189	(23)	1,708	1,870	(162)
Operating Expenditure	**1,624**	**1,557**	**67**	**16,094**	**16,202**	**(108)**
SURPLUS / (DEFICIT)	**304**	**(134)**	**(438)**	**3,612**	**494**	**(3,118)**
CLINICAL SUPPORT						
Total Income	(721)	(617)	(104)	(8,130)	(6,402)	(1,727)
Pay Costs	2,015	2,008	7	17,584	17,211	374
Non-pay Costs	1,018	1,237	(218)	10,800	12,129	(1,328)
Operating Expenditure	**3,034**	**3,244**	**(211)**	**28,385**	**29,339**	**(955)**
SURPLUS / (DEFICIT)	**(2,312)**	**(2,627)**	**(315)**	**(20,255)**	**(22,937)**	**(2,682)**
COMMUNITY SERVICES						
Total Income	(3,521)	(3,540)	18	(35,129)	(35,220)	91
Pay Costs	2,548	2,663	(115)	25,398	26,196	(798)
Non-pay Costs	1,074	1,332	(259)	9,913	12,438	(2,525)
Operating Expenditure	**3,622**	**3,996**	**(373)**	**35,311**	**38,634**	**(3,323)**
SURPLUS / (DEFICIT)	**(101)**	**(456)**	**(355)**	**(182)**	**(3,414)**	**(3,232)**
ESTATES AND FACILITIES						
Total Income	(434)	(195)	(239)	(4,339)	(2,023)	(2,316)
Pay Costs	902	962	(59)	9,014	9,439	(425)
Non-pay Costs	626	729	(103)	6,263	6,626	(363)
Operating Expenditure	**1,528**	**1,690**	**(162)**	**15,277**	**16,065**	**(787)**
SURPLUS / (DEFICIT)	**(1,094)**	**(1,495)**	**(401)**	**(10,938)**	**(14,042)**	**(3,103)**
CORPORATE						
Total Income	(4,746)	(8,967)	4,221	(53,095)	(89,251)	36,156
Pay Costs	1,503	1,522	(19)	17,201	15,115	2,086
Non-pay Costs	1,559	1,489	70	23,362	14,025	9,336
Capital Charges and Financing Costs	993	1,032	(40)	9,927	10,107	(179)
Operating Expenditure	**4,054**	**3,011**	**1,044**	**50,489**	**29,140**	**21,349**
SURPLUS / (DEFICIT)	**692**	**5,956**	**5,264**	**2,606**	**60,111**	**57,505**
TOTAL						
Total Income	(24,649)	(25,128)	478	(249,608)	(248,799)	(808)
Pay Costs	16,241	16,557	(316)	160,448	166,315	(5,866)
Non-pay Costs	7,416	7,539	(123)	79,233	72,378	6,855
Capital Charges and Financing Costs	993	1,032	(40)	9,927	10,107	(179)
Operating Expenditure	**24,650**	**25,128**	**(478)**	**249,608**	**248,799**	**809**
SURPLUS / (DEFICIT)	**(0)**	**(0)**	**0**	**(0)**	**0**	**(0)**

Page 9

Medicine (Sarah Watson)

The division is behind plan by £2,515k in month (£18.8m YTD).

Clinical income is behind plan in month by £1.64m and £12.6m YTD. This continues to be driven by the reduced activity against plan across the Trust as a result of COVID 19 and is witnessed in medicine across all types of activity (elective, non-elective & outpatient). It is noted that this loss of divisional income is offset within the Corporate division due to the guarantees over the block contract.

The significant change in operating models necessary to cope with wave 1 of the COVID-19 Pandemic brought with it a significant and immediate reduction in activity levels across Medicine in March 2020. From April to November 2020, we have been recording that this reduction between anticipated and actual activity has been narrowing. However, as a result of the Trusts decision in December to pause non-urgent procedures and face to face outpatient appointments in response to Wave 2, the gap between anticipated and actual activity for both Elective and Outpatient activity is now increasing. Elective activity is now 39% behind plan (December 34%) and Outpatient activity is 15% behind plan (December 14%).

Non-Elective Activity had already been reducing as a result of the 2nd national lockdown in November 2020. This reduction in activity was further exacerbated by the impact of Wave 2 in early 2021 with the shortfall between planned and actual activity increasing to 27% (December 17%).

With the effect of Clinical Income removed, Medicine division is recording an adverse variance of £879k in month (£6.2m YTD). Continuous drivers of this variance are *identified* additional costs of COVID (£87k) and unmet CIP schemes (£187k). Other factors driving this include:

- Overspends in Oncology and Rheumatology for Drugs (£106k)
- One-off spend of £49k for tele-Derm services in month.
- Increased additional sessions (£51k above budget in month) and temporary medical staffing, both registrar and Junior Drs in month (£170k).

The division has recorded £10.6m of expenditure towards COVID YTD, £3.65m is a result of additional costs being incurred due to COVID, £5.0m is using existing resources (e.g. medical wards) solely towards COVID. The remaining £1.9m is recognising the CIP schemes that are unable to be met due to COVID.

Surgery (Simon Taylor)

The division is behind plan by £209k in month (£16.5m year to date).

COVID has had a major effect on Surgery's income, due to pausing significant elective activity to support the treatment of COVID patients. As a result Surgery underachieved the income plan by £962k in month (£17.1m YTD).

Pay was underspent by £153k in month (overspent by £1.9m YTD) due to temporary staffing to support COVID pressures.

Non-pay has underspent by £600k in month (£2.4m YTD) due to the lower levels of activity using fewer consumables.

Due to the effect of COVID some of the divisions CIP schemes will not be achievable, until normal service is possible.

Women and Children's (Michelle O'Donnell)
In January, the Division reported an adverse variance of £438k (£3,118k YTD).

The second COVID peak has depressed in-month inpatient and outpatient activity. COVID has depressed activity with low levels of elective activity in Gynaecology and low levels of non-elective activity in Paediatrics. Consequently, income is behind plan by £505k in January (£3.0m YTD).

Pay reported a £90k underspend in-month (£54k YTD). This is due to vacancies within maternity services

Non-pay reported a £23k overspend in-month (£162k YTD). Non-pay costs were high in-month as the Maternity service purchased funded equipment as a result of a Local Maternity System initiative.

Clinical Support (Michelle O'Donnell)
In January, the Division reported an adverse variance of £315k (£2,682k YTD).

Income for Clinical Support reported £104k behind plan in-month (£1.7m YTD). In-month, activity from outpatient radiology, direct access radiology and breast screening dipped as the second wave of COVID took effect. Overall activity has increased from the start of the year as the department has overcome many of the COVID related capacity constraints.

Pay reported a £7k underspend in-month (£374k YTD). In-month, COVID support initiatives in Radiology and Pathology caused the overspend. Year to date, it has been difficult to fill vacancies in Radiology, Outpatients and Pharmacy.
Non-pay reported a £218k overspend in-month (£1,328k YTD).The vast majority of the in-month and year to date overspend relates to COVID recovery expenditure with private sector suppliers.

Community Services (Michelle Glass)
The division reports an in-month over spend of £355k (£3.2m YTD)

Income reported an over recovery of £18k in month (£91k YTD). Where income is linked to a cost and volume contract, the division will continue to track and forecast the impact of COVID on the activity levels.

There was an in-month over spend on pay of £115k (£798k YTD). The overspend was incurred to support the division's response to COVID and the division has a favourable underlying pay variance without COVID costs. The division is utilising agency staff to cover some vacant roles in Integrated Therapy services as well as to provide a peripatetic team of nurses operating across the Community Health Teams and additional staffing to support winter beds in the community. This resource will continue to be required until the end of the financial year to ensure capacity is in place to meet increasing demand for community services, including some double up care.

Non-pay reported an adverse variance of £259k in January (£2,525k YTD). This primarily reflects delays in the delivery of some CIP schemes due to the impact of COVID, additional costs incurred to support the Division's COVID response and an overspend on Community Equipment. Additional community equipment costs have been incurred to provide the equipment needed to enable timely hospital discharges, including an increase in same day and out of hours deliveries and to support more than a doubling of discharges through Pathway 1 this year. Additional community equipment costs have been incurred to support end of life patients to remain at home in line with the revised end of life patient strategy and to provide community equipment for additional external bed capacity

COVID recovery planning and linked service transformation is being used to inform the forecast; whilst some additional costs will be incurred to support our response and winter planning, we also anticipate our learning from COVID to create opportunities for the cost improvement programme, which will be developed for 2021/22.

FINANCE AND WORKFORCE REPORT – January 2021

Statement of Financial Position at 31 January 2021

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2020	Plan 31 March 2021	Plan YTD 31 January 2021	Actual at 31 January 2021	Variance YTD 31 January 2021
	£000	£000	£000	£000	£000
Intangible assets	40,972	48,986	46,824	44,697	(2,127)
Property, plant and equipment	110,593	142,614	134,176	126,403	(7,773)
Trade and other receivables	5,707	6,366	6,366	5,707	(659)
Total non-current assets	**157,272**	**197,966**	**187,366**	**176,807**	**(10,559)**
Inventories	2,872	3,000	3,000	3,055	55
Trade and other receivables	32,342	18,000	18,000	18,076	76
Cash and cash equivalents	2,441	2,005	20,005	27,104	7,099
Total current assets	**37,655**	**23,005**	**41,005**	**48,235**	**7,230**
Trade and other payables	(33,692)	(30,838)	(29,426)	(37,094)	(7,668)
Borrowing repayable within 1 year	(58,529)	(3,200)	(3,200)	(4,864)	(1,664)
Current Provisions	(67)	(70)	(70)	(68)	2
Other liabilities	(1,933)	(2,000)	(22,000)	(24,875)	(2,875)
Total current liabilities	**(94,221)**	**(36,108)**	**(54,696)**	**(66,901)**	**(12,205)**
Total assets less current liabilities	**100,706**	**184,863**	**173,675**	**158,141**	**(15,534)**
Borrowings	(52,538)	(51,358)	(52,622)	(51,458)	1,164
Provisions	(744)	(750)	(750)	(741)	9
Total non-current liabilities	**(53,282)**	**(52,108)**	**(53,372)**	**(52,199)**	**1,173**
Total assets employed	**47,424**	**132,755**	**120,303**	**105,942**	**(14,361)**
Financed by					
Public dividend capital	74,065	164,063	150,059	132,553	(17,506)
Revaluation reserve	6,942	6,900	6,900	6,942	42
Income and expenditure reserve	(33,583)	(38,208)	(36,656)	(33,553)	3,103
Total taxpayers' and others' equity	**47,424**	**132,755**	**120,303**	**105,942**	**(14,361)**

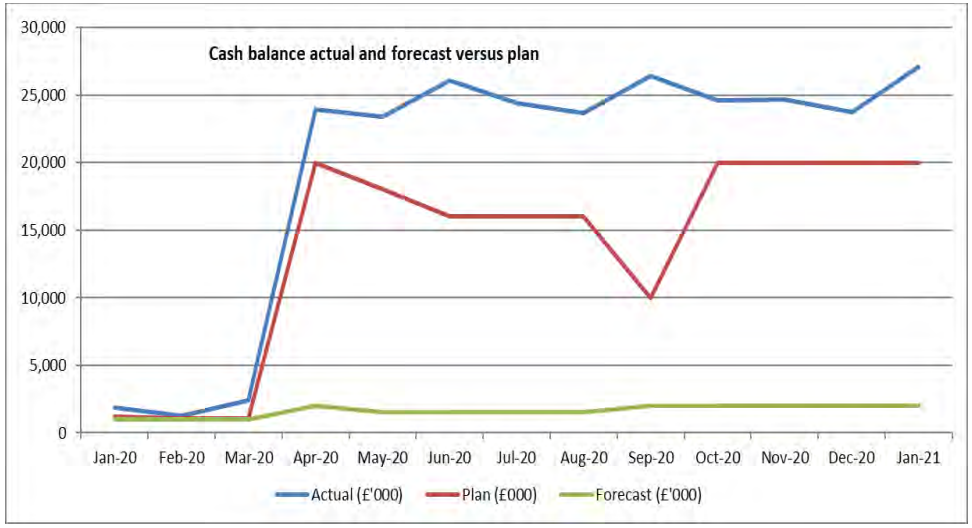
There have been no significant movements in the Balance Sheet since the previous month. Capital is showing as being slightly below plan and work is currently being undertaken to review the capital forecasts to ensure that the capital programme remains on track for the year.

Contract payments continue to be received in advance during the current pandemic. These receipts are shown against other liabilities.

Public dividend capital (PDC) continues to be drawn down to support our capital programme and will all be drawn by the year end. The plan includes over £9m of PDC that we were expecting to draw in relation to the planned project for ED, however this project has been put on hold and therefore the PDC relating to this project will not be drawn down.

Cash Balance Forecast for the year

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



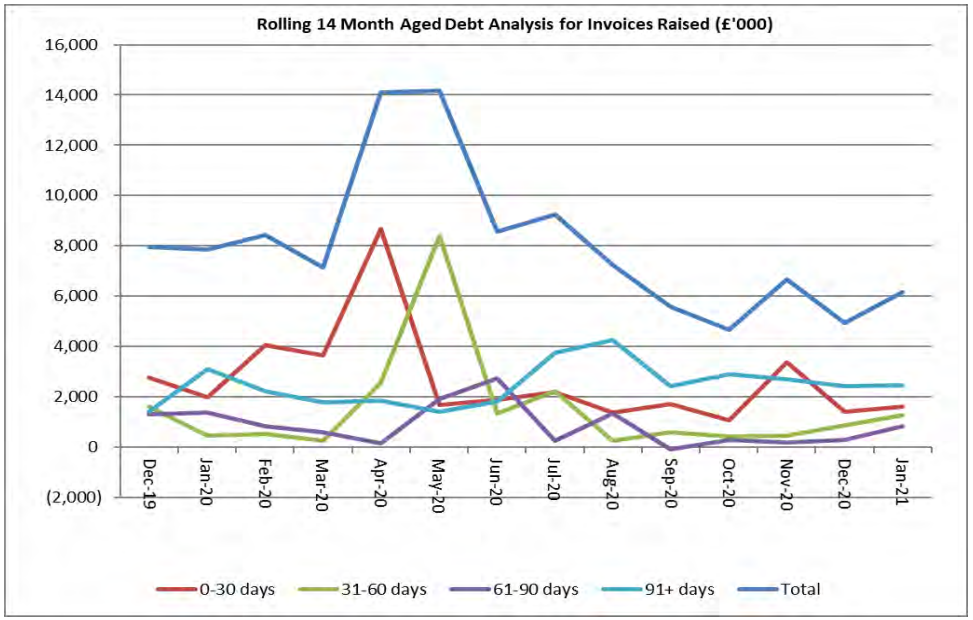
The cash balance has increased significantly and this is due to the current cash regime within the NHS. Contract payments have been paid in advance to ensure that there are adequate cash balances across the NHS and to ensure that payments to suppliers can be made quickly to keep the supply chain in full flow.

Contract payments will not be made to us in March as the Trust has in effect already received the March income through the advanced payments. Therefore there is a requirement to continuously monitor the cash position on a daily basis. Cash flow forecasts are required to be submitted to NHS England every fortnight to ensure that adequate cash reserves are being held within the NHS. Based on current forecasts, the Trust will not require any revenue support during 2020/21. Capital support will be required to support the Capital Programme and this will be received as PDC.

FINANCE AND WORKFORCE REPORT – January 2021

Debt Management

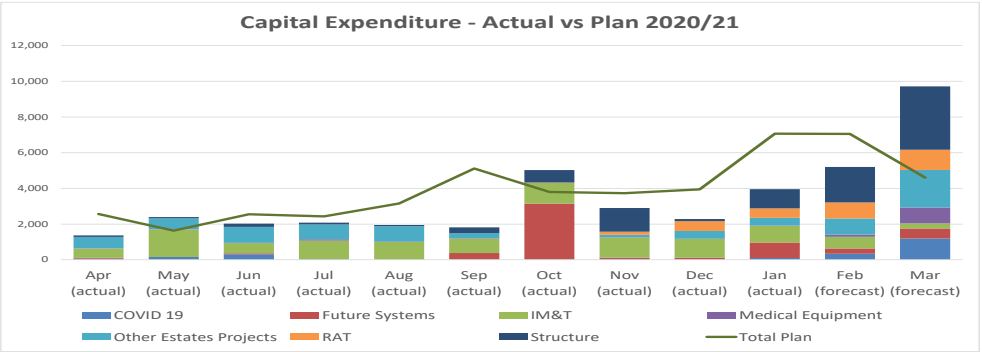
The graph below shows the level of invoiced debt based on age of debt.



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

The overall level of sales invoices raised but not paid has remained stable, with a slight increase as at the end of month 10. The large majority of the debts outstanding are historic debts. Over 77% of these outstanding debts relate to NHS Organisations, with 36% of these NHS debts being greater than 90 days old. We are actively trying to agree a position with the remaining corresponding NHS Organisations for these historic debtor balances.

Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Actual £'000	Aug Actual £'000	Sep Actual £'000	Oct Actual £'000	Nov Actual £'000	Dec Actual £'000	Jan Actual £'000	Feb Forecast £'000	Mar Forecast £'000	Total 2020-21 £'000
COVID 19	58	153	305	32	10	17	16	46	26	103	335	1,194	2,295
Future Systems	51	2	62	3	0	364	3,138	78	90	865	302	557	5,512
IM&T	520	1,541	568	1,037	988	813	1,156	1,118	1,048	934	653	289	10,665
Medical Equipment	16	16	16	75	27	16	27	16	16	16	125	887	1,253
Other Estates Projects	639	610	895	838	852	285	0	139	436	433	901	2,110	8,138
RAT	0	0	0	0	0	4	1	177	550	529	900	1,132	3,293
Structure	83	69	178	95	74	315	686	1,328	113	1,080	1,984	3,551	9,556
Total / Forecast	1,367	2,391	2,024	2,080	1,951	1,814	5,024	2,902	2,279	3,960	5,200	9,720	40,712
Total Plan	2,562	1,632	2,546	2,430	3,151	5,113	3,799	3,734	3,945	7,063	7,053	4,608	47,636

The initial capital budget for the year was approved at the Trust Board Meeting in January 2020. The capital programme is under constant review and there have been a number of amendments made since it was approved.

The Coronavirus pandemic has had a significant impact on the capital programme both in terms of the items on the capital programme and the timing. The ED scheme is now being deferred indefinitely and the decant ward has been delayed; these are the main reasons for the reduction in the forecast capital expenditure figure. However, expenditure on the new hospital has been forecast the figures include the purchase of Hardwick Manor. The prime focus of the programme has been to support the Coronavirus response with significant expenditure on medical equipment, building works and IT including greater provision of home working. The figures shown are as submitted to NHSI these have remained unchanged since the previous month. Meeting the forecast will be challenging with pressures on both the Estates team and IT that will prove difficult. The reporting categories for the table and graph have been reassessed to reflect the major projects that are being undertaken in the year.

10:40 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

Comfort Break - 10 minutes

13. People and organisational development (OD) highlight report

To APPROVE a report

For Approval

Presented by Jeremy Over

Board of Directors – Friday 26 February 2021

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

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

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

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

- Putting You First Awards
- Our WSFT People Plan – action tracker
- Just and learning culture – progress in HR services
- Consultant appointments

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

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

Previously considered by:	N/A

Putting you first

Risk and assurance:	Research demonstrates that staff that feel more supported will provide better, higher quality and safer care for our patients.
Legislation, regulatory, equality, diversity and dignity implications	Certain themes within the scope of this report relate to legislation such as the Equality Act, and regulations such as freedom to speak up / protected disclosures.
Recommendation:	For information and discussion. Feedback is sought from the Board as to the future content and frequency of this report.

Putting You First – February awards

Newmarket Community Hospital portering team: Steve, Dom, Graham and Dave

Steve, Dom, Graham and Dave became the newly-founded portering team at Newmarket Community Hospital last year. They have fully embraced this role and made it their own. They have built relationships across the site with various teams and picked up the ways each area works. They have made the role of porters really work – nothing is too much trouble for this friendly happy bunch.

We really appreciate all they have done, their help and presence on site. They even decorated the patient's courtyard for Christmas.

They fully deserve recognition for establishing this role and their positive can-do attitude.

Gary Ingalla

After some concerns were raised that Filipino staff members might be reluctant to receive the Covid-19 vaccination, I contacted Gary Ingalla for advice.

Even though on annual leave, he was his usual helpful and charming self and willing to help. In fact he then spent a significant amount of time contacting Filipino colleagues and posting on relevant social media groups to encourage vaccination.

This kind of leadership is exactly what Gary is famous for, but this is obviously above and beyond the requirement of his role and I feel it should be recognised.

Our West Suffolk People Plan - "What Matters" to our staff

Following on from last month's board report we continue to focus on the five WMTY themes:

- WMTY 1: Promote the value of great line management
- WMTY 2: Creating an empowering culture
- WMTY 3: Build relationships and belonging at WSFT
- WMTY 4: Appreciating All Staff
- WMTY 5: The Future and Recovery

As agreed at the previous Board meeting, an action tracker to monitor the various activities that form the first phase of the People Plan has been developed and is attached as an appendix to this report. This takes us to April 2021.

In common with the national People Plan, we have focused our plans on what is needed right now, in response to the pandemic and its unprecedented impact on staff and teams.

The What Matters to You work identified some medium-term priorities also, and these are indicated in the action tracker for April 2021 onwards. It is recommended that further refinement of these actions takes place in light of the learning from the staff survey results for 2020, which should be forthcoming within the next month. We plan to share the results with staff and seek their views and interpretation of the results, to ensure that the ensuing actions are the ones that are most relevant and responsive.

Comments and feedback in relation to the action tracker are welcomed. It is anticipated that oversight of the People Plan and its ongoing development and delivery fall within the scope of the new Involvement Committee, which is anticipated to be established in the near future (following a hiatus caused by the pandemic).

Our Just Learning journey – progress in HR services

Whilst the impacts of working during Covid-19 have continued to influence progression with this priority, the HR service has taken steps forward with actions and planned activity to embed this culture change and the way that we manage employee relation issues across the trust.

A review of HR policies has commenced, starting with the Disciplinary Policy, with a change of emphasis on pre-investigation and informal resolution and learning, with language used reflective of supportive, kind and compassionate approach. Agreement of this first policy and commitment to the just and learning approach will set the template for the review and development of other HR policies and the template letters that sit alongside each process, to ensure that the tone and language is supportive to the individual. Integral to the change is the role of the learning reviewer role and an agreed feedback mechanism for learning recommendations.

A pre-investigation assessment toolkit will be formally introduced to sit alongside HR policies and be used at the first stage to review all employee relations cases to determine from the outset whether it is appropriate for the case to be dealt with formally, with the objective that the best outcome where possible is informal resolution. This approach is already being promoted and reflected in the coaching conversations with managers in relation to the management of employee issues and has resulted in a reduction in formal cases. In addition, the Deputy Director of Workforce is currently using this approach to review all cases and this has resulted in a number of cases being dealt with successfully at the informal stage. Submission of monthly tracker report of open and closed cases will be provided to the Board from April 2021 onwards.

The group of ten individuals who have been benefitting from the training provided by Mersey Care NHS Trust and Northumbria University will complete the programme at a final event during the last week of February.

Recent Consultant Appointments

Post:	Consultant Medical Microbiologist
Interview:	22 January 2021
Appointee:	Dr Gillian Urwin
Start date:	1 February 2021
Current post:	Locum Consultant West Suffolk NHS Foundation Trust: October 2020 - present
Previous Position:	*July 1996 – October 2020* Consultant Microbiologist: East Suffolk and North Essex NHS Foundation Trust

Post:	Consultant Medical Microbiologist
Interview:	22 January 2021
Appointee:	Dr Beverley Palmer
Start date:	TBC
Current post:	Consultant Microbiologist East Suffolk and North Essex NHS Foundation Trust: August 2018 - present
Previous Position:	*February 2014 – July 2016, and January 2017 – July 2018* Locum Consultant Microbiologist: Cambridge University Hospitals NHS Foundation Trust

Post:	Consultant Physician in Stroke Medicine (8 PAs WSFT / 2 PAs CUH)
Interview:	11 February 2021
Appointee:	Dr Juliana Delos Reyes
Start date:	TBC
Current post:	Specialist Registrar in Geriatric Medicine James Connolly Memorial Hospital, Dublin: July 2020 - present
Previous Position:	*August 2018 – July 2020* Stroke Clinical Fellow: Cambridge University Hospitals NHS Foundation Trust

Jeremy Over
Executive Director of Workforce & Communications
February 2021

NHS
West Suffolk
NHS Foundation Trust

What Matters to our Staff: Our WSFT People Plan actions

To April 2021 and beyond

Putting you first

What Matters to our staff – 5 themes

1. The importance of great line managers
2. Creating an empowered culture
3. Building relationships and belonging
4. Appreciating all of our staff
5. The future and recovery

WMTY1: The importance of great line managers

NHS West Suffolk NHS Foundation Trust

Actions for October 2020 to April 2021

Why it matters: We saw and heard lots of examples of great line managers and how they kept their staff informed and supported during COVID. The positive impact a good manager can have on staff and the value they bring is clear. We want to help every line manager to be great

Action	Lead	Start	End	Status
Use staff survey results to have conversations with staff about what great line management looks like for WSFT (including what it isn't)	CS/ DP	Mar '21	Jun '21	Planned
Develop and promote a shift brief / debrief checklist for managers, to support great leadership, teamwork and staff well-being	SD/ EB	Feb '21	Feb '21	Complete
Promote the use of 360 feedback – executive directors to role model this	JO	Jan '21	Mar '21	In progress
Implement the HR business role to help support and coach line managers	CS	Jun '20	Nov '20	Complete
Review flexible working policy and enhance carer's leave – to support managers to support their staff	CS	Nov' 20	Apr '21	In progress
Review current arrangements for line management support of consultant and SAS-grade medical staff and options for the future	JO / NJ	Mar '21	May '21	Planned

Beyond April 2021:

- Listen to what support managers need and feed into our plans
- Review our training and development offer for current and future line managers
- Considering how 'well-being discussions' with staff (as proposed in the national People Plan) should be embedded at WSFT

WMTY2: Creating an empowered culture

NHS West Suffolk NHS Foundation Trust

Actions for October 2020 to April 2021

Why it matters: You have told us it can feel like a 'top down' culture in the organisation currently, where subject matter experts feel unable to influence what we do. This is not how we want the organisation to feel

Action	Lead	Start	End	Status
Focus on culture change at 5 o'clock club sessions during Autumn 2020/Winter 2021 period (Just Culture; Civility Saves Lives; Speaking Truth to Power)	DP	Sep' 20	Feb '21	Complete
Train a core group in principles and practice of restorative just culture	JO	Nov '20	Feb '21	Ongoing
Pause and review current HR cases to ensure all informal options to resolve have been explored	CS	Oct '20	Dec '20	Complete
Implement board tracker for HR cases to improve visibility	CS	Feb '21	Apr '21	Ongoing
Implement co-produced new organisational oversight arrangements for quality, safety and governance (3 I's)	RJ	Aug '20	Mar '21	Ongoing
Strengthen the capacity of the role of Freedom to Speak Up Guardian at WSFT	JO	Jul '20	Nov '20	Complete
Undertake a refreshed Board self-assessment of FTSU culture	JO	Feb '21	Mar '21	Ongoing

Beyond April 2021:

- Work with Speak Up Guardians to improve confidence and psychological safety in reporting
- Support individual teams benefit from the 'civility saves lives' learning, working in partnership with human factors team
- Review of all supporting letters and documentation to ensure reflective of just culture approach
- Support managers in the adoption of revised HR policies which incorporate just culture principles
- Monitor and evaluate the changes to organisational oversight (3 I's)

WMTY3: Build relationships & belonging at WSFT

NHS West Suffolk NHS Foundation Trust

Actions for October 2020 to April 2021

Why it matters: We want WSFT to feel inclusive for everyone, especially for BAME colleagues – including making sure our leadership reflects our diversity. WMTY also showed that we need to do much more to bring acute and community together so that we create a single organisation and culture. There are still clear divides between these two parts of WSFT.

Action	Lead	Start	End	Status
Support our valued EU colleagues in relation to Brexit impact, including communication around the UK settlement scheme	CS	Sep '20	Jun '21	Complete
Ensure robust Covid-19 risk assessment processes in place for staff with provision of advice and support for shielding, redeployment and well-being	DP	Apr '20	Feb '21	Complete
Support the establishment and early development of a WSFT staff network for our BAME colleagues	DP / JO	Jun '20	Mar '21	Ongoing
Present the annual EDI report to Board of Directors	DP / JO	Oct '20	Oct '20	Complete
Monitor take-up of the Covid-19 vaccine by ethnicity, promote the benefits and support BAME colleagues with the information and assurance they need	NJ / JO	Jan '21	Apr '21	Ongoing
Following WMTY, undertake deeper listening and engagement with staff in Community Services	HB	Sep '20	Dec '20	Complete

Beyond April 2021:

- Agree plans for ensuring the Board and senior leadership reflect the diversity of WSFT workforce
- Take forward the wider lessons learned from Community Staff listening and engagement
- Participate in the national reciprocal (reverse) mentoring scheme for the NHS
- Review and adoption of the national civility and respect toolkit

WMTY4: Appreciating all of our staff

NHS West Suffolk NHS Foundation Trust

Actions for October 2020 to April 2021

Why it matters: You told us that we need to do more to make you feel appreciated, particularly for staff that are not working on the front line. You told us how much you appreciated the extra things we did to look after you during COVID. However not everyone was aware that they could access these things – and some staff felt excluded. We also need to do more to help our colleagues that are and have been shielding at home.

Action	Lead	Start	End	Status
Continue to support, grow and learn from our new staff psychology service	JO	Sep '20	Apr '21	Ongoing
Deliver Flu and COVID vaccination programmes for all our staff	NJ	Oct '20	Apr '21	Ongoing
Support staff working at home with access to technology and support around well-being	CB / JO	Apr '20	Apr '21	Complete
Learn from the 'Supporting Staff in Stressful Times' project work and implement recommendations	PM / JO	Oct '20	Apr '21	Ongoing
Monitor the impact of staff benefits implemented during pandemic and make recommendations for any future changes (hot drinks; parking etc..)	JO / CB	Apr '20	Apr '21	Ongoing
Increase staff rest areas to ensure the impact of social distancing is mitigated	HB	Dec '20	Feb '21	Complete
Establish new, more inclusive and interactive communication forums for staff	HD	Nov '20	Jan '21	Complete
Additional focus on well-being during early 2021: Love Yourself week; Abbeycroft partnership; Well-being Wednesdays	JO / HD	Feb '21	Mar '21	Complete

Beyond April 2021:

- Consider options for formally appreciating and celebrating the contribution of all staff, post-pandemic
- Continue to support the re-introduction of volunteer roles, as Covid-19 restrictions allow

WMTY5: The future and recovery

NHS West Suffolk NHS Foundation Trust

Actions for October 2020 to April 2021

Why it matters: You have told us that you are fearful of recovery and how we will return to old levels of activity when we have social distancing and PPE to factor in. And you have told us you are tired. You have also told us you would like to keep home working (for those that are able to do so)

Action	Lead	Start	End	Status
Provide 'what matters to you' support and facilitation to staff most affected by Covid-19 pressures	JO / SR	Jan '21	Mar '21	Ongoing
Support staff and teams to benefit from a recuperation phase as part of the reset from the pandemic	HB / JO	Feb '21	Apr '21	Ongoing
Consider the longer-term options and policy for supporting staff to work at home where this is possible / desired	JO	Feb '21	Apr '21	Ongoing
Consider how to build on the increased engagement and regular dialogue around workforce and staff support, generated through current weekly meeting	JO	Mar '21	Apr '21	Planned
Facilitate wider discussion of the 2020 staff survey results to ensure staff's views, ideas and priorities are heard (WMTY banner)	JO	Mar '21	Jun '21	Planned
Implemented the designated 'well-being guardian' role at WSFT as defined in the national People Plan	JO	Feb '21	Mar '21	Ongoing
Consult with divisions to agree support and trajectories for teams to recover key workforce activities (appraisal; mandatory training)	JO / HB	Feb '21	Mar '21	Ongoing

Beyond April 2021:

- Agreement of a co-produced, new 5-year strategy for WSFT
- Development of medium to long term workforce and education plans
- Develop longer-term People Plan informed by the staff survey results and feedback / discussion

14. Quality, safety and improvement reports

To APPROVE the reports

Presented by Susan Wilkinson and Nick Jenkins

14.1. Maternity services quality & performance report

For Approval

Trust Open Board – 26th February 2021

Agenda item:	14.1			
Presented by:	Sue Wilkinson, Executive Chief Nurse/ Karen Newbury, Head of Midwifery			
Prepared by:	Karen Newbury – Head of Midwifery/Rebecca Gibson Compliance Manager			
Date prepared:	February 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:

- Strategy update
- External assurance and oversight of CQC improvement plan
- National best practice publications and local HSIB reports
- Learning from incidents / learning from deaths
- Maternity Clinical and Quality dashboard **(**Annex A**)**
- Continuity of Carer progress (see Quality dashboard Annex A)
- Neonatal Nursing Staffing report (Annex B – CNST requirement)
- Perinatal Mortality Tool Quarterly Report (Reported separately to Closed Board)

Strategy update

A draft Maternity Quality and Safety Framework has been developed which will replace the Maternity Risk Management Strategy. It includes all aspects of Clinical Governance and it reflects the Trust's overarching policies and processes. The draft has been circulated to key Maternity staff for comment as well as being shared more widely with the wider Trust Safety and Quality teams. As part of this piece of work all groups and forums involved in Quality and Safety are reviewing their Terms of Reference to ensure that these are clear on the purpose, level of decision making, core membership and escalation of concerns.

It is now in its final development stage (ensuring the roles, responsibilities and committee structures are accurate) and includes the updated roles for the lead clinicians within Maternity and Obstetrics. The aim is now to finalise all internal sign-off by the end of February with a view to providing a copy to the CCG and NHSE for their information following the assurance visit

Ockenden

The review by Donna Ockenden of maternity care at The Shrewsbury and Telford Hospital NHS Trust identified a number of important themes which the report states must be shared across all maternity services as a matter of urgency including '*Local Actions for Learning*' and early recommendations stated as '*Immediate and Essential Actions*'.

https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf

Following Executive sign off and approval at LMS the Assessment & Assurance tool was submitted to NHSE on the 12th February 2021. We await feedback

External assurance and oversight of CQC improvement plan

In February the CCG and local stakeholders are undertaking an assurance visit. In addition the CQC are undertaking a nation-wide regulatory review of Maternity services according to their new framework (which takes into account restrictions on on-site visiting due to COVID). A proforma has been completed and submitted to the CQC in advance of the next local review call (these happen as standard on a monthly basis).

The outcome of both of these will be provided in next month's report.

National best practice publications and local HSIB reports

MBRRACE-UK provides a national reporting framework for the surveillance and investigating the causes of maternal deaths, stillbirths and infant deaths. Since the last Maternity Board report, no new reports have been issued

HSIB have now issued a number of maternity national learning reports. These collate the learning from multiple investigations and require consideration of their content alongside those issued for WSFT specific cases. National reports are more likely to contain safety recommendations for national bodies (e.g. the CQC) but the impact of these national recommendations will be relevant locally. To date HSIB have issued ten local reports for WSFT cases and the outcome of these have been presented locally in Maternity as well as within the Board quarterly quality & learning report (see separate board agenda item this month).

It is intended that the Maternity MBRRACE and HSIB action plans (which form part of the wider Maternity quality & safety improvement plan) will be monitored using the framework of the Improvement Board including the opportunity to demonstrate 'business as usual' when actions are fully embedded. The Maternity clinical audit programme for 2021/22 will provide a source of assurance as part of the wider quality & safety framework.

Learning from incidents / learning from deaths (LfD)

The LfD group is due to receive the annual perinatal mortality report in March 2021.

Maternity dashboard (see Annex A)

Indicators of maternity safety & quality are regularly reported and reviewed at monthly Maternity Governance meetings. A sub-set are provided for board level performance (the Performance & Governance dashboard). In January there were six indicators categorised as Red and none as Amber on our clinical dashboard (NB: RAG rating currently still based on National Maternity Perinatal Audit 2016/2017 data. There is an ambition to update all indicators to reflect more recent standards such as 'Saving Babies lives' care bundle v2 and that of the other units within our LMNS and this is in development as part of a regional project to develop a standard dashboard for all maternity units in the region.

The **Quality Dashboard** is also included. This gives assurance that the maternity service has a robust monitoring and auditing programme relating to quality and safety. The indicators include, appraisal completion, mandatory training overview, equipment safety checks, and audit results. The RAG rating has been determined by the department and purposely to reflect a small window of non-compliance. This will be reviewed once compliance is improved and embedding of changes is reflected. Longer term the plan is to move from RAG rating to a more SPC / 'plot the dots' style of reporting in line with the national NHSI model.

Indicators	Narrative
Total Women Delivered Total Number of Babies born at WSH Midwifery Led Birthing Unit (MLBU) Births	Variable month by month. With increased number of induction of labours this is affecting the number of women eligible to birth in the birthing unit
Inductions of Labour (ex pre-labour & twins)	With the full implementation of SBLCBv2 and an increase of gestational diabetes this is to be expected. This was exceptionally high in November, but within normal parameters in December

Indicators	Narrative
Supernumerary Labour Suite Co-ordinator	NHSI – Improvement Officer supporting workforce plans to resolve this issue.
Appraisal completion Mandatory training	Part of wider Trustwide improvement plans
Emergency equipment checks Smoking cessation / CO checks Domestic violence checks	Identified non-compliance is discussed at an individual level with clinicians including escalation to line manager any continued non-compliance. In addition an 'all Consultants' feedback session was provided in November
Swab count Drug chart completion	Compliance has remained low for December – new staff and CoC midwives. Further support regarding documentation to commence.
MLBU 'fresh ears' (documentation)	Quality assurance midwife lead working with the Birthing unit lead midwife on strategies to improve performance

LMNS Perinatal Quality Oversight Highlight Report

A new highlight report has been introduced across the region to enable LMNS (Local Maternity & Neonatal Systems) to demonstrate individual Trust's positions on key elements of safety and quality. The highlight report will enable comparison across the LMNS and to share learning.

Local audit / monitoring

Currently a report is submitted monthly to the CQC for the indicators highlighted within the Section 29A letter. Compliance has been high and any areas of non-compliance have been addressed and documented within the report. Results from January 2020 report are represented in our quality dashboard (see Annex A)

CNST Maternity incentive scheme

Now in its third year, the maternity incentive scheme supports the delivery of safer maternity care through a '10 steps to safety' framework underpinned by an incentive element to the trust's contributions to the CNST (clinical negligence scheme for trusts).

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

Other Maternity indicators including those incorporated elsewhere in board reporting schedule

- Maternity serious incidents in January - one

These are reported in the closed board 'serious incidents, complaints, claims and inquests' report on a monthly basis. This includes details of the incident, duty of candour status and whether it is reportable to the HSIB or for local investigation. Sadly, there was one SI reported in Maternity in January:

  - WSH-IR-66949 STEIS 2021/2366 Intrapartum stillbirth

As per protocol the case was reported to HSIB, MBRRACE and a local rapid review took place to identify if there were any learning points / issues for immediate action. The Perinatal Mortality Review Tool was also completed.

In discussion with improvement officer, CCG, CQC and Regional Chief Midwife it has been recommended that an external thematic review is commissioned for all maternity's serious incidents including HSIB cases for the last two years. All cases have been collated awaiting commissioning of external panel by executive board.

Neonatal Nursing Staffing Report (Annex B – CNST requirement)

This report recommends an overall small increase in the total number of staff, including Qualified In Speciality trained staff, however a robust staffing review is required first to take into account the impact of transitional care.

Perinatal Mortality Tool Quarterly Report (Closed Board – CNST requirement)

The report outlines the details of perinatal deaths occurring within the trust and the reviews and actions of theses from October 1st 2020- December 31st 2020 (Quarter 3). The report includes completed investigations from Quarter 2. There were three deaths reported for quarter three, one preterm stillbirth and two intrapartum stillbirths. Findings, learning points and areas of good practice have been identified however for the two intrapartum stillbirths the HSIB investigations are still ongoing. Outcomes of reviews and actions of perinatal deaths reported in Quarter 2 have been included with ongoing action plans.

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

Annex A – Maternity Clinical and Quality Dashboard

NHS West Suffolk NHS Foundation Trust

	Green	Amber	Red	Apr20	May20	Jun20	Jul20	Aug20	Sep20	Oct20	Nov20	Dec20	Jan20
Total Women Delivered	>208 or <216	>216 or <208	> 224 or <2 00	178	180	187	174	183	202	203	178	159	181
Total Number of Babies born at WSH	>208 or <216	>216 or <208	> 224 or <2 00	179	182	190	175	187	204	206	181	160	183
Twins		No target		1	2	3	1	4	2	3	3	1	2
Homebirths	2.5%	2% or less	Less than 1%	5 2.8%	7 3.9%	5 2.7%	3 1.7%	2 1.1%	6 3%	7 3.4%	4 2.2%	3 1.9%	6 3.3%
Midwifery Led Birthing Unit (MLBU) Births	≥20%	19- 15%	14% or less	3 1.7%	12 6.7%	26 13.9%	22 12.6%	20 10.9%	27 13.4%	26 12.8%	17 9.6%	17 10.7%	16 8.8%
Labour Suite Births	77.5%	69% - 74%	68% or less	170 95.5%	161 89.5%	154 82.4%	149 85.6%	161 88%	169 83.7%	170 83.8%	157 88.2%	139 87.4%	159 87.8%
Total Caesarean Sections	<26.%		> 26%	34 19.1%	36 20%	56 29.9%	46 26.4%	43 23.5%	48 23.8%	47 23.2%	39 21.9%	33 20.8%	47 26%
Total Elective Caesarean Sections	11%	>11% -13%	13% or more	14 7.9%	14 7.8%	23 12.3%	14 8%	20 10.9%	20 9.9%	18 8.9%	11 6.2%	10 6.3%	14 7.7%
Total Emergency Caesarean Sections	14.3%	14.4%-14.9%	15% or more	20 11.2%	22 12.2%	33 17.6%	32 18.4%	23 12.6%	28 13.9%	29 14.3%	28 15.7%	23 14.5%	33 18.2%
Total Instrumental deliveries	12% - 14%	>14% - 15%	> 15%	9.6%	10.6%	7.0%	8.6%	11.5%	14.9%	14.3%	10.1%	14.5%	13.3%
Inductions of Labour (ex pre labour & twins)	<31%	>31% -32.9%	>33%	39.9%	35%	32.6%	36.2%	39.3%	38.1%	38.9%	52.8%	36.2%	39.7%
Postpartum Haemorrhage 1500 mls or more	<3.5%	3.5% - 3.8%	> 3.8%	1.7%	1.1%	8%	4.0%	2.7%	2.5%	3.9%	2.8%	2.5%	2.8%
Shoulder Dystocia	2	3-4	5 or more	3	7	4	4	5	2	2	3	5	1
Unit Closures	0		1	0	0	0	0	0	1	0	0	0	0

West Suffolk NHSFT		MIDWIFERY SERVICE: QUALITY DASHBOARD									
QUALITY TOPIC		Denominators									
		RAG	GREEN	= Standard or above	AMBER	≥5% below standard	RED	> 5% belo			
STAFF SUPPORT & DEVELOPMENT											
Appraisal completion	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan
Midwives Hospital % in date	90%				94.0%	97%	97%	97%	100%	89%	82%
Midwives Community & ANC % in date	90%				83.0%	90%	80%	100%	98.50%	98.50%	95%
Support Staff Hospital % in date	90%				90.0%	90%	88%	84%	72%	76%	81%
Support Staff Community & ANC % in date	90%				100.0%	100%	No data	93%	91.50%	91.50%	91.5%
Medical Staff % in date	90%	Medical Staff appraisal suspended during Covid pandemic									
Mandatory Training Overview	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan
Midwives: % compliance for all training	90%		70.3%	74.8%	77.6%	78.3%	79.9%	80.1%	81.9%	92.2%	93.4%
Midwives: % compliance with PROMPT training	90%		52.7%	75.0%	75.9%	77.2%	81.4%	85.5%	93.3%	89.7%	86.4%
Midwives: % compliance with GAP training	90%			79.0%	91.0%	92.0%	98.0%	96.0%	96.0%	96.0%	96%
Midwives: % compliance with Safeguarding Children training	90%					99.3%	No data	99.0%	94.0%	94.0%	97%
Midwives: % compliance with Fetal Monitoring training	90%										68.6%
ANC Midwives: % compliance with Fetal Monitoring training											40%
MCA: % compliance for all training	90%		81.5%	83.2%	84.9%	85.6%	81.2%	85.7%	86.0%	92.8%	92.5%
MCA: % compliance with PROMPT training	90%		58.8%	72.2%	72.2%	72.2%	57.1%	65.0%	80.0%	83.3%	87.5%
MCA: % compliance with Safeguarding Children training	90%					99.4%	No data	100.0%	94.0%	91.0%	97%
Obstetric Medical Staff: compliance with PROMPT training	90%			70.0%	70.0%	73.3%	57.1%	69.6%	76.0%	79.2%	84%
Obstetric medical staff: % compliance with GAP training	90%			88.0%	83.0%	58.0%	92.0%	87.0%	83.0%	86.0%	83%
Obstetric Medical Staff: compliance with Safeguarding Children training	90%						No data	84.0%	50.0%	84.0%	90%
Obstetric Medical Staff: % compliance with Fetal Monitoring training											89.5%
Anaesthetic compliance with PROMPT training	90%						No data	50.0%	53.9%	53.9%	60%
Theatre staff compliance with PROMPT training	90%						No data	34.3%	47.4%	47.4%	50%
Sonographer: % compliance with GAP training	90%			93.0%	93.0%	79.0%	86.0%	79.0%	86.0%	93.0%	93%
EQUIPMENT SAFETY											
Checking of Emergency Equipment	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan
Labour Suite: Adult Trolley	100%			86%	100%	100%	100%	100%	100%	100%	100%
Labour Suite: Resuscitaires				73%	86%	76%	88%	96%	98%	97%	92%
Ward F11: Adult Trolley					97%	100%	97%	100%	100%	100%	100%
Ward F11: Resuscitaire					77%	84%	93%	97%	100%	100%	100%
MLBU: Resuscitaires	100%				95%	100%	93%	94%	97%	97%	96%
Community: Emergency Bags					89%	98%	95%	84%	82%	100%	96%
Checking of Fridge Temperatures	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan

Labour Suite	100%				97%	100%	100%	100%	93%	97%	97%
Ward F11					100%	100%	93%	100%	100%	97%	100%
MLBU					97%	100%	100%	100%	100%	100%	100%
ANC					100%	100%	100%	100%	100%	100%	100%
Ambient Room Temperature (where medication is stored)	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan
Labour Suite	100%				97.0%	100.0%	100%	100%	93%	97%	97%
Ward F11					100.0%	100.0%	97%	100%	97%	97%	1005
MLBU					97.0%	100.0%	100%	100%	100%	100%	100%
ANC					100.0%	100.0%	100%	100%	100%	100%	100%
Checking of CD's	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan
Labour Suite	100%				100.0%	98.0%	100%	100%	100%	100%	100%
Ward F11					100.0%	100.0%	97%	100%	100%	97%	100%
MLBU					97.0%	100.0%	100%	100%	100%	100%	100%

MONTHLY QUALITY & SAFETY AUDITS:

	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan
Supernumerary Status of LS Coordinator	100%				84%	74%	No data	83%	70%	91%	90%
1-1 Care in Labour	100%	97.4%	100.0%	100.0%	100.0%	100.0%	99.5%	100.00%	100%	100%	100%
MW: Birth Ratio	1:28	1:26	1:26	1:27	1:30	1:27	1:31	1:31	1:27	1:25	1:29
No. Red Flags reported				3	4	2	1	14	12	12	4
DOCUMENTATION & CARE AUDITS	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan
Compliance with MEOWS completion	100%			98.0%	99.5%	99.0%	99. 8%	99%	99.3%	99.40%	99.6%
Compliance with NEWTT completion	100%	97.0%	97.0%	96.0%	95.0%	99.0%	100%	100%	100%	97.50%	98%
Carbon Monoxide Monitoring											
Smoking at booking recorded	95%	Audit suspended due to Covid-19				100.0%	100%	100%	100%	100%	97.5%
Smoking at 36 weeks recorded	95%					45.0%	78%	74%	85%	97.50%	93%
Compliance with DV questions											
Antenatal period	100%					95.0%	100%	98%	98%	100%	98%
Postnatal period	100%					97.5%	95%	90%	80%	94%	90%

Swab Count Compliance											
Birth	100%				56.0%	85.0%	87%	93%	100%	73%	85%
Suturing	100%				54.0%	90.0%	87%	96%	92%	66%	78%
Compliance with completing WHO checklist @ CS	95%	No audit		93.0%	96.0%	96.0%	90%	96%	100%	96%	96%
Recording of Pain Score											
Labour Suite	100%					99.0%	100%	100%	98%	100%	100%
Triage						100.0%	100%	100%	100%	100%	100 %
MLBU						100.0%	100%	100%	100%	100%	100%
Ward F11						97.0%	100%	100%	98%	100%	100%
MDAU						100.0%	100%	100%	100%	100%	100%
Completed Drug chart information: weight and allergies	100%						7.00%	73%	76%	60%	48%
Fresh Eyes											
Labour Suite	100%						20%	100%	80%	100%	100%
Fresh Ears											
MLBU	100%					80.0%	50%	80%	88.80%	88%	89%
Epidural response <30 min	90%					92%	98%	87%	98%	Data per 1/4	Data per 1/4
Breast Feeding											
Total women delivered who breastfed their babies within the first 48 hrs	80%	76.7%	72.8%	80.7%	71.4%	79.2%	82.2%	81.8%	73.10%	77.8%	80.5%
Unicef baby friendly audits	10, 8, 6		0	0	0	0	40	0	0	0	9
LSCS decision to delivery time met											
Grade I LSCS	95%		100%	100%	100%	100%	91%	100%	None	100.0%	100%
Grade 2 LSCS	80%		81%	67%	95%	78%	83%	82.3%	68%	75%	58%
Neonatal Outcomes											
Mag Sulpate for preterm infats											
Pre-term infants bith in right place											
Continuity of Care Outcomes											
Women Booked onto the continuity pathway	Number									415	473
	%									18%	20.6%

Women who received 70% of care	Number									31	36
	%									1.30%	2.9%
Governance											
Oututstanding Datix (last day of the month)											
Out of date guidelines										0	0
Number of serious incidents										1	2

Annex B Neonatal Nursing Staffing report (CNST requirement)

See separate report attached

Neonatal Nursing Staffing Review – October 2020

Report Title	Assurance of Safe Nursing staffing standards in the NNU
Report for	Approval and Information
Report from	Maternity and Neonatal Services January to June 2020
Report Author	Sharon Farthing – Matron Paediatric Services. Beverley Gordon – Project Midwife. Karen Ranson- Neonatal Unit Manager.

1. Report Title

Neonatal Nursing Staffing Audit January to June 2020

2. Purpose of the Report

Monitoring of Neonatal Nursing staffing levels against BAPM standards and actions required as a result of the audit being completed using the Dinning tool.

3. Background

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

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

This safety action requires a review of obstetric, anaesthetic and Neonatal medical staff and neonatal Nursing staffing levels supporting Maternity Services.
This report concentrates on the Neonatal nursing standards expected in a Special Care Unit – level 1 Neonatal Unit.

The West Suffolk Hospital Neonatal Unit is a Level One Unit equipped to care for babies ranging from 30 weeks gestation to full term, according to their clinical conditions and needs. There are 12 cots, 1 Intensive care, 3 High Dependency Care and 8 Special Care. The designated Level Three Unit is Addenbrookes in Cambridge, a baby needing more intensive care is stabilised within the Unit, and transferred to the nearest Level Two or Three Unit via a designated transport service, The Acute Neonatal Transport Service. Once stable, the baby is transferred back for on-going care. We are supported and care is standardised by the East of England Neonatal Network, which encompasses the 17 Neonatal Units in the region of all levels.

The National Quality Board has provided a standardised tool – the Dinning tool – to monitor the nursing staffing levels in the unit against national standards for the local requirements. The BAPM standards (2011) have 2 different definitions of Intensive Care and High Dependency Care and both of these are assessed in the tool.

The safety element of this to ensure that the neonatal unit has the required numbers and experience of staff in post to safely nurse babies to the required standard. The Trust is required to ensure that there are safe staffing levels on the Neonatal Unit to manage the care of babies who require additional support after birth and to transfer in-utero or ex-utero babies who may need care and treatment outside the limitations of the unit.
It should be noted that there is no allowance for neonates being managed under the Transitional Care pathway within this tool and therefore this is an additional group of babies required oversight and care delivered by the NNU nursing staff.

4. Required Standards - Neonatal nursing

The neonatal unit meets the service specification for neonatal nursing standards. If these are not met, an action plan is in place and agreed at board level to meet these recommendations

Neonatal nursing workforce

The Trust is required to formally record to the Trust Board minutes the compliance to the service specification standards annually using the neonatal clinical reference group nursing workforce calculator. For units that do not meet the standard, an action plan should be developed to meet the standards and should be signed off by the Trust board and a copy submitted to the Royal College of Nursing (Fiona.Smith@rcn.org.uk) and Neonatal Operational Delivery Network (ODN).

The nursing establishment in the budget is usually set historically and based on the activity of the unit. The budget for this year was set on the number of posts in each band.
The band 5 nurses are given the opportunity to undertake the Qualified in Specialty (QIS) course after approximately 2 years of experience in a neonatal unit. The course takes about 1 year and requires a 12 week placement in a level 3 unit. The Unit used for this is Norfolk and Norwich University Hospital. There is a rolling programme to give all band 5 nurses the opportunity to undertake the course which runs from September each year. The Trust supports 2 nurses per year. Due to the Covid crisis, the course for staff for the 19/20 year has been suspended. Once the clinical placement can be undertaken the priority will be for the staff member on the current course to complete this. Currently 1 band 5 registered nurse is undertaking the course.
In addition, the band 3 nursery nurses can undertake a special care module within QIS in order to provide a higher level of care within transitional care. Currently 1 band 3 nursery nurse is undertaking this course.
The Unit has either a band 6 or band 7 shift leader. All of these staff are QIS. The shift leader is not currently supernumerary.

Declared Cots

DECLARED COTS	
NICU	1
HDU	3
SCBU	8

The number of cots and the breakdown of levels of care has not changed since changing from level 2 to level 1 unit.

Care Level Days

	CRITERIA	
CARE LEVEL DAYS 1st APRIL -30th SEPTEMBER 2015	BAPM 2001	BAPM 2O11
NICU		27
HDU		194
SCBU		807

NUMBER OF SHIFTS PER DAY	2

5. The Audit Process

The audit was originally undertaken 1st July 2020 and based on the unit activity and staffing levels for the period January to June 2020. The audit was undertaken by the Practice Development Nurse, Ward Manager & Matron. The results were generated electronically on the basis of the data submitted. The ODN requested that the tool was submitted to themselves for confirmation and verification of the data presented. They requested for this to be checked and information confirmed on the 16th September 2020.

The ODN have identified an error in the way that data on cot occupancy is reported on the tool and have therefore stated that these figures should be doubled.

6. Audit results

Current Unit Staffing – Direct Care Only

CURRENT UNIT STAFFING: DIRECT CARE ONLY			
		WTE BUDGET	WTE IN POST
BAND 7		0.32	0.32
BAND 6		12.28	10.88
BAND 5 QIS		0	1.12
BAND 5		7.12	6
BAND 4		1	1
BAND 3		1.64	1.64
TOTAL NUMBER OF NURSES		22.36	20.96
INDICATIVE BUDGET AT MID POINTS INCLUDING ON COSTS		£735,898	

These results indicate that there is a shortfall of 1.40 WTE between the budget and staff in post. Whilst there is no budget for band 5 nurses who have completed the QIS course, the staff in post at this level contribute to the shortfall in band 6 nurses. However, the band 5 QIS will not be a shift leader so the requirement is for the band 6 posts to be filled to ensure that there is adequate shift leader cover.
This includes the shift coordinator who is not currently supernumerary but does not include management and education hours for the ward manager and the PDN.

Occupancy Against Declared Cots ***

OCCUPANCY AGAINST DECLARED COTS				
	NICU	HDU	SCBU	TOTAL
BAPM 2001	0.00%	0.00%	0.00%	0.00%
BAPM 2011	7.40%	17.72%	27.64%	23.47%
COTS REQUIRED AGAINST ACTIVITY AT 80% OCCUPANCY				
	NICU	HDU	SCBU	TOTAL
BAPM 2001	0	0	0	0
BAPM 2011	0	1	6	7
DIFFERENCE TO DECLARED COTS @ BAPM 2001	-1	-3	-8	-12
DIFFERENCE TO DECLARED COTS @ BAPM 2011	-1	-2	-2	-5

ODN have indicated that there is an error with the calculations for cot occupancy and these should be doubled. This suggests that the cot occupancy is **46.94%** for this period of time.

The data does not consider any babies having transitional care either in the unit or on the wards which accounts for approximately 17% of babies born each year.

The occupancy in the neonatal unit does not reflect any transitional care (TC) activity either on the ward or in the Special Care unit and admissions from home to TC. This accounts for approximately 28 % of babies admitted to the Neonatal Unit each year. The following table breaks down the figures for TC and the bed days.

There is an expectation that cot occupancy will be around 70%. Figures show that the cot occupancy has exceeded this figure in 6 out of the last 8 months.

	January	February	March	April	May	June
Number of babies in TC	13	16	20	19	22	20
Bed days	33	42	64	44	48	44
Number of babies admitted from home	18	1	7	2	10	9
Bed days	37	2	15	4	20	18
TOTAL	31	18	27	21	32	29
TOTAL Bed days	70	44	79	48	68	62

Include staffing model should be a ratio of 1:4 Care of the baby should be overseen by a registered nurse whilst the mother is cared for by the midwife and maternity support staff. Joint working is in place to ensure care is delivered according to guidelines.

Nursing Staff against toolkit

NURSE STAFFING AGAINST TOOLKIT		
	BAPM 2001	BAPM 2011
WTE REQUIRED AGAINST ACTIVITY	6.62	20.33
WTE POSITION AGAINST BUDGET	15.74	2.03
BUDGET POSITION	£493,053	£76,505
WTE POSITION AGAINST IN POST	14.34	0.63
CURRENT QIS/REG	63.89%	
CURRENT REG/TRAINED	88.19%	

This is the current situation and indicates a shortfall of 0.63 of staff in post required for the activity and acuity of babies but does not account for care of Transitional Care babies.

Suggested Skill Mix – Direct Care Only

SUGGESTED SKILL MIX: DIRECT CARE ONLY			
	BAPM 2011		WTE CHANGE
BAND 7	0.74		0.42
BAND 6	7.90		-4.38
Band 5 QIS	5.22		5.22
BAND 5	3.90		-3.22
BAND 4	2.58		1.58
BAND 3	0.00		-1.64
TOTAL NUMBER OF NURSES	20.33		0.42
QIS/REG	78.03%		
REG/TRAINED	87.30%		

There is a suggested increase of 0.42 in the overall number of staff to provide direct care.
There are suggested differences in the number of staff at each grade and experience e.g. a difference of 0.42 in the WTE number of band 7's required but indicates that less band 6 nurses are required (-4.38).
The shift coordinators are either band 6 or band 7 nurses and are currently not supernumerary. Additional band 6 hours are being advertised in order to work towards this being possible at least some of the time. This would lead to increased assurance of safe staffing levels when staff need to attend high risk births, allow the ward manager to participate in governance forums such as meetings, audits, case reviews, responding to urgent requests for updates and service developments and needs and to ensure that mandatory training and competencies are being met by all the relevant staff. This would also provide some additional support during escalation of activity or acuity when required.

It suggests that there should be more band 5 QIS and less band 5 nurses. However, due to the QIS training of the band 5's being limited to a small number per year, the current figures would reflect a progressive increase in the number of staff completing the QIS training and succession planning. It takes around a year for the QIS training to be completed and it involves the staff being at a level 3 unit for 3 months.

The results suggest an increase in the number 63.89% to 78.03% for staff having completed the QIS course and the overall number of registered or trained staff to be slightly changed from 88.19% to 87.30% with a suggested increase in the number of band 4 staff delivering direct care rather than being a band 3. However, the unit uses the band 3 nursery nurses effectively and it is not anticipated that this situation requires a change at this current time.

There is currently an advert out to recruit a band 6 registered QIS trained nurse (1.0 WTE).

7. Summary of findings

The findings of the toolkit indicate that the cot occupancy is just under 50% in this period of audit although the number of babies does not take into account the neonates having Transitional Care who are still under the care of the neonatal nurses. With the continued aim to reduce Term admissions to the Neonatal Unit,

this should not be ignored when calculating the number of staff who are required to deliver direct care. An overall small increase in the total number of staff and QIS trained staff is suggested. However, when taking into account the TC work, a more robust staffing review is required and consideration needs to be given to having a supernumerary shift leader as well.
Recommended occupancy for NNU from NHS toolkit 2009 Quality - is 70%. Figures show that in 6 out of the last 8 months, occupancy has exceeded this.

8. Recommendations

- There should be a review of the staffing levels and skill mix to enable this to reflect the activity and acuity going forward.
- Allowance should be made for staffing of TC and enabling staff to complete QIS.
- It will be a challenge to predict future demands, recruitment, and retention of staff whilst having a historical workforce in established posts. However, due to the length of time needed to train and obtain QIS competence and training, the budget should reflect future proofing for safe staffing levels.
- The review should be confirmed by the ODN to ensure that the findings of the toolkit have been applied appropriately
- An action plan should be formulated and agreed by all interested parties and submitted to the Divisional Management team for approval prior to submission to the Trust Board.
- Complete Dinning tool or equivalent each year and report on findings to reflect staffing needs and budget setting.

9. Action Plan

Project title	*Neonatal Nursing Staffing*

Action plan lead	Name: Sharon Farthing	Title:	Contact:

Recommendation	Actions required	Action by date	Person responsible	Comments/action status
There should be a review of the staffing levels and skill mix to enable this to reflect the activity and acuity going forward. - Allowance should be made for staffing of TC and enabling staff to complete QIS. - It will be a challenge to predict future demands, recruitment, and retention of staff whilst having a historical workforce in established posts. However, due to the length of time needed to train and obtain QIS competence and training, the budget should reflect future proofing for safe staffing levels.	Staffing review to be undertaken utilising the information from this tool. To include future succession planning.	31/1/21	Sharon Farthing/Karen Ranson/ Ops Lead	
An action plan should be formulated and agreed by all interested parties and submitted to the Divisional Management team for	Report and action plan to be submitted to Child Health for approval and Maternity Governance for information prior to submission to Divisional Board for escalation to Board	31/12/20	Sharon Farthing/Karen Ranson/	

approval prior to submission to the Trust Board.				
The review should be confirmed by the ODN to ensure that the findings of the toolkit have been applied appropriately.	Report to be submitted to ODN for review and confirmation of findings	31/12/20	Sharon Farthing/Karen Ranson/	
Complete Dinning tool or equivalent each year and report on findings to reflect staffing needs and budget setting.	Repeat staffing tool assessment July 2021 and compare findings with current staffing levels	31/7/21	Sharon Farthing/Karen Ranson/	

Appendix 1 – Completed toolkit September 2020 ***

AUDIT INPUTS

TRUST	West Suffolk NHS Trust
UNIT	West Suffolk
COMPLETED BY	Sharon Farthing
DATE COMPLETED	16/09/2020

DECLARED COTS	
NICU	1
HDU	3
SCBU	8

CRITERIA		
CARE LEVEL DAYS 1st APRIL -30th SEPTEMBER 2015	BAPM 2001	BAPM 2011
NICU		27
HDU		194
SCBU		807

NUMBER OF SHIFTS PER DAY	2

CURRENT UNIT STAFFING: DIRECT CARE ONLY		
	WTE BUDGET	WTE IN POST
BAND 7	0.32	0.32
BAND 6	12.28	10.88
BAND 5 QIS	0	1.12
BAND 5	7.12	6
BAND 4	1	1
BAND 3	1.64	1.64
TOTAL NUMBER OF NURSES	22.36	20.96
INDICATIVE BUDGET AT MID POINTS INCLUDING ON COSTS	£735,898	

AUDIT OUTPUTS

OCCUPANCY AGAINST DECLARED COTS				
	NICU	HDU	SCBU	TOTAL
BAPM 2001	0.00%	0.00%	0.00%	0.00%
BAPM 2011	7.40%	17.72%	27.64%	23.47%

COTS REQUIRED AGAINST ACTIVITY AT 80% OCCUPANCY				
	NICU	HDU	SCBU	TOTAL
BAPM 2001	0	0	0	0
BAPM 2011	0	1	6	7
DIFFERENCE TO DECLARED COTS @ BAPM 2001	-1	-3	-8	-12
DIFFERENCE TO DECLARED COTS @ BAPM 2011	-1	-2	-2	-5

NURSE STAFFING AGAINST TOOLKIT		
	BAPM 2001	BAPM 2011
WTE REQUIRED AGAINST ACTIVITY	6.62	20.33
WTE POSITION AGAINST BUDGET	15.74	2.03
BUDGET POSITION	£493,053	£76,505
WTE POSITION AGAINST IN POST	14.34	0.63
CURRENT QIS/REG	63.89%	
CURRENT REG/TRAINED	88.19%	

SUGGESTED SKILL MIX: DIRECT CARE ONLY		
	BAPM 2011	WTE CHANGE
BAND 7	0.74	0.42
BAND 6	7.90	-4.38
Band 5 QIS	5.22	5.22
BAND 5	3.90	-3.22
BAND 4	2.58	1.58
BAND 3	0.00	-1.64
TOTAL NUMBER OF NURSES	20.33	0.42
QIS/REG	78.03%	
REG/TRAINED	87.30%	

14.2. Infection prevention and control assurance framework

For Approval

Board of Directors – 26th February 2021

Item	14.2			
Presented by:	Sue Wilkinson Exec Chief nurse			
Prepared by:	Rebecca Gibson – Compliance Manager			
Date prepared:	February 2021			
Subject:	NHSE ICT assurance framework			
Purpose:	x	For information		For approval

Executive summary:

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

This month's report contains an updated dashboard and an update of the integrated 'learning from outbreaks' plan.

In mid-February, NHSE issued an updated BAF and Annex A includes the details of the additions. These will be subject to a local baseline assessment with an update provided in next month's report.

In addition, whilst not specifically infection prevention & control related, there is a new Covid clinical audit about to commence the output of which will be included in future iterations of the 'learning' report either in this IPC report or another forum. The audit is focussing on:

- Use of dexamethasone/other steroids among patients with severe/critical COVID-19
- Use of venous thromboembolism (VTE) prophylaxis among patients with COVID-19

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

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

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

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

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

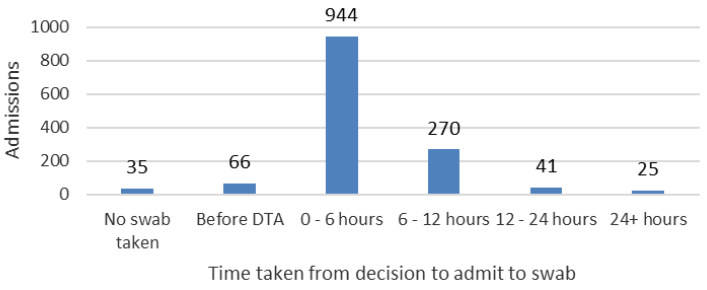
Measure	Time period reported	Data		
		Previous	Last period	This period
Compliance to Antimicrobial stewardship (AMS) standards	Q2	91.7%	ND	ND
AMS ProTectis compliance	Q2	85.8%	ND	ND
Nosocomial C19 (probable + definite)	Jan 21	2	91	60 ↓
Staff work-related C19 cases reported to RIDDOR	Jan 21	0	0	0
Incidents relating to C19 management	Jan 21	43	47	79 ↑
Admissions swabs within 24 hours of DTA	Jan 21	97%	95%	97% ↑
C19 clusters / outbreaks	Jan 21	3	6	3 ↓
Staff sickness / absence due to C19	Jan 21	316	695	856 ↑
Staff uptake of lateral flow test	To date	New	3205	3354 ↑

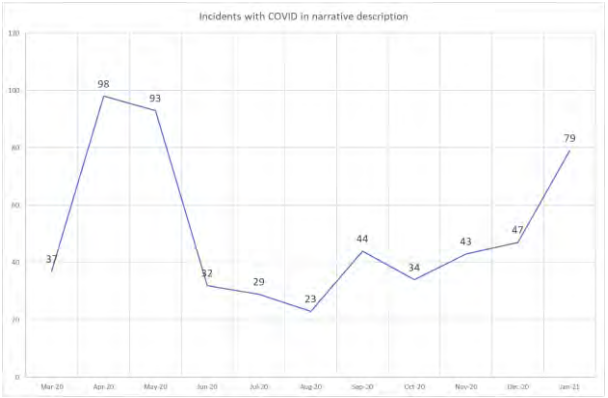
Associated charts / tables / narrative

C-19 admission swabs

96% of patients had a swab taken within 24 hours of the DTA in January and 97% in total.

35 patients (3%) do not have a record of having a swab taken in this episode





The number of **incidents relating to C-19** recorded in January rose considerably compared to recent months. Whilst the Apr/May spike included health & safety RIDDOR reporting (pre-changes) this was not the case in January.

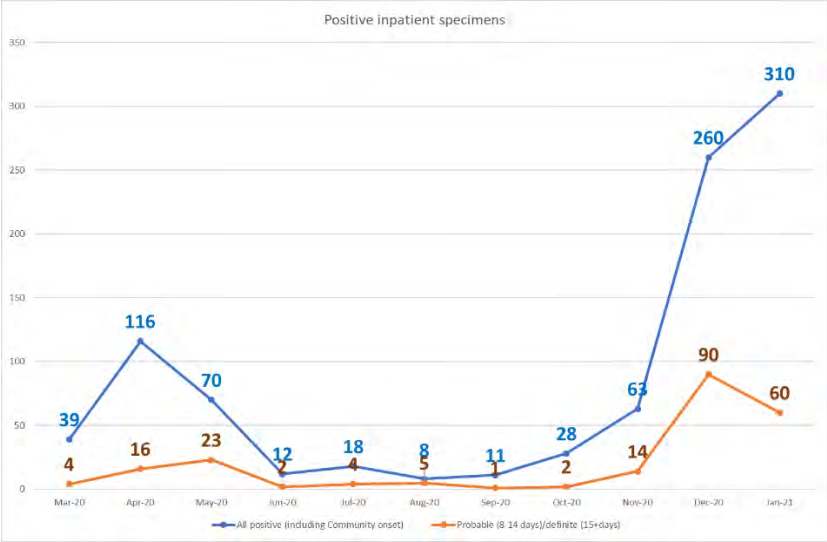
There was a range of incident types recorded although the highest number (23/79) were in the infection prevention category).

67/79 January reported incidents were green and there were six amber and six red:

Detailed of all the red incidents can be found in the separate SI report.

5/6 red and 4/6 amber incidents were outbreak/clusters including reporting in January of December incidents. The others were as follows:

- Cross infection risk (amber)
- Category 3 Pressure ulcer on a Covid +ve patient (amber)
- Delay in an ERPC procedure whilst awaiting a Covid test result (red)



Nosocomial (Hospital-Onset) C19

[*definition based on first positive specimen (swab date) X days after admission]*

There were 60 identified probably/definite cases in January. This is a decrease compared to December which is particularly encouraging when viewed against the increases in community prevalence over the same period.

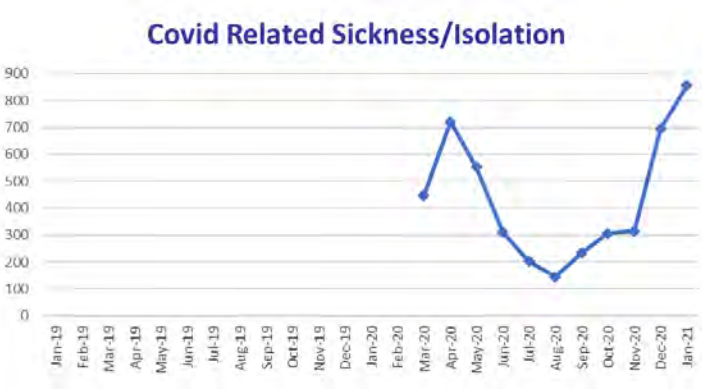
- Number of staff accepted a kit – 3354
- Number of positive LFD – 226
- Number of positive PCR – 215
- Number of negative PCR – 13
- **94% confirmed positive**

Staff uptake of lateral flow test

The number of staff accepting and using the lateral flow tests continues to increase and the outcome of those tests is now available as shown here.

This forms part of the updated BAF (see Annex A) which will enable us to declare compliance with the required prompt.

The data also demonstrates a high level of accuracy (94%) of the positive results when re-tested with PCR



Sickness / isolation

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

In January 2021 there were 856 episodes recorded, an increase from December.

We anticipate this will start to reduce when February's data is available.

Action and learning from COVID outbreaks / ward clusters

To date the organisation has reported 15 outbreaks requiring ward closure, ward infection clusters or staff infection clusters*.

NB: Most of the outbreak/clusters which began in December were not reported as such until January.

**In line with national reporting requirements each ward closure event is reported as a serious incident (SI) on STEIS whereas outbreaks and clusters are reported locally as amber. This does not change the infection prevention review (including IMT review), just the report template and need for STEIS record.*

Ward	Month	Ward	Month	Ward	Month	Ward	Month	Ward	Month
G9	May20	G5	Nov20	G4	Dec20	F10	Dec20	Rosemary	Jan21
F3	Jul20	Rosemary	Nov20	G3	Dec20	F7	Dec20	F3	Jan21
F12	Oct20	F5	Nov20	G8	Dec20	Kings Suite	Dec20	G5	Jan21

'Learning from outbreaks' seeks to look beyond compliance with a framework and instead identify what the causal factors are behind each outbreak / cluster and what can be put into place to address these.

To date (six reports completed) the main points are as follows:

- Data information systems
- Onsite COVID-19 testing capacity
- Test and Trace system
- Use of PPE
- Staff exposure to aerosol generating procedures (AGPs)
- Staff movement between wards
- Trust-wide learning
- Staff wellbeing
- Movement of patients throughout the hospital
- Unknown source of transmission
- Patient movements / interactions around ward environment away from their bed space
- Patient non-concordance (including through lack of mental capacity) leading to increased risk of transmission to patients and staff.

(*Additional since last month's report*)

- Lack of social distancing and screening.
- Frequently touched surfaces and shared facilities requiring enhanced cleaning regime
- Adequate physical segregation of patient – no sharing/mixing of personal equipment
- Confused and wandering patients may present an increased risk of transmission of COVID-19.
- Time limited housekeeping service for (Rosemary ward)
- Adapted process for collecting patient's meal trays after use without IPC guidance.

Key initial actions put into place to address these are listed here.

- Lateral flow rapid tests and SAMBA machines live (24/7) for all admitted patients enable prompt confirmation of patient's infection status both on admission and throughout hospital stay.
- Daily review of patients in each ward by Matrons enables identification of small number of individuals "suitable to outlie" in the event of operational pressure. Recorded on eCare.
- Robust Test and Trace system in place coordinated by the Tactical team including an on-call arrangement for the weekends.
- Lateral flow testing kits available for all patient facing staff (on a voluntary basis) with take-up to date over 3,000 staff submitting results centrally. Opportunities to report on outcomes will now be considered as part of the COVID IPC dashboard development however data quality issues mean that this data is not yet available.
- All respiratory patients requiring AGPs are on F7, G9 or in ITU. In an exceptional case where a patient is known to be negative and requires an AGP in an alternative location (e.g. because clinical condition requires them to be placed elsewhere) they will have a Consultant review beforehand to make sure there is a low suspicion of C-19 and they will be nursed in a dedicated side-room.

- Staff COVID vaccination programme (separately reported to board).
- Inpatients asked to wear masks when moving about shared areas and, if able and comfortable to do so, whilst sitting in bed. Supported through posters and a patient information leaflet.

(*Additional since last month's report*)

- Increased frequency of PPE and environmental audits
- Discourage patients from sharing belongings and encouraged to remain in their bed spaces where possible.
- Increased environmental cleaning and monitoring of frequently touched surfaces/ hygiene facilities.
- Mixing of differing patient contact cohorts from separate bays to a single bay to be discouraged. However, it is recognised that the demand for beds may override this practice. Where this occurs a risk assessment should be completed and recorded by Infection Control.
- COVID curtains/screening installed to help mitigate where social distancing is breached.
- All food trays to be collected and transported via a trolley.

Standard	Additional prompts in Feb21 update (underline is where an addition to a current prompt has been added)
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	• Systems and processes are in place to ensure: o there are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative o that on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance. • Monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice on: o staff adherence to hand hygiene o staff social distancing across the workplace o staff adherence to wearing fluid resistant surgical facemasks ▪ a) clinical ▪ b) non-clinical setting o staff compliance with wearing appropriate PPE, within the clinical setting • Implementation of twice weekly lateral flow antigen testing for NHS patient facing staff, which include organisational systems in place to monitor results and staff test and trace • Additional targeted testing of all NHS staff, if your trust has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health team. • There are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace • The Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep • This Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board • There are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	• Monitor adherence environmental decontamination with actions in place to mitigate any identified risk • Monitor adherence to the decontamination of shared equipment

Standard	Additional prompts in Feb21 update (underline is where an addition to a current prompt has been added)
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	• Face masks are available for all patients and they are always advised to wear them • Monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so) • there is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document https://www.england.nhs.uk/coronavirus/key-actions
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	• adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk • staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace • clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas
8. Secure adequate access to laboratory support as appropriate	There are systems and processes in place to ensure that: • All emergency patients are tested for COVID-19 on admission. • Those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise. • Those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission. • Sites with high nosocomial rates should consider testing COVID negative patients daily. • Those being discharged to a care home are being tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge • Those being discharged to a care facility within their 14 day isolation period should be discharged to a designated care setting, where they should complete their remaining isolation. • All Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission.

14.3. Nursing staffing report

For Approval

Trust Board – February 2021

NHS West Suffolk NHS Foundation Trust

Agenda item:	14.3			
Presented by:	Susan Wilkinson, Executive Chief Nurse			
Prepared by:	Daniel Spooner Deputy Chief Nurse			
Date prepared:	February 2021			
Subject:	Quality and Workforce Report & Dashboard – Nursing January 2021			
Purpose:	X	For information		For approval

Executive summary:

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

Highlights

- Nursing fill rates have fallen below 90% in January across many areas
- Sickness rates increased across all staff groups and higher than the first wave of Covid 19
- Nurse quality indicators appear to have been impacted due to this shortfall
- Addition staffing mitigation continued to be mobilised in January

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

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

Recommendation:

This paper is to provide overview of January's position about nursing staff and actions taken to mitigate, future plans and update on national requirements.

The dashboard provides summary of nursing staffing levels and effect on nurse sensitive indicators

1. Introduction

Whilst there is no single definition of 'safe staffing', the NHS constitution, NHS England, CQC regulations, NICE guidelines, NQB expectations, and NHS Improvement resources all refer to the need for NHS services to be provided with sufficient staff to provide patient care safely. NHS England cites the provision of an *"appropriate number and mix of clinical professionals"* as being vital to the delivery of quality care and in keeping patients safe from avoidable harm. (NHS England 2015).

West Suffolk NHS Trust is committed to ensuring that levels of nursing staff, which includes Registered Nurses, Midwives and Nursing Associates and Assistant Practitioners, match the acuity and dependency needs of patients within clinical ward areas in the Trust. This includes ensuring there is an appropriate level and skill mix of nursing staff to provide safe and effective care using evidence-based tools and professional judgement to support decisions. The National Quality Board (NQB 2016) recommend that on a monthly basis, actual staffing data is compared with expected staffing and reviewed alongside quality of care, patient safety, and patient and staff experience data. The trust is committed to ensuring that improvements are learned from and celebrated, and areas of emerging concern are identified and addressed promptly.

Since March 2020 the NHS has managed the Coronavirus outbreak. Coronavirus has become a global health emergency. Matrons and Heads of Nursing and Midwifery review staffing on a daily basis to ensure; sufficient ward care capacity, to support the surge in critical care capacity, with appropriate estate, equipment, expertise and support in place to deal with the increase demands that coronavirus has created. This paper will identify the safe staffing and actions taken for January 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 January within the data submission deadline. Table 1 shows the summary of overall fill rate percentages for these months and for comparison the previous two months.

	Day		Night	
	Registered	Care Staff	Registered	Care staff
Average fill rate for October 2020	100%	93%	97%	109%
Average fill rate for November 2020	101%	97%	99%	110%
Average fill rate for December 2020	94%	84%	94%	98%
Average fill rate for January 2021	92%	78%	94%	94%

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

Although Trust fill rate has on the whole maintained >90%, 48% of our reported wards have fallen below 90% for RN day shifts in January. A full list of ward by ward fill rates can be found in appendix 1a and 1b. This is driven by sickness, staff isolation. The matron of the day (MOD) mitigates short notice staffing shortfalls and the Trust has mobilised additional staff to support inpatient areas during January. Some areas have had low bed occupancy due to ward closures which has mitigated this to some degree however, at times this has not completely mitigated all risk. In incidences such as these, Datixs have been completed to represent the pressures at Trust level (section 9).

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 levels for Nursing/Midwifery and support staff were impacted in the initial months of Covid 19, both April and May saw an increase in absences in both nursing and support staff, these are demonstrated in chart 2. In December the Trust began to see an increase in admission of Covid 19 positive patients and also an increase in community prevalence of Covid 19 infections within Suffolk and these pressures continued into January. Sickness rates in January are now higher than in the first wave of this pandemic.

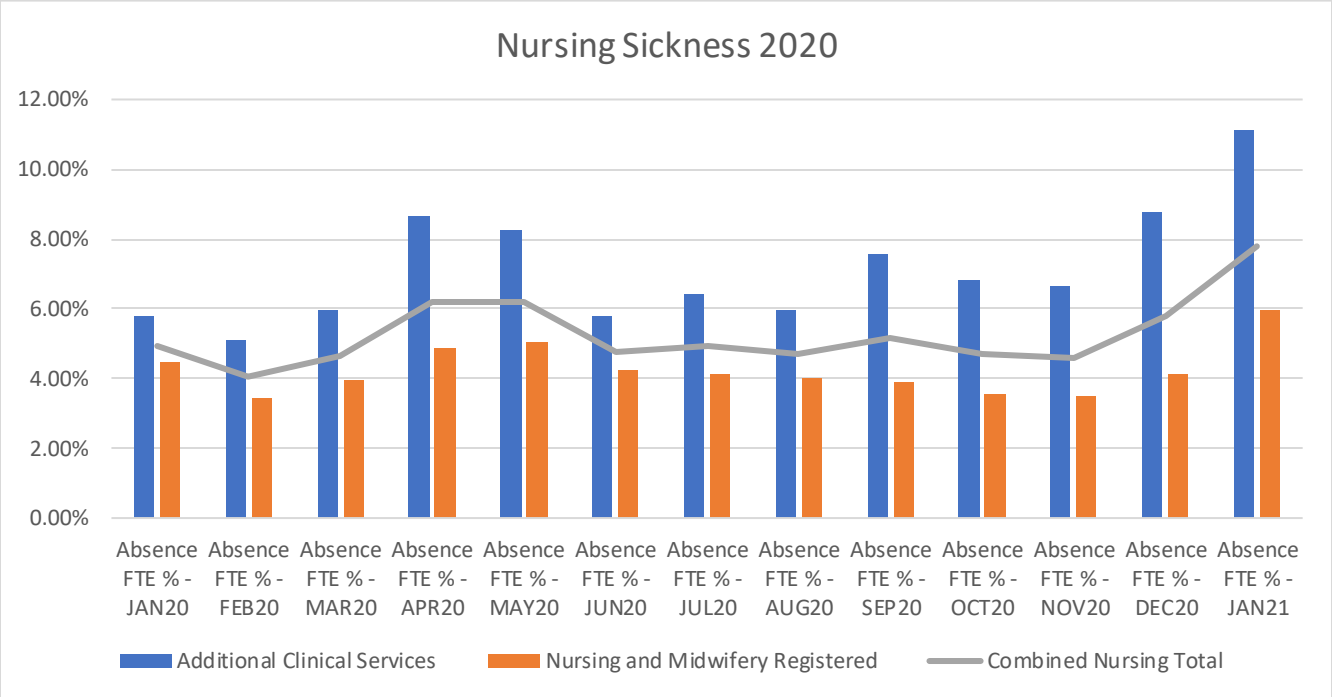


Chart 2.

	July	Aug	Sept	Oct	Nov	Dec	Jan 21
Unregistered staff (support workers)	6.41%	5.95%	7.56%	6.85%	6.65%	8.75%	11.13%
Registered Nurse/Midwives	4.11%	4.01%	3.89%	3.57%	3.47%	4.16%	5.98%
Combined Registered/Unregistered	**4.93%**	**4.69%**	**5.15%**	**4.70%**	**4.58%**	**5.78%**	**7.79%**

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). Incidences of self-isolation have not exceeded levels observed in the first wave. This is likely due to lateral flow testing and a reduction in the isolation timeframe following a change in national guidance.

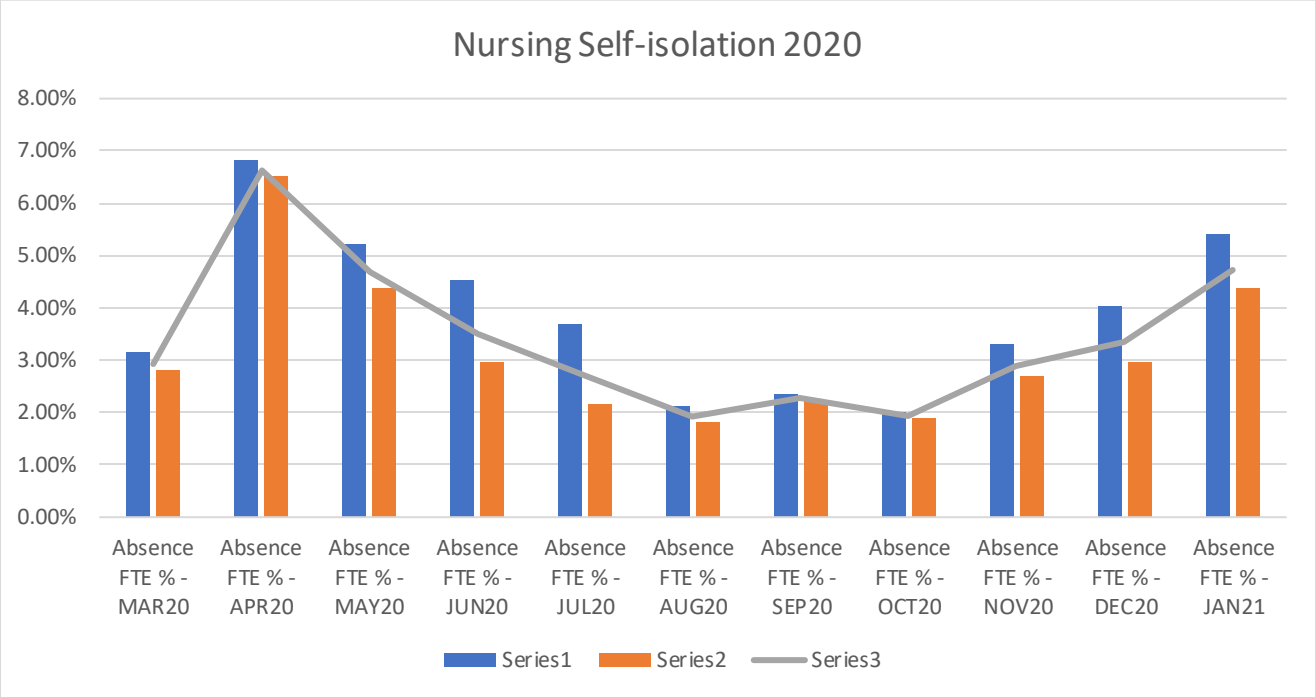


Chart 3

5. Patient Flow and Escalation

Good patient flow is central to patient experience, clinical safety and reducing the pressure on staff. It is also essential to the delivery of national emergency care access standards. (NHSI 2017). Ward closures and moves can add additional staffing challenges and opportunities. In recent months ward relocations and structural repair have challenged flow and staffing. In this report period no wards were closed due to ward relocations or structural repair, how two wards have been closed to admission due to local covid outbreaks these included;

- G5
- F3

Additional wards closed at the end of December impacted on patient flow, patient placement and phased reopening was planned accordingly. Staffing is reviewed daily across all divisions by the 'Matron of the day'. This role is the escalation point for all wards to raise issues regarding staffing shortfall or concerns. The Matron ensures that all areas are supported and staff are redeployed from areas of low activity or acuity to support where needed.

6. Recruitment and retention

Vacancies: Registered nursing (RN):
The vacancies have increased from 39.2 WTE to 65.1 WTE in January. This is driven by an additional 22.5 WTE added into month 10 total WTE from the winter contingency ward. In addition, a data cleanse from the finance ledger has the non-nursing Covid costs have been removed, demonstrating a more accurate vacancy picture. Using this data, the vacancy rate for RN/RM is 9.6%. This is likely to be more favourable as reported data for Midwifery is indicating a WTE vacancy of 17.9 which is not accurate. a separate review of midwifery staffing will be included in next month's report for better clarity.

	Ward Nursing	Sum of Actual Period 5 (Aug)	Sum of Actual Period 6 (Sept)	Sum of Actual Period 7 (Oct)	Sum of Actual Period 8 (Nov)	Sum of Actual Period 9 (Dec)	Sum of Actual Period 10 (Jan)	Sum of CURRENT MONTH VARIANCE
RN Substantive	Ward	578.3	576.7	587.4	609.4	603.9	609.8	67.2
	CV19 Costs	8.9	8.5	6.0	11.4	10.3	2.0	(2.0)
Total: RN Substantive		**587.2**	**585.2**	**593.4**	**620.8**	**614.2**	**611.8**	**65.1**

Table 4

Vacancy rates are reviewed in the monthly 'check and challenge' meetings that commenced this month. Areas with significant shortfall (>15%) are supported in giving authorisation to seek temporary staffing solutions earlier than the standard 72-hour window. A breakdown of ward by ward vacancies can be found in Appendix 2.

Vacancies: Unregistered Nursing assistants (NAs): The vacancy rate of unregistered support staff is demonstrating an under establishment of 16.7 WTE and 4.2%. There is a national ambition to reduce NA vacancies to 0% by April. The trust has joined this program and has received funding for additional HR support, to quicken onboarding, and also for pastoral care to support new NA in the clinical environment.

	Ward Nursing	Sum of Budget Period 5 (Aug)	Sum of Budget Period 6 (Sept)	Sum of Budget Period 7 (Oct)	Sum of Budget Period 8 (Nov)	Sum of Budget Period 9 (Dec)	Sum of Budget Period 10 (Jan)	Sum of CURRENT MONTH VARIANCE
Nursing Unregistered Substantive	Ward	320.2	330.7	330.7	334.5	299.3	380.6	16.7
	CV19 Costs	80.1	42.4	33.3	37.3	84.8	0.0	0.0
Total: NA Substantive		**400.3**	**373.2**	**364.0**	**371.9**	**384.0**	**380.6**	**16.7**

Table 5

Overseas Nurse (OSN) recruitment:

Four Nurses arrived from the Philippines in January and a further 5 have been appointed this month. Interviews continue to ensure that our pipeline ambition of five arrivals a month continues.

New starters

	November	December	January
Registered Nurses	10	10	16
Non-Registered	11	11	11

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

In January sixteen RNs completed induction; of these; four community nurses, two midwives, three bank staff and seven for the acute trust.
NA recruitment remains consistent with ten staff joining the acute trust and one staff member joining the bank service

7. Quality Indicators

Falls

Falls per 1000 bed days reduced in January following a sharp rise in December (Chart 6). A full list of falls and locations can be found in appendix 3. Unlike pressure ulcers this nursing quality indicator has not been adversely affected by the escalating shortfalls seen this month.

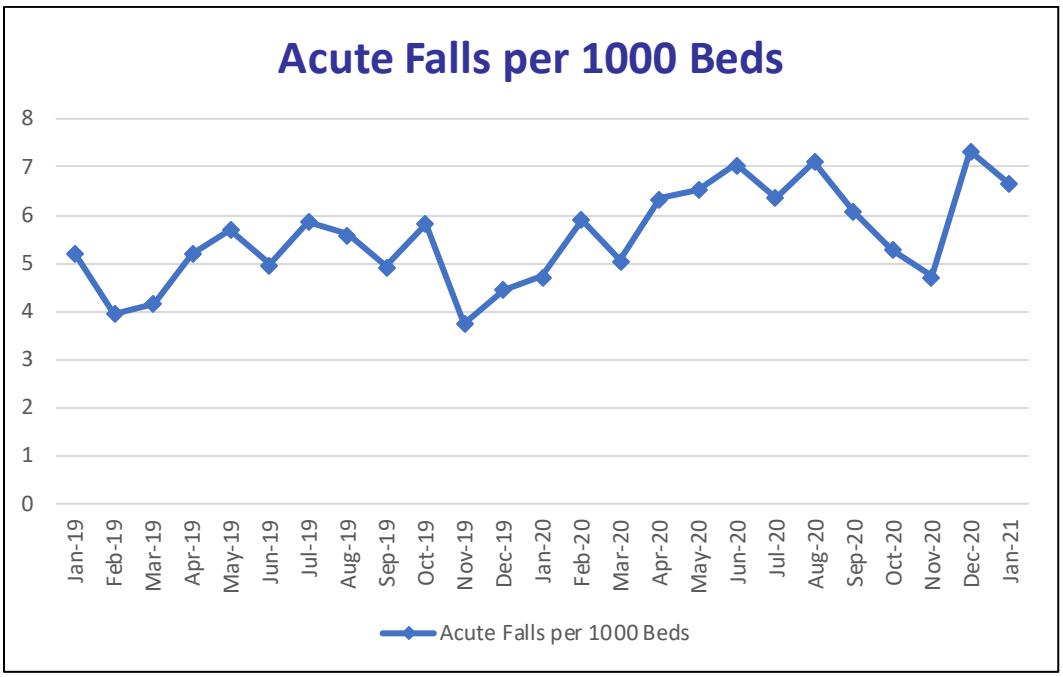


Chart 6

Pressure Ulcers

January saw a large increase in hospital acquired pressure ulcers (HAPU). This is likely to be driven by the significant nursing shortfall of both RNs and NAs observed in January. Further evidence by the staffing red flag incidences that occurred this month of staff's inability to maintain frequency of care rounding (see section 9). Positively 94% of these incidences are category two HAPU which means early signs of skin damage are being identified.

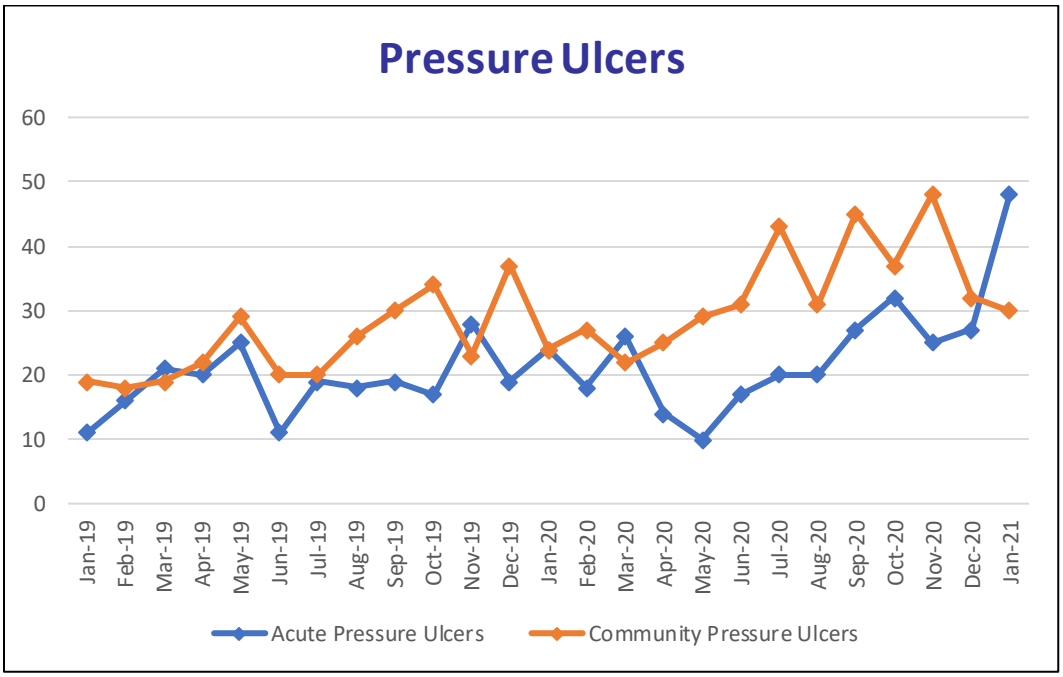


Chart 7a

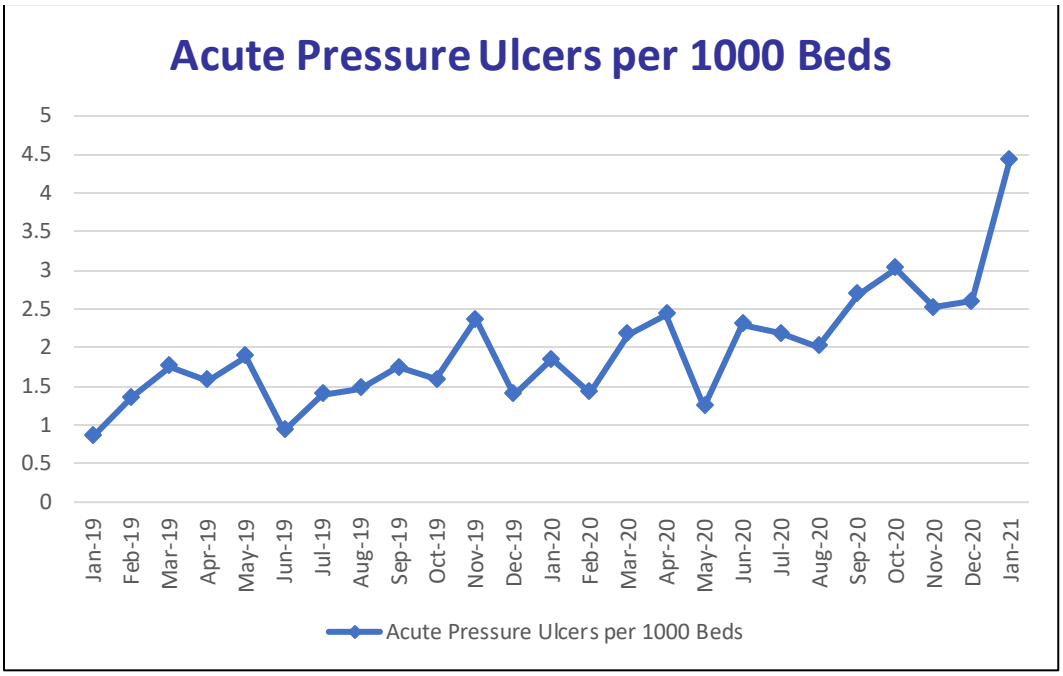


Chart 7b

8. Compliments and Complaints

Table 8 demonstrates the incidence of complaints and compliments for this period. There has been a large drop in complaints and compliments this month. This is likely to be driven by national lockdown measures, which limits footfall within the wards and hospital. This reduction was also observed during the first national lockdown. The 'clinical helpline' was re-established on 18th January and already has received positive feedback from service users. The helpline has received an average of 171 calls a day to assist relatives who are unable to attend the wards to receive updates of the care of our patients.

	Compliments	Complaints
April 2020	14	8
May 2020	14	9
June 2020	8	3
July 2020	7	21
August 2020	18	21
September 2020	20	20
October 2020	11	17
November 2020	34	13
December 2020	44	22
January 2021	11	7

Table 8

9. Adverse Staffing Incidences

As per the nursing resource improvement plan, staffing incidences are now being captured on Datix with recognising any red flag events that have occurred as per National Quality Board (NQB) definition (Appendix 4). Nursing staff are encouraged to complete this as required so any resulting patient harm can be identified.

- In December there were 46 incidences, this is a reduction of two from December. G3 reported the most incidences with 8 red flag events. Only one area reported harm following a fall due to low staffing

A breakdown of the impact on patients is reported in Table 9.

Red Flag	Nov 20	Dec 20	Jan 21
Registered nursing shortfall of more than 8 hours or >25% of planned nursing hours	4	11	11
>30-minute delay in providing pain relief	1	2	3
Delay or omission of intention rounding	8	17	17
<2 RNs on a shift	1	2	6
Vital signs not recorded as indicated on care plan	3	10	3
Unplanned omissions in providing patient medication	0	4	4

Table 9.

10. Maternity Services

A full maternity staffing report will be attached to the maternity monthly paper.

Red Flag events

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

- There were four red flag incidents reported in January 2021 relating to delay in commencing induction of labour

Midwife to Birth ratio

In January 2021 the Midwife to Birth ratio was 1:29 this is the upper limit of a safe ratio, Birthrate+ recommend a Midwife to Birth ratio of 1:27.7.

Supernumerary status of the labour suite co-ordinator

This is a requirement for CNST 10 steps to safety and was highlighted as a 'should' from the CQC report Jan 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 January 90% compliance was achieved. The escalation policy was activated however there is a time delay from on-call staff being called to them physically being present on the unit. To note, all women received one to one care in labour. We are currently working with our NHS Improvement officer to find long-term resolution to this problem. Recruitment drive for further labour suite co-ordinators has been completed and awaiting start dates.

11. Establishment Review using the Safer Nursing Care Tool (SNCT)

As per NQB (2016) recommendations and strengthened by the developing workforce safeguards document (NHSE, 2018), acute providers are expected to formally review nursing establishments biannually. The biannual acuity and dependency audit commenced in September and concluded in October. During this month, review meetings were arranged with the nursing leaders of the areas to triangulate the outcomes of the audit with professional judgement and nurse sensitive indicators such as falls and pressure ulcers incidences. The recommendations of this review was presented to the Trust public board in January 2021. A number of recommendations were made to address staffing skill mix and set establishments that would meet the current needs of patients within our Trust. All recommendations were approved and will be included in budget setting for 2021/22. The review will have an impact on nursing vacancies in April 2021 as funding becomes available as the review will provide a net increase of approx. 19 RNs and a net reduction of 4 NAs.

The review is being repeated in February 2021 to ensure that our Biannual review captures winter and summer variances.

12. Resource Management

Following Lord Carters review in 2016 operational productivity is improved when eRostering is used to its fullest potential (NHSE, 2020). WSH has had eRostering in use for many nursing teams for a while, however, formal oversight has been light due to covid 19 restriction. In order to better identify improvements and best practice, virtual monthly meetings between the Deputy Director of Nursing, eRostering team and nursing leaders have been re-established and commenced in October as planned. These 'check and challenge' meetings will identify areas of good practice in roster management and areas of improvement and will track concordance. The meetings have driven an improvement plan that will be updated monthly (appendix 5). All actions are on track or completed other than the rapid response pool of staff. This is delayed following a payment solution to be realised by Serco partners.

In December, a nursing resource management audit was completed by RSM. The final report is still pending.

13. Covid 19 additional assurance

As mentioned staffing pressures have increased due to the emergence of the second wave in mid-December and continued in January 2021. Additional actions have been taken to further mitigate safety. It is acknowledged that due to the unprecedented staffing challenges that care delivered will be the safest possible care we can deliver which allows risks to be taken/accepted where needed. Actions to further strengthen and support staffing have included;

- Extension of agency lead time to encourage temporary staff fill
- Repatriation of non-patient facing clinical staff to clinical areas (ITU, inpatient wards)
- Utilisation of AHP to support RN team in F7 and G9 respiratory services
- AHP teams to extend scope of intervention to assist basic care needs of their patient group
- Quality Impacts Assessment for all changes to ward demographic and patient group
- Bespoke competency training to ward teams if patient group changes: for example, NIV training on G9, acute surgical care on F4.
- Expectation of ward managers to fully support clinical duties during January and to be reflected on e-Roster.
- Working across the ICS to explore mutual aid and utilisation of clinical staff from across the system.
- No overseas nurses, currently completing the OSCE program have joined the emergency NMC register as they have newly arrived in the country, and it was felt this would have delayed them getting their UK registration
- Bank incentive scheme approved and commenced mid January to address RN shortfall
- NMC authorised student nurses to join nursing workforce. Twenty-five nursing students are predicted to join the workforce in early February.

14. Recommendations and Further Actions:

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

Appendix 1b. Fill rates and CHPPD. January 2020 (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
Name	Day Reg Planned Hrs	Day Reg Actual Hrs	Day Unreg Planned Hrs	Day Unreg Actual Hrs	Night Reg Planned Hrs	Night Reg Actual Hrs	Night Unreg Planned Hrs	Night Unreg Actual Hrs	Day Reg Fill Rate	Day Unreg Fill Rate	Night Reg Fill Rate	Night Unreg Fill Rate				
Rosemary Ward	753	924	1168.5	755.25	655.5	732.5	600.5	703	123%	65%	112%	117%	467	3.5	3.1	6.7
Glastonbury Court	714.5	805.5	1046.75	561	714	698	541.5	431	113%	54%	98%	80%	390	3.9	2.5	6.4
Acute Assessmen	2138.5	1681	2489.25	1607.5	1782.5	1517.5	1426	1311	79%	65%	85%	92%	761	4.2	3.8	8.0
Cardiac Centre	2735	2284.35	1285	1179.5	1782.5	1506.5	713	632.5	84%	92%	85%	89%	632	6.0	2.9	8.9
F10	1422	1163	1414.5	1228.5	1069.5	848	1059	1024.667	82%	87%	79%	97%	707	2.8	3.2	6.0
G9	1422	1300.75	1415.5	1267.983	1414.5	1261	1058	1081.5	91%	90%	89%	102%	752	3.4	3.1	6.5
F12	544	628.75	337.75	243.75	709	615.9833	356.5	310.5	116%	72%	87%	87%	240	5.2	2.3	7.5
F7	1426	1547.083	2081.5	1658.083	1426	1393	1760.75	1552.75	108%	80%	98%	88%	683	4.3	4.7	9.0
F9	1426	1054	2112.733	1415.233	1069.5	850.5	1414	1255.5	74%	67%	80%	89%	744	2.6	3.6	6.1
G1	2520.833	2012.033	994	655.5	713	719.75	356.5	271.5	80%	66%	101%	76%	361	7.6	2.6	10.1
G3	1426	1253.75	2139	1703.75	1069.5	1038.167	1069.5	1299.5	88%	80%	97%	122%	864	2.7	3.5	6.1
G4	1438.5	1352.5	2071	1762.5	1067.5	975.5	1423.5	1268.333	94%	85%	91%	89%	896	2.6	3.4	6.0
G5	1768	1175.5	1746	1197.5	1062.5	960.8333	1418	1126.5	66%	69%	90%	79%	760	2.8	3.1	5.9
G8	2086.05	1543	1761.917	1331.75	1414.5	1220.333	1051.5	896.3333	74%	76%	86%	85%	615	4.5	3.6	8.1
F8	1426	1240	2115	1558.5	1069.5	891	1420.5	1318.5	87%	74%	83%	93%	723	2.9	4.0	6.9
Critical Care	2769.75	3974	341	599.5	2821.5	3364.5	0	0	143%	176%	119%	N/A	388	18.9	1.5	20.5
F3	1782.5	1290.5	2134	1707.5	1069.5	943	1425.5	1243	72%	80%	88%	87%	732	3.1	4.0	7.1
F4	943	974	908.5	739.3333	714	683.5	644	647.5	103%	81%	96%	101%	602	2.8	2.3	5.1
F5	1719.5	1286.5	1397.5	1128	1069.5	875	713	679	75%	81%	82%	95%	698	3.1	2.6	5.7
F6	2012.25	1842	1647	1337	1069.5	1001	713	811.5	92%	81%	94%	114%	939	3.0	2.3	5.3
Neonatal Unit	1020	1094	218	224.5	1056	1092	156	120	107%	103%	103%	77%	116	18.8	3.0	21.8
F1	1207.5	1427.5	598	653	1069.5	1289.25	0	103.5	118%	109%	121%	100%	115	23.6	6.6	30.2
F14	744	773.25	144	117	744	685	0	12	104%	81%	92%	100%	106	13.8	1.2	15.0
Total	35,444.88	32,626.97	31,566.40	24,632.13	26,633.00	25,161.82	19,320.25	18,099.58	**92%**	**78%**	**94%**	**94%**	**13291**	**4.3**	**3.2**	**7.6**

Appendix 2. Ward by ward vacancies (January 2020): Data adapted from finance report

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

Ward/Department	Registered Nursing (RN)				Ward/Department	Non Registered Nursing (HCSW)			
	Budgetted establishment	Actual establishmet	Vacancy rate (WTE)	Vacancy percentage		Budgeted Establishment	Actual Establishment	Vacancy rate (WTE)	Percentage Vacancy rate
AAU	30.1	24.8	5.4	17.8%	AAU	28.3	22.8	5.5	19%
Accident & Emergency	64.0	60.8	3.2	5.0%	Accident & Emergency	26.5	23.3	3.2	12%
Cardiac Centre	40.7	37.0	3.7	9.2%	Cardiac Centre	15.7	17.0	(1.3)	-8%
Glastonbury Court	11.7	11.0	0.7	5.9%	Glastonbury Court	12.6	11.2	1.4	11%
Critical Care Services	45.0	44.5	0.5	1.2%	Critical Care Services	1.9	3.8	(1.9)	-102%
Day Surgery Wards	11.0	8.4	2.6	23.5%	Day Surgery Wards	3.9	3.9	(0.0)	0%
F14	12.8	11.2	1.6	12.3%	F14	1.0	1.0	0.0	0%
Hospital Midwifery	57.7	39.8	17.9	31.0%	Hospital Midwifery	15.6	12.3	3.3	21%
Neonatal Unit	20.8	19.0	1.8	8.7%	Neonatal Unit	4.3	4.4	(0.1)	-3%
Rosemary ward	12.4	14.8	(2.3)	-18.8%	Rosemary ward	13.5	16.0	(2.5)	-19%
Recovery Unit	21.9	19.3	2.6	11.7%	Recovery Unit	0.9	0.9	0.0	1%
Ward F1	26.2	22.0	4.2	16.2%	Ward F1	7.2	7.3	(0.1)	-1%
Ward F12	10.2	9.5	0.7	6.8%	Ward F12	5.9	5.0	0.9	15%
Ward F3	22.2	18.7	3.5	15.8%	Ward F3	25.8	24.7	1.2	5%
Ward F4	14.2	14.4	(0.2)	-1.7%	Ward F4	13.9	9.3	4.6	33%
Ward F5	22.2	18.4	3.8	17.0%	Ward F5	12.9	15.0	(2.0)	-16%
Ward F6	24.0	18.4	5.6	23.2%	Ward F6	14.8	15.9	(1.1)	-8%
Ward F7	22.3	22.0	0.3	1.4%	Ward F7 Short Stay	28.3	22.3	6.1	21%
Ward F9	19.3	15.1	4.3	22.0%	Ward F9	25.8	21.2	4.6	18%
Ward G1	28.7	23.5	5.1	17.9%	Ward G1	10.5	10.0	0.6	6%
Ward G3	19.5	18.3	1.3	6.4%	Ward G3	25.6	24.5	1.0	4%
Ward G4	19.5	17.9	1.6	8.1%	Ward G4	25.4	21.1	4.3	17%
Ward G8	27.5	24.3	3.2	11.6%	Ward G8	20.6	19.0	1.6	8%
Continuity of Carer Midwifery	27.3	29.9	(2.6)	-9.5%	Continuity of Carer Mid				
F8	19.4	18.7	0.7	3.4%	F8	25.8	24.1	1.6	6%
G5 (WEW)	22.5	11.0	11.5	51.1%	G5 (WEW)	12.7	10.9	1.8	14%
Ward F10*	19.2	16.4	2.8	14.6%	Ward F10	18.0	19.0	(1.0)	-6%
Respiratory Ward - G9	23.7	20.6	3.1	12.9%	Respiratory Ward - G9	18.0	14.9	3.1	17%

Appendix 3:

Ward by Ward breakdown of Falls and Pressure ulcers January 2020

HAPU

January 2021	Cat 2 (Minor)	Unstageable	Total
Total	46	3	49
Critical Care Unit	7	0	7
G4 - ward	6	1	7
Short Stay and Frailty - G5	5	1	6
G8 - ward	4	1	5
F7	5	0	5
G3 - Endocrine and General Medicine	3	0	3
Respiratory Ward	3	0	3
Cardiac Centre - Ward	2	0	2
F4 - ward	2	0	2
F5 - ward	2	0	2
Renal Ward	2	0	2
F12 Isolation Ward	1	0	1
F9 - ward	1	0	1
Rosemary Ward	1	0	1
Acute Assessment unit (AAU)	1	0	1
Integrated Therapies	1	0	1

Falls

January 2021	Jan 2021	Total
Total	81	81
F6 - ward	9	9
F10	7	7
F3 - ward	7	7
Short Stay and Frailty - G5	7	7
Acute Assessment unit (AAU)	6	6
Emergency Department	5	5
G3 - Endocrine and General Medicine	5	5
F5 - ward	4	4
F9 - ward	4	4
G1 - ward	4	4
F12 Isolation Ward	3	3
G4 - ward	3	3
Respiratory Ward	3	3
Rosemary Ward	3	3
F7	3	3
Cardiac Centre - Ward	2	2
G8 - ward	2	2
Glastonbury Court	2	2
F4 - ward	1	1
Renal Ward	1	1

Appendix 4: Red Flag Events

Maternity Services

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

Acute Inpatient Services

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

Appendix 5: Nursing resource management improvement plan

Utilising Nursing Resource Improvement Plan							Version date: 18.02.2021 V2.5
Find no.	Improvement required	Improvement action	Action Owner	Overall status RAG	Completion date	Actual completion date	Current status / overall RAG rationale
1.1	Improved confidence and knowledge in using eRostering and expectations of robust roster management	Review rostering training program. Scope adequacy of eRostering training with senior nursing team (survey monkey)	DS/LR		1.2.21		21.1.21 Action not progressed formally. Individual training needs captured at check and challnge meetinsg
1.2		Implement roster check and challenge meetings with ward teams. Including KPIs, with clear TOR and deliverables	DS		12.10.20	9.10.20	TOR completed and circulated to Matrons. First check and challenge meetings scheduled for 9.10.2020
2.1	eRosters to be update live	Review and update rostering policy with clear accountability and responsibilities	DS/LR		28.2.21		Policy to be updated on completion of RSM audit complete date amended to 31.1.21. 21.1.21: delay in publication of RSM audit findings. Expected final eport due end of January. 18.2.21: final report still pending date extended to end of February
2.2		Review and scope roster access to ensure all that are responsible for staff management/moves are able to	LR		1.11.20	21.1.00	21.1.21: no concerns raised around access at roster review meetings, action to be closed and managed on case by case basis
2.3		Include unify fill rate discussion in check and challenge to explore inconsistencies of roster management	DS		12.10.20	9.10.20	Check and Challenge meetings commenced in October. Unify review and narrative included to inform board paper.
2.4		Review redeployment function as feedback from staff is that 'Blue boxing' is onerous and not ser friendly therefore not used	LR		1.12.20	7.12.20	Complete: Redeployment process has been improved by introducing quicker way to use this functionality. roster team to scope alternate simpler way to redeploy staff.
3.1	Shifts to be filled by temporary staffing are clearly escalated and filled efficiently by WSP	Define and agree staffing shortfall escalation process for forward planning	DS		28.2.21		Policy to be updated to capture changes of this improvement plan. Date amended to 31.12.20. will meet review deadlines. As per action 2.1. date extended to capture actions and recommendation of RSM audit
3.2		implement 8 week roster lead time (current 6 weeks)	LR		1.1.21	11.11.20	Complete: 8 week roster lead time implemented commenced on roster starting 17th January. Communication to nursing staff completed. Reiterated at Check and challenge meeting 11.11.20
4.1	Ensure WSP working practices are maximised to provide more capacity to source temporary staff	Implement electronic time sheet management for bank shifts	CN/LR		1.12.20	1.12.20	On track to commence on 1.12.2020. Rationale and benefits discussed in Check and Challenge meeting. Comms and 'how to guide' to be sent week commencing 16.11.20. Complete: live as of 1st December. Coms completed, wash up and implementation review to be establsihed
4.1.1		Arrange wash up review post implementation of electronic time sheets, addressing any staff feedback	CN/LR		31.12.20	18.2.20	9.12.20: meeting scheduled for 18.12.20 18.12.20: wash up meeting demeonstrates, positive implementation with good compliance and from majority of areas.
4.2		Clarify time owing or adjust shift times in rostering policy	DS/CS		1.12.20	18.12.20	DS to review with CS to establish working practices and clarity to inform rostering policy. 11.12.20: Meeting established for 18.12.20: Complete: agreed that additional hours <6 should time adjusted not additional bank shift. Will be refelcted in
5.1	Clarity on nurse vacancies	Ward to board reporting to use single point of information. Data cleanse to be complete from finance	NM/DS		1.11.20	24.10.20	Data cleanse complete by finance team. Removing anomalies for cross charging non nursing covid costs. September staffing paper displaying accurate figures
5.2		Finance training to be delivered to all ward managers	NM		1.12.20	3.11.20	Complete: 4x sessions scheduled in November 2020. delivered by Deputy Director of Finance to Ward Managers and Matrons. First session delivered 3.11.2020
5.3		Programme of Biannual establishment reviews to be rolled out	DS		1.12.20	9.12.20	1st interaction of audit completed in October 2020. Output meetings completed with the nursing team to add professional judgement. Establishment recommendations to go to board, via execs Establishment review completed and presented to scrutiny. Pending outcome and approval of investment
6.1	Improved daily oversight and management of staffing risks	SafeCare to be reintroduced to be tool for oversight/risk management	LR/DS		28.2.21		Areas for inclusion have been scoped and agreed. CNIO confirmed that data pull can come from eCare. DS to clarify expectations with SafeCare and amend launch date, delayed due to competing priority of CV19 wave 3. Completion date extended to 28.2.21 18.2.21: SafeCare training dates agreed for roll out in February to launch in March
6.2		Increased reporting of red flag events on Datix	DS		1.11.20	22.9.20	Datix template updated with mandatory field to demonstrate staffing shortfalls and NQB red flag events. Discussed and informed at NMCC in September
6.3		Implement and deliver rapid response pool for addressing late notice short falls	DS/LR		1.11.20		Partial: proposal approved by exec team. Waiting for serco to comfirm payment method for shifts 09/12/2020 - calculations have been obtained to update Healthroster and ESR. Len Rowland needs to review calcualtions and liase with SBS to implement. Delays with payment process remain with Serco. Len R to escalate
6.4		Scope and deliver bank incentive scheme for RNs to mitigate significant staffing shortfall observed in January 2021	DS/CS		31.1.21	22.1..31	bank incentive proposal presented to covid strategic group for agreement. Approved 18.1.21 for £300 bonus if 75 hours of RN bank worked between 11.1.21 to 31.3.21. Communications complete and incentive scheme is live

14.4. Improvement programme board report

For Approval

Trust Open Board – February 2021

Agenda item:	14.4			
Presented by:	Steve Dunn, Chief Executive Sue Wilkinson, Executive Chief Nurse			
Prepared by:	John Connelly, Head of PMO			
Date prepared:	11 February 2021			
Subject:	Improvement programme board report			
Purpose:		For information	X	For approval

The Improvement programme board meeting, held on 8th **February 2021**, considered the following:

- Receive and consider reports from senior responsible officer (SRO) cluster groups. This included approval of issues escalated from the groups and proposed changes to the improvement plan
- Review the updated improvement plan - the version received was updated based on the approved changes from the cluster groups (**Annex A**)
- Consideration of additional items to be added to the improvement plan
- Reviewed the forward plan

A summary of key issues and outcomes from the meeting include:

The continuing evolution of the Trust's Improvement Programme was evident at the Feb '21 IPB with two key additions to the IPB presentation pack:

- A draft Maternity Improvement Plan was presented by the Nursing Director / IPB Executive Lead as an integrated document incorporating planned improvements from a range of sources, including the Ockenden Report, HSIB Report, external site visits and self-assessment. The submission of the Maternity Improvement Plan is indicative of the Trusts executive leadership and ownership of the Trust improvement programme.

- Future reporting links between the IPB and the Divisional Boards are presented in Appendix 7. A PMO Improvement Programme Manager (IPM) will be responsible for managing the flow of improvement plan information from Divisional Boards to the IPB. These plans will be allocated by the IPB to the relevant SRO Cluster. Similarly, the IPM will engage Divisional Boards with wider implementation opportunities based on existing IPB Plans. The appointment of PMO IPM's as an embedded divisional resource will also support links with the Trusts Quality & Patient Safety governance / Divisional Governance Managers

Ten change requests submitted for approval at February IPB were approved including:

1. Three plans move from Black to Blue:
- Plan No 22: Maternity – Carbon monoxide monitoring
- Plan No 24: Maternity – Vital observations tool for women
- Plan No 50: Maternity – WHO Checklist / 5 Steps to safer surgery

2. Four plans move from Green to Black (Complete):
- Plan No. 3 / 4.3: Incident reporting and investigations

- Plan No. 4.2: Mortality Reviews
- Plan No. 56: Supervision of Midwives
- Plan No 59: Bereavement Care Pathway

3. One plan moves from Red to Amber:
- Plan No 4.1/41: Clinical Audit

4. The completion dates for one plan was extended:
- Plan No 33: Pathology extended by 2 months to 31.03.21

5. The completion dates for one plan was brought forward:
- Plan No 73: Senior leaders have the skills to use patient outcome data to improve services: Brought forward by 2 months from 31.05.21 to 31.03.21

The following change requests submitted for approval at February IPB were not approved:

1. One plan moving from Red to Green:
- Plan No 73: Senior leaders have the skills to use patient outcome data to improve services The project end date of 31.03.21 was agreed, however it was deemed more appropriate to move the RAG to Amber at this stage until the outstanding actions were progressed further.

Additional plan changes were agreed at IPB including:

- The request to extend the completion date for Appraisal Plan Nos. 55, 64, 71 by six months to 30.06.21 was withdrawn by the Workforce Director. Divisions will be engaged at PRM regarding recovery planning for both Appraisals and Mandatory Training in February with the plan to feedback considered timeframes at March IPB. It was agreed that Mandatory Training Plan Nos.12, 32, 63, 70 would move to Red in line with the status of Appraisal plans for consistent reporting purposes.

- Plan No 7: Performance reporting: Moves from Green to Amber and the 28.02.21 completion date is not being extended. There is one outstanding action regarding RTT Training and the plan is to identify and train staff without impacting the organisation during the pandemic.

Other information:

- External Maternity assurance visit undertaken 17.02.21

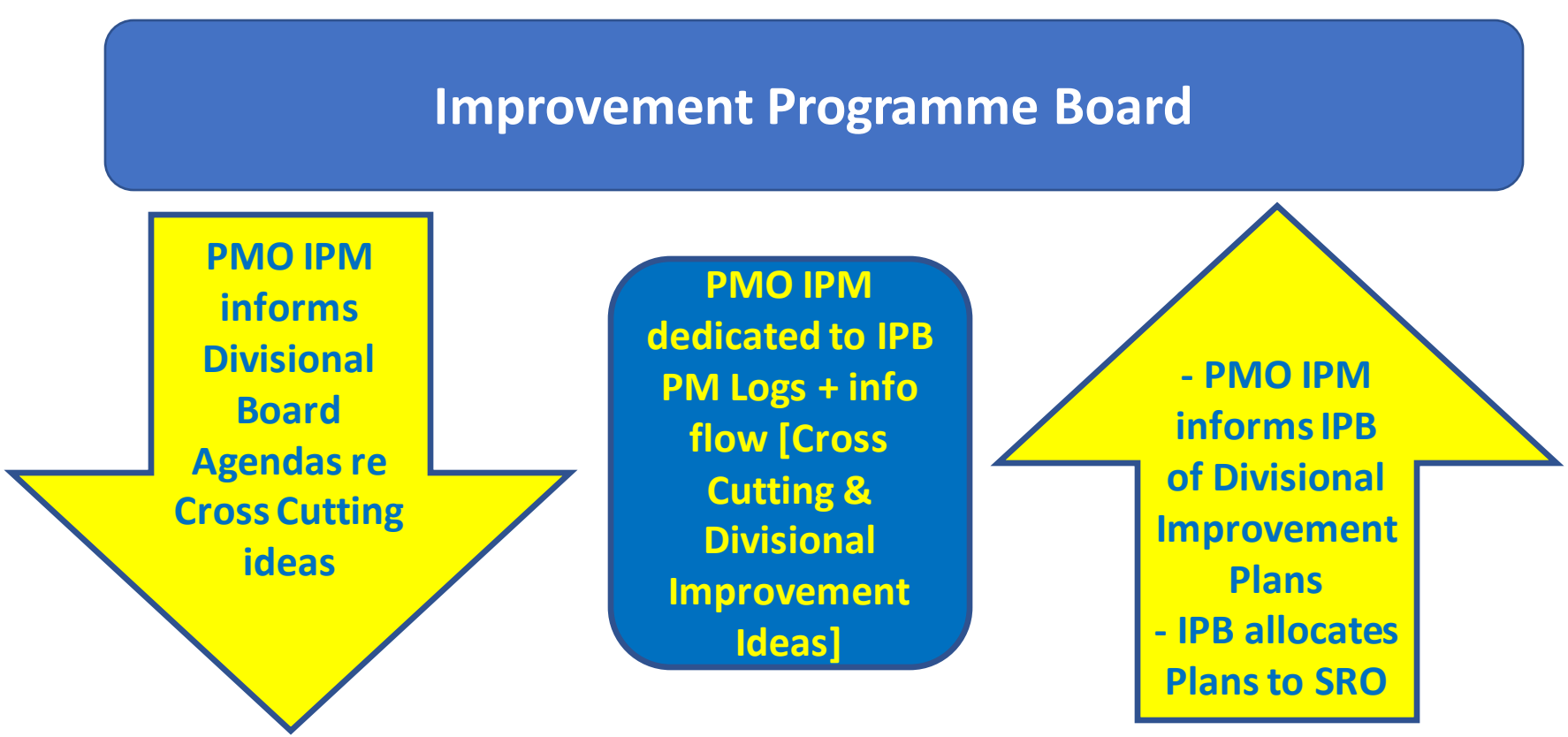
- CCG Chief Nursing Officer met with WSFT Community Service Head of Nursing to review Plan No. 31 – Recording Pain Assessments in the Community

- Stage 2 Improvement Programme audit will be undertaken in February 2021

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	See individual references throughout the document
Recommendation: 1. Note the report and contents 2. Approve the updated Trust improvement plan (Annex A)	

Appendix 7: Trust Improvement Plan - IPB links with Divisions



Next Steps / Actions

1. ADO's add IPB as Divisional Board Agenda item:
   a. Cross Cutting
   b. Divisional Improvement Ideas
2. PMO IPM allocates WSFT Improvement Programme Reference Numbers to Improvement Plans
3. WSFT Improvement Plans added to SRO Cluster Group & plan prioritisation agreed
4. PMO appointing Improvement Project Managers (IPM's) to support divisional project delivery as an embedded resource
5. Link to wider Quality & Patient Safety Governance / Link to Divisional Governance Manager

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale
1	The trust must take definitive steps to improve the culture, openness and transparency throughout the organisation and reduce inconsistencies in culture and leadership. To include working relationships and engagement of consultant staff across all services.	1. Implement Trust-wide staff engagement project to elicit feedback to inform decision-making, including establishment of a BAME Staff Network. 2. Establish an executive team development programme, including 360. 3. Utilise the medical engagement scale to better understand and support improvement for the factors underpinning clinical engagement. 4. Establish a staff psychological support service to enhance well-being support for our teams. 5. Provide an organisational development update to the Board.	Stephen Dunn	Jeremy Over	Green	**28.02.21** ~~31.03.21~~ ~~30.11.20~~	**IPB Update 08.02.21: Key actions presented below (1 - 9) in response to stated improvement actions. <u>The work to continue and embed these actions in incorporated into our People Plan</u>.** **1. 'What Matters to You' captured feedback from over 2,000 staff with 5 key themes arising. Shared Trust-wide through Green Sheet on 4.9.2020. 2. People Plan for WSFT incorporating WMTY, Jus on 6.11.2020** **3. Board Development programme in place; proposal for next steps approved at Board in Nov. Revised Executive Director objectives for 2020/21 agreed and being tracked. 360 feedback proposal** **4. M.E.S is ready to launch, working with BWLG and following a briefing to MSC in November. Decision to pause at January IPB due to current impact of pandemic.** **5. Staff Psychological Support service established and operational. Recruitment to expand the team complete. Feedback from service fed into culture plans. Progress shared with ICS who want t** **6. BAME and Disabled staff networks set-up. Comms support to improve profile in place. Annual E&D report to TEG and Board in September.** **7. 4xHRBPs recruited and commencing during period Sept-Nov 2020, aligned to clinical divisions.** **8. Regular workforce director report to Board now established, with feedback incorporated.** **9. Plan submitted to H.E.E. detailing actions to respond to the concerns raised by the review.** Other Updates via SRO Cluster and Planning Reviews: - Merseycare NHS Trust presented their 'Just and L November. - HR Business Partners recruited to support cultural improvement with review and implementation of HR policies that is consistent. HR investigations paused to check all restorative options considere 2020 national NHS staff survey launched this month. Concern re. survey 'fatigue' coming quickly on the heels of WMTY. Weekly COVID workforce and staff support engagement meeting continues to meet Medical Director leading on clinical director role development
2	The trust must ensure the culture supports the delivery of high quality sustainable care, where staff are actively encouraged to speak up raise concerns and clinicians are engaged and encouraged to collaborate in improving the quality of care.	1. Recruitment a new Lead Freedom to Speak Up Guardian, who in turn will develop a network of Speak Up ambassadors. 2. Implement lessons learned from external review of whistle blowing matters	Stephen Dunn	Jeremy Over	Green	**28.02.21** ~~31.03.21~~ ~~30.11.20~~	**IPB Update 08.02.21:** **1. Interviews for FTSU Guardian completed 11.08.2020. Amanda Bennett & James Barrett appointed. Publicised in Green Sheet 2.10.2020. AB commenced 1.10.2020, JB on 01.11.2020. Contact arra** **2. Further Speak Up plans and improvements detailed in separate project plan within IPB pack.** **3. External review in progress. Information gathering phase still ongoing.** **4. Proposal for the future oversight and governance arrangements for workforce and culture to be developed, to include option of a WSFT People Board, mirroring ICS and Regional arrangements.** **5. Staff consultation programme undertaken to support Pathology transfer. Dedicated HR support in place. Transfer took place 1.11.2020.** **6. Anaesthetics team have fed back to execs following consideration of report's recommendations. Support being provided to new Clinical Director and Clinical Leads for the specialty. Action pla** **7. Task and Finish Group to enhance support for staff in stressful times established. Survey launched to all staff in November. Results received and being analysed.**
3	The trust must ensure that processes for incident reporting, investigation, actions and learning improve are embedded across all services and that risks are swiftly identified, mitigated and managed. The trust must ensure that incident investigations and root cause analysis are robust and that there are processes for review, analysis and identification of themes and shared learning.	1. Review of current incident pathways and their compliance to highlight areas for improvement. Include the outcome of this review in the design of new pathways as an integral element of the implementation of the Patient safety & improvement framework (PSIRF) 2. Ensure all divisions are supported to achieve these outcomes through the central patient safety / clinical governance team	Susan Wilkinson	Lucy Winstanley	Black	**31.01.21** ~~30.06.20~~ ~~31.12.20~~	**IPB Update 08.02.21: The request to IPB is to move the action to Black (Complete). PSIRF launched on 1st Feb 2021. Reviewing pathways to inform improvement will commence as part of the assu** **- All divisions have a Patient Safety & Quality manager to ensure the divisions are supported to achieve these outcomes through the central patient safety / clinical governance team** IPB Update 11.01.21: Plan remains on track for completion on 31.01.21. IPB Update 14.12.20: Please refer to November IPB update below. There are no further updates this month. Update 10.11.20: IPB have approved requests to extend plan target date to 31.01.21 and to move the plan RAG to Green. Update 09.11.20: Request to IPB is to move the plan RAG from Amber to Green and to extend the end date to 31.01.21. The plan has been reviewed and there is a three stage approval process for PSIRP includ -PSIRP pilot site work is due to start and complete by end October -Project leads and HoNs are conferring to develop a new way to ensure learning is shared at ward level -Number of actions in plan has been revised accordingly. Update 18.10.20: Plan updates made to accommodate issue of wider shared incidents learning which can be accommodated via cross cutting framework approved at IPB. Update 12.10.20: Request to IPB is to approve the move the overall Plan RAG to Amber as work is progressing within constraints of: - National PSIRF programme - WSFT review of Patient Safety and Quality Expectation PSIRF document accounting for organisational changes complete 31.12.20 1. Trusts Patient Safety and Learning Strategy document is on intranet - will be informed/updated with outputs from internal PS&Q review and Project Group - WSFT PSIRF Project group formed first meeting first week August 20. - Co-production with PSIRF being developed at ICS meeting in partnership with Trust. - Regional and National meetings have recommenced following Covid-19. - Heads of PS, Clin Gov, Human Factors, LfD and QI have established an internal informal forum and will continue to work closely together through structure review - Review of (non SI) incident pathways / addressing untimeliness of investigations is dependent on PSIRF work 2. A PSIRP stakeholder consultation will be undertaken when draft is complete. There have been two PSRIP Project Group meetings and a third planned to develop the document which will need to be signed off - JD for divisional Governance Manager under review taking in to account divisional / service level requirement to support consistency ref: incident investigations, learning and improvement - PS, Human Factors, QI, LfD working together to establish framework for regular shared learning bulletins and events on track for Aug 20 - PSIRF education, training to be rolled out
4.1	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - clinical audit is monitored and reviewed to drive service improvement.	1. Review and define opportunities to improve the current organisational pathways for recording and reporting on local and national audit participation including consideration of a new bespoke audit information system. 2. Working with divisions, develop a structure to enable the inclusion of audit actions within wider divisional improvement plans 3. Widen the scope of clinical effectiveness to address all elements of national best practice including but not limited to NICE guidance, Royal college publications, HSIB and other national best practice publications	Nick Jenkins	Rebecca Gibson	Amber	**31.03.21** ~~01.07.20~~ ~~31.12.20~~	**IPB Update 08.02.21:** **Request to IPB is to move the plan from Red to Amber as an appointment has been made to the substantive Clinical Audit post with 08.03.21 start date. The appointee should be able to hit the gro** **B4 support role within the wider Trust restructuring which would provide additional capcity and the prepared VAF will be submitted for approval. The requirement for agency to fill the remaining 6** **has been the long standing plan. There are acknowledged challenges regarding an interim appointment progressing / coordinating the delivery of the work whilst home working and the plan actio** **- Paper being written to go to next CSEC meeting early March ref HSIB Plan to address non Maternity publications. (Maternity publications already being done)** **- Ref: Developing a guide to represent audit actions within wider divisional action plan - now incorporated within wider Q&S Strategy following Dec 20 meeting - to be extended across services in o** IPB Update 11.01.21: Progress has been made this month but the plan cannot move to Amber until the interim appointment is made as there may be a lengthy notice period for the substantive appointee and the end date is 31.03.21. - Appointment made to Clinical Audit post. Start date to be agreed. - Agency has provided details of a potential interim solution and the aim is to agree a contract when the start date for the substantive is known. - Maternity meeting took place in December. Output will be encompassed in Maternity Quality & Safety strategy currently under development. - HSIB plan – paper being written to go to next CSEC meeting to address non Maternity publications. (Maternity publications already done)

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4.2	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - mortality reviews are monitored and reviewed to drive service improvement.	1. Set up the National Medical Examiners service which will review all deaths and agree a reporting pathway into the trust for any cases requiring further review. 2. Supported by the appointment of a Learning from deaths (LfD) caseload manager; 3. Implement the LfD strategy including the specific action to streamline and centrally capture learning from local M&M reviews	Nick Jenkins	Jane Sturgess	Black	**31/03/21** ~~01/07/20~~ ~~31/10/20~~	**IPB update 08.02.21: Request to IPB is to move plan to Black (Complete) and begin the audit process. Improvement actions 1 and 2 are complete. Mortality reviews are being monitored and reviev process.** Cluster Update 25.01.21: Suggest request to IPB to extend completion date to 31.05.21. The action to develop a communications strategy between ME & Families following deaths and ensure links with LfD team is progressing. A strateg Medical Staffing Committee and senior leaders and is going to VOICE for discussion in January. Feedback will be complete by end of Feb at which point SOP can be written with realistic end date April / May 202 - ME to LfD pathway will be BAU subject to audit to be presented at April '21 SRO Cluster - Cases are being referred on PALS to LfD pathway and so action is complete (Black). BAU will require process audit to be led by PALS to ensure cases are not missed and are completed in a timely fashion. - A structured LfD QI Plan is in place but Trust reporting pathways still under review and will require full alignment to complete.
4.3	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - incidents are monitored and reviewed to drive service improvement.	1. Through participation in the national pilot for the implementation of the Patient safety & improvement framework (PSIRF) design pathway for monitoring, investigation and review of outcomes from incident reporting 2. Implement the trust patient safety & learning strategy developed in 2019	Susan Wilkinson	Lucy Winstanley	Black	**31.01.21** ~~30.06.20~~ ~~31.12.20~~	**See No 3**
4.4	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - complaints are monitored and reviewed to drive service improvement.	1. Undertake NHSE&I patient experience framework assessments across the whole Trust 2. Review of divisional reporting of actions and learning from complaints, including accurate recording of service improvement linked directly to changes as a result of feedback	Susan Wilkinson	Cassia Nice	**Blue**	31.10.20	**IPB Update 14.12.20: The PALS service compliance regarding the timely response to complaints has achieved the 90% target every month since April 2020.** The Cluster update 17.11.20: Blue now approved by IPB. BAU now being monitored via board attendance and papers being provided quarterly. Update 09.11.20: Request to IPB is to move Plan 4.4 to Blue (BAU) as 3 board papers have been collected demonstrating attendance. A member of the patient experience team are in attendance at divisional boa compliments, formal complaints and Friends & Family Test satisfaction results. There is cross-cover to ensure consistent representation. Papers are sent to the group ahead of the meeting to allow for discussion Update 20.10.20: Plan is reported as on track to move to BAU on schedule. Update 12.10.20: The overall RAG is expected to move to BAU (Blue) in November based on 3 months compliance data being collected in terms of attendance at divisional board meetings. Divisional board minutes will be include - The plan is to return to IPB in November with an ongoing BAU assurance plan e.g. review sample of learning and testing the implementation with divisions. The outputs will form part of the quarterly report to PE Update 14.09.20: - All actions complete - Team attending divisional board meetings to evidence BAU - Quaterly 'You Said/We Did' ward posters prepared to demonstrate engagement with patient feedback. There will be a running programme for these to be updated and displayed to evidence ward-level service i
5	The trust must ensure that effective process for the management of human resources (HR) processes, including staff grievances and complaints, are maintained in line with trust policy. To include responding to concerns raised in an appropriate and timely manner and ensuring support mechanisms in place for those involved.	The management of HR processes, including investigations, will be strengthened by embedding the following in practice: 1. Monitoring time lines for each case 2. Reviewing cases that are not progressing in a timely fashion, taking action where possible. 3. Actions to be recorded on the database and effectiveness reviewed at subsequent fortnightly Case Review meetings. 4. Escalate cases where there is a significant delay to the Executive Director of Workforce for review in regular meeting with Deputy Director of Workforce 5. Consider use of external investigators where there is a lack of internal investigatory resources 6. HR Policies will be reviewed to ensure a more kind and compassionate approach that is aligned to a 'just' culture.	Jeremy Over	Claire Sorenson	Green	**31.03.21** ~~31.10.20~~	**IPB Update 08.02.21: The December IPB update is current and correct with the addition that fortnightly case review meetings are now in place although the cases themselves are limited in number** **IPB Update 11.01.21: The December IPB update is still current and correct.** **IPB Update 14.12.20:** **- 10 Trust representatives attended Merseycare/Northumbria University training in November - "restorative just and learning culture"** **- Meetings began 10/12/20 to develop our WSH plan to commence the implementation of this cultural change within the Trust** **- Investigation toolkit, flow chart, guides, template letters, ToR template, Commissioning Manager's checklist, Support Manager/HR advisor's checklist and 'Just Culture' investigation training prog underway, starting with the Disciplinary processes and policy** **- Escalation of cases with significant delay is an embedded way of working** **- Fortnightly Case Review meetings are in place to commence in January.** IPB Update 09.11.20: - Recruited 4 HRBP all in place by 2.11.20. Supports cultural movement. Update 12.10.20: - HR Business Partners are currently being appointed to lead on adopting and embedding kind, compassionate and inclusive processes and ways of working. - HR Business Partners will be aligned and support all divisions and corporate services across the Trust. - HR Business Partners will also support a planned review and development of HR policies to ensure they are written and advise kind and compassionate investigations which are followed by managers and leade [Policies for Review by January 2021: Disciplinary, Capability, Improving Health, Wellbeing and Attendance, Grievance, Bullying and Harassment, Freedom to Speak Up, Appraisals, Organisational Change]. Oth - Merseycare HR policies received and will be reviewed as a benchmark for our own HR policies - Formulataion of an Investigation Toolkit is progressing and due to complete in November '20, utilising a working group. - The wider HR Team will support our managers to ensure delivery of compassionate and timely HR Investigations, effectively supporting staff through the investigation process. - A training programme provided by Merseycare and Northumbria will take place in November - A pre investigation assessment process is currently being introduced to ascertain whether informal interventions and measures are taken rather than launching a formal investigation process.

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6	The trust must ensure that robust processes are embedded for patient follow up appointments and those on surveillance pathways. To include systems and process for regular oversight and assurance that patients are not being lost to follow up across all specialties within the organisation.	1. Review, re-design and embed processes for booking and monitoring of all follow up patients, including ward attenders. 2. Develop and embed Standard Operating Procedures for patients on a surveillance pathway. 3.Identify and deliver training for process changes to relevant staff groups for both follow ups and surveillance. 4. Design and embed electronic and reportable surveillance worklist within each department. 5. Design process for accountability and escalation of issues for all surveillance pathways. 6. Work through an audit process of patients who are on the missing follow up list. 7. Design a new tool with cerner for a follow up PTL that can combines the qualities of the missing follow up list with those of the specialities own worklists	Helen Beck	Hannah Knights	Amber	**31.03.21** ~~01.08.20~~	**IPB Update 08.02.21: Expect plan to move to Green 22.02.21 and Black (complete) in March. Audit plan in place ensuring progress visibility.** **IPB Update 08.02.21** **Follow Ups: Outpatient workflow SOPs complete and will be added to the Trust Intranet. Training programme will run via ESR which is due to commence 22nd February, with completion by 31st Ma** **therefore be the date that all outpatient areas use message centre for follow up appointments.** **Options to upgrade the data quality dashboard with added functionality of electronic follow up request lists are still being explored, with positive demonstrations from other Cerner sites using this** **Surveillance** **First surveillance review meeting held with service leads on the 2nd February 2021 to review surveillance pathways that are currently overdue and actions in place to resolve. This information will f** **Audit of surveillance pathways will commence in March 2021 and become part of the Trusts yearly audit programme.** **Automated electronical surveillance lists are being explored but this is a longer term aspiration** Update 21.01.21: Certain key early to mid January meetings were delayed due to Covid-19 but have been re-scheduled to 21.01.21. IPB Update 11.01.21: Key meetings to be held as from mid-January. The December IPB update is still current and correct. Cluster Update 17.12.20: Plan has now been rationalised and remains Amber. In order to go Green all reportable electronic waiting lists will need to be in place. Further update will follow meetings planned for Ja IPB Update 14.12.20: - Follow ups – Demo of new data quality dashboard has been reviewed and a package offer is awaiting with financials. This includes a possible tool to create an electronic follow up waiting list. All of the relevant S and full training will commence for roll out early in the New Year. - Message Centre: The roll out of the use of message centre for appointments is the first priority and this will be implemented before the end of the year. - Surveillance – All SOPs for each surveillance pathway are now finalised. Databases are currently still held within local departments however solutions for surveillance worklists are being reviewed. Change reque - Next steps; each department to report surveillance numbers in weekly access meetings, divisional boards and PRM from January onwards. Responsibility of SOP maintenance and audit framework to be agreed - Plan will be ready to move to Green when the Follow Up and Surveillanve waiting lists are electronic. Update 18.11.20: A package offer from MBI regarding the new dashboard is being awaited, which looks like it will cover all requirements. Use of Message Centre/eCare for secretaries is ready to go, subject to tru surveillance database is useful as an MDT/clinical tool and worklists are to be rolled out on this basis, although the need for a separate reporting mechanism has been identified and the Information Team are wor IPB Update 09.11.20: Move to Amber approved.
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.	The main themes from the actions plans are: 1. RTT Reporting – update to the reporting solutions to remove as many as possible of the manual workarounds within RTT reporting. Requires support from Cerner on technical fixes and testing by the WSFT Information Team. 2. RTT Training – working with users of the system and patient pathway trackers to ensure accurate information recorded relating to RTT pathways. 3. Data Quality – work to ensure there is a programme in the organisation to focus specifically on DQ. 4. Theatres Information – development of the initial theatres dashboard after end user pilot to version 2.	Craig Black	Nickie Yates	Amber	**28.02.21** ~~31.12.20~~	**IPB Update 08.02.21: Agreed at IPB to move back from Green to Amber and the end date remains 28.02.21. Plan is to identify and train some staff re remaining training action which will not impact organisation negative** **'IPB Update 08.02.21: Verbal update by SRO.** 'IPB Update 11.01.21: Data Quality: - The request to IPB is to extend the completion date to 28.02.21 as the earliest expected timeframe that the DQ strategy papers can be processed via TEG is 1st February 2021 at which point the clinical input will have been completed a - The DQ Manager recruitment process will also be progressed in January and the post will be filled as per relevant notice period for the succesful candidate. RTT Training: The RTT Training launch is planned for early January and so this will also complete within the revised timeframe (subject to confirmation by the Head of Elective Access). IPB Update 14.12.20: Data Quality: - Approval of Data Quality Strategy expected at Dec 20 TEG. Still awaiting some feedback regarding nursing and clinical aspects of strategy. - Strategy Job Description for Data Quality Manager progressing RTT Training: - NHSE/I are supplying package regarding e-learning solution nationally for RTT Training. This will replace previous plans to procure from external training provider, saving money in the process. Head of access to confirm when NHSE/I 'IPB Update 09.11.20: SRO to provide verbal update. IPB Update 12.10.20: SRO to provide verbal update Update 07.09.20: Request IPB approval based on+S16 progress regarding collation of RTT training data and data quality work to move Plan 7 from Amber to Green based on Dec 20 completion timeframe. - Next steps rationalise plan before next SRO Cluster' Update 03.08.20: 1. RTT Reporting: workarounds with significant risk addressed - modifications built in to system hence relevant actions BAU (Blue). A bespoke e-learning package is being considered for those still outstanding from Ideal Health. Update defined outcomes. [Blue] 2. RTT Training: Remains amber. List of trained / not trained will be reviewed at next cluster and agree training compliance threshold. Update 10.08.20: Plan is to bring data regarding those requiring training and training delivered and se can be determined not yet available but information is being gathered. Meeting 31.08.20 re producing new e-learning through external company to monitor compliance with training. Cut-down e-learning training versions produced for clini 3. Data Quality: Data Quality strategy going to IG Steering Group 05.08.20 and agreement is crucial to completing the action at which point the overall RAG for Plan No 7 can move to Green and the embedding evidence will for the DQ S Update 07.09.20: Further engagement with key stakeholders required before returning to IGSG in October and then to TEG. End date Dec 20 so project is Green. 4. Theatre Dashboard live and approved via Trust Board. Use of dasboard embedded so can move to Blue
8	The trust must continue to develop information technology systems and integration across the community services	1. Submit Business case for approval at Trust Board 2. Appoint Project Manager 3. Establish programme reporting governance to Digital Board 4. Undertake technical reviews at Community Sites 5. Undertake infrastructure upgrades including service migration, provision of laptops and remote access solution 6. Monitor programme delivery	Craig Black	Mike Bone	Blue	31.12.20	Update 31.07.20: Change Control: End date moved to 31.03.21 with additional item No 5 in MB Plan version 31.07.20 for IPB approval 10.08.20 Update 03.08.20: 1. Business Case approved at Trust Board in March 20 2. Project manager appointed 3. Programme Reporting to the Digital Board is now an embedded process 4. Reviews of technical requirements in Community completed 16.07.20 which can be evidenced. 5. Infrastructure upgrades have been signed off and are being implemented. 6. Programme delivery being monitored via Digital Board and key risks and mitigations identified including partner (NEL CSU) Community data storage/transfer. Move Plan 8 to Black. IPB approval required. Update 10/08/20: IPB approved move to Black as all CQC requirements have been met although it is acknowledged improvement of Community IT will be a permanently ongoing process. **Update 10.08.20: The plan contains actions with defined outcomes in line with the agreed actions and these are already operational and so the IPB has agreed to move the plan to Blue (BAU) whilst**

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9	The trust must continue to take action to improve performance against national standards such as the 18 week referral to treatment (RTT) standard, six week diagnostic standard ad access standards related to suspected and confirmed cancer management	1. Develop business cases for Orthopaedics, Ophthalmology, General Surgery and Gynaecology 2. Business Cases to include up to date demand and capacity models, outline plans and costings to reduce current backlog, whilst balancing demand to enable the services to meet the national standard. 3. Continue to update Action Plans for all other specialities on a monthly basis 4. Review and monitor plans at new RTT steering group meeting with the ADO's, Weekly Access Meeting and Cancer PTL Meeting 5. Develop comprehensive action plan for Endoscopy now demand and capacity exercise complete for review at new bi-weekly Endoscopy oversight meeting	Helen Beck	Hannah Knights	Red	31.3.21	**Update 22.10.20: Holding statement has been written to reflect the fact that this plan is no longer monitored at IPB but remains visible in the SRO Cluster pack.** Update 02.09.20: Request to IPB is that Plan 9 is removed from list of plans reviewed in detail at IPB as the actions are no longer valid and the work is being covered in other forums. Otherwise the plan actions v development of business cases (2). Updates discussed in 02.09.20 SRO cluster meeting: Cancer - System demonstration planned w/c 07.09.20 to develop cancer training strategy Diagnostics - Work continuing to assess the impact of new guidance on post polypectomy and post cancer resection surveillance guidance. Now reviewing patients due 2024 RTT: -RTT Business Cases awaiting approval for CT, MRI, Endoscopy re Covide Recovery -RTT Action Plans will be revirewed in detail at the weekly access meetings from 09.09. Plan information including revised waiting lists, actions and risks to recovery. - Further amendments will be made to the RTT National Validation Programme participation information. First upload was completed 27.08 followed by contact with the national team 27.08. So far only a few rec
10	The trust must ensure that the duty of candour is carried out as soon as reasonably practicable, in line with national guidance	1. Continue to highlight key areas of non (or late) compliance via the IQPR and divisional performance reporting pathways. 2. Seek staff feedback on reasons for non (or late) compliance with DoC to identify opportunities for improvement using QI methods 3. Enable staff to fully achieve the remit of the Being Open framework through provision of training and support recognising that the patient / family conversations can be emotive and distressing both for the families but also the clinicians providing that message on behalf of the organisation	Susan Wilkinson	Lucy Winstanley	Black	**31.12.20** ~~31.10.20~~ ~~31.08.20~~	**IPB Update 08.02.21: January update remains current and correct: plan is marked complete and Duty of Candour improvement work is continuing as part of PSIRF and the PSLS.** IPB Update 11.01.21: The request to IPB is to move the plan to Black (Complete). The Duty of Candour improvement work will be captured as part of PSIRF and the Patient Safety and Learning Strategy. IPB Update 14.12.20: The request to IPB is that the overall RAG for the plan is moved from Red to Green. The service is BAU in terms of the agreed CQC actions and has gone over and above these commitments as presented in previ context of a review regarding the development of the PSIRF work Update 20.10.20: Development of webinars and other training forums are being considered as a short-term solution for DoC training until a more robust trust-wide patient safety training programme is in place. IPB Update 12.10.20: Co-production approach with support from Suffolk Healthwatch agreed to oversee assurance process. Update 12.10:20 Plan subject to same constraints as Plan 3 with development of the Trust's Patient Safety and Quality Agenda. -- DoC Mandatory training and education will be provided for consultants, senior nursing staff, senior managers and executive directors regarding offering effective and empathetic apologies to patients and families where there has been - Review of PS&L strategy now reflects data sources, training requirements and consideration of document through PSIRF - Registration of DoC Improvement Plan, Datix review and introduction of data in PRM all complete, - IQPR/compliance monitoring on track but not embedded - Matrons and CD meetings will be part of escalation mechanism - Daily briefings have been key in improving timeliness of completion / also reporting in PRM - DoC work is continuing. The actions are designed to improve what currently doing. Challenge is to understand how better to support staff to complete the DoC and that compliance is timely including complex patient groups and this is
11	The trust must ensure effective processes are in place to meet all the requirements of the fit and proper persons regulation	1. Put in place clear procedures that ensure full compliance with all FPP requirements and record keeping, including recruitment, ongoing declarations and appraisal. 2. Implement structured reporting and audit of compliance through the audit committee.	Jeremy Over	Angie Manning	Green	**28.02.21** ~~30.11.20~~	**IPB Update 08.02.21: Plan 11 will move to Black when final document versions have been ratified by internal audit (date tbc).** **- Fit & Proper Persons Policy updated and approved by Trust Council members Jan '21 and is on the Trust intranet** **- Robust reporting checklist has been developed and approved by the Executive Director of Workforce and Communications and Trust Council members** **- Final audit has gone back to auditors and evidence is being collated re audit response queries** **- The final versions of these will need to be ratified at the Audit Committee** IPB Update 11.01.20: Update provided at December IPB is still current and correct. IPB Update 14.12.20: Request to IPB is to extend completion date to 28.02.21. - Draft audit report has come through and WSH responses have been added and sent to the Executive Director of Workforce and Communications for review - More robust reporting checklist has been developed and has been sent to the Executive Director of Workforce and Communications for review - Necessity for minor changes to the policy has been identified - The final versions of these will need to be ratified at the Audit Committee
12	The trust must ensure that mandatory training attendance, including training on safeguarding of vulnerable children and adults, improves to ensure that all staff are aware of current practices and are trained to the appropriate level	1. Build, review and implement the mandatory training recovery plan with tracking to ensure 90% compliance	Jeremy Over	Denise Pora	Red	**31.05.21**	**Update 08.02.21: Move plan to Red. Real concerns amongst staff about achieving these targets. MT will be reviewed with divisional teams at PRM to determine realistic delivery timeframe and fee applies to appraisals.** **Update 08.02.21: Suspension of face-to-face training, including mandatory and with agreed exceptions, extended to 31.3.21. The Trust is highly unlikely to achieve 90% compliance in all subjects (the capacity of staff to undertake it – which are severely compromised by the impact of the pandemic. The prioritisation of mandatory training will need to be set in the context of the overall trust re to achieve 90/95% compliance will be developed by the Education and Training team working with the Mandatory Training Steering Committee by 30.4.21** IPB Update 11.01.21: Mandatory training recovery plan to be reviewed and reset in the light of cancellation of all face-to-face refresher mandatory training for at least six weeks from 6th January 2021 IPB Update 14.12.20: - Two actions outstanding including tracking process for which deadline is 31.05.21. Still dependent on implementation of ESR Self Service. - Mandatory Training recovery plan implementation contines with end date 31.03.21. Update: Overall MT compliance risen by 1% based on 08.10.20 data Update 12.10.20: Multiple additional activities are in place to improve Mandatory Training compliance including Moving and Handling, Resuscitation and Conflict Resolution for both Acute and Community staff. T greater staffing capacity risk with winter approaching. The divisions will be engaged with the diverse training offer and compliance rates monitored to enable staff to take the required time off to complete their ma Update 09.09.20: Compliance slightly down on last month. Mandatory training requirements have increased due to additional winter pressure recruitment and additional provision being made. This is exacerbating including OOH and external providers. Issues of staff not attending at short notice and courses running under capacity being addressed via MTSG.

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13	The trust must ensure staff complete patient risk assessment to identify patients at risk of deterioration and risk assessments for day to day care activities.	Put eCare change requests in place to amend: 1) Changes to triage form, mandate safeguarding concerns yes/no box 2) Changes to triage form, mandate falls history/risk of yes/no box, to then generate ED falls assessment if yes ticked 3) Changes to ED safety checklist, to mandate all fields, to add n/a column, to move pressure area assessment from 2nd hr to 1st hr, to add drop down box on pressure area assessment to choose from skin intact, DTI, category 1-4 (to be able to choose more than one) 4) To mandate observation, pain score fields on triage form for both adult & paediatrics 5) To communicate changes to staff 6) To complete weekly audits to monitor compliance 7) To request compliance data from the information team 8) To have 1-1 with staff to identify areas of concern and address if required 9) Add to perfect ward 10) Monitor through weekly compliance audits and regular communications with ED staff re changes and be proactive with feedback re further changes	Susan Wilkinson	Ian Pridding	Blue	31.8.20	**Update 12.10.20:** **SW to provide 3 months data for LN. LN to provide external assurance re ED data. Assurance visit will be planned reporting back to IPB Dec '20.** **- Plan 13 will move to appendix 6 for BAU Plans from November as holding place for Blue (BAU) Plans within the pack.** **- Appendix 6 will inform Appendix 2 Schedule of Embeddeness to include BAU quarterly reviews** Update 14.09.20: Request to IPB to move Plan 13 to Blue (embedded) as 3 months compliance data is in place and process to address compliance issues embedded - All actions complete and 3 months compliance data now received from information team. - A 4% - 7% dip was identified overnight between+S26 9pm - 4am with the lowest compliance at 93% on Fridays. - This is being addressed by the co-ordinators - Weekly compliance audits are in progress - Safety checklist also added to the Perfect Ward App
14	The trust must ensure staff record medication temperatures and escalate any concerns in line with its medications policy.	1) Pharmacy to audit all fridge temperatures in Emergency Department. Actions to address issues resulting from temperature audit: - Introduction of trays into the fridge to keep stock together to minimise time looking for drugs - Pharmacy Assistant responsible for stock replenishment to return all excess fridge stock to pharmacy to improve airflow within the unit - Assess requirement of rigid cold blocks in fridge and remove if unnecessary - Installation of more accurate external fridge thermometers on advice of pharmacy - Request monthly audits from pharmacy to ensure continued compliance 2) Ambient temperature monitoring Ensure appropriate systems and processes are in place to monitor ambient room temperatures in areas where drugs are stored and appropriate escalation processes where required. Actions to address issue: - Installation of thermometers in all rooms used for storage of drugs. - Introduction of ambient room temperature checking on to existing fridge temperature checks - Compliance to be audited within monthly perfect ward assessments 3) Escalation of increased temperatures Ensure appropriate escalation of increased temperatures to Unit Manager to ensure appropriate action taken Actions to address issues - Email communication to all staff to remind to escalate high temperatures to Unit Manager (regular escalations since communication.) - Issue included in weekly hot topics discussed at all handovers. - Unit manager informs pharmacy of any escalations to ensure appropriate actions if required. 4) Long term strategy: Trust wide consideration of centralised temperature monitoring	Susan Wilkinson	Dona Bowd	**Blue**	31.08.20	**IPB Update 14.12.20: Request to IPB is move plan to BAU (Blue) based on external assurance visit findings:** **Monitoring and assurance** **• Daily checks of fridge and ambient room temperatures.** **• Monthly perfect ward audits.** **• Outcomes of pharmacy audits.** **• Evidence of fridge, ambient room checks; evidence in range; evidence of escalation when out-of-range and appropriate actions re stock.** **Cluster Update 16.11.20:** **Plan changed to BLUE pending approval at next IPB.** IPB Update 09.11.20: Expectation is that this plan will move to BAU at December IPB subject to assurance visit 20.10.20 report and IPB approval. Update 12.10.20: Evidence gathering process underway. Expectation is that plan moves to BAU November 2020. Update 14.09.20: All actions complete. Data gathering in progress including daily manual checks and monthly Perfect Ward audits.
15	The trust must ensure that staff records in relation to equipment and medication checks are completed.	1) Review of documentation for equipment and medication checks Departmental review of existing documentation with a view to simplifying checklists and improve compliance. 2) Review of online checking duplication of paper and online checking was causing confusion and impact on compliance. 3) Long term strategy to replicate improved paper checklist on to the online system. 4) All changes communicated to staff via email and hot topic	Susan Wilkinson	Dona Bowd	Black	**31.11.20** ~~31.10.20~~ ~~30.09.20~~ ~~31.03.20~~	**IPB Update 08.02.21: Online resus trolley checklist has been live since 23.11.20 with a smooth transition from paper to online. Compliance data will be captured and the expectation is that the plan** IPB Update 11.01.21: In process of capturing 3 months assurance data. IPB Update 14.12.20: Request to IPB is to move plan to Complete (Black) as system issues have been resolved with go live date 23.11.20. Update 09.11.20: Request to IPB is to extend the completion date by one month to 30.11.20. Revised plan is to go live 09.11.20 with final IT tweaks resolved. This item is also subject to the external assurance recommendations Update 20.10.20: The project is delayed due to technical problems. Online checks cannot continue until November and so the plan has moved back to Amber, despite its end date having been extended to 31.10. Update 12.10.20: Request to IPB is to extend project completion timeframe by one month to 31st October. Changes in IT staffing mean that final tweaks to template re online resus checking still need to be comp Update 14.09.20: - Final action on plan now green. No further delays are expected and so IT will finalise and upload online customised chacking template for ED by the end of September '20, in line with extended completion timeli
16	The trust must improve medicines management, particular in respect of management of controlled drugs, storage of patients' own medications and monitoring ambient room temperatures in drugs rooms.	<u>Controlled drugs and storage of patients own mediciation</u> 1. Review of existing policiies (confirmed as fit for purpose) 2. Ensure staff awareness of procedures and put in place systematic review of compliance 3. Ensure effective action is taken to address individual or themes of non-compliance <u>Ambient room temperatures</u> 1. Email communication to all staff to remind to escalate high temperatures to Unit Manager (regular escalations since communication.) 2. Issue included in weekly hot topics discussed at all handovers. 3. Unit manager informs pharmacy of any escalations to ensure appropriate actions if required. 4. Long term strategy: Trust wide consideration of centralised temperature monitoring	Susan Wilkinson	Simon Whitworth	**Blue**	31.10.20	**IPB Update 14.12.20: Request to IPB is to move plan to BAU (Blue) based on external visit report.** **Monitoring and assurance** **- Completed checklists.** **- Perfect ward provides assurance for compliance with completion of checklists.** **- Monthly audit for quality of checks.** **- Check lists fit for purpose and evidence safe practice, effective governance.** **- Audits used to confirm safe/effective practice and improve/further develop practice** Cluster Update 16.11.20: Actions approved as BAU at cluster level, although plan RAG reverted to Black pending external assurance IPB Update 09.11.20: The expectation is that the plan will move to Blue (BAU) at the December IPB subject to external assurance site visit and evidencing 3 months Perfect Ward audit data. Update 12.10.20: Request to IPB is to move plan to Black (complete). All actions complete preparing to move to BAU assurance process in November. - Plan to run 3-month BAU audit from Nov '20 with Perfect Ward App calibrated is on track with the pharmacy team piloting use of the audit tool presently so that BAU can be achieved by Feb '21.
17	Obsolete		Obsolete	Obsolete		**Obsolete**	

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale
18	The trust must ensure that all bank and agency staff have documented local inductions.	West Suffolk Professionals 1. A generic trust induction checklist is to be enhanced and re-implemented for all new agency and bank workers. This will be followed up with a local area induction to be completed during first worked shift. 2. Agency and Bank workers will complete local area induction on the commencement of their first shift. 3. If additional shifts are undertaken in different areas, it is the expectation of the trust that a local induction will be conducted for each new area worked. 4. All bank staff training is to be reviewed and recorded on OLM. Medical Staffing 1. All Agency staff are given induction booklets before their first day, which they are required to sign and return a statement confirming they have read and understood this on their first day. 2. Bank medical staff are formed by current training and trust doctors, therefore are covered by local induction process. Ad hoc audits will be undertaken by WSG and MS with findings reported to HRD on a quarterly basis	Jeremy Over	Chris Nevill / Helen Kroon	**Black**	**31.12.20**	**Update 08.02.21: Currently in process of collectiing evidence to support BAU** IPB Update 11.01.21: Request to IPB is to move the the to complete status (Black) as all actions are complete including the training for new starters. The scope does not extend beyond the training / onboarding IPB Update 14.12.20: 4/5 actions now complete and plan remains on track to complete within timeframe. - The process has now been implemented to ensure a generic Trust induction checklist is recorded on OLM.
19	The trust must ensure that medicines are stored securely within the main and day surgery theatre department.	1. Identify storage requirement and purchase cupboards 2. Local audits planned whilst areas accessible re Covid-19 3. Identify cupboard locations and estates to hang cupboards 4. Risk assessments can then take place 5. Perfect Ward App to be introduced to ensure compliance	Helen Beck	Irene Fretwell	Black	**31.3.21**	**IPB Update 08.02.21: All actions complete, evidence being collated to support move to BAU status.** Update 21.01.21: Confirmation email received from CCG which accepts that risk assessment is no longer required as drugs from DSU airway trolley have been removed and are securely stored in the locked drug IPB Update 11.01.21: Still awaiting CCG response which will form part of evidencing before plan can move to BAU. IPB Update 14.12.20: The decision has been taken that drugs will not be stored on the difficult airway trolley and so the risk assessment is no longer required. This information will be shared with the CCG as shar Agreement required regarding evidencing move to BAU. Further update 09.11.20: Move to Black approved by IPB IPB Update 09.11.20: Request to IPB is to approve plan move from Green to Black. Project lead has confirmed that the outstanding actions are completed regarding the risk assessment for the DSU trolley in the Update 22.10.20: CQC auditors have carried out an assurance visit on theatres, surgery and wards and gave very positive feedback, recommending the overall plan be marked complete. IPB now requested to ap
20	The trust must improve monitoring ambient room temperatures in drugs rooms.	1. MDT meeting to access temperature monitoring options available 2. Prepare baseline assessment of ambient temperatures in Clinical Area 3. Investigation cost associated with automated temperature monitoring equipment and Air conditioning 4. Ordering of Max/Min room temperature thermometers 5. Creation of Ambient temperature monitoring record book for clinical areas 6. Creation of Ambient temperature monitoring email address for wards to use to report temperature exclusions 7. Distribution of max/min room temperature thermometers to inpatient clinical areas 8. Ordering of second batch of Max/Min room temperature thermometers 9. Distribution of second batch of max/min room temperature thermometers to inpatient clinical areas 10. Creation of MedicBleep ambient temperature reporting message group 11. Creation of Perfect Ward monitoring tool for Ambient temperature monitoring 12. Completion of Risk Assessment of actions if high ambient temperatures recorded	Susan Wilkinson	Simon Whitworth	**Blue**	28.2.20	**IPB Update 14.12.20: Request is to move plan to BAU (Blue) based on external assurance visit report findings.** **Evidence for delivery** **• Outcome and recommendations from pharmacy temperature audit.** **• Communications to staff via email and hot topics.** **• Examples of escalations from staff to unit manager (email examples available)** **- Examples of escalations from unit manager to pharmacy (email examples available).** **Monitoring and assurance** **• Daily checks of fridge and ambient room temperatures.** **• Monthly perfect ward audits.** **• Outcomes of pharmacy audits.** **• Evidence of fridge, ambient room checks; evidence in range; evidence of escalation when out-of-range and appropriate actions re stock.** Cluster Update 17.11.20: Plan and Actions approved as BAU at cluster level. Changed to BLUE pending approval at next IPB meeting in Dec-20 Update 20.10.20: The expectation is that the plan will move to Blue (BAU) at the December IPB subject to the findings of the external assurance visit 20.10.20. and evidencing 3 months Perfect Ward data.
21	The trust must improve monitoring of women's records and ensure that a greater number of records are audited monthly.	Audit programme to be put into place including sampling methods and timescales	Susan Wilkinson	Karen Newbury	**Blue**	28.2.20	**Cluster update 17.11.20: IPB approved as Blue.** **Update 09.11.20: The request to IPB is to move the Plan to Blue (BAU) based on the external assurance report presented at the October IPB.** IPB Update 12.10.20: Move 21, 23, 25 and 26 to BAU (Blue). Plan No's 22 and 24 are not ready to move to BAU. Update 12.10.20: Maternity Deep Dive completed 25.09.20. Report will be presented at October IPB as part of BAU assurance process. Update 10.08.20: Deep dive approach agreed at IPB as part of assurance to move plans to Blue (BAU).
22	The trust must ensure that carbon monoxide monitoring assessments and records are in line with trust policy..	Monitor compliance through audit and (when required) action to address non-compliance	Susan Wilkinson	Karen Newbury	**Blue**	**28.02.21** ~~01.12.20~~	**IPB Update 08.02.21: IPB approved BAU status. Reassurance monitoring will take place via Maternity Improvement Plan** **IPB update 08.02.21:** **Request to IPB is to move to Blue (BAU) following 3 months of assurance data** IPB Update 11.01.21: Re-introducing Co2 by beginning of Jan '21 and will then be subject to 3 month audit as part of BAU process. Update 20.10.20: RAG status remains Black (complete) as monthly check must continue until carbon monoxide monitoring recommences (still on hold due to COVID). Update 12.10.20: Actual test for Co monitoring levels is still on hold nationally due to Covid as this is an aerosol generated procedure. Mitigation is limited to asking questions only but monitoring is in place to ensure that questions Action implemented, assurance testing ongoing. Recognised that pandemic has impacted on our ability to deliver this monitoring - this is mitigated through appropriate referral to the smoking cessation advisor. Update 08.07.20: The RAG for Plan 22 cannot move from Black to Blue (BAU) given national stop on carbon monoxide monitoring assessments through pandemic.
23	The trust must ensure that women are asked about domestic violence in line with trust policy.	Monitor compliance through audit and (when required) action to address non-compliance	Susan Wilkinson	Karen Newbury	**Blue**	28.2.20	**Update 09.11.20: The request is to move the Plan to Blue (BAU) based on the external assurance report presented at the October IPB.** Update 12.10.20: Maternity Deep Dive completed 25.09.20. Report will be presented at October IPB as part of BAU assurance process.

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale
24	The trust must ensure that they implement a nationally recognised monitoring vital observations tool for women attending triage on labour suite and the maternity day assessment.	1. Project plan for the implementation of MEOWS first in the maternity areas (complete) and then in the wider hospital for peripartum ladies (including the wider group of miscarriage, termination and ectopic pregnancies) 2. Continue to monitor compliance through audit and (when required) action to address non-compliance	Susan Wilkinson	Karen Newbury	Blue	**28.02.21** ~~01.12.20~~ ~~28.02.20~~	**IPB Update 08.02.21: IPB approved BAU status. Reassurance monitoring will take place via Maternity Improvement Plan** **IPB update 08.02.21: Request to IPB is to move to Blue (BAU) following completion of three audits** IPB Update 11.01.21: The plan is expected to move to BAU when audits are delivered by a Head of Nursing from outside the department in February rather than being completed internally at the request of the Re Cluster Update 17.11.20: New target date to move into BAU: 31.01.21. Update 20.10.20: Currently continuing monthly auditing. Update 12.10.20: Maternity Deep Dive completed 25.09.20. Report will be presented at October IPB as part of BAU assurance process.
25	The trust must ensure they implement a national recognised monitoring vital observations tool for new born babies on the labour suite and F11 ward.	1. Project plan for the implementation of NEWTTS (complete) 2. Continue to monitor compliance through audit and (when required) action to address non-compliance	Susan Wilkinson	Karen Newbury	Blue	28.2.21	**Update 09.11.20: The request is to move the Plan to Blue (BAU) based on the external assurance report presented at the October IPB.** Update 12.10.20: Maternity Deep Dive completed 25.09.20. Report will be presented at October IPB as part of BAU assurance process.
26	The trust must ensure they carry out daily checks of resuscitation equipment.	1. Key actions are to remove paper checking of resuscitation equipment and replace with electronic checking	Susan Wilkinson	Karen Newbury	Blue	31.1.21	**IPB Update 09.11.20: The request IPB is to approve the Plan move to Blue (BAU) based on the external assurance report presented at the October IPB.** IPB Update 12.10.20: Aproved to move to BAU. Update 12.10.20: Plan is to move overall RAG to Blue (BAU) at end of October when 3 months data will have been collected. A booklet for all audit processes is in place. Action implemented, assurance testing ongoing
27	The trust must ensure clinical guidelines are up to date.	1. Through the divisional leadership review and update all clinical guidelines and issue through the approval pathway 2. Put in place systematic system to support the management, reporting and monitoring of clinical guidelines across the Trust to ensure they are kept up to date	Susan Wilkinson	Karen Newbury	Black	**31.10.20** ~~08.02.20~~	**IPB Update 08.02.21: Plan is complete. The wider Trust improvement opportunities will also be identified through the process presented in today's pack, taken as an action from last month's IPB t** IPB Update 11.01.21: The current RAG status is Black as all guidelines in the original ask have been updated. Maternity have gone beyond the original ask and continued to identify additional guidelines that hav process needs to be in place and so the BAU timeframe is a further 3 months (April 2021). IPB Update 14.12.20: There are a further three guidelines that have gone out of date and have been updated and will go through the governance in December and so the process is working. Subject to discussio Update 09.11.20: The request to IPB is to approve the plan move from Green to Black as all the guidelines have now been updated. Update 20.10.20: Plan remains Green and on track to meet completion date. Update 12.10: Request to IPB is to move Plan RAG from Amber to Green. Only three guidelines remain to be completed and the expectation is that these will be completed by the end of June '20. Update 23.06.20: 29/36 guidelines updated in maternity. Project plan being prepared to roll-out new technology to support management of clinical guidelines. Update 23.06.20: Clarity needed re divisional engagment via Tri Update 21.07.20: - Maternity guidelines nearing completion Update 18.08.20: - Tri-divisional representatives will feed in on this as the matter is organisation-wide - Discussed at the Quality Group 18.08.20
28	The trust must ensure patients can access the service when they need it and receive the right care promptly in line with national targets.	See No 9	Helen Beck	Helen Beck with ADOs	Red	31.3.21	See No 9
29	The trust must ensure diagnostic test results are available in a timely manner.	Review reporting arrangements for relevant diagnostics services. Ensure appropriate escalation procedures are in place for delays. Address the negative impact of COVID on diagnostic testing and reporting.	Helen Beck	Helen Beck	Blue	31.12.20	**Further update 09.11.20: Move to Blue approved by IPB** IPB Update 09.11.20 Request to IPB is to move this plan to BAU as final action to provide clarification regarding the SOP is complete. Three months worth of diagnostics data has already been presented in the P Update 12.10.20: Update 12.10.20: Radiology performance report received for Sept 20 for presentation at Oct IPB as part of BAU assurance process. - Plan is to share Diagnostics waiting times with patients. Update 14.09.20: IPB approve move to Black Update 03.09.20: - Request to IPB is to move the Plan to Black (Complete) as all actions are complete and can now be audited. - SOP regarding timely results for clinics has been reviewed and performance reporting has also been resolved.
30	The trust must ensure there is an effective process in place for monitoring patients requiring a follow up appointment and for those on surveillance pathways.	See No 6	Helen Beck	Hannah Knights	Amber	**31.03.21** ~~01.08.20~~	**See plan No. 6**

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale
31	The trust must ensure staff complete and record patient pain assessments in patient records.		Helen Beck	Michelle Glass	Red	**31.03.21** ~~31.12.20~~ ~~01.03.20~~	**IPB Update 08.02.21: Add updted action plan items to Improvement action column (currently blank).** **IPB Update 08.02.21: Sent on behalf of SB/SW** **• Improvement actions to be discussed with Lisa Nobes and Sharon Basson during meeting scheduled for 18th February.** **• Training re: pain recording provided to S1 Super Users by Chris Barlow, during January 2021.** **• Lead Pain Nurse to include training re: S1 (community specific) completion of Pain Tool on Staff Induction Training.** **• Lead Pain Nurse to undertake a one hour training session for staff via MS Teams to discuss completion of the Pain Tool in S1 – this will be mandatory for end of life nurses and District Nurses.** **• Key S1 changes still not complete, hindering progress, these include:** **o Uniformity of pain tool within Core Template and Care Plans, currently creating confusion for clinicians. Completed today by SystmOne group but will only take effect in new care plans and nev** **o Unable to save Pain Tool in S1 if clinicians wishing to enter a negative response (regarding time of last medication administration). Mandatory field Change Request made, S1 Group meeting applied to S1 which replaces the questionnaire. This can be completed / saved and is live now in S1. Comms re changes are being sent via the Super Users group and through Team cascade** **o Creation of a mandatory reminder to complete Pain Tool. Prompt pop up reminder being designed – to be applied by 28/2/21; to be trialled in the syringe driver care plan during March 2021** **o NB: the above points only evident due to clinician attempts to complete Pain Tools, as per Improvement Plan.** Update 21.01.21: A revised action plan has been drafted following the meeting with Sandra Webb and PMO. The plan will be reviewed further with Sharon Basson, Sandra Webb and Michelle Glass to support co - Compliance report with December data expected in Mid-January. - Sharon Basson and Lisa Nobes to meet separately for reassurance that patients are not in pain and that it is a recording the evidence issue rather than the pain assessments not being carried out. IPB Update 11.01.21: The request to the IPB is to extend the completion date for this plan to 31.03.21. Whilst progress has been made and many actions have been completed, including links with SystemOne, t issue that pain scores are being recorded manually but not always using the recordable template, and so plan will be to resolve this matter. Expectation is that reported compliance will improve when data for Dec plan will be reviewed at the next SRO Cluster. Planned refresher training has also been delayed due to COVID pressures. Cluster Update 17.12.20: Meeting to revise plan to be organised for January.
32	The trust must ensure all staff complete mandatory training including safeguarding training.	See No 12	Jeremy Over	Denise Pora	Red	31.5.21	**See plan no. 12**
33	The trust should ensure that consultant and team communication is improved in relation to the North East Essex and Suffolk Pathology Services (NEESPS). The trust should ensure that a review of the current working environment, equipment and processes within Pathology services is undertaken to identify and address any immediate ongoing concerns.		Nick Jenkins	Fiona Berry	**Green**	**31.03.21** **31.01.21** **31.12.20** ~~01.03.20~~	**IPB Update 08.02.21: Request to IPB is to extend completion date by a further two months to 31.03.21.** **- The LIMS review is ongoing and further time is required to make the decisions as to whether to share LIMS with ESNEFT or to procure independently.** **- Development of the Operational Plan was subject to receipt of the Attain Report which on publication has not proved to be helpful and so the plan is to build the Operational Plan from a WSFT per** **- Review of technical equipment complete but will be subject to review based on possible relocation.** IPB Update 11.01.21: Request to IPB is to extend the completion date by one month. There has been considerable focus and progress on this plan but unfortunately there is some project slippage associated with IPB Update 14.12.20: - Attain report received for review regarding physical space of pathology service - Similarly, a report regarding the technical equipment is also being produced - A business case for the digitisation of pathology service is being prepared for completion by the end of the year for approval - Plan for submitting accreditation expected by the end of the year Update 10.11.20: Estates and technical reviews are due for completion by the end of November. The aim by the end of the year is that a business case for digital pathology and a plan for submitting accreditation
34	The trust should ensure that effective processes are in place to promote and protect the health and wellbeing of all staff.		Jeremy Over	Denise Pora	**Black**	**31.12.20**	**IPB Update 11.01.21: The December IPB update is still current and valid.** **Update 14.12.20: Request to IPB is to move plan to Complete (Black). All actions in plan complete with effective processes in place. BAU audit to be discussed at next cluster** Cluster update 16.11.20: Mental health section of West Suffolk Wellbeing Plan reviewed. Plan marked Complete
35	The trust should ensure that complaints are responded to in a timely manner, within trust policy.		Susan Wilkinson	Cassia Nice	**Blue**	**31.12.20**	**IPB Update 14.12.20: The request to the IPB is that the plan moves to BAU (Blue). The PALS Service has achieved the 90% compliance target regarding the timely response to complaints for the la** Update 20.10.20: The requirements of this finding are believed to already be in place. The action plan to evidence this will be presented at cluster on 17.11.20. Prior update: agency backfill / senior nurse team undertaking complaint writing
36	The trust should ensure all staff follow infection prevention and control procedures and bare below the elbow guidance at all times.		Susan Wilkinson	TBC		**31.10.20** ~~11.02.20~~	**IPB Update 11.01.20: A new lead needs to be being found for this plan, as Anne How has left the Trust. To be discussed at SRO Cluster 19.01.20.** Update 20.10.20: A detailed action plan is now being worked upon for this finding.
37	The trust should ensure that cleaning chemicals hazardous to health are stored in an appropriate locked location.		Susan Wilkinson	TBC		**TBC** ~~31.10.20~~ ~~28.02.20~~	**IPB Update 08.02.21: This plan is now being looked at by the new Medicine HoN and conversations are underway to establish a project team to move the plan forward.** IPB Update 11.01.20: The detailed plan is under review and due to be scrutinised by the SRO cluster on 19.01.20. Update 20.10.20: A detailed action plan is now being worked upon for this finding.
38	The trust should ensure that all sharps and syringes are stored securely away from patients and visitors.		Susan Wilkinson	Joss Ball / Sandra Mulrennan		**TBC** ~~31.10.20~~	**IPB Update 08.02.21: In progress of completing handover from Natalie Bailey to Joss Ball and Sandra Mulrennan.** IPB Update 11.01.20: The detailed plan is under review and will be reported on by Joss Ball at the SRO cluster on 19.01.20. Update 20.10.20: A detailed action plan is now being worked upon for this finding.
39	The trust should ensure shared learning from never events with staff across the hospital.		Susan Wilkinson	Lucy Winstanley	**Green**	**31.01.21** ~~30.06.20~~ ~~31.12.20~~	**See Plan 3.**
40	The trust should display safety thermometer data and utilise this to improve services.		Susan Wilkinson	Natalie Bailey		**31.10.20**	**Update 20.10.20: This plan is now obsolete.**
41	The trust should ensure that appropriate action plans to address national audit shortfalls are implemented and effectively monitored.	See Plan No 4.1	Nick Jenkins	Suzette De Coteau-Atuah	**Amber**	**31.03.21** ~~01.07.20~~ ~~31.12.20~~	**See Plan No 4.1**

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale
42	The trust should ensure team meetings are undertaken to share information with ward staff.		Helen Beck	Sarah Watson	Black	**30.11.20** ~~31.10.20~~	**IPB Update 08.02.21:** **- A report has been drafted to evidence communications methods used on wards** **- This has been used as the basis for a Communications Guide to share these methods, which is now being reviewed** **- The next step is to prepare a staff survey to give assurance that staff are effectively receiving communications via these methods** Update 21.01.21: Initial Communications Report has been finalised, circulated to the Cluster and is held by PMO. SRO decision required regarding development of a 'tips guide' and/or an assurance survey can n IPB Update 11.01.21: Request to IPB is to progress the RAG to Black (Complete) as an evidential report has been prepared which includes all modes of communication developed to share information with teams part of assurance discussion to move this plan to BAU. These methods include: •Shift huddles recorded on specific forms •Update newsletters •Email groups for circulating important information to staff while providing an audit trail •Closed social media groups (WhatApp, Facebook etc.) The report includes specific details of which methods are used in which areas. Copies of the report are available upon request. IPB Update 14.12.20: Verbal update by ADO for Medicine. Plan reverts to Red. IPB Update 09.11.20: SRO reported that plan is progressing but will need an extension. Verbal reassurance has been given that ward-level communication is happening and this is due to be evidenced this mont Update 24.09.20: Clinical areas are updating staff via secure messaging whilst covid is preventing face to face meetings. Managers are also encouraging staff to read **the trust daily bulletins and green sheet.** **Prior update: SM's to confirm face to face meetings happening and evidence at Board. Not do-able during Covid-19**
43	The trust should consider displaying information on how patients and visitors can lead healthier lives.	Improvement plan: 1. Improved permanent resourcing for the public health team a. a new half time public health coordinator post has been established, repurposing time from an existing role. The role needs to be recruited to. 2. Understand the potential barriers in medicine and the drivers of success elsewhere a. The public health consultant will work with the medicine triumvirate to explore any barriers and understand whether an active decision has been made not to display health promotion materials b. The public health coordinator will establish relationships with service managers and administrators in the other clinical services and understand how the areas showing good practice are achieving it 3. Create an action plan a. A collaborative plan will be agreed with the medicine leadership team, based on the learning that is generated b. The public health coordinator will solve any problems with consistent supply and distribution of health promotion materials that are found in the other clinical services	Nick Jenkins	Helena Jopling	**Green**	**31.05.21** ~~31.12.20~~	**IPB Update 08.02.21: Majority of Medical Ward audits completed 28.01.21 (Only 1 outstanding).** IPB Update 11.01.21: Request to IPB is to extend the end date by one month to 31.01.21. All actions complete with the exception of the planned ward level audit in December which did not go ahead due to the e in a planned way to limit exposure. IPB Update 14.12.20: Request to IPB is to move plan to Green as all actions are either complete or on track to complete by 31.12.20. - Sustaiable method of supply agreed. Onelife Suffolk contract confiremed and supply of materials on request agreed. - Audit tool designed and agreed. All divisional areas will be audited annually, one per quarter. - Audit registration sent to audit co-ordinator - All new records will be stored electronically by the public health team and available to Quality & Safety Board for assurance purposes.
44	The trust should continue to work to reduce the number of bed moves at night for non-clinical reasons.	Revised SOP and improved performance as evidenced by a reduction in non-clinical bed moves after 10pm.	Helen Beck	Alex Baldwin	Black	**31.10.20** ~~29.02.20~~	**IPB Update 08.02.21: All actions are complete; 3 months data will be collected from the 1st February to support the assurance process.** Update 21.01.21: Action plan item no. 5 (further review of SOP) confirmed complete. IPB Update 11.01.21: December IPB update still valid and correct. A six month review cycle and BAU determination is more meaningful for this plan. IPB Update 14.12.20: Request to IPB is to move this plan to Complete (Black). Non clinical bed move numbers after 10pm have reduced to less than two per month for each clinical area compared to 2019. Cluster Update 19.11.20: Plan RAG changed to BLACK. Pending approval at next IPB meeting in Dec-20 (by which time the final action should be complete). Update 18.11.20: The plan is expected to move to Black at December IPB. Evidence from data collected demonstrates that non clinical bed move numbers after 10pm have reduced to less than two per month for The plan will be updated to reflect planned actions to continue review. IPB Update 09.11.20: SRO to provide update. Update 12.10.20: Plan was completed in January. However data will be refreshed as part of embedding audit and as part of that proposal project end date is extended to 31.10.20. This exercise will rebase the p stage.
45	The trust should continue to promote the freedom to speak up guardian so that all staff understand what the role is and know who their guardian is.		Jeremy Over	Denise Pora	**Green**	**30.06.21** ~~31.10.20~~ ~~29.02.20~~	**IPB UPdate 08.02.21: The iImproving Everyone's Experience action plan is complete hence only one action outstanding for completion.** IPB Update 11.01.21: Request to IPB is to extend the the end date to 30.06.21. There are two outstanding actions. The FTSU NGO review is still pending the publication of the rapid external review and the completion date 31.1.2021 is therefore unrealistic. Dependent on NHSE/I and the FTSU NGOs office for delivery - Improving everone's experience action plan green as HRBP now in place undertaking work with 31.01.21 end date IPB Update 14.12.20: Two outstanding actions. - National Guardians Office Review will not take place until the external rapid review has been completed and is outside Trust control - Improving everone's experience action plan green as HRBP now in place undertaking work with 31.01.21 end date. IPB Update 09.11.2: Both new FTSU Guardians in place and planning underway. This includes communications – meeting scheduled for 26.11.2020 between FTSU Guardians, Communications team and Deput Update 21.07.20: Plan being reviewed to underpins actions contained in Plans 1 & 2 and reflects content of documents discussed in the SRO (including Dido Harding letter)
46	The trust should ensure effective processes are in place for oversight of referral to treatment times across all specialties with action plans in place to improve the specialties where national standards are not being met.					**31.10.20**	See No. 9
47	The trust should ensure that the labour suite coordinator is supernumerary.		Susan Wilkinson	Karen Newbury	**Amber**	**31.03.21** ~~08.02.20~~	**IPB Update 08.02.21: Plan remains Amber. Two new Band 7 roles have been recruited but there are concerns around pulling from the Band 6 pool. Plan status to be reviewed at Cluster on 16.02.21** IPB Update 11.01.20: Benchmarking exercise is now complete. All units have 2 Band 7s on per shift/24 hours a day. New roles have gone out to advert and interviews are planned for w/c 11.01.20. Update 14.12.20: Working with Improvement Officer Mai Buckley to deliver the plan. Commence bennchmarking exercise with similar sized units to see how achieve. Prior update: Budget setting / CQC Saving babies lives / CNST

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale
48	The trust should ensure a higher percentage of staff complete mandatory training including PROMPT.		Susan Wilkinson	Karen Newbury	**Amber**	**30.04.21** ~~31.12.20~~	**IPB Update 08.02.21: Ongoing. Mandatory training compliance for all midwives stands at 90%. Doctors' compliance is more variable. Training is down due to Covid but plan is still on track to ach** PB Update 11.01.20: Ongoing. Due to new strain of Covid PROMPT training to be held virtually until it is safe to reintroduce classroom sessions. Update 14.12.20: Aim is to be compliant with all staff groups not just midwives by 30.04.21. Update 17.11.20: meeting took place between Nick Jenkins, Lead anaesthetists, Obstetrics, Simon Taylor and Karen Newbery and it was agreed that the 6 Obstetric Anaesthetists consultants and all of the trainee Previous Update: Red: Prompt needs to be 90% Unknown: PDN needs support
49	The trust should ensure team meetings are held to share information with ward staff.		Susan Wilkinson	Karen Newbury	**Blue**	**31.10.20**	**Update 14.12.20: Request to IPB is to move plan to BAU (Blue). Actions complete and unit meeting minutes available as evidence.**
50	The trust should ensure there is effective audit of the use of the World Health Organisations (WHO) and five steps to safer surgery checklist and take actions on results that do not meet trust standards.		Susan Wilkinson	Karen Newbury	**Blue**	**31.10.20**	**IPB update 08.02.21: Request to IPB is to move plan to Blue (BAU) following third monthly audit of 3 consecutive months above compliance rate 95%** IPB Update 11.01.21: December IPB update still current and correct. BAU date will be reviewed at next Cluster. Update 14.12.20: Complete and audited monthly. Need 3 consecutive months above compliance rate 95% to move to BAU.
51	The trust should ensure that staff report all incidents in line with trust policy.		Susan Wilkinson	Karen Newbury	**Black**	**31.10.20**	**IPB Update 08.02.21: December IPB update still current and correct. Still awaiting update on DATIX as team were significantly affected by Covid in December.** Update 14.12.20: All complete and DATIX being completed as required. BAU to be discussed at cluster. Update 20.10.20: An action plan is currently being updated for this finding for presentation at cluster on 17.11.20.
52	The trust should ensure that they close incident investigations within trust deadlines.		Susan Wilkinson	Karen Newbury	**Blue**	**30.09.20**	**Update 14.12.20: The request to IPB is that this plan moves to BAU (Blue).The improvement visit recommended this action is BAU.** Update 20.10.20: An action plan is currently being updated for this finding for presentation at cluster on 17.11.20.
53	The trust should consider displaying safety performance information.		Susan Wilkinson	Karen Newbury	**Blue**	**31.10.20**	**Update 14.12.20: The request to IPB is that this plan moves to BAU (Blue). Action complete. Poster are up in all areas. Safety Board infophonic - staff are aware of local risks in each area** Update 20.10.20: An action plan is currently being updated for this finding for presentation at cluster on 17.11.20.
54	The trust should ensure that action plans are created and followed for national and local audits.		Susan Wilkinson	Karen Newbury	**Blue**	**31.10.20**	**Update 14.12.20: Request to IPB is to move this plan to BAU (Blue) as it is complete. Recruitment of an additional midwife has enabled maternity governance team to complete this action. Minutes** Update 20.10.20: An action plan is currently being updated for this finding for presentation at cluster on 17.11.20. Prior update: National & Local Audits
55	The trust should ensure that appraisal rates are met for staff.	1. 90% compliance for all areas within the trust 2. Improve the Trust system for recording appraisal meetings. 3. Overall compliance at 90% 4. All appraisers have the required training to undertake appraisal meetings 5. Encourage a culture of appraisal within the organisation 6. Support streamlining for junior doctors.	Jeremy Over	Denise Pora	Red	**31/12/2020**	**IPB Update 08.02.21: SRO advise that specific extension date is not requested at this point and that in line with Mandatory Training, the plan is to engage the divisions regarding realistic recovery t** **Update 08.02.21: Request to IPB is to extend completion date by six months to 30.06.21 as a number of the actions have been paused in the second wave of covid including ESR self service and ap** Update 11.01.21: Update provided at the December IPB still current and correct IPB Update 14.12.20: Will be reviewed at next cluster as there are dependencies with the plan progressing eg ESRSS IPB Update 09.11.20: The IPB decision was that the plan was not ready to move to Amber from Red as further progress is required around compliance. IPB Update 09.11.20: The request to IPB is to approve the plan move from Red to Amber in the context of the identified actions which demonstrate a handle on the plan. Update 29.10.20: (1) HR business partners start working with divisional team in November to support those areas struggling to reach 90% compliance. (2) Trust is moving toward ESR manager and supervisor se National decision on implementing an annual appraisal policy as part of A4C pay progression has been delayed due to COVID-19. (4) Appraiser training is expected to be fully restarted as e-learning by 28.02.21. actions. (6) Study leave has been utilized to complete any outstanding mandatory training for junior doctors.
56	The trust should ensure that processes are in place for the supervision of midwives.		Susan Wilkinson	Karen Newbury	**Black**	**31.01.21**	**IPB update 08.02.21: Request to IPB is to move plan to Complete (Black) following the completion of PMA training by five midwives and service going live on 02.02.21. Guidance requested from IP** IPB Update 11.01.21: Five midwives have completed the PMA Training and are due to qualify Jan '21. Service will commence Jan '21. Update 20.10.20: An action plan is currently being updated for this finding for presentation at cluster on 17.11.20.
57	The trust should ensure the collection of friends and family data in all areas.		Susan Wilkinson	Karen Newbury	**Green**	**28.02.21**	**IPB Update 08.02.21: Previous update remains correct.** IPB Update 11.01.21: Work is ongoing. Covid spike has reduced speed of progression. Update 14.12.20: Progressing but currently using manual paper submissions. The plan going forward would be to put the data on telephone text for women to complete. Update 20.10.20: An action plan is currently being updated for this finding for presentation at cluster on 17.11.20.
58	The trust should ensure consumable equipment is not opened prior to use to prevent infection prevention and control risks.		Susan Wilkinson	Karen Newbury	**Green**	**28.02.21**	**IPB Update 08.02.02: Weekly changing of consumables needs to be agreed trust-wide. To be confirmed with Resus HoN by next Nursing Cluster: 16.02.21** IPB Update 11.01.21: Work is ongoing. Covid spike has reduced speed of progression. Update 14.12.20: Not quite complete. Still in discussion re storage of adult consumables and how often to change. Update 20.10.20: A detailed action plan is now being worked upon for this finding.
59	The trust should ensure an evidence-based bereavement care pathway is put in place.		Susan Wilkinson	Karen Newbury	**Black**	**31.01.21**	**IPB Update 08.02.21: Request to IPB is to move the plan to Black (complete) as pathways are now in place** IPB Update 11.01.21: Awaiting ratification via women's health governance Update 14.12.20: Bereavement midwife in post working on pathways so should complete by 31.01.21 Update 20.10.20: An action plan is currently being updated for this finding for presentation at cluster on 17.11.20.
60	The trust should ensure that women's pain scores are consistently completed.		Susan Wilkinson	Karen Newbury	**Blue**	**30.11.20**	**Update 14.12.20: Request to IPB is to move this plan to BAU (Blue) as more than three months' data has been collected showing 100% compliance.**
61	The trust should consider security enabled doors in the paediatric outpatient department.		Helen Beck	Michelle O' Donnell	**Red**	**28.02.21** ~~31.12.20~~ ~~01.05.20~~	**IPB Update 08.02.21: Estates have confirmed they are awaiting costs of the installation of mag locks to the doors, and what will also likely be new doors to enable this fitment. This is being chased** Update 21.01.21: SRO has made direct contact with the Estates team to expedite the process. A member of the Estates team has visited the paediatrics department (the project has moved onto the Estates listing IPB Update 11.01.21: Request to IPB is to extend the end date by two months to 28.02.21 as the plan is not yet on the priority list with estates and to move the plan to Red as there is assurance presently regardi IPB Update 09.11.20: Door not fitted / plan not completed due to issues getting the contractor on site during Covid. This project will be completed in house (Estates) rather than using an external contractor.
62	The trust should consider a system to monitor the average waiting times for a follow up appointment.		Helen Beck	Helen Beck	Amber	**31.03.21** ~~01.08.20~~	See No. 6
63	The trust should continue to improve mandatory training completion rates to meet the trust's target completion rate of 90%.	See No 12	Jeremy Over	Denise Pora / Michelle Glass	Red	**31.05.21**	**See No. 12**

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale
64	The trust should continue to improve appraisal completion rates to meet the trust's target completion rate of 90%.	See No 55	Jeremy Over	Denise Pora / Michelle Glass	Red	**31/12/2020**	**See No. 55**
65	The trust should ensure that governance and oversight are strengthened to ensure performance and local audit are monitored and measured to improve practice.	Review of governance and oversiht team and function to include within this local audit requirements to inform quality assurance will be formulated	Nick Jenkins	Michelle Glass / Nic Smith-Howell	**Green**	**31.03.21**	**IPB Update 08.02.21: Plan cannot complete until links are made with the central clinical audit team. The central team audit facilitator starts in their role 8th March 2021.** 'IPB Update 11.01.21: Plan actions will be reviewed at next SRO Cluster with view to moving plan status to Black (Complete). IPB Update 14.12.20: The request to IPB is to move the plan to BAU (Blue) in line with plan 66. Post-IPB note: BAU withheld by IPB - RAG still Green. IPB Update 09.11.20: Request to IPB is to approve the plan move from Amber to Green and also to extend the completion timeframe in line with Plan 4.1.
66	The trust should ensure that processes are in place and effective to monitor compliance with best practice and national guidance relevant to the service.	ICPS Leads will continue to review current guidelines and practices in place and monitor at service meetings. Audit programme to be considered to monitor adherence and effectiveness of guidance. Services will continue to monitor incident themes and any complaints and this in turn will be reviewed by the ICPS Integrated Working Forum and Service Management Group. ICPS will liaise with corporate/clinical governance leads to establish more robust interface with the NICE group to consider relevance of published guidance/updates with community service pathways.	Helen Beck	Michelle Glass / Nic Smith-Howell	Blue	**31.10.20**	**IPB Update 14.12.20: Request to IPB is to move the plan to BAU (Blue) as the community clinical audit model is BAU. There is a caveat that the Trust model is still awaiting to recruit to the clinical** Cluster Update 19.11.20: Agreed to request move to BLUE at next IPB, explaining that plan is BAU within service but needs to be monitored by central clinic audit posts at governance level to ensure all issues are Further update 09.11.20: Move to Black approved. IPB Update 09.11.20: Request to IPB is to move plan from Amber to complete (Black) as all actions are complete and the service is responding effectively to best pratice guidance. There is a clinical governance evidence base. Update 26.10.20: Action 3: October SMG meeting agenda and presentation provided to evidence guidance work.
67	The trust should ensure records are maintained to show cleaning has been completed in line with cleaning schedules.	Systems in place already but practice to be reinforced to ensure compliance with cleaning standards. Perfect Ward app to be reviewed and updated for use with community paediatric teams to assist with audit of standards.	Helen Beck	Michelle Glass / Nic Smith-Howell	**Black**	**31.12.20**	**IPB Update 08.02.21: All actions complete, evidence being collated to support move to BAU status.** SRO Cluster Update: 21.01.21 Email confirmation from project lead ref. plan item 2: SOP agreed and all in place so can progress to black (complete). Update 21.01.21 (Pre-Cluster): Awaiting assurance from project lead regarding plan item 2 (SOP) IPB Update 11.01.21: December IPB update is current and correct. IPB Update 14.12.20: Request to IPB is to move plan to Complete (Black). New cleaning records in clinic rooms have been initiated so BAU operational. Audit results to follow in 3 months. Further update 09.11.20: Move to Green approved by IPB. IPB Update 09.11.20: Request to IPB is to move this plan from Amber to Green. Further amendment to agreed SOP required to be finalised in November and revised practice implemented. Manual audits will pre Update 22.10.20: This plan is on track for completion, only waiting for Perfect Ward monitoring. Update 23.09: - ICPS service leads have met and reviewed cleaning standards and reported back to SMG. Additional equipment has been purchased to improve infection control measures. - SOP being written and will be validated at October SMG - PW App under review and will be pulled if not beneficial but manual audits remain critical to audit process anyway - Audit findings are being shared routinely at SMG and Divisional Clinical Governance Group
68	The trust should ensure that facilities for audiology assessments in the Ipswich child development centre improve.	The trust should ensure that facilities for audiology assessments in the Ipswich child development centre improve.	Craig Black	Nic Smith - Howell	Blue	**31.7.20**	**Risk: Update 21/05/20: There is a timeframe delivery risk re flooring supplier from Holland so now looking at alternatives. Nic SH to obtain update from estates (Luke Goldfinch). Timeframe exten handover planned mid July. Leave end date as 31.07 for contingenies at Green. Update 03.08.20: POD completed and handed over - Audiology equipment fitted and tested - fully compliant testing facilities in 2 audiology rooms on St Helen's House site Proposal to IPB to move Plan No 68 to Black and agree evidence required to moe plan to Blue as embedded. Update 10.08.20:The plan contains actions with defined outcomes and these are already operational and so the IPB has agreed to move the plan to Blue (BAU).**
69	The trust should consider using an acuity tool to assess whether there were enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.		Susan Wilkinson	Tracey Oats	Amber	**31.12.20**	**Revised end date 31.12.20**
70	The trust should continue to improve mandatory training in key skills to all staff to meet trust targets.	See No 12	Jeremy Over	Denise Pora / Michelle Glass	Red	**31.12.20**	**See No. 12**
71	The trust should continue to improve appraisal completion rates to meet the trust's target completion rate of 90%.	See No 55	Jeremy Over	Denise Pora / Michelle Glass	Red	**31/12/2020**	**See No. 55**
72	The trust should ensure that patients individual needs and preferences are taken into account when planning care.		Susan Wilkinson	Tracey Oats		**31.12.20** ~~30.04.20~~	**Revised end date 31.12.20**

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale
73	The trust should ensure that all senior leaders have the skills to access and use patient outcome data to improve services. Specific to Newmarket Hospital	1. MDT to review outcome data to ensure that this provides robust information around patient outcomes measures 2. Consult with patients and stakeholders around outcome measures which are meaningful to them 3. Consider and plan resources required to make these changes 4. Agree new outcome measures and process for collecting data 5. Update Information Team around changes, as above 6. Agree forum to review data 7. Agree process for initiating change as a result of above 8. Discuss contractual reporting requirements with Information Team	Helen Beck	Sharon Basson	Amber	**31.03.21** ~~31.05.21~~ ~~31.12.20~~	**IPB Update 08.02.21: Request to move to Green at IPB not approved. The assumption was that the plan was moving from Amber when it was in fact previously Red. The agreement reached at IPB w approved to move to Amber and completion of outstanding actions will be reviewed again at March IPB. Request to bring forward the extension date approved.** **IPB Update 08.02.21: Request to IPB is to move the plan to Green and to amend project end completion date to 31.03.21 given the progress made for the individual improvement actions within the agreed, Barthel score is in place for appropriate patients, consult with patients and stakeholders around outcome measures which are meaningful to them, and a governance forum established to requirements can be met, and to agree process for initiating change resulting from agreed completed actions, and to discuss contractual reporting requirements with Information Team.** Update 21.01.21: Meeting with clinical team 21.01.21 to assess feasibility of progressing this plan using the same group that progressed plan 74. IPB Update 11.01.21: Request to the IPB is to extend the completion date to 31.05.21. Meeting planned for 14.01.21 to develop new plan for this finding, acknowledging the pressures on Newmarket Hospital. Cluster update 17.12.20: meeting to develop new plan to be organised for January. New completion date required. Earlier update: Revised end date 31.12.20
74	The trust should ensure that individual goals and outcome measures are routinely monitored and audited to improve care.		Susan Wilkinson	Gylda Nunn	Green	**31.03.21** ~~30.08.20~~	**IPB Update 08.02.21: 9/10 actions now complete.** **Family access to unit: E-care solution in place (as per December update below) and this process has been agreed and is monitored at weekly MDT meetings** **Telephone calls are being used to facilitate family access to patients during the pandemic restrictions** IPB Update 11.01.21: December IPB update still current and correct. IPB Update 14.12.20: 80% (8/10 actions) complete. Need e-Care solution in place to complete project re: agree process / patient guidance and sharing goals and outcomes in order to update patient / family re pr
WSFT_ 001	Perinatal Clinical Quality Surveillance Model	1. Enhanced Safety (Ockenden Report)	Susan Wilkinson	Karen Newbury	Green	**31.01.21**	**Update 02.02.21: LMNS safety pathway commenced; awaiting finalisation of Regional Safety slide set** - Trust Response 21.12.20: Plan being developed by maternity department based on guidelines received last week. Anticipate plan being completed and presented to Open Board 31st January 2021. - Regional Response: A statement of commitment to agree and implement a plan. The quality surveillance document has now been published on Friday 18th December 2020. - Trust Response 29.12.20: Trust already prepare statement of commitment and plan to follow by 31.01.21 - Update 20.01.21: Awaiting Guidance from National Team/LMNS before implementation can be completed
WSFT_ 002	Consultant led ward rounds twice daily on labour suite	3. Staff training and working together (Ockenden Report)	Nick Jenkins	Ravi Ayyamuthu	Amber	**30.04.21**	**Update 02.02.21: Extra ward rounds on weekend evenings in practice, but job plans not yet reviewed and updated due to Covid** •Trust Response 21.12.20: Currently, the department fulfils 12 of the 14 weekly ward rounds required. Twice daily ward rounds Monday to Friday and once daily formal ward rounds on Saturday and Sunday. The •Regional Response 23.12.20: Standard Operating Procedure for a minimum of twice daily consultant obstetrician ward rounds with supporting audit (spot check audit to be completed prior to 15th Jan submissio •Update 20.01.21: Delay is due to job planning. Mitigating actions are expected to be agreed at meeting 20.01.21
WSFT_ 003	MDT Training Scheduled	3. Staff training and working together (Ockenden Report)	Susan Wilkinson	Karen Newbury	Complete	**31.03.21**	**Update 02.02.21: Training has been scheduled but completion of training is at risk due to lack of anaesthetist availability** •Trust Response 21.12.20: MDT Training schedule is in place. •Regional Response 23.12.20: One spot check audit undertaken by 15th January 2020 •Update 20.01.21: Need to ensure 90 percent compliance
WSFT_ 004	Named consultant lead/audit	4. Managing Complex Pregnancy (Ockenden Report)	Nick Jenkins	Ravi Ayyamuthu	Amber	**31.01.21**	**Update 02.02.21: A list of named leads for a range of conditions is in place for new patients, but legacy patients will not yet be able to benefit from this** •Trust Response 21.12.20: All women in consultant led care are allocated a consultant. However, the system will be made more robust and under review with completion date 31.01.21 •Regional Response 23.12.20: Name of the Consultant Obstetric Lead with supporting audit from the previous 12-month annual audit cycle or spot check audit complete prior to submission on 15th January 2021 **•Update 20.01.21: This is currently being reviewed**
WSFT_ 005	Development of Maternal Medicine Centres	4. Managing Complex Pregnancy (Ockenden Report)	Helen Beck	Michelle O'Donnell	Green	**31.01.21**	**Update 02.02.21: Trust is ready to link with MMCs once they are set up. Until this is in place, monthly meetings with Norfolk and Norwich for complex cases are in place as mitigation** •Trust Response 21.12.20: WSH commits to complying with the developments of maternal medicine specialist centres. •Regional Response 23.12.20: Standard Operating procedure and care pathway to which identifies how women are referred into a Regional Maternal Medicine centre if the Trust does not have its own on site. Cor taken **•Trust Response 29.12.20: Trust has care pathway SOP in place available for external view via Internet**
WSFT_ 006	Risk assessment recorded at every contact	5: Risk assessment throughout pregnancy (Ockenden Report)	Susan Wilkinson	Karen Newbury	Amber	**31.01.21**	**Update 02.02.21: Work is continuing to increase the profile of risk assments and to ensure that high-risk women do not go to the birthing unit** •Trust Response 21.12.20: Process is in place for risk assessments to be completed and recorded at every contact which is audited and acted upon. •Regional Response 23.12.20: Spot check audit completed prior to the 15th January 2020 submission (if not already available as part of the annual audit cycle) plus a statement of commitment to sign up to the N **•Trust Response 29.12.20: A statement will be made to commit to the national risk assessment process when it is available**
WSFT_ 007	Pathways of care clearly described, on website	7: Informed Consent (Ockenden Report)	Susan Wilkinson	Lee White	Amber	**31.01.21**	**Update 02.02.21: Work is ongoing to get guideliness added to Trust website and to make information leaflets available in top 5 languages** •Trust Response 21.12.20: Trust can confirm that the trust has pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. This includes inform Risk assessments are completed for individual clinical situations allowing for discussion and informed choice and we have a guideline in place for women who request care outside of guidance. •Regional Response 23.12.20: Pathways of care clearly described, on website. This needs to be evidenced and accessible on Trust website with links to be supplied. •Trust response 29.12.20: Pathways of care clearly described on the Trust website including information leaflets regarding choices. Reviewing to ensure this information is available in top 5 languages. •Update 20.01.21: Guidelines need to be added to website and leaflets reproduced in top 5 languages
WSFT_ 008	Trustwide Baby Abduction Policy	Develop a baby abduction policy (West Suffolk Site Visit Summary Report 06.01.21)	Helen Beck	Barry Moss	Amber	**28.02.21**	**Update 02.02.21: Draft policy exists and is on track for sign-off by the end of February and to go to Divisional Board in March** Update 06.01.21: The policy is still in discussion with the Estates team. The MIA provided a sample baby abduction policy from another unit with their permission
WSFT_ 009	Maternity Strategy	Development of a maternity strategy remains outstanding (West Suffolk Site Visit Summary Report 06.01.21)	Susan Wilkinson	Karen Newbury	Red	**TBC**	**Update 02.02.21: Completion date for this will depend on finalisation of the Trust Organisational Strategy** Update 06.01.21: The development of a maternity strategy remains outstanding
WSFT_ 010	Maternity Risk Management Strategy	The maternity risk management strategy to be approved by the triumvirate, chief nurse and trust governance lead which must work in harmony with the new Trust governance strategy (West Suffolk Site Visit Summary Report 06.01.21)	Susan Wilkinson	Michelle O'Donnell	Amber	**28.02.21**	**Update 02.02.21: Strategy is on track for sign-off by the end of February and to go to Divisional Board in March**
WSFT_ O11	Embed dedicated consultant obstetric governance, guidelines, and labour ward / fetal monitoring lead roles	Dedicated consultant obstetric governance, guidelines, and labour ward / fetal monitoring leads: these roles need to be embedded (West Suffolk Site Visit Summary Report 06.01.21)	Nick Jenkins	Ravi Ayyamuthu	Red	**28.02.21**	**Update 06.01.21: A new CD has recently been appointment for the division. This is individual is now dedicated consultant obstetric governance, guidelines, and labour ward / fetal monitoring leads governance processes and MDT training**
WSFT_ 012	Embed safety huddles and twice daily obsteric MDT ward rounds in practice	Safety huddles and twice daily obstetric MDT ward rounds have not been embedded in practice (West Suffolk Site Visit Summary Report 06.01.21)	Nick Jenkins	Ravi Ayyamuthu	Amber	**28.02.21**	**Update 02.02.21: Morning obstetric ward rounds are in place but the weekend rounds have not yet been embedded** Update 06.01.21: Safety huddles and morning obstetric MDT ward rounds have not been embedded in practice
WSFT_ 013	Implement RAG triage tools	RAG Triage tools have not been implemented (West Suffolk Site Visit Summary Report 06.01.21)	Susan Wilkinson	Karen Newbury	Amber	**28.02.21**	**Update 02.02.21: This procedure has not yet been implemented due to lack of staff availability** Update 06.01.21: RAG Triage tools have not been implemented
WSFT_ 014	Midwifery-led birth centre criteria pathway	Midwifery led birth centre criteria pathway has not been completed (West Suffolk Site Visit Summary Report 06.01.21)	Susan Wilkinson	Karen Newbury	Amber	**28.02.21**	**Update 02.02.21: Strategic lead has not been available due to clinical commitments in January but pathway is anticipated to be ready for sign-off by the end of February and to go to Divisional Boar** Update 06.01.21: Midwifery led birth centre criteria pathway has not been completed
WSFT_ 015	Additional Ward Clerks	Bank shifts remain unfilled due to sickness/shielding (West Suffolk Site Visit Summary Report 06.01.21)	Susan Wilkinson	Lee White	Amber		**Update 06.01.21: Additional funding has been identified for a temporary ward clerk; however bank shifts remain unfilled due to sickness/shielding**
WSFT_ 016	Divisional Governance Review	Divisional governance review to be completed (West Suffolk Site Visit Summary Report 06.01.21)	Helen Beck	Michelle O'Donnell	Amber	**14.01.21**	**Update 02.02.21: This has dependcies with the wider Trust governance reviews**

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale
WSFT_017	Senior Staff (Band 7 and above) Development Programme	Develop Labour Ward Band 7/ ward manager's leadership development programme (West Suffolk Site Visit Summary Report 06.01.21)	Susan Wilkinson	Karen Newbury	Amber	**1.1.22**	**Update 02.02.21: In progress**

14.5. Quality and learning report - Q3

For Approval

Trust Open Board – 26th February 2021

Agenda item:	14.5			
Presented by:	Sue Wilkinson – Executive Chief Nurse			
Prepared by:	Rebecca Gibson - Compliance Manager			
Date prepared:	February 2021			
Subject:	Quality and Learning report			
Purpose:	X	For information		For approval

Executive summary:

This report provides a summary of key learning points, trend analysis and opportunities for improvement that have arisen from in the quarter ending 31/12/20.

Key highlights in this report are as follows:

- Learning themes from investigations in the quarter
- PSIRF 'go live'
- HSIB reports
- Learning from Deaths
- Quality assurance
- Raising concerns

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:

1. Receive this report for information

1. Learning themes from investigations in the quarter

SI RCA reports submitted in Q3

There were 15 SI reports submitted in Q3.

- Two cases submitted related to Never Events (NE); one an actual NE and one a 'near miss'.
- Two unrelated cases relate to patients with learning disabilities/difficulties (LD). The trust had an external assurance review of LD in late 2020. The formal report has not yet been received, but there was informal positive feedback at the time. This will be presented to the Improvement Programme Board when available.
- The learning from one case reporting a ward closure due to a COVID outbreak is included in the separate IPC BAF report to the Board so is not repeated here.
- 3/15 cases which relate to a patient's death whilst in WSFT care have the final report reviewed by the 'learning from death' group to determine preventability (the cases for Q3 are due to be presented to the February LfD group meeting).

Incident details	Learning
WSH-IR-62110 Never Event: Unintentional connection of a patient requiring oxygen to an air flowmeter	Post arrest patient was placed on supplementary O_2 but the O_2flow meter had been placed into the medical gas port and so patient was on medical air instead of oxygen for about 10 minutes. No harm came to the patient Immediately following this event all areas in hospital with medical air ports were inspected to ensure medical air flow meters were disconnected if not in use. **Root cause** Medical air flow meter left in situ following the use of nebuliser for a patient in that bed space prior to this patient. **Lessons learned** Medical air inlet should be capped at all times when not in use and the flow meter should have been removed immediately after use. Good practice is not to use the medical air flow meter for nebulisation- a machine designed for just the use of nebulisation can be borrowed via Medical Equipment Library **Actions** • Store medical air flow meters in Medical Equipment Library • Create a standard operating procedure for the use of medical air flow meters (areas that need to use them have to contact the critical care outreach team) • Update oxygen and suction daily checklist to include medical air checks (cap when not in use), location of all medical air ports and pictures of medical air and oxygen flow meters **Shared learning** Ward governance meetings, ward managers meeting and NMCC meeting
WSH-IR-60678 Near miss NE: Wrong site block	Patient in ED diagnosed with a (right) fractured neck of femur. Local anaesthetic administered to left groin in error in preparation for a fascia iliac compartment block as part of the pain management strategy. Error identified before the block. Discussion with CCG confirmed near miss therefore not reported as a Never Event. Classified as minor harm to patient **Root cause** Confusion as patient was distressed, in pain and was holding the left hip. **Lessons learned**: Not to rely on patient appearance as a guide to which side there is problem but to complete a safety standard for an invasive procedure checklist, check with investigations and verbally with the patient when possible.

Incident details	Learning
	Actions / Shared learning • Include in the Control of Risk in the Emergency Department lecture for all junior staff in ED Investigator • Inform doctors of requirement in person, by email and in teaching
WSH-IR-60334 Unexpected death of patient	The local clinical team raised a concern about this case for wider review following an unexpected deterioration, cardiac arrest and death. **Root causes** Failure to recognise, monitor and escalate a deteriorating patient as per NEWS2 policy. Inadequate telemetry provision, with lack of a dedicated, appropriately trained individual to monitor the system 24/7, and a lack of a failsafe method of contacting or alerting wards following the occurrence of a life-threatening event **Lessons learned** Advice not sought from hospital haematology service. Myelodysplasia patients can potentially be seriously ill but look relatively well Poor documentation **Actions** • Re-establish teaching sessions on wards for deteriorating patients, to include frequency of observation and escalation. • Uplift a registered nurse to monitor telemetry 24/7 on Cardiac Unit • Business case for dedicated telemetry monitoring in the Cardiac Unit • Implement Medic Bleep baton-holder nurse co-ordinator role for wards, to act as a point of contact for escalating concerns of patients on telemetry monitoring • Review and perform gap analysis on national guidance regarding telemetry provision • Fluid monitoring for adult patients' clinical guideline (CG10354-2) to be laminated and attached to the drug trolley for nursing staff awareness • Implement blue droplet sign on wards for patient's bed space to indicate that the patient is on a fluid chart • Nursing staff handover to include review of fluid balance status and which patients require a fluid balance chart. • Re-establish teaching sessions on wards for fluid balance chart, stool chart, food diary, documentation of care and treatment, accountability entries, labelling of paper records (such as ECGs), and documentation of communication with Cardiac Unit if patient is on telemetry and is given treatment that may alter the monitoring **Shared learning** Learning from Deaths meeting discussion - seeking advice from specialist teams for patients with complex diagnosis Medical Divisional Board and ward governance meetings to underline importance of referral to specialist teams for patients with complex diagnosis
WSH-IR-61397 Unexpected death of a patient with learning disabilities	**Root Causes:** Triggers for sepsis (were negated as the patient responded well to the fluid challenge over the course of the day). This led the clinicians to believe that their issues were that of dehydration as opposed to sepsis. The patient was around their baseline at admission and discharge, and therefore, as this was normal for them (due to their chronic issues) their clinical status was felt to be improved. **Lessons Learned**: • Further tests (other than urine sample) were not taken (I.e. blood tests)

Incident details	Learning
	• Sepsis is currently a paper-based tool with no accompanying local guideline **Actions** • Review current sepsis tools to ensure relevant and up to date • Explore if sepsis 6 tool can be included in e-Care to alert when flags present
WSH-IR-61867 Unexpected death	**Root cause**: Lack of escalation to senior clinicians over the bank holiday weekend when patient began to show signs of becoming unwell (possible symptoms of ileus/ obstruction) Methods of doctor handover for orthopaedic patients out of hours does not lend itself well to good communication about potential need for reviews of patient's that may be at risk of deterioration or changes in clinical circumstances **Lessons Learned** • Poorly completed fluid balance charts/ lack of escalation regarding drop in urine output • Failure to listen to the patient's spouse's concerns when they felt patient was unwell • Ortho-geriatrician provision limited to three days per week resulting in lack of reviews in between **Actions** • Trial revised handover for the surgical division whereby the two on call OOH junior doctors each attend a separate handover to include both general surgery and orthopedics (this will ensure that any patient concerns are handed over to the consultant/ registrar in the morning) • For both general surgical and orthopedic teams to make use of the sick patient list (as is used by the medical division) during handover • Development of an SOP and guidance for revised handover process • Carry out audit of new handover process for quality assurance purpose • Funding to be secured for additional ortho-geriatrician provision to work towards every orthopaedic patient receiving a review by a senior doctor Monday to Friday • Develop link nurse role for deteriorating patient **Shared learning** • Feedback to junior doctors involved regarding escalation of patients, and importance of documentation • Wash up meeting to share report and learning • Present report as part of a shared learning event and relevant joint meetings • Education for ward staff regarding importance of fluid balance / importance of referring to CCOT
WSH-IR-60731 IT system issue re Anaesthetic records	During review of an anaesthetic chart identified that some data was missing. It transpired this was due to a "data purge" within Cerner system set-up after a 90day period, and only 5 minutely data kept. This had medicolegal implications. Following the conclusion of this investigation it was confirmed that there was no indication of any patient harm as a consequence of this. **Root cause**: There was not an adequate briefing provided to the West Suffolk Hospital on the presence, activity and effects of routine purge activity that Cerner had set as operational recommendations for the Anaesthesia module. **Actions** • The system purge was paused and has now been cancelled to prevent further recurrence

Incident details	Learning
	• System-wide review of purge functions across the whole West Suffolk Hospital Cerner system to uncover any other similar issues and pre-empt the development of similar where new functions come online • Process to be devised such that affected records can be flagged as such, so that on future review it is immediately clear that apparent incompleteness is as a result of the purge and not poor record keeping on the part of the clinician. • All eCare module launches include clinical subject matter experts and in future such clinical staff will be included in the module review of system management operations
WSH-IR-60890 Potential failures of discharge arrangements for patient with LD. Patient found deceased four days post-discharge.	Package of care not reinstated on discharge provided assistance with personal care and a wellness check only. Following initial referral to Coroner, the patient's death was subsequently recorded as natural causes (not neglect). **Root cause**: The discharge checklist was not fully completed to confirm the patient's medical status as optimised for discharge, otherwise this would have been picked up by the discharge planning team who would have reinstated the once daily care package for discharge **Lessons learned** Patient was seen by Learning Disability lead; however, there was no documentation on the notes about learning disability passport. **Action** • Staff to initiate the discharge checklist as early as possible, complete the care needs column on the checklist at the initial point of contact. • Care coordinator to discuss care needs with every patient and document in patient's record and whiteboard, with extra caution being taken for patients with learning disabilities • Medical team and the ward team to be reminded of the importance of and to complete, the discharge checklist • Care coordinator/nurse in charge to update the medically optimised status on the whiteboard after confirmation from the medical team • Care Coordinator/ nurse in charge to contact the NOK/ relative as soon as decision to discharge is made • Staff on the ward to contact Learning Disability lead and issue a passport if patient does not have one (folder now readily available on the ward)
WSH-IR-61178 Patient given medication for which they had a documented allergy	Allergies to Iodine (given in the CT contrast medium) and alcohol (in Oromorph). Patient did not come to serious harm as a consequence of error. **Root causes**: • Patient allergies not verbally communicated to radiology prior to CT scan • Ethanol recorded under allergies on eCare; but not Oramorph. • Radiologist did not check CRIS prior to the administration of Iodine • Consultant did not follow process and ask if the patient had any allergies. **Lessons learned** Lack of knowledge that contrast contains Iodine and that analgesic Oromorph contains ethanol. **Actions** • Radiographer checklist amended to include a specific question around contrast and allergies. • Explore if checking of CRIS can be added to the radiographer's checklist. • Audit tool to be developed to seek assurance

Incident details	Learning
	Shared learning Bulletin to all CT staff and discuss the incident and actions at the next safety meeting. Report shared and lessons communicated to ED medics, to highlight the importance of verbal communication, especially out of hours.
WSH-IR-60584 Covid ward closure	See separate IPC BAF Board report for details
WSH-IR-60480 WSH-IR-62512 WSH-IR-62146 Patient falls	Thematic review of the three Falls reports submitted in Q3 resulted in the following recommendations: • Use the scoop and hoist for assisting patients off the floor when injury suspected • Confirm staff aware of how to complete lying/ standing blood pressures and importance of ensuring that this is recorded. • Falls prevention strategies to be fully utilised. • Importance of documentation in patient care record **Actions** The use of scoop and hoist following fall has been highlighted to the manual handling team so can be incorporated into annual staff training. Posters explaining lying/standing blood pressure from the Royal College physicians are available and have been sent to the ward managers with opportunities for ward-based training for any staff who would like it. A lying/standing blood pressure column has been added to the safety dashboard on e-Care. See Section 3 - for details on changes in investigation of Falls under PSIRF.
WSH-IR-61181 WSH-IR-60775 WSH-IR-60951 Pressure ulcers	These were all new PUs developed within the care of the Community health teams. Themes identified included: • Patient's clinical condition • Importance of regular risk assessment (Waterlow and MUST) • Patient concordance and staff understanding of non-concordance pathway • Importance of referral pathways to dieticians • Care home support, guidance and education • Limitations of digital review vs visits (acknowledged as impact of Covid) • Reduced staffing numbers in delivery of care within Leg Ulcer Clinic • Patient anxieties in accessing services / hospital appointments during Covid

2. Patient safety incident response framework

PSIRF Patient safety incident response framework	*PSIRP* Patient safety incident response plan	*PSII* Patient safety incident investigation

The Trust has moved from the Serious incident framework to the PSIRF from the 1st February.

As previously reported there are a set of categories which will require a PSII, some are national requirements and some have been agreed locally. An internal process has been put into place to capture these and future reports will include the learning from these events.

Falls

As part of the PSIRP; falls resulting in major harm (e.g. neck of femur # or serious head injury) will no longer be subject to a comprehensive RCA report. Instead the trust, alongside other PSIRF 'early adopters' is participating in the national Falls audit.

With the falls pilot, there will be a hot debrief at the time of the fall. The information collected in this will allow earlier identification of any concerns. It will also act as an opportunity to discuss what happened and to ensure strategies / management in place to prevent further falls. The debrief would include all members of the MDT and therefore raise the awareness of falls and fall prevention strategies within a ward environment. An after-action review will also be completed for any falls resulting in harm or those where it is felt there could be a learning opportunity.

Pressure ulcers

A 'patient safety audit' method is being used. This seeks to examine a suitably large sample (not based on severity of cases) against a set of measurable clinical standards to identify key areas for improvement. Datix is already set up to capture and report this and it will be a pilot to test if it is a suitable tool to address other high-volume generic incident categories.

Maternity / Obstetrics

As part of the development of an updated Maternity risk management / quality & safety framework, a matrix has been agreed for "Maternity incidents, adverse outcomes and externally reportable events investigation pathways". This has been incorporated into the PSIRP.

Preventable deaths

A pathway to identify deaths deemed '*clinically assessed as more likely than not due to problems in care*' has been agreed with the Medical Examiner role providing the initial point of identification and requiring a second independent clinical viewpoint provided by the LfD reviewers.

Other subjects

Over the next three months divisions will be approached to consider piloting one (or more) of the 'other methods' set out in our PSIRP with aims to:

- test the different methods
- widen the understanding of the principles of PSIRF
- address some of the subjects highlighted through the divisional stakeholder review that didn't end up in the final PSIRP

3. HSIB reports

3.1 Issued in Q3 20/21 which relate to the care of a WSFT patient

This provides details of HSIB Maternity reports which relate to the care of a WSFT patient that have been issued. The report contains a high-level summary of the learning, local review of content and any actions arising from these reports. A full action plan from each HSIB report received is submitted to the CCG.

Local ref.	Case (date)	Final report receipt	Key learning points	Safety actions identified following review of HSIB report and recommendations
WSH 58400	Neonatal death (Apr20)	Nov20	Information should be shared with the mother and father when risks emerge which might influence the safety of the care pathway to ensure they are able to make informed decisions.	Develop the existing VBAC pathway document to incorporate an individualised care plan to include a further formal meeting at 36 weeks which takes into account any new risks that arise during the pregnancy, and facilitates informed decision making for women regarding mode of birth.
			A holistic approach to care in labour which includes analysis of fetal heart rate monitoring. This should be consistently applied and incorporate an ongoing assessment of risk factors for both mother and baby.	Appointed midwife and obstetric fetal monitoring leads. Twice weekly MDT staff training includes discussions around human factors when reviewing and interpretation of a CTG together and ongoing and newly developing risks.
			The Trust to ensure that a member of the intrapartum team maintains a helicopter view to maintain situational awareness to ensure the safe management of complex clinical situations (RCOG, 2017).	Introduction of a minimum of twice daily multidisciplinary Labour Suite ward rounds which include weekends and bank holiday. Include a second band 7 at night to support the supernumerary co-ordinator on LS. (appointed but not in place yet)
WSH 58103	Therapeutic cooling (Apr20)	Oct20	Neonatal medical and nursing staff are supported to know how to use ventilator equipment, including set up troubleshooting when the ventilator is not performing as expected.	Introduced annual training for paediatric team use of ventilator to include troubleshooting. Use of the ventilator and troubleshooting added to nurses mandatory training.
			The Trust to ensure that multidisciplinary team communication is clear, precise, structured, and documented.	Development of a proforma to support resuscitation and ensure accurate information handed to regional team. Introduced multidisciplinary Sim training sessions with a focus on effective communication and team working.
			2. The Trust should ensure that blood gas measurements are completed in a timely way, taking into consideration the previous result and ventilation strategy.	Disseminated learning to all paediatric and neonatal staff. Development of a blood gas work book. QIS nurses training includes blood gas interpretation.

3.2 National HSIB reports issued in Q3 20/21

Whilst HSIB documents are available for specialty level review and learning, there is not currently a formal structured process for receipt and responding to publications that are not specifically related to the care of a WSFT patient (i.e. national thematic reports) although it is anticipated that these may be reviewed locally. A proposal for the management of these reports is being presented to the next CSEC meeting as part of the wider improvement plan for clinical audit (trust ref. 4.1).

Publications (non-Maternity) issued in Q3 were as follows:

Issued	Title
Oct 20	Management of venous thromboembolism risk in patients following thrombolysis for an acute stroke
Oct 20	COVID-19 transmission in hospitals: management of the risk
Dec 20	Procurement, usability and adoption of 'smart' infusion pump
Dec 20	Placement of nasogastric tubes

4. 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

The LfD Caseload Manager started in February; this new post will enable the development of an LfD 'learning into action' project programme for 2021/22. The first iteration of this will be reported in the next edition of this report.

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

	Deaths	Deaths with an SJR* completed	SJRs classified as Poor / Very poor care
Jan-Mar	302	72 (134 for SJR)	13
Apr-Jun	254	99 (161 for SJR)	12
Jul-Sep	188	40 (102 for SJR)	7
Oct-Dec	286	44 (133 for SJR)	12

** SJR - Structured Judgement Review*

5. Quality assurance (QA)

During COVID the previous formal Tuesday morning walkabouts ceased due to the pandemic requirement to reduce visitation to ward areas. This gave an opportunity to review the QA process to ensure the scope and outcome was as efficient as possible providing assurance of safety and quality in the organisation. Multi professional QA visits involving external partners will provide a level of assurance to enable the Improvement Board to classify a number of actions within the wider plan as 'business as usual' and provide a formal pathway for review of the quality and safety agenda. To date these have taken place in:

- Visit to Maternity in September
- Visit to Main Theatres, Day Surgery and ED in October to review medication security.
- QA 'round table event' (in place of a visit) reviewing care for patients with a learning disability in December
- Visit to Maternity in February

6. Raising concerns

WSFT has in place a number of options for staff to raise their concerns internally including opportunities to do this anonymously. Formal pathways include talking to: line managers, member of the human resources department, trade union representative and the 'Freedom to Speak Up' Guardians, Intranet reporting form or answerphone message on anonymous reporting phone-line. Concerns raised through all the above methods are captured on a trust database held on a secure drive active since January 2020.

In the period Nov20 – Jan21 no concerns were raised through the email web-form or through the anonymous reporting telephone line. 5/37 concerns were raised anonymously, 9/37 included elements of patient safety/quality and 8/37 including elements of bullying and/or harassment. No staff reported experiencing detriment as a result of raising their concern.

Route for raising concern	
Freedom to Speak Up Guardian	15
Senior Independent Director (SID)	0
Chief Executive	22
Anonymous phone line	0
Web form	0
Other e.g. NED other than SID	0

Division / Directorate of staff member raising concern			
Medical	13	Clinical support	2
Surgical	7	Women & children	1
Corporate	3	Community / Integrated services	2
Other / not disclosed	8	Estates & facilities	1

Staff group raising concerns			
Not disclosed	7	Maintenance and ancillary	1
AHP	2	Manager	0
Medical	3	Senior leader	0
Registered nursing and midwifery	16	Professional and technical	0
HCA	2	Other	0
Administrative and clerical	7		

7. Mitigated red risks

During Q3 there were two red risk downgraded or closed:

1) *Management of outbreaks and cases of infection in the Trust* (15)

The risk assessment has been downgraded to amber (annually x Major)
The current mitigation includes:

- Use of standard infection prevention and control precautions
- Trust policies and clinical guidelines on
    - management of specific infectious conditions.
    - management of outbreaks of infectious conditions.
    - disposal of clinical waste and contaminated linen.
- Provision of alcohol hand gel at point of care in all areas
- Provision of personal protective equipment to reduce exposure to infectious agents.

2) *Management of follow up appointments from inpatients, ward attenders and outpatients* (4054)

The risk assessment has been downgraded to amber (annually x major)
The current mitigation includes:

- PTL tracking for patients on RTT pathways
- Secretaries check the follow up when typing the patient letter
- Local databases (managed by Pas) of patients requiring follow up appointments (from Apr20)
- Full review and update of all the outpatient admin process undertaken
- All out patient admin SOP updated

- Planning for mandatory training and roll out.
- Staff training part of local induction for new starters regarding the process of follow up.
- Oversight of follow up booking capacity and demand at weekly access meetings
- Use of e-Care message centre in some specialities to reduce risk of lost paper (slips/books).
- Creation of follow up referral template in message centre
- Secretarial pools set up on message centre (Surgery and Medicine)
- Use of the cymbio dashboard to identify unbooked follow ups and data quality issues
- Regular monitoring of patient complaints, GP queries/issues, PALS, claims and incidents to identify any thematic issues around follow up booking

8. Learning from RIDDOR incidents

There were eight incidents in Q3 reported to the HSE under **RIDDOR**, which is an increase of 3 incidents from the previous quarter:

- Four incidents were due to a slip, trip or a fall
- Three incidents were from physical assaults
- One incident was due to moving and handling

Learning and mitigation included:

- Additional staff training and awareness
- Staff reminded to follow SOPs and procedures which are in place
- Staff reminded to remove hazards

9. Learning from patient and public feedback:

Nine complaints received in Q2 were deemed to be upheld at the time of producing this report. Actions from these are set out in the table below. The complaints team are reviewing ways of ensuring that actions are implemented and effective including monthly spot checks, this has been delayed slightly whilst the team were supporting the 'keeping in touch service'. More details will be provided in the next report

Ref.	Issues identified	Actions and learning
WSH-COM-1826	• Delay in patient's fractured hip being diagnosed. • Patient developed pressure ulcers during admission. • Poor communication about Covid-19 swab prior to discharge. • Staff member seen using phone on ward.	• Patient's x-rays did not show any clear fracture prior to discharge. X-ray images discussed at x-ray review meeting. • Ward manager has arranged refresher training with tissue viability team regarding completion of risk assessments for pressure areas. • Ward manager has reminded staff about performing Coivd-19 swab tests within 48hrs of patients being discharge to prevent delays and the possibility of care home refusing to accept patients on discharge. • Ward manager has reminded staff that personal use of mobile phones on the ward is not permitted and they should only be used for work reasons such as medic bleep.
WSH-COM-1781	• Incorrect medications prescribed to patient despite family contacting ward and providing details of drug regime. • Staff did not contact family when patient experienced a severe headache and uncontrolled jerking	• Ward manager has highlighted to nursing staff that when they receive information regarding prescriptions that they should inform a doctor in person and document the name of the doctor whom they have spoken to. • Ward has implemented a communications book so that information is handed over to the nurse in charge of the shift. • Patient's case has been discussed during ward's monthly clinical governance meeting for learning and reflection.
WSH-COM-1856	• Patient's daughter did not receive any information regarding an incident about their parent's unsafe discharge for over 8 weeks.	• Raised in governance meeting 'hot topic' communications to department. • Blue wristband initiative for dementia patients being introduced to the emergency department.
WSH-COM-1824	• A scan was not performed on patient when they first attended ED. Patient represented a week later and was diagnosed with a bowel obstruction.	• Further investigation should have been carried out during patient's first attendance. Junior doctors have therefore been reminded to refer patients to the senior doctor on call for a second opinion and confirmation. • Senior doctors have also been reminded to ensure that a thorough investigation is completed on patients attending the ED. • Both junior and senior doctors involved in patient's care have reflected on patient's care.
WSH-COM-1841	• Patient did not undergo a CT scan in the ED following a fall.	• Doctors involved with patient's care have been spoken with and the importance of undertaking CT scans on patients who have experienced a fall and possible head injury has been highlighted. • Impact of patient's case highlighted during ED medical staff lecture to remind all staff of the importance of carrying out CT scans on patients.

Ref.	Issues identified	Actions and learning
WSH-COM-1827	• Patient was discharged from ED without receiving IV antibiotics and told to attend Ipswich hospital.	• Patient's case has been fed back to ED team for reflection and learning.
WSH-COM-1833	• A delay occurred in patient being prescribed regular tramadol causing them to experience withdrawal symptoms.	• Ward staff have been reminded to escalate any concerns about medications or possible missed medications to the doctor on duty. • Ward staff have been encouraged to review pharmacist notes on eCare so that these can be escalated to the medical team if necessary. • Junior doctor involved has been spoke with and the importance of medicine reconciliation and the impact of delayed medications on patients has been highlighted.
WSH-COM-1684	• Significant delay in patient undergoing and endoscopy procedure under sedation which delayed a diagnosis of cancer. • Delay caused by human error and poor organisation and a lack of general anaesthetic lists for diagnostic endoscopic procedures. • Poor staff attitude when patient failed to tolerate endoscopy procedure.	• Existing standard operating procedure for nurse endoscopists has been reviewed to ensure that clear pathways of escalation at the time of failed endoscopy procedures with clear channels of communications are highlighted. • Process for availability of anaesthetists for endoscopy procedures to be reviewed and a timetable for these procedures to be organised on a monthly basis to avoid delays. • Endoscopy staff have been reminded of the importance of remaining professional and compassionate towards patients at all times.
WSH-COM-1799	• Patient's call bell left out of reach. • Bruising caused whilst staff assisted patient with mobilisation and whilst bed sheets were changed. • Poor communication with patient.	• A nursing assistant on the AAU has taken responsibility for educating colleagues on the placement of patient call bells so that they are within reach of patients. • Ward staff reminded of how delicate patients' skin can be and the importance of using correct moving and handling techniques to support patient moves from side to side when changing sheets. • Staff reminded that if bruising is evident on a patient's skin or if an accident occurs an incident form should be completed. • Ward manager has spoken with moving and handling trained to ensure that during next mandatory training session the correct use of side rails and how to support patients' position without pulling limbs is included. • Ward manager to monitor the number of slide sheets on the unit and ensure that there is adequate stock to aid with moving a patient's position. • Ward staff have been reminded to communicate effectively, explain and apologise for any delays in attending to a patient.

11:40 BUILD A JOINED-UP FUTURE

15. Future system board report

To APPROVE report

For Approval

Presented by Craig Black

Trust Board Meeting – 26 February 2020

Agenda item:	15			
Presented by:	Craig Black, Executive Director for Resources & Deputy CEO			
Prepared by:	Gary Norgate, Programme Director			
Date prepared:	15/02/2021			
Subject:	Update on the Future System Programme			
Purpose:	X	For information		For approval

The following paper provides an overview of progress being made towards the development of a new health and care facility in West Suffolk. Since last month's meeting we have made progress on several fronts and had one major meeting which could have a significant bearing on the timing of our project.

As a general indication of health, the status of the overall Future System Programme remains 'Green' with significant strides having been made in several key areas:

Strategic Outline Case – The strategic outline case is the first significant step towards developing our design and securing funding for a new health and care facility. In the last month we have secured formal support for the publication of the case from the Suffolk and North East Essex Integrated Care System, the West Suffolk Clinical Commissioning Group and the West Suffolk Foundation Trust Board. That said, our colleagues in NHSI/E and Department of Health have developed a centralised, programmatic approach to ensure all of the 40 Health Infrastructure Plans (HIP) benefit from best practice whilst being scheduled in a way that ensures effective use of funding and resources (in essence this is aimed at avoiding the cost and inefficiency of 40 bespoke designs whilst ensuring the most developed cases are scheduled appropriately). The logic of the approach makes very clear sense, however, the down-side is potential impact on the timing of formal appraisal of our SOC.

With this last point in mind, our Future System Team attended its dedicated roundtable with the National HIP Programme (NHP) on 5 February 2020. The objectives of the session were to;

- Position our project as one that enjoys the full support of its system and that has a compelling and pressing case for change.
- Ensure the central team understand the full extent of the progress made to date including the work we have done to understand modern methods of construction, the progress being made towards a planning application and the level of system wide co-production that is underway.

The session was conducted in a positive air and feedback positive. We are therefore pressing to be considered as a 'fast follower', developing our design in parallel with the work underway at another trust and allowing us to progress our plans within a seed funded budget without delay.

Estates – Work continues on the development and execution of plans to understand and mitigate the concerns we have received from our community and those risks that may otherwise impact a successful planning application. In the last month our technical team have met with representatives of Natural England, Suffolk Wildlife Trust and other important agencies to ensure the details and sensitivities of Hardwick Manor's unique ecology are fully understood.

Clinical Workstream – Also critical to the shape and layout of a new building is the clinical model that it will contain and facilitate. To this end, the Clinical workstream have been holding training workshops to ensure our co-production leads (including our newly appointed GP colleagues) understand the business case and workshop processes. Armed with this information, they are now commencing the next round of clinical engagement and design. In parallel, work has commenced on the exploration of opportunities for provider collaboration. Specifically, members of the ESNFT, WSFT and CCG teams are developing the methodology through which a clinically lead, data driven assessment of collaboration opportunities will be assessed.

Communications and Engagement – Our communications and engagement team have been working with our clinical team and Healthwatch Suffolk to develop the best possible environment through which our public can engage and meaningfully co-produce. To this end we have recruited and launched the co-production community engagement panel. We are also delighted to announce the recruitment of 4 patient voice representatives who will work alongside the engagement panel to ensure all voices and ideas are heard and acted upon. The details of the how the two groups will work and interact are shown below. Alongside the co-production activities, the team is continuing to ensure regular communications on progress are maintained. To date the following communication media have been established:

- New microsite launched https://www.wsh.nhs.uk/new-healthcare-facility which received more than 5,000 visits in under a month.
- Launched a dedicated newsletter with nearly 150 registered users within the first three weeks.
- Regular staff communications utilising existing channels including online face 2 face briefings and staff newsletter
- Briefings shared with stakeholders including politicians at key milestone points

Finance and Economic Workstream – the financial and economic models contained within the SOC were finalised at a meeting with DOHSC and NHSI/E on 30th January. This is a monthly forum and has proved invaluable when it comes to ensuring our options appraisal and financial modelling complies with the requirements of the investment process. Said models were presented and discussed at the aforementioned Roundtable with the following specific aims.

- Encourage a discussion on the phasing of our programme (our existing buildings are out of date and require significant proactive management and ongoing investment, consequently, we believe we have a strong, well developed case that supports prompt investment)
- Discuss the potential size of the likely capital investment available for the construction of a new facility.
- Illustrate the fact that our commissioners and other partners within the Suffolk health and care system have a full understanding of the potential revenue impact of the programme

Digital – Sarah Jane Relf and Liam Mclaughlin will pick up responsibility for, respectively, translating the digital blueprint into tangible designs and leading on the technical realisation of our vision.

All in all, a month in which the strategic outline case has been completed, phase 2 of the clinical design has commenced, tangible progress has been made towards understanding our preferred site and we have continued to demonstrate our commitment to co-producing a new facility with our community, for our community. Next month will hopefully produce some clarity of the extent to which our proposed pace of development will be supported by the National HIP Programme.

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:	Part of Scrutiny Committee work program.						
Risk and assurance:							
Legislation, regulatory, equality, diversity and dignity implications	None						
Recommendation: The Board are recommended to note the progress being made towards the realisation of plans to build a new hospital.							

11:00 GOVERNANCE

16. Governance report

To APPROVE the report, including subcommittee activities

For Approval

Presented by Richard Jones

Board of Directors – 26 February 2021

Agenda item:	16			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	19 February 2021			
Subject:	Governance report			
Purpose:	X	For information		For approval

This report pulls together a number of governance items for consideration and approval:

1. **Agenda items for next meeting** (for information)
   Annex A provides a summary of scheduled items for the next meeting and is drawn from the Board reporting matrix, forward plan and action points. The final agenda will be drawn-up and approved by the Chair.

2. **Use of Trust seal** (for information)
   To note that there has been no use of the trust seal to report.

3. **Trust Executive Group report** (for information)
   TEG continued with a different structure and approach to its meetings, focusing the agenda on key strategic issues. The meeting on 1 February considered:

   - Operational challenges, including winter/Covid pressures
   - Staff support as we move into operational reset for elective activity
   - Structural risk and decant ward proposals
   - The new format for divisional performance review meetings was approved, focussing on a shared session across divisions to promote collaborative working and sharing of concerns and improvements with a greater focus on strategic developments. Going forward the PRM will be underpinned by performance review by the Insight Committee
   - The red risk report was received, this included 'top risks' for staff engagement and raising concerns; COVID-19 response and recovery, including delivery of access standards; pathology services; and building structure.

4. **Audit Committee report**
   The Audit Committee meeting was held on 29 January 2021. The key issues and actions discussed were:

   - Deep Dive – 'Risk Appetite Session' - This session was led by Janine Combrinck from BDO. This interactive session took the Committee Members through a thought-provoking presentation followed by a poll for each Member to decide on the level of risk for different scenarios. The results of the poll are to be collated and presented back to Members and will be used across the organisation to assist in risk appetite and tolerance consideration.
   - Internal Audit report – this presented the first draft of the Internal Audit Plan for 2021/22. Discussions were held around the proposed reviews and RSM confirmed that they would bring a further iteration of the Audit Plan back to the next Committee meeting.
   - Internal Audit Progress Report – this confirmed that ten final reports have been issued to date. It also noted the progress with implementing management actions and that 33 had been closed since the Committee meeting in November. It was noted that the new process that has been adopted at the Trust for the Executive Leads to review the outstanding actions on a monthly basis had helped to improve the closure of these items.

Internal Audit also noted that there had been a number of changes made to the Internal Audit Plan for this current financial year, mainly in relation to the changing requirements of the Trust. The Audit Committee formally approved the changes to the Plan for 2020/21.

- Counter Fraud – The Counter Fraud Progress Report was presented, which confirmed that the 2020/21 Plan is continuing to progress. The final report on the proactive exercise on agency staff has been issued and a follow up on the actions raised will be completed in June 2021. RSM confirmed that there has been a lot of fraud alerts issued in the last few months and that these have all be appropriately actioned by the Trust. They also confirmed that, due to Counter Fraud not attending any face to face inductions at the Trust over the last year, that they would be completing a proactive exercise around Payroll in order to utilise the days included in the Plan for 2020/21.
- External Audit – External Audit presented their Audit Plan for 2020/21. External Audit confirmed that the risks included in the Plan were largely standard and no different to the prior year. They also informed the Committee of the change in approach to their work on value for money (VFM) as required by the NAO, which may require wider involvement of key personnel across the Trust. External Audit asked the Committee to confirm that they were not aware of any fraud, which the Committee confirmed. External Audit also confirmed that, although two independence issues had been identified, mitigating actions have been put in place to ensure that they maintain their independence. The Committee approved the Audit Plan for 2020/21.
- Charitable Funds Annual Report and Accounts – The Audit Committee received delegated authority from the Trust Board to approve the Annual Report and Accounts. The Chair of the Charitable Funds Committee confirmed that the Annual Report and Accounts had been discussed and reviewed alongside the Auditor's Report, for which an unmodified audit opinion had been issued. The Charitable Funds Committee recommended approval of the Annual Report and Accounts and the Audit Committee confirmed the approval.
- Year End Financial Reporting – A paper was presented on considerations for the 2020/21 Annual Report and Accounts. This covered the Trust's ability to continue as a going concern, proposed accounting policies and significant accounting estimates. The items considered in the paper will be monitored and an update will be provided at the Committee meeting in April.
- Review of Partnership Organisations – A paper was presented on the annual requirement to consider the assurance processes around Partnership Organisations. The Collaborative Procurement Hub is the main partner, for which relevant assurances have been obtained. No issues were noted from this review.

5. **Council of Governors** (for information)
A Council of Governors meeting was held on 11 February 2021 via Microsoft Teams. This summary is presented to the board of directors for information to provide insight into these activities. Key points from the meeting were:

- Due to COVID social distancing requirements the public were excluded from to attending this meeting but able to observe via YouTube
- The Chair welcomed everyone to the meeting, in particular newly elected governors who were attending their first formal meeting of the Council of Governors
- A written report was received from the Chair which provided a summary of the focus of the meetings and activities that she had been involved in over the last three months
- The Chief Executive's report provided an update on the challenges facing the Trust and highlighted the key strategic issues
- Responses to governors' issues raised were received and clarification provided
- The quality and performance and finance reports were reviewed and questions asked on areas of challenge
- An update was provided on the Trust's People Plan and the priorities for the next six months
- An overview of progress was given on Future Systems and the work being undertaken relating to estates, clinical design and finance, as well as the structure of the current building
- A presentation was received on the review of the Trust's strategy and feedback from governors was invited

- Governor nominations for the Nominations Committee and Engagement committee were approved. Further nominations for membership of the engagement committee were invited
- Proposals for governor training and support were received and approved
- Nominations were sought for governors to act as readers for the draft operational plan and annual report, including quality reporting. It was explained that national guidance and timings for these had not yet been received
- A summary of the register of interests of governors was received and reviewed
- A report was received from the lead governor and a verbal report from staff governors.

6. **Remuneration committee** (for information)
A meeting was held on 16 February 2021 via Microsoft Teams. The committee approved the nationally recommended increase of 1.03% payable to very senior managers for 2020/21 (effective from 1 April 2020).

7. **Review of non-executive directors (NEDs) responsibilities**
The responsibilities of the NEDs is reviewed annual to ensure that a good balance exists and key responsibilities covered. The summary appended to this report (**Annex B**) is subject to change as a result of a number of factors including: allocation following completion of induction for new NEDs, departure of the current audit committee chair and allocation of roles within the revision committee structure for insight, involvement and improvement. As a result these responsibilities have been scheduled for further review in April 2021 in the Board's forward plan

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**		**Invest in quality, staff and clinical leadership**		**Build a joined-up future**		
	X		X		X		
Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X	X	X	X	X	X	X
Previously considered by:	The Board receive a monthly report of planned agenda items.						
Risk and assurance:	Failure effectively manage the Board agenda or consider matters pertinent to the Board.						
Legislation, regulatory, equality, diversity and dignity implications	Consideration of the planned agenda for the next meeting on a monthly basis. Annual review of the Board's reporting schedule.						

Recommendation:

The board is asked to **note** the contents of the report

Annex A: Scheduled draft agenda items for next meeting – 26 March 2021

Description	Open	Closed	Type	Source	Director
Declaration of interests	✓	✓	Verbal	Matrix	All
Deliver for today					
Patient/staff story	✓	✓	Verbal	Matrix	Exec.
Chief Executive's report	✓		Written	Matrix	SD
Operational report	✓		Written	Action	HB
Integrated quality & performance report	✓		Written	Matrix	HB/SW
Finance & workforce performance report, including: - draft budget and capital programme for 2021/22	✓		Written	Matrix	CB
Risk and governance report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
Invest in quality, staff and clinical leadership					
People plan, including: - People plan update - Staff recommender scores (if published) - Appraisal performance - Education report - including undergraduate training - Consultant appointment report - "Putting you first award"	✓		Written	Matrix	JMO
Quality, safety and improvement report - Infection prevention and control assurance framework - Maternity services quality and performance report (inc. Ockenden) - Improvement programme board report - Nurse staffing report - Quality priorities – review of 2020/21 and planning for 2021/22	✓		Written	Matrix	SW / NJ
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	SW
Build a joined-up future					
Digital programme board report	✓		Written	Matrix	CB
Future system board report	✓	✓	Written	Matrix	CB
Strategic update, including Alliance, System Executive Group and Integrated Care System (ICS)	✓	✓	Written	Matrix	KV / SD
Governance					
Governance report, including - Agenda items for next meeting - Use of Trust's seal - TEG report - Annual report and operational planning guidance - Risk appetite statement	✓		Written	Matrix	RJ

- Planning for annual governance review					
Scrutiny Committee report		✓	Written	Matrix	LP
Confidential staffing matters		✓	Written	Matrix – by exception	JMO
Reflections on the meetings (open and closed meetings)		✓	Verbal	Matrix	SC

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Non-executive directors' responsibilities – February 2021

	Primary responsibilities	Responsibilities as required	Lead assurance roles
Sheila Childerhouse **Chair and Non-executive director** **Term:** 1 Jan 2018 - 31 Dec 2020	• Chair Board – Public, Closed (**Chair**) • Quality & Risk Committee (**Chair**) • Scrutiny Committee • Remuneration Committee • Council of Governors (**Chair**) *Option to attendance any other Board committees* • Improvement Programme Board • ICS chairs meeting (Chair) Pending appointment of new NED: • Digital Programme Board • 2nd Clinical Safety & Effectiveness Committee (only attend if Richard Davies unavailable) • *Improvement Programme Board (provisional new meeting)*	• Board Workshops • External relationships • Consultant appointments • Quality walkabouts • Governor meetings with NEDs • Investigations and appeals • CCG Board meetings	• Integrated care system • NHS England and Improvement • NED link to CEO • NED link to Director of Integration and Partnerships

	Primary responsibilities	Responsibilities as required	Lead assurance roles
Richard Davies **Non-executive director** **Term:** 1 Mar 2017 – 28 Feb 2020 **Reappointed:** 1 Mar 2020 – 28 Feb 2023	• Board meeting – Public, Closed • Audit Committee • Quality & Risk Committee • Remuneration Committee • Improvement Programme Board • Future System Board Subcommittees of Q&RC: • Clinical Safety & Effectiveness Committee • Learning from deaths group (Chair)	• Board Workshops • Consultant appointments • Quality walkabouts • Revalidation Support Group • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• Senior Independent Director, including whistleblowing • NED link to Medical Director • Patient safety, including learning from deaths • Safeguarding children
Angus Eaton **Non-executive director** **Term:** 1 Jan 2018 – 31 Dec 2020	• Board meeting – Public, Closed • Audit Committee (**Chair)** • Remuneration Committee (**Chair**) • Charitable Funds Committee • Ethics Committee • Future System Board	• Board Workshops • Consultant appointments • Attend Q&RC • Quality walkabouts • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• NED link to Director of Finance • NED link to Director of Workforce & Communications • Staff health and wellbeing • Risk management • Procurement - moved from Gary
Louisa Pepper **Non-executive director** **Term:** 1 September 2018 – 31 Aug 2021	• Board meeting – Public, Closed • Audit Committee • Quality & Risk Committee • Remuneration Committee • Scrutiny Committee (**Chair**) • Ethics Committee (**Chair**) Subcommittees of Q&RC: • Corporate Risk Committee • 2nd Patient Experience Committee	• Board Workshops • Consultant appointments • Quality walkabouts • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• NED link to Chief operating office • Access, including RTT • Security • Emergency preparedness, resilience and response (EPRR) – including COVID response • Pathology

	Primary responsibilities	Responsibilities as required	Lead assurance roles
Alan Rose **Deputy Chair and Non-executive director** **Term:** 1 April 2017 – 31 March 2020 **Reappointed:** 1 April 2020 – 31 March 2023	• Board meeting – Public, Closed • Audit Committee • Quality & Risk Committee • Scrutiny Committee • Remuneration Committee • Clinical Excellence & Discretionary Awards Committee Subcommittees of Q&RC: • Patient Experience Committee • 2nd Corporate Risk Committee	• Board Workshops • Consultant appointments • Quality walkabouts • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• Deputy Chair • NED link to Chief Nurse • Patient experience and public engagement • Safeguarding - adults • End of life (moved from Richard)
David Wilkes **Non-executive director** **Term:** August 2020 – August 2023	• Board meeting – Public, Closed • Audit Committee • Remuneration Committee • Charitable Funds Committee (**Chair**) • ***Attending wide range of committees during induction***	• Board Workshops • Consultant appointments • Quality walkabouts • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• To be confirmed
Rosemary Mason **Associate non-executive director** **Term:** August 2020 – August 2022	• Board meeting – Public, Closed • Audit Committee • Remuneration Committee • ***Attending wide range of committees during induction***	• Board Workshops • Consultant appointments • Quality walkabouts • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• To be confirmed

12:15 ITEMS FOR INFORMATION

17. Any other business

To consider any matters which, in the opinion of the Chair, should be considered as a matter of urgency

For Reference

Presented by Sheila Childerhouse

18. Date of next meeting

To NOTE that the next meeting will be held on Friday, 26 March 2021 at 9:15am in West Suffolk Hospital

For Reference

Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

19. The Trust Board is invited to adopt the following resolution:

“That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest” Section 1 (2), Public Bodies (Admission to Meetings) Act 1960

For Reference

Presented by Sheila Childerhouse