Board of Directors (In Public)

Schedule	Friday 26 March 2021, 9:15 AM — 11:45 AM GMT
Venue	Via video conferencing
Description	A meeting of the Board of Directors will take place on Friday, 26 March 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 03 26 Mar.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

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 26 February 2021
   For Approval - Presented by Sheila Childerhouse

   Item 6 - Open Board Minutes 2021 02 26 Feb 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. Chief Executive's report
   To RECEIVE an introduction on current issues
   For Report - Presented by Stephen Dunn

   Item 8 - Chief Exec Report Mar 21 Dunn.docx

09:40 DELIVER FOR TODAY

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

   Item 9 - Operational Board update March 2021.doc

   Item 9 Appendix 1 - Operational Board update March 2021.doc

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

Item 10 - Integrated quality and performance report - February 2021.pdf

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

Item 11 - Board report Cover sheet - M11.docx

Item 11 - Finance Report- February 2021 Final.docx

Comfort Break - 10 minutes

10:30 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

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

Item 12 - People OD highlight report March 2021.doc

Item 12 - Psych report.docx

Item 12 - ETD report.docx

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

13.1. Maternity services quality & performance report
For Approval

Item 13.1 - Maternity Quality and performance report Mar 2021.docx

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13.2. Infection prevention and control assurance framework
For Approval

Item 13.2 - COVID IPC assurance framework.docx

13.3. Nursing staffing report
For Approval

Item 13.3 - Nurse Staffing final.docx

13.4. Improvement programme board report
For Approval

Item 13.4 - Improvement Programme Board Report.docx

Item 13.4 - Improvement Programme - Status Summary Action Plans OUT.xlsx

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11:10 BUILD A JOINED-UP FUTURE

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14. Digital programme board report
To approve report
For Approval - Presented by Craig Black

Item 14 - Digital Board - March 2021.doc

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

Item 15 - Future system board overview Mar 2021.doc

11:30 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 WSFT Quality report 2019_20.pdf

11:45 ITEMS FOR INFORMATION

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

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18. Date of next meeting
    To NOTE that the next meeting will be held on Friday, 30 April 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 March 2021 at 9:15**. The meeting will be held virtually via video conferencing.

Sheila Childerhouse
Chair

Agenda (in Public)

9:15 GENERAL BUSINESS		
1.	**Resolution** The Trust Board is invited to adopt the following resolution: "That representatives of the press, and other members of the public, be excluded from the meeting having regard to the guidance from the Government regarding public gatherings."	Sheila Childerhouse
2.	**Apologies for absence** To note any apologies for the meeting and request that mobile phones are set to silent.	Sheila Childerhouse
3.	**Declaration of interests for items on the agenda** To note any declarations of interest for items on the agenda	Sheila Childerhouse
4.	**Questions from the public relating to matters on the agenda** (verbal) To receive questions from members of the public of information or clarification relating only to matters on the agenda	Sheila Childerhouse
5.	**Review of agenda** To agree any alterations to the timing of the agenda.	Sheila Childerhouse
6.	**Minutes of the previous meeting (attached)** To approve the minutes of the meeting held on 26 February 2021	Sheila Childerhouse
7.	**Matters arising action sheet (attached)** To accept updates on actions not covered elsewhere on the agenda	Sheila Childerhouse
8.	**CEO report (attached)** To receive an introduction on current issues	Steve Dunn
9:40 DELIVER FOR TODAY		
9.	**Operational report (attached)** To approve the report	Helen Beck
10.	**Integrated quality and performance report (attached)** To approve a report	Sue Wilkinson / Helen Beck
11.	**Finance and workforce report (attached)** To approve report	Craig Black
	Comfort break – 10 minutes	
10:30 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP		
12.	**People and OD highlight report (attached)** To approve report	Jeremy Over

13.	**Quality, safety and improvement report** To approve reports: 13.1 Maternity services quality and performance report, including Ockenden report (attached) 13.2 Infection prevention and control assurance framework (attached) 13.3 Nurse staffing report (attached) 13.4 Improvement programme board report (attached)	Sue Wilkinson / Nick Jenkins
11:10 BUILD A JOINED-UP FUTURE		
14.	**Digital programme board report (attached)** To approve report	Craig Black
15.	**Future system board report (attached)** To approve report	Craig Black
11:30 GOVERNANCE		
16.	**Governance report (attached)** To approve report, including subcommittee activities	Richard Jones
11:45 ITEMS FOR INFORMATION		
17.	**Any other business** To consider any matters which, in the opinion of the Chair, should be considered as a matter of urgency	Sheila Childerhouse
18.	**Date of next meeting** To note that the next meeting will be held on Friday, 30 April 2021 at 9:15 am in West Suffolk Hospital	Sheila Childerhouse
RESOLUTION TO MOVE TO CLOSED SESSION		
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5. Review of agenda

To AGREE any alterations to the timing of the agenda.

For Reference

Presented by Sheila Childerhouse

6. Minutes of the previous meeting

To APPROVE the minutes of the meeting held on 26 February 2021

For Approval

Presented by Sheila Childerhouse

DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 26 FEBRUARY 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		

Action

GENERAL BUSINESS

21/024 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, including governors and members of the public who had joined via YouTube.

21/025 APOLOGIES FOR ABSENCE

Apologies for absence were received from Kate Vaughton.

21/026 DECLARATION OF INTERESTS FOR ITEMS ON THE AGENDA

No declarations of interest were received.

20/027 QUESTIONS FROM THE PUBLIC RELATING TO MATTERS ON THE AGENDA

Q Could assurance be provided that the vacancy for a supernumerary person intended for the labour suite was being resolved?

A This would be answered under agenda item 14.1 maternity services quality and performance report.

Q The mandatory training overview showed a worrying percentage for foetal monitoring training; although Covid may have been the reason for this, could assurance be provided that this was being addressed?

A This would be answered under agenda item 14.1.

Q Could clarification be provided on the expenditure on the emergency department and the extent to which this was being developed?

A This would be answered under agenda item 12, finance and workforce report.

21/028 REVIEW OF AGENDA

The agenda was reviewed and there were no issues.

21/029 MINUTES OF MEETING HELD ON 29 JANUARY 2021

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

21/030 MATTERS ARISING ACTION SHEET

The ongoing actions were reviewed and the following noted:

Ref 1915; community services leaders to recommend appropriate community effectiveness metrics for future reporting. It was requested that the target date for completion was extended as it may also take longer to produce the output metrics given all the work around capacity, demand etc that was currently going on. It was agreed that an update would be provided at the board meeting next month and the metrics would be available as soon as possible.

The following actions had been noted in the minutes of the board meeting on 26 January but were not recorded in the action plan:

21/009; consider how NEDs could undertake virtual ward visits. This had been included in the action sheet for the closed board **but should be in the open board.**

21/015; provide detailed report of FTSU trends and numbers to next meeting. **The board would be receiving a report on this next month.**

The completed actions were reviewed and there were no issues.

21/031 STAFF STORY

- Three messages were read out from very appreciative relatives who had been able to speak to their loved ones via the keeping in touch service. This had been very important, particularly for the two families who were able to talk to them for the last time.
- There was also a message of appreciation for the clinical helpline thanking the advisors who were so caring and friendly and provided updates about tests and results and the discharge arrangements for their loved ones.

- These messages emphasised how vital these services were to so many families. The clinical helpline also enabled staff to be made to feel useful and contribute where they were required to self-isolate and work from home.
- It was noted how enthusiastic all the team were in both these services and also the joyful response of patients who were able to talk to their families through the keeping in touch service.
- This highlighted the way in which these services had utilised the Trust's IT system in many ways. Both these services had been set up very rapidly at the start of the pandemic and this was a great credit to everyone involved.
- There was also a real focus in the team on the wellbeing of staff and ensuring that they actively 'switched off' at the end of their day.

Q Was there an angle of the keeping in touch service that could be linked to community services so patients and families could easily keep in touch?

A This was something that should looked at in the future. Community teams were now delivering more and more acute care to patients in their own homes who might be a long distance away from their families.

ACTION: work with system colleagues to consider extended keeping in touch service to community setting. **S Wilkinson**

- It was noted that there were variations of this type of service in the community which were operated by third sector organisations who supported individuals who were 'trapped' in their homes and whose families were often not local.

21/032 CHIEF EXECUTIVE'S REPORT

- There was now a roadmap for coming out of lockdown and strong evidence that the vaccines were effective which was very encouraging.
- The pressure on acute services had significantly reduced, however community teams still faced considerable demands and pressures.
- WSFT was seeing considerable increases in waiting times and was working with staff in terms of how to reset activity and trying to improve access for the community.
- Significant changes had been made to the footprint of the emergency department, the first phase of which opened recently. The estates team and everyone who had been involved were commended for this achievement.
- A 'love yourself' week had recently taken place with a number of very good sessions giving advice to staff about how they could look after themselves.
- The Trust continued to reflect on how to support staff in speaking up and was committed to improving this as it moved forward.
- A number of staff were mentioned in this report and this highlighted an ongoing passion to improve services for the local population.
- The government had announced significant legislative changes which were set out in the annex to this report. A session would be arranged for the Council of Governors to talk about integration and the wider implications of the white paper etc.

Q Once the learning from the virtual Covid ward had been evaluated, were there any plans to develop this and replicate it other specialties?

A This definitely had potential but the current ward was very small. There were a number of services that this could be applied to, eg heart failure patients, frailty patients.

Q Where did the Chief Executive consider that the Trust was on its cultural journey; what were the next key issues that needed to be focussed on and how could the board do things differently as a result of feedback from this process?

A There had been significant engagement with staff through 'What Matters to You' (WMTY), and this combined with the national people plan and WSFT people plan had provided the areas to focus on. The results of the national staff survey would also be received very soon and this would provide further opportunities and focus to link with WMTY.

The priority would be whether the Trust was moving fast enough in some areas of the cultural journey and it would continue to think about how to encourage staff to speak up and how it could become more of a learning organisation. There was also a need to think about how to support managers to ensure they were the best they could be and had the appropriate leadership skills. A board development programme was also currently being undertaken.

Q The appointment to the new role of head of mental health was a very good initiative and would assist in linking with partner organisations. Would the board have the opportunity to learn more about what this role involved?

A It was proposed that the board should receive a presentation on this or a report as part of the quality report.

ACTION: consider how the board could receive more information on the role of the head of mental health. **S Wilkinson**

Q What would the white paper mean for WSFT, eg a shared director between social care and health in the area?

A Rosemary Mason had been asked to take on a particular role in becoming more engaged with the alliance as further links were formed. The proposals in the white paper would bring organisations closer but there were still likely to be two distinct systems, ie heath care and social care. However, this framework should help to bring this together further and a joint post would result in greater integration and liaison between teams. The white paper would provide further opportunities and reinforce much of what WSFT was already doing.

DELIVER FOR TODAY

21/033 OPERATIONAL REPORT

- Covid numbers were still declining although the rate of decline had slowed.
- The Trust had consolidated its critical care back into one unit, although regionally the critical care position was still above the baseline and WSFT could still be asked to provide support.
- There was a suggestion that there could be a potential for another surge in the autumn and Trusts were being encouraged to plan for this as they moved forward.
- A regional conversation had taken place yesterday about the reset phase. There was currently no national guidance on what reset/recovery waiting times might look like except for the need to treat patients in clinical priority order.
- Currently Trusts were being asked to develop their own local plans for what they could deliver in quarter one; by quarter two there may be a more prescriptive requirement.

- There was a nervousness about this both organisationally and regionally as this was what happened coming out of the first surge. However, the risk of a repeat of the previous experience had reduced, both regionally and nationally as there was a recognition that staff were exhausted and different organisations and staff groups had faired differently.
- Organisations were also expected to maintain compliance with the current level of infection control guidance at least until the end of 2021 which would impact on capacity and ability to deliver.
- There was a concern that there was currently no national focus on community services and WSFT was trying to ensure this area was not forgotten.
- At present there was no guidance on the financial position that organisations would be recovering in. Regional guidance at the moment was to only treat the first priority cohort of patients; further guidance was expected.
- However, WSFT would get special dispensation to move faster as it would face issues when it moved it remedial work as a result of the RAAC plank scenario.

Q Although there were uncertainties around the reset process it was likely that patients would expect to get back to being treated. How would the Trust communicate this to the public?

A Plans were currently being developed as this would be more challenging due to the RAAC plank programme. These proposals would go the next scrutiny committee meeting and would provide the local picture. The Trust was also waiting for national guidance on what would be expected. Once the plans were finalised and agreed they would be communicated regionally and through the CCG and WSFT. There would also be individual patient communication which would be worked through with the clinical teams over the next couple of weeks and might differ in different services.

Q The appendix to this report was very helpful in showing how organisations compared. Should the Trust consider how some of this comparative data might be a source to aspire to as it would also be good culturally to have ambitions as the Trust ultimately wanted to be exceptional again? Should it think about what it hoped to achieve but also what it could achieve at a stretch?

A Some of the historic measures would not be very helpful moving forward for a while. Once there was clarity around national expectations and plans WSFT would collate different metrics to help to do this.

ACTION: consider appropriate metrics to help drive ambition to be exceptional. **H Beck**

- A discussion had taken place with the regional team about getting better comparative benchmarking data across the system. However, some of the constraints ie RAAC plank situation, would need to be taken into account and the Trust would need to be innovative and do things differently during this period.

Q A lot of actions had been put in place in endoscopy, when was it likely that an impact would start to be made on the back log and how confident was Helen Beck in the measures that had been taken?

A Endoscopy was concentrating on the delivery of the two-week standard for rapid access patients, it would then focus on the six-week standard for routine referrals and then focus on keeping on top of surveillance patients.

WSFT had been slow to come out of the first wave as there had been a number of operational changes that it had not been aware of previously. The newly appointed

lead for cancer had done an amazing job in addressing the issues and progressing this. The Trust had been on track to deliver the two-week standard at the end of January but due to the next wave of Covid it had had to slow down endoscopy activity, although it continued to deliver some activity. Demand had also increased; therefore, it would be two to three months before the two-week standard would be delivered but during this time it was expected that step changes and improvements would be seen quite quickly.

ACTION: provide visibility of the endoscopy recovery trajectory to the board. **H Beck**

Q Could the board be assured that WSFT would continue to use the BMI as well as looking at in-sourcing and out-sourcing in order to secure treatment for patients?

A The ICS implemented 'surge' in February which meant that WSFT had access to 100% of the BMI's capacity. However, this was only for ten sessions per week and this arrangement would finish at the end of next week although the BMI had agreed that this could continue for another week. At the end of March all national arrangements would end and there would be no national funding or national contact, therefore the Trust would have to revert to previous arrangements.

The CCG had some directly contracted work with the BMI and this was likely to be at the previous baseline of funding. Conversations were taking place with the managing director of the local BMI to consider what else could be done under local contracts, however these conversations were progressing slowly.

- With the proposed changes and greater integrated working there were likely to be conversations about delivering waiting lists across the ICS and how to collaboratively deliver the best service for patients as an organisation and a system.
- The region was keen to continue using the independent sector, however WSFT made little use of the BMI due its size and the range of services it was able to deliver. A meeting had taken place with regional colleagues earlier this week and it was recognised that losing this capacity would be an issue, although this would be less for WSFT than some other organisations.
- The consultation on the clinical review of emergency department standards, which WSFT had been part of the pilot for, had now closed. Information on what the new national standards would be was expected to be announced in the near future.
- A recruitment process was currently underway for an Integrated Director of Health and Adult Social Care (West). Two NEDs and the lead governor would be invited to join the stakeholder panel. The successful candidate would have an agreed portfolio with health and social care and would join board and executive team meetings.

21/034 INTEGRATED QUALITY AND PERFORMANCE REPORT

- More helpful and positive metrics needed to be developed to measure referral to treatment times (RTT) against. It was expected that there may be targets and expectations for the delivery of P2 priority patients initially and then moving to P3 priority patients in due course. There were likely to be regional and national directives for this and the board would be kept updated on these.

ACTION: develop metrics for IQPR when further information received. **H Beck**

- The cancer 2 week wait for urgent GP referrals had been impacted by the endoscopy position but it was noted that this metric was likely to be superseded by the 28-day diagnostic standard in due course which was considered to be a more helpful metric in terms of assessing cancer performance.

- The 62-day standard for treatment was being impacted by diagnostic waiting times. However, once a patient had a diagnosis the Trust was able to treat them very rapidly with no delays. The only exception was in 104 day waits where there delays in some of the tertiary centres; these patients still showed on WSFT's waiting lists as they were originally its patients.

Q Re community non-consultant led waits, ie speech and language therapy (SALT) and wheelchair services, what improvement was expected to be seen and how; a 26 week wait for a wheelchair was a very long time?

A It was expected to see provision for this in the financial budget this year as there was a need for additional resources and further recruitment. Pre-Covid a lot of money had been put into delivering additional activity in this area, however wheelchairs were expensive items and demand had outstripped the numbers that the Trust had been funded to provide. This had also been impacted on by Covid as it required people to visit the service to ensure that they were being supplied with the correct device and correct fit, and a number of these patients had been shielding.

- Acuity measures and dependency had risen during the last couple of months as a result of the pandemic.
- Falls continued to be focused on and the Trust was now starting to review all falls resulting in harm through the Patient Safety Incident Response Framework (PSIRF) process; the falls co-ordinator was leading on this programme.
- An increase in pressure ulcers was being seen in the acute setting. A number of these were device related pressure ulcers and critical care patients who had been very unwell and placed in the prone position for long periods of time. These would be reviewed to see if there was any learning that could be shared.
- As in the first wave there had been a reduction in the number of complaints received, however this was expected to increase in the coming months as people reflected on the care they or their relatives had received. The team had been very focussed on Keeping in Touch and the clinical helpline which had had a slight impact on their ability to close complaints but they had kept in touch with people to ensure they were kept updated.

Q Was it possible to reinstate the use of statistical process control (SPC) charts for maternity quite quickly as it would be useful to see the progress being made?

A It should be possible to implement these for maternity fairly quickly.

ACTION: consider the use of statistical process control (SPC) charts for maternity as soon as possible. **C Black**

Q As the board had agreed to a significant investment in nursing establishment and skill mix, could it be assured around the drive and aspiration to see significant improvements in quality measures, ie falls, pressure ulcers etc.

A This would be the result of a change in skill mix, however it would not be a sudden change and would take some time to improve.

21/035 FINANCE AND WORKFORCE REPORT

- The Trust continued to plan to breakeven this year due to external income as a result of Covid.

- There was a level of uncertainty around the financial position for next year and it was currently very difficult to set a budget as the income position remained volatile; a lot of the issues related to earlier discussions at this meeting.
- The draft budget that had been prepared remained the same as it was originally for this financial year with the Trust proposing a deficit budget for next year. However, this would depend on the level of income; if it continued as this year the financial plan would be nearer breakeven than shown in this report. Further detail would be taken to the closed board and the brought to the open board when there was more certainty.
- The principal drivers were the shortfall in the cost improvement programme (CIP) for this year together with some of the initiatives that had been implemented this year and the Trust would seek to continue, eg 'keeping in touch'. These had been included in the draft budget, as had the increase in nursing establishment.
- Although the Trust would seek to continue expenditure that had made this year that was driving quality improvement, it was important to ensure value for money from these investments, ie quality improvement.
- The other area of uncertainty for next year was capital. The ICS was expected to receive some indication of the capital budget for next year in the next couple of weeks and this would be reported to the board next month.
- The Trust had successfully submitted a bid a few years ago to extend and completely refurbish the emergency department (ED) as it was not adequate for the demand on it. This was a £15m scheme that would have taken three years to complete. It would have been a phased development which would have created a significant amount of disruption. Subsequently, the decision had been made that this level of disruption would not be beneficial, therefore it was decided to cease this scheme.
- However, earlier this financial year, as a result of Covid, the Department of Health (DH) had announced that additional capital would be available to improve facilities within organisations for management and isolation of patients. WSFT had put in a bid and was awarded £3m to expand capacity in ED. This was being done in two phases; the first phase opened last month and the second phase would open next month.

Q It would be helpful to get a context on how the source of this funding was viewing WSFT and its financial position, ie how was the deficit of £10.5m being perceived externally and in context with other Trusts.

A In terms of the wider perspective and deficit proposal, the feeling of uncertainty was pervasive. All organisations were waiting for increased certainty on the income position and the outcome of the white paper, ie system financial targets. Therefore, it was difficult to make a judgement about an individual organisation's position until it was understood what the system would be aiming for.

WSFT's position was not dissimilar to other organisations, ie broadly proposing a financial position that was similar to what they entered this year with.

Q Re the investment being made in the current building and facilities, what was the approach to depreciation given that the hospital had a limited life?

A At present it had been agreed with the auditors that the Trust would continue to depreciate assets as in the past until there was more certainty around the future system programme. Once the full business case had been approved there would be more certainty around when the existing hospital would close and move into the new facility, at which point depreciation would need to be accelerated.

Q Re cash; assuming that the budget for next year included sufficient cash resources to fund everything., if the Trust did not achieve its CIP for next year and the theatre work was delayed so that it could not do as much elective activity as planned, would there be sufficient cash to fund this deficit?

A The Trust's cash position had been artificially boosted due to funding for Covid but this was likely to return to a more normal level as it moved through next year.
When planning for a deficit position the Trust would also submit a plan to borrow against its cash shortfall. It was expected that it would be given approval to borrow £10.5m to cover this shortfall.

If an organisation breached its financial plan and the cash shortfall that had been agreed, it would need to apply for emergency cash. This was not a good position to be in and a position that WSFT had not been in for at least ten years.

Q Looking forward, would the white paper mean that Trusts were likely to be more restricted than currently, ie reduced power of financial directors and a transfer into the broader system?

A The proposals in the white paper meant that financial targets that were issued would be system wide targets which would increase the need to work closely with other organisations. WSFT had good relationships within the ICS which would stand it in good stead as it moved into the new environment.

One of the implications of the white paper was that there would be reserved power over Foundation Trust's capital planning limits, but this was not likely to affect WSFT.

- Over the last three years CIP planning had been managed centrally through the project management office (PMO). David Wilkes had met with the lead for the PMO to gain assurance around the approach to the CIP as it had effectively been put on hold due to Covid. He explained how the PMO worked prior to Covid with a number of managers working in a central pool and monthly CIP meetings.
- It had now been decided to put these managers into individual divisions. A meeting had taken place and the teams were actively working through this and relationship between this work, the improvement board and the new governance structure. Further information would be provided once it had been agreed how this would be managed in the future.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

21/036 PEOPLE AND ORGANISATIONAL DEVELOPMENT (OD) HIGHLIGHT REPORT

- The board congratulated the staff members who had been nominated for Putting You First awards in February and thanked them for their commitment to the Trust and developing relationships between staff.
- The themes from the people plan had been based on feedback from WMTY. One of the benefits of the pandemic was that it had helped the organisation to focus on what was really important and to make things happen quickly, ie the here and now.
- The focus and activity for the first six months of the people plan was shown in the appendix to this report. This plan would continue to be developed following the results of the staff survey which would help understand what needed be prioritised.
- Details of the Trust's just and learning journey and the work of the HR team in supporting this were provided in the report.
- The board noted the recent consultant appointments.

Q Were sufficient resources available, in terms of funding and people, to enable training around a just and learning culture and other requirements for training to be undertaken over the coming months?

A The biggest constraint with training had been the time for people to do this due to Covid. There were different types of training, including mandatory training, a lot of which was undertaken online. The Trust had taken a strategic decision to postpone face to face training for a period of time and this would be reviewed in a couple of weeks. As the Covid situation improved training programmes would be increased.

Q Re staff vaccinations; was the support being given to staff who had concerns about being vaccinated achieving a positive result?

A The latest position on vaccinations and ethnicity was not available; the last report showed a small difference between white and BAME staff group vaccination numbers. This information would be included in the next month's report. It had been very difficult to improve the position over the last two weeks as there had not been any vaccine available in the organisation. It was hoped to vaccinate people who had not yet had their vaccination in the coming week, when a delivery of the AstraZeneca vaccine arrived.

ACTION: include vaccination data by ethnicity in future reports. **J Over**

21/37 QUALITY SAFETY AND IMPROVEMENT REPORT

37.1 Maternity services quality and performance report, including Ockenden report

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

- Re the question submitted prior to this meeting around the red indicator on the maternity dashboard (annex B) for total women delivered, it was explained that it was not possible to do anything about the number of births. There had not been an increase in numbers as a result of the first lockdown, however it was now expected to see an increase.
- Continuity of care should also encourage mothers to have their babies a WSFT and the team was looking at developing this further.
- Re the question relating to training; WSFT used an online package which had to be completed by January each year. This meant that if someone started training in July 20/21 they had until January21/22 to complete this. Therefore, this had been reviewed as reporting training on an annual basis was not robust enough and there was a need to look at compliance training month by month. This had already increased from 60% to 70%, due to how it was being reported.
- The supernumerary status of labour suite coordinator was a very slow process, partly due to Covid and sickness absence and a lot of work was being undertaken with the improvement officer to address this. A recruitment drive had taken place and two new external labour suit coordinators had been appointed which meant that there would be two band 7s on every shift.
- Initial feedback from the recent assurance visit had been very positive.
- The neonatal nurse staffing report highlighted the actions being put in place to keep mothers and babies together.

Q Where there any highlights or concerns from the assurance review.

A The highlight was the positive feedback that it was very apparent that a lot of work had been undertaken and there was very good engagement across all areas.

Areas of recommendation were ongoing, ie triage delay, number of maternity care assistants and 24-hour admin support.

Q What did Karen Newbury consider to be the three main priority areas that needed to be focussed on and were more likely to have a positive outcome for patient safety?

A Continuity of care; this was better for mothers, babies and staff but required an increase in the number of midwives. Finer details around foetal monitoring; a new process was being introduced which was about simplifying things. Supporting the unit with the right numbers of additional staff, ie maternity care assistances, nursery nurses and ward clerks.

Q A number of recommendations had been made around neonatal staffing; were these moving forward and on target?

A Karen Newbury was no longer the professional lead for the neonatal unit, therefore was not able to give a definite answer. However, this needed to be looked at along with providing more robust transitional care to keep mothers and babies together. This would require an increase in band 4 nursery nurses.

ACTION: include recommendations re neonatal staffing in staffing review. **S Wilkinson**

37.2 Infection prevention and control assurance framework

- There had been a reduction in the number of Covid outbreaks and nosocomial probable and definite infections.
- There was a slight increase in incidents relating to Covid management but this was not unexpected.
- Swabs taken within 24 hours of decision to admit had increased to 97%.
- An updated BAF had been received from NHSEI and this would be incorporated into the database in future reports.

Q There were a lot of metrics and monitoring relating to the acute side of the Trust; what protocols were in place within the community teams?

A Rosemary ward and Glastonbury were community beds and followed the same protocols as the acute setting. Infection control procedures were also followed by staff going into people's homes. Protocols and monitoring were in place in the community but it was difficult to audit patients' homes.

Q How confident could the board be that there were sufficient resources to do what needed to be done in this area?

A The Trust had been unsuccessful in recruiting a lead infection control practitioner and had acted someone up into this position. However, there was still a vacancy for a lead infection prevention and control nurse and the Trust was waiting for the appropriate time to advertise this role. It was also working the across the system and with the CCG to look at what could be done to pool resources.

Considerable support had been provided in relation to e-care and data collection as well as from the safety investigation and learning teams.

- The regional infection prevention and control nurse had undertaken a visit to AAU and G5. They had been very complimentary, particularly of the cleanliness and also advised on improvements that could be made in some areas.

- PPE was very much a focus of the community teams and ensuring that they were wearing appropriate levels of PPE. However, this was difficult when donning and doffing when visiting people in their own homes and transferring from a car to a private house.
- It was important to share and learn from Covid outbreaks as ward managers felt very responsible. It was important to understand how people felt about this and that it was understood that they were not to blame.

ACTION: consider how to share the learning from infection prevention throughout the organisation. **S Wilkinson**

37.3 Nurse staffing report

- There had been significant challenges with fill rates in January due to increased acuity and dependency of patients and an increased level of staff sickness or absence due to self-isolation.
- Item 13 in this report, Covid 19 additional assurance, explained how members of staff had been utilised in a more creative and flexible way. Staff who had come forward and taken part in this were commended for their willingness and commitment.
- There had been an increase in incidents and a reduction in performance in nursing quality indicators but this should improve in February as staff returned from absence and the number of Covid cases reduced.

Q WSFT was one of the three Trusts in the region which had been highlighted as doing very well with their plans to reduce the number of nursing assistant vacancies to zero. How close to this was the Trust likely to get?

A The nurse staffing establishment review would help in this respect as the number of registered nurses would be increased, therefore this would reduce the number of nursing assistants required. The Trust's aspiration was for zero vacancies but this would take a while to achieve.

37.4 Improvement programme board report

- There was a new look improvement plan for maternity with the sources of assurance required aligned.
- The whole improvement plan had been updated as it was originally in response to the CQC report but had now moved towards a WSFT improvement plan to incorporate other areas. This would enable the development of a robust assurance plan on how to measure quality and impact of improvements.

37.5 Quality and learning report – (Q3)

- The Trust moved to the patient safety incident response framework (PSIRF) on 1 February
- There was also a new look emerging incident response (EIR) meeting which cases would be brought to and there would be a round table discussion. These meetings would be the way forward and would be supportive and interactive.
- It was proposed that there should be NED representation at these as this would help to provide assurance.
-

Q PSIRF meant that to some extent the Trust could choose which cases it investigated in detail. How could patients and relatives be assured that WSFT was never going to be in a position where it chose to investigate cases that were less challenging to investigate?

A The remit of PSIRF was that the board agreed what the themes for investigation would be; other incidents would be reviewed and discussed by the panel. There were guidelines for what Trusts should be doing and how they should do it. This did not exclude the investigation of serious incidents or RCAs for incidents.

Q It was reassuring to see the data which showed that people were raising concerns; how could the board be assured that that these were being heard and responded to?

A The board had completed a self-assessment around its freedom to speak up culture and leadership approximately 18 months ago and as a result of receiving a limited assurance internal audit and action plan, the Trust had committed earlier than normal to doing a further board self-assessment. Board members would be asked for their input into this over the next month.

ACTION: include information on how concerns were listened to and responded to in next report. **J Over**

Q Re action and learning from public feedback; do members of the community who have given feedback receive this information?

A Yes, if they formally wrote a letter of complaint. However, the Trust could always do more and was looking at how it could improve the feedback provided.

Q Re raising concerns; did the Trust look at the lessons learned and how to learn lessons from this throughout the organisation?

A This would be included as part of the board self-assessment.

Regular meetings took place with the freedom to speak up guardians to look at any themes that had been identified.

BUILD A JOINED-UP FUTURE

21/038 FUTURE SYSTEM BOARD REPORT

- The SOC had been completed and a meeting had taken place with the national and regional team. The feedback had been very positive and there was a recognition of the large amount of work that had been done. The Trust was further ahead than they expected it to be.
- WSFT was hoping that progress would be accelerated but was waiting to see the results of the review of all 40 organisations.
- The purchase of Hardwick Manor last year was a noteworthy achievement as the issue land availability was something that programmes repeatedly came up against and the fact that WSFT had land available was a significant positive.
- Work continued on the estates workstream and the Trust was working with architects who were involved in some of the HIP (health infrastructure plan) one schemes, particularly relating to a modular method of construction where things could be done quickly and routinely.

- The clinical workstream continued at pace with good engagement from clinical staff in the organisation and also with colleagues in the wider system, including three GPs who were leading the on the primary care aspect of the workstream to create a more integrated system.
- A lot of work had been going on around communication and engagement. This had been discussed with the department of health (DH) as there was a concern that with the number of programmes that were being undertaken there was a need to managed the public's expectations, ie this was a ten-year plan for the development of 40 hospitals. It was important to ensure that WSFT's communication set the right level of expectation, particularly around timescales.
- The financial aspect of the new schemes was a concern for the DH and there was a strong focus on the financial model.
- The Trust would continue to build on the excellent work around the digital programme in the existing organisation and make sure that this moved into the new system. This was one of the most advanced digital programmes in the country.

Q As the programme progressed over the next few months and years, would the public receive bulletins about travels arrangements etc alongside the engagement process?

A Communication was a significant workstream within the programme. The engagement programme would have clinical representatives as well as from the wider community including governors. All of these issues would feature, although some would be outside WSFT's direct control.

Transport was a particular issue, especially as the Trust was trying to ensure that the new system was environmentally sustainable. This needed to incorporate travel arrangements, parking etc and was an important aspect of the new development. The role of the engagement group would be to collate questions and areas of concern so that these could be addressed in communications/bulletins that were issued.

Q The modular method of construction bore an alarming resemblance to the RAAC planks, ie a new generation of best buy hospitals. Could the assurance be provided that this was being very carefully considered?

A WSFT was very aware of this as a risk and this had been a focus of discussions. The land that came with Hardwick Manor presented some challenges and the need to work with the environment, ie trees on the site, which meant that the solution would have to be bespoke and could limit the use of the modular method of construction.

GOVERNANCE

21/039 GOVERNANCE REPORT

- The annual governance review would be discussed with NHSEI as to what it would look like. This would also provide an opportunity to pick up some of the changes to the CQC assessment framework. Further details would come back to the board.
- The NEDs' responsibilities which were appended to this report were in draft and would be confirmed when the new committee structure was introduced in April. The responsibilities of David Wilkes and Rosemary Mason, who were appointed last year, would be also be confirmed together with changes as a result of the resignation of Angus Eaton and the appointment of a new audit chair.

ITEMS FOR INFORMATION

21/040 ANY OTHER BUSINESS

There was no further business.

21/041 DATE OF NEXT MEETING

Friday 26 March 2021, 9.15am

RESOLUTION TO MOVE TO CLOSED SESSION

21/042 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 March 2021

Agenda item:	7			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	19 March 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
1915	Open	29/1/21	Item 12	Community services leaders to recommend appropriate community effectiveness metrics for future reporting	Timing is being reviewed with the team and a update will be provided in the March Board operational Board	HB	26/03/21	Green
1927	Open	26/2/21	Item 8	Consider future provision of keeping in touch service for acute and community services		SW	30/04/21	Green
1928	Open	26/2/21	Item 9	Schedule briefing on the Trust's newly-created role of head of mental health	Agenda item scheduled for June Board to outline early experience in the new role.	SW	25/06/21	Green
1929	Open	26/2/21	Item 11	When clearer on national reset expectations (standards/targets) develop local metrics for IQPR to support local innovation and drive improvement		HB	30/04/21	Green
1931	Open	26/2/21	Item 11	Consider use of SPC charts within maternity (prior to reintroduction within wider IQPR)	For inclusion in IQPR	CB	30/04/21	Green
1933	Open	26/2/21	Item 14.1	Consider how neonatal staffing is reviewed in the context of wider maternity services	This will be reviewed with the commencement of the Deputy Head of Midwifery and will be re-assessed using the latest staffing assessment tool.	SW	28/06/21	Green
1934	Open	26/2/21	Item 14.5	Consider how we take lessons from infection prevention and the learning report into the organisation	Reviewing options for developing this role within the quality assurance team	SW	30/04/21	Green
1935	Open	26/2/21	Item 14.5	Next speaking-up report to include focus on “listening-up” (learning and action to improve)		JMO	30/04/21	Green

Closed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1918	Open	29/1/21	Item 15.4	Provide an implementation plan for the nursing investment approved by the Board in January '21	**Included in nurse staff report**	SW	26/03/21	Complete
1919	Open	29/1/21	Item 15.5	Provide analysis of staffing and nursing quality metrics performance over time	**Included in nurse staff report**	SW	26/03/21	Complete
1930	Open	26/2/21	Item 11	Provide the Board with visibility of the endoscopy recover trajectory	**AGENDA ITEM**	HB	26/03/21	Complete
1932	Open	26/2/21	Item 13	Include vaccination take-up data by ethnicity in future people reports	**AGENDA ITEM**	JMO	26/03/21	Complete

8. Chief Executive’s report

To RECEIVE an introduction on current issues

For Report

Presented by Stephen Dunn

Board of Directors – 26 March 2021

Agenda item:	8			
Presented by:	Steve Dunn, Chief Executive Officer			
Prepared by:	Steve Dunn, Chief Executive Officer			
Date prepared:	19 March 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

I am extremely proud of how our teams have reacted throughout the pandemic. In the last few weeks we have seen a **massive fall in infection rates** and in the number of Covid-19 patients in hospital. The complexities of managing patient flow remains very challenging and our staff are under sustained pressure. Not only has the Covid-19 pandemic provided one of the biggest challenges in the history of the NHS, it has meant a lot of things we have previously taken for granted, such as seeing loved ones, socialising and going to the gym, have halted due to various lockdowns.

We will be supporting staff to take part in the minute's silence on Tuesday 23 March at 12:00 GMT as part of a **national day of reflection** to mark the anniversary of the UK's first Covid lockdown. The total number of recorded deaths linked to coronavirus in the UK stood at 335 on that date. There have now been 143,259 deaths, according to the latest figures. Locally one year ago, F7 ward became our first Covid-19 ward. It's been an incredibly challenging year for our teams but their dedication to caring for patients has known no bounds, I am so very grateful for everything our staff have done.

At the end of February the Prime Minister set out his four-step route out of lockdown and for many of us, news that we could potentially have some sort of normality in our lives again is a massive relief. While there is still a long way to go, there is a glimmer of light at the end of this very long tunnel. The impact for our staff of not only working through a pandemic, but also dealing with the consequences of it in their personal lives, is bound to take an effect which means **looking after our mental wellbeing is more important than ever**. At the start of the pandemic, a staff support psychology team was established to provide extra emotional and mental wellbeing support for colleagues across the Trust. The team, who has seen over 425 individuals across the Trust since the start of the pandemic, is led by consultant clinical psychologist Emily Baker. Emily has always told us that "it's okay not to be okay", and her team are only a call away when staff or teams need to talk to someone. They have also been leading on Wellbeing Wednesdays, with every week bringing a new topic of discussion as well as being available every Monday and Friday for a chat in the Virtual Coffee Lounge.

With the national **Covid-19 vaccination** programme topping 27.6m people, more than half the adult population, having received at least one dose of a vaccine. Back in January, Trust staff were among some of the first to receive the vaccination as part of the first of the Joint Committee on Vaccination and Immunisation's priority groups. We set up a pop-up vaccination centre in Quince House on the West Suffolk Hospital site and in the first round administered more than 16,000 jabs to health and social care staff from across the region. The Covid-19 vaccine is designed to be given in two doses. Early studies have shown that just the first dose offers very strong protection, but we have now started giving second doses to ensure maximum defence against the virus. From mid-March our vaccination team - drawn from nursing, pharmacy, estates, and administration staff from across the Trust, as well as our dedicated volunteers – once again took over the top of Quince House. By getting vaccinated we can all keep protecting each other - what an amazing job they are doing. Please see Appendix A of this report, for a detailed update on the staff vaccination programme.

We were able to welcome Jo Churchill MP as a volunteer steward supporting the vaccination programme. Mrs Churchill said: "I was incredibly impressed with the vaccination hub. It's a very efficient but still very caring approach, and there is a great team of volunteers supporting the NHS staff. Getting vaccinated is extremely important in tackling Covid-19, and I want to say thank you to everyone at West Suffolk Hospital for the great work they are doing to protect us all."

This month, I was honoured and privileged to receive, on behalf of the Trust's COVID-19 vaccination team, The Lord Lieutenant of Suffolk Award in recognition of outstanding service to the community in Suffolk during the COVID-19 pandemic. In a letter accompanying the certificate,

Clare, Countess of Euston, thanks the Trust for the contribution we have made during the COVID-19 crisis and she thanks the vaccination team for all the work they have done to help protect some of the most vulnerable people in our community.

Our **Covid-19 rapid self-testing kits** for staff have helped us identify more than 200 Covid-19 infections before symptoms appeared, cutting off the spread of the disease. By staff testing and reporting their results twice a week, they can help keep Covid in check and protect colleagues and the community. Each test takes around 30 minutes to perform, and can be done easily at home by following the simple instructions provided. You can also find a video guide on our Covid staff zone website. Even if they've already had the Covid-19 vaccination, staff can still take part in testing. The vaccines were highly effective in trials, but no vaccine is 100% effective so we need to stay alert - staff also continue to follow all social distancing and other infection prevention control measures.

One of the biggest staff surveys in the world; the results of the latest **NHS staff survey** were published earlier this month. The results tell us what staff think and feel about working in the NHS – now, and compared with previous years, and compared with other similar organisations. Around 2,000 staff at West Suffolk took part – a 46% response rate and I'd like to thank staff for their contribution to these important results. There can be no doubt that it has been a tough year and some of the changes in scores may or may not be related to the impact of the pandemic. Some of the headlines are:

- West Suffolk's scores in the staff survey have generally improved year-on-year and in 2019 were some of the best in the country
- This year we've seen a reduction in most of our scores, although many remain well above the average for organisations like ours
- In some areas the reductions are small; in others they are more significant
- This is concerning and means it's more important than ever to use the survey results to learn and make improvements, together with our staff
- The scores are an average for the whole organisation – there will be groups (departments, divisions, job roles, demographic groups) where the scores are higher or lower than the average.

There is a huge amount of data and analysis and we are just beginning to understand all of the findings and trends so much more to do over coming weeks. Many themes resonate with the finding of our *What Matters to You* staff engagement work, and it may be the case that some of the actions that have already taken place will help. But we will make sure there are ways for staff to feedback on what the survey says, and what we do about it.

At a recent staff briefing, Amanda Bennett and James Barrett, our Freedom to Speak Up (FTSU) Guardians, underscored the importance of speaking up including about patient safety, quality of care or bullying or harassment. We continue to work to support a culture that ensures that staff feel secure in raising concerns and confident that appropriate action will be taken to address their concerns. We will ensure that we work with different groups, including staff representatives and our FTSU guardians, to develop our People Plan further and the Board will maintain oversight of this work.

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 **operational reset** in the next phase of the pandemic recognising the impact over the last year on waiting times, our 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.

In these difficult time with restricted patient visiting I am really pleased that patients are now able to access a **free entertainment system** (including TV, radio, newspapers and magazines) from their phone or tablet. The patient entertainment system, being offered in partnership with technology company WiFi SPARK,is now available to all inpatients at our Trust. The system includes television programmes, live radio, magazines, newspapers and Sudoku. Patients can access the system on the phone or tablet by connecting to NHS WiFi and visiting www.wifitv.co.uk.

A West Suffolk Hospital patient has found a unique way of aiding her recovery from breast cancer surgery - painting **portraits of the 'NHS heroes'** that looked after her. Chris Goddard, 68, from Thetford, painted the portraits of the doctors and nurses who looked after her as a way to say thank you for her care. Chris was diagnosed with breast cancer following routine breast screening in October 2020 but her treatment was delayed after she tested positive for Covid-19. She had her second surgical appointment in February. Chris has so far finished six portraits, with another seven planned, and is donating each of them as presents to the members of staff featured. What a lovely surprise to receive such a thoughtful gift for our dedicated staff.

Over the last year, the **community digital team** and IT department have been preparing to move our community staff from the IT support with North East London Commissioning Support Unit (NEL CSU), that they have had for many years, to IT support from WSFT. We have spent the last six months working with the teams across the county to move them one by one onto WSFT laptops and email addresses, as well as moving all of their files and folders. The last team has completed its move in early March – the last of just over 600 laptops and 450 workstations which include a docking station, keyboard, mouse and screens. The IT engineers have moved more than one terabyte of data, equivalent to about 750 movie downloads, which includes almost a million files and 100,000 folders. The majority of the staff are now using 'cloud' storage through Microsoft SharePoint – the first of the Trust's teams to do so. I would like to thank all of our community staff for their patience during this move as I know this has caused a lot of changes to how they have worked. The IT team has worked really hard to make this as easy as possible for everybody and minimise impact on working lives and patient care. To have achieved this during the latest wave of the pandemic is truly amazing.

A new solution to improve the **medicines management workflows**, to reduce risk and improve patient safety related to the administration of medicines is being introduced. This will be achieved by using e-Care functionality to make patient safety improvements. These changes will improve the medicines management processes and patient safety around medicines administration. Registered nurses, substantive staff, bank workers and those who administer medicine completed three separate e-learning packages to support this important transition. These changes will be introduced alongside the e-Care go live for maternity and neonates. These are exciting times as we continue to drive digital safety and improvement.

West Suffolk Hospital's radiology department has been **accredited with the Quality Standard in Imaging (QSI)** by the United Kingdom Accreditation Service (UKAS) for the tenth year in a row. The department was one of the first in the region to be accredited by UKAS - a certification service that ensures there are robust systems in place to deliver a safe, effective and high-quality service to patients. When awarding the department with the accreditation, UKAS acknowledged the teamwork and ongoing dedication of staff, who have stepped-up in very difficult circumstances throughout the year. The team, which has worked throughout the Covid-19 pandemic, has experienced unprecedented pressure - seeing more patients than ever while having to deal with wearing full PPE as well as covering for staff sickness and isolation. I am so proud of the radiology department for all they have done in securing accreditation for the tenth year in a row. This has been one of the hardest 12 months in the history of the NHS, so to be celebrating a whole decade of accreditation under these circumstances is fantastic.

The Trust **chaplaincy team** has always been there to meet the needs of all our staff, patients and visitors, offering care and support to the whole community with a welcome for everyone. Faced

with increasing demands from coronavirus, the team recruited Reverend Michael Womack, a retired rector from Waveney, to provide extra support over the winter. The chaplaincy has received positive feedback from the staff and the wider community, which highlighted that the team is praised as responsive and caring.

Appendix A – Staff Vaccination at West Suffolk Foundation Trust

Presented by:	Nick Jenkins			
Prepared by:	Jo Rayner			
Date prepared:	19 March 2021			
Subject:	Staff Vaccination at West Suffolk Foundation Trust			
Purpose:	x	For information		For approval

Executive summary:

In November 2020 a multi-disciplinary project team was formed to deliver a hospital hub vaccination programme. The first dose programme started on 4th January through to 5th February 2021 and vaccinated 16,000 people – mainly health and social care workers but also around 1,000 patients. The second dose programme started on 15th March and is due to run through to 16th April 2021. Around 76% of WSFT staff were vaccinated in the first doses programme and those who missed this are being vaccinated in additional clinics. Analysis of the data shows no disproportionate take up in the vaccine across the staff groups at the Trust.

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		x

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

Recommendation:

Trust Board to note the update on the vaccination programme.

The Vaccination Programme at West Suffolk Foundation Trust (WSFT)

Background

In November 2020 a multi-disciplinary project team was formed to deliver a hospital hub vaccination programme. The first dose programme started on 4th January through to 5th February 2021 and vaccinated 16,000 people – mainly health and social care workers but also around 1,000 patients. The second dose programme started on 15th March and is due to run through to 16th April 2021. There are no first doses of Pfizer being delivered at Quince House and any staff who missed the programme in January and February are invited to the extra clinics that are being run using the Astra Zeneca vaccine.

Vaccination Programme

Through the Pfizer programme, just under 76% of WSFT staff received a vaccination with the second doses scheduled in the 12-week window as per national guidance. Another 60 staff members have since been vaccinated or are booked into the next clinic.

Information taken from the booking system shows that 4363 of staff at WSFT have had at least one dose of vaccine administered, of which 2689 has completed their treatment and have received 2 doses of vaccine. There are 1653 booked to receive their 2nd dose.

An analysis of the data show that the vaccinated profile matches that of the demographic of our staff and there is no concern around disproportionate take up of the vaccination. This is covered further in this month's workforce report.

Some of our staff will not have been eligible for a vaccine during the first programme if they had COVID as 28 day window from testing positive is required before receiving the vaccine. Stock of Astra Zeneca has been received to enable additional clinics to be run to vaccinate those staff members who still require a vaccination. So far around 60 staff members have booked into these additional sessions and more will be made available as the need arises.

Using a bespoke booking system, staff members booked their first and second appointments at the same time to ensure second doses were scheduled. Reminder messages have been issued in the last few weeks and an online self-serve option is available to change an appointment if it is no longer suitable. Data is being analysed to ensure anyone who does not attend is contacted to ensure they have an opportunity to rebook an appointment with in the 12 week window if it is still required. As well as the paper card that is provided at the vaccine appointment, an electronic vaccine card was emailed to staff with their vaccine details and the date of their second appointment.

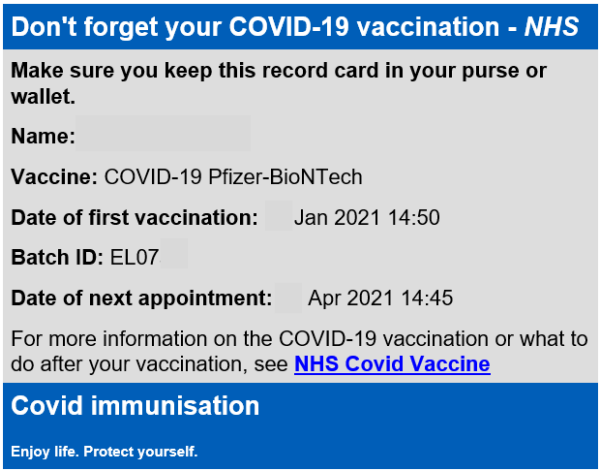
Feedback

The vaccination programme has been well received and team have received may compliments on the process, many of those from colleagues across the Trust, just one example below;

"I had mine this morning and was so completely impressed with how professional and streamlined it was. Professional, calm, reassuring, safe and clean are just a few words that come to mind. A huge thankyou to all those involved."

The vaccination team also received a Greatix for the programme in Quince House;

“Dear Whoever is responsible for organising COVID vaccinations and all the staff who have been involved. You have been nominated for a Greatix for, Easy to book, could get an appointment. From arrival to departure there was an efficient, effective, welcoming and friendly service. It was just very impressive!”


Don't forget your COVID-19 vaccination - *NHS*

Make sure you keep this record card in your purse or wallet.

Name:

Vaccine: COVID-19 Pfizer-BioNTech

Date of first vaccination: Jan 2021 14:50

Batch ID: EL07

Date of next appointment: Apr 2021 14:45

For more information on the COVID-19 vaccination or what to do after your vaccination, see **NHS Covid Vaccine**

Covid immunisation

Enjoy life. Protect yourself.

The vaccination team also welcomed a visit on Friday 19th March 2021 from Jo Churchill MP. Jo wanted to visit to see the team in action and thank everyone for their efforts in supporting the vaccination campaign.

Next Steps

A letter has been sent to our staff members who are showing in the data to have not had a vaccine. The purpose of the letter is to offer support to staff and sign post them to advice to help

inform their decision. The letter also gives information as to how to book into the additional vaccine clinics that are available on site for those who may have missed the Pfizer clinics in Jan/Feb.

Feedback from the letters will be collated along with the themes which will be used to further support staff to access the vaccine.

09:40 DELIVER FOR TODAY

9. Operational report

To APPROVE the report

For Approval

Presented by Helen Beck

Trust Board – 26 March 2021

NHS West Suffolk NHS Foundation Trust

Agenda item:	9			
Presented by:	Helen Beck, Executive Chief Operating Officer			
Prepared by:	Helen Beck, Executive Chief Operating Officer Alex Baldwin, Deputy Chief Operating Officer Lesley Standring, Head of Operational Improvement			
Date prepared:	22 March 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. The paper also outlines progress against the actions identified by the ReThink review into community services.

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 March we have seen a continued reduction in COVID demand and at the time of writing we have two positive inpatients. There are currently no COVID positive patients in critical care and the unit is operating within its baseline capacity.

ED attendances and non COVID admissions are starting to rise but remain below average. However due to reduced G&A capacity we are no longer consistently maintaining social distancing. This is being mitigated by the installation of "COVID curtains" to create a physical barrier between bed spaces.

The most recent regional data corresponds to the decreasing demand experienced by the trust. Forecast suggest that by mid-March the trust will have 1 COVID positive patient, with a plausible upper limit of 12. However, due to smaller numbers there is a wider confidence limit.

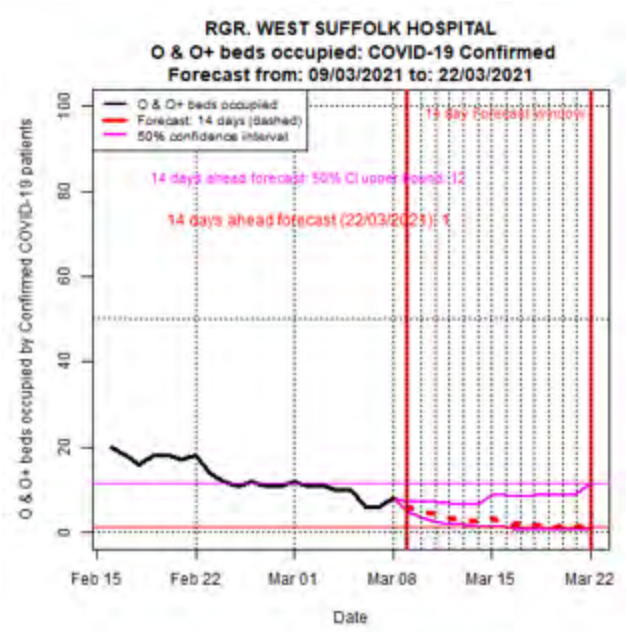


Table 1: Cambridge Judge Business School WSFT forecast, 9 March 2021.

RAAC failsafe programme and operational impact

As previously reported the trust is moving in to a phase of extensive roof failsafe work. In response to concerns regarding the north light structure on the east side of the building, earlier in March ward G5 was closed and ward F9 decanted to that area. [G5 was the winter escalation ward which we planned to close in April. This was brought forward to facilitate the move].

Invasive investigation of the F9 structure needs to be repeated on F10, F11 and antenatal. This will be achieved by a series of decants facilitated by the return of F7 to a short stay medical ward. Operational and IPC planning is underway to create COVID capacity on F12 and G9 but we are only in a position to deliver this enhanced inspection plan and maintain all services because the level of COVID admissions remains low.

The above plan diverges from the initial ward decant plan. We await input from the estates project team before agreeing any additional revisions to the overall failsafe phasing or timescales.

Elective restoration

Further to the report to Board last month we have developed an indicative restoration plan. This sets out our ability to deliver restored elective, outpatient and diagnostic services through 21/22. At the time of writing national restoration guidance has yet to be received however we expect to be set a threshold of 70% in April 21, rising 5% in subsequent months to 85% from July to September. Based on our initial analysis we are generally in a good position to meet this threshold with the exception of first outpatients (for which our maximum post COVID, social distance adjusted throughput is 82%) and elective inpatients which relates to theatre shutdown from May to September. Further work is ongoing to address the remaining 3% gap in first outpatient appointments as soon as possible given that we are advised that there will be no changes to social distancing requirements for the foreseeable future.

Plan (% of baseline)	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Max in 20/21
Total referrals		87%	89%	91%	93%	95%	100%	103%	103%	103%	103%	103%	103%	87% (Dec 2020)
First Outpatients		74%	77%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%	77.9% (Dec 2020)
Follow up outpatients		79%	83%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	92.1% (Nov 2020)
Daycases		77%	73%	78%	74%	78%	86%	86%	86%	88%	88%	90%	90%	75.5% (Nov 2020)
Elective Inpatients		83%	54%	38%	42%	42%	82%	109%	109%	120%	120%	120%	120%	89.4% (Nov 2020)
Plan (% of baseline)	**Mar-21**	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**	**Max in 20/21**
MRI		80%	82%	83%	84%	84%	86%	86%	88%	88%	90%	90%	90%	86% (Oct 2020)
CT Scans		82%	87%	88%	88%	92%	100%	100%	100%	100%	100%	100%	100%	103% (Dec 2020)
Endoscopy		84%	80%	80%	80%	85%	85%	86%	88%	89%	90%	90%	90%	77% (Nov 2020)

Table 2: indicative restoration plan. % of pre COVID baseline.

Furthermore, we have developed a series of mitigations which improve both daycase and elective throughput. These include a combination of internal additional sessions, insourcing, use of BMI, outsourcing [use of a modular theatre located on the Ipswich site is being explored] and extension of existing outsourced service provision. Please note that funding has not yet been secured for this additional activity, but it is anticipated that any activity above the 85% threshold will attract additional funding.

Plan (% of baseline)	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
First Outpatients		74%	77%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%
Follow up outpatients		79%	83%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Daycases		77%	76%	81%	77%	81%	86%	86%	86%	88%	88%	90%	90%
Elective Inpatients		86%	69%	53%	59%	58%	94%	119%	119%	131%	131%	129%	131%
Plan (% of baseline)	**Mar-21**	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**
MRI		80%	82%	83%	84%	84%	86%	86%	88%	88%	90%	90%	90%
CT Scans		82%	87%	88%	88%	92%	100%	100%	100%	100%	100%	100%	100%
Endoscopy		104%	99%	106%	101%	105%	105%	105%	106%	108%	110%	111%	109%

Table 3: restoration plan inclusive of mitigation activity.

A full summary of our restoration plan will be presented once national guidance has been received.

Endoscopy restoration

As detailed above there is a detailed endoscopy restoration and recovery plan which has been developed by the service. Ongoing use of insourced and outsourced capacity in addition to increased 'in-hours' throughput sees the service quickly return to pre-COVID levels of activity and then exceed them through the second half of 21/22.

This additional capacity will support the elimination of the waiting list backlog, which currently stands at 2339. It will also support elimination of the 2WW backlog which is currently 89. This has reduced significantly in the last 4 weeks and is expected to be cleared within the next 6. Patient choice is the final barrier but the teams are working proactively with these patients to ensure they are treated as soon as practicable.

Community Update

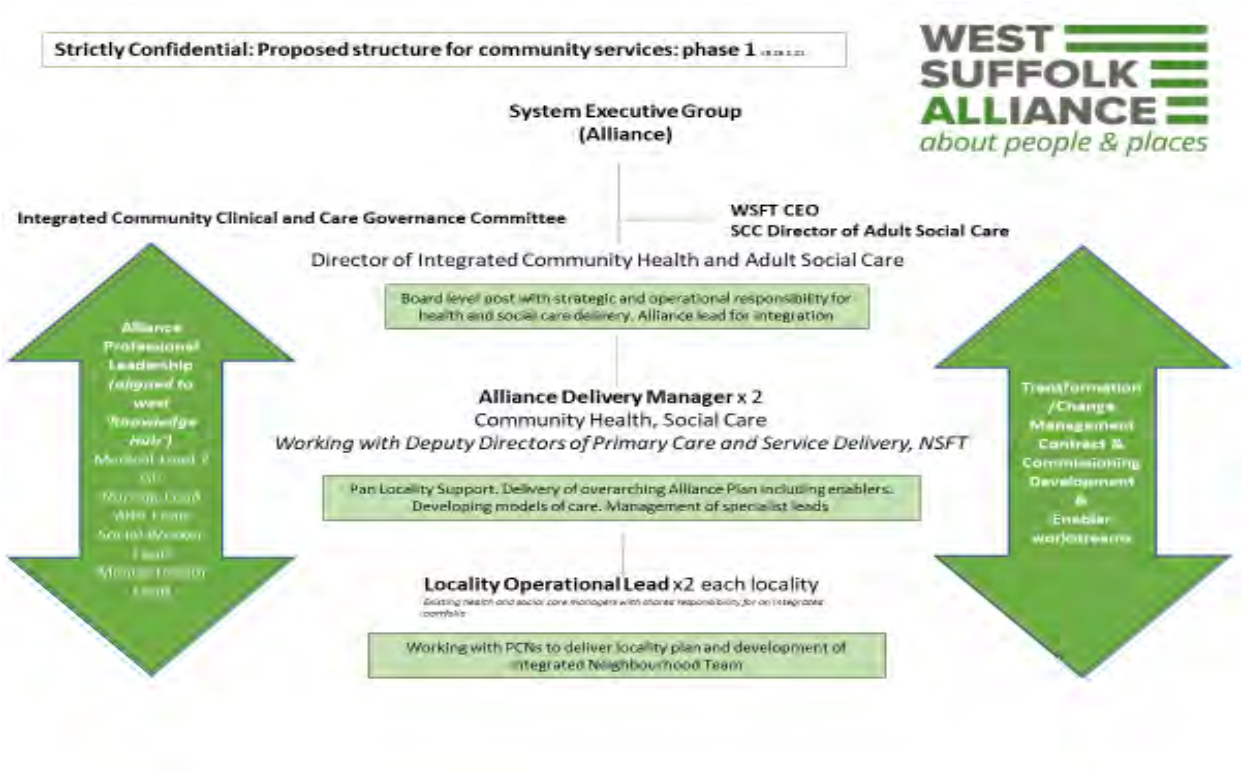
Implementation of the Rethink Recommendations

The final Rethink report has now been shared via presentations to individual locality teams and a copy of the report emailed to all community staff in adult health and social care.

A comprehensive action plan which encompasses the ReThink recommendations along with the alliance plan and the future systems strategic objectives for community is currently being developed and aligned This will be monitored through monthly meetings with the executive directors, TEG, social care divisional management team and the alliance coordination cell.

The main focus over the last six weeks has been the restructure which is in 2 phases:
Phase 1 - is the appointment of a Director of integrated community health and adult social care for the west of Suffolk the current lead for adult social care will be interviewed without competition for the post on the 22nd March 2021.

Phase 2 - HR from SCC and WSFT are working closely with the project leads to get ready to consult with all community health and social care staff on the planned restructure as set out below. This will run from 12th April - 18th May 2021



Another key recommendation from the report is addressing the data desert within community services. We have now successfully migrated all of the community teams onto the WSFT system and this now gives us the foundation to move forward at pace. Getting the data strategy right is crucial and a system group has been pulled together led by Kevin McGinness to do this work. We plan to have a data-led approach which will flow down to team and neighbourhood level. Alongside outcomes for patients we will have visibility on waiting list, productivity, complexity and quality. Good progress is being made with a number of projects which have previously been outlined to the board.

- Benson capacity and demand modelling. The first phase baseline data capture is complete and will be fed into Malinko baseline for District nursing activities. The second phase modelling has commenced and runs monthly. Meetings have been set up for week of 22nd March to discuss findings with team leads and district nurses.
- Healthroster rollout is progressing well with 3 community teams now live and plans to have the rollout complete by the end of April. This will provide vital information to support the Malinko scheduling system.
- Malinko Implementation is scheduled to take place between May-August. Initially there will be one pilot team in month one with other teams coming on board over the following

months. There have been some concerns around the ability to integrate the system with System One and maintain full community data set reporting but these are being proactively worked through and the team are confident they can meet these time frames.

Recommendation

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

Trust Board – 26th March 2021

Agenda item:	9			
Presented by:	Helen Beck, Executive Chief Operating Officer			
Prepared by:	Alex Baldwin, Deputy Chief Operating Officer			
Date prepared:	250321			
Subject:	Appendix to operational Update			
Purpose:	x	For information		For approval

Executive summary:

This appendix provides a trust summary of weekly activity relative to other organisations in the East of England.

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: For information

Appendix1: EOE activity report 21 03 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: 07 Mar 2021	as a % of last year	Same week in March 2019	w/e 14 Mar 2021	as a % of the same week in March 2019	Same weeks last year	4 weeks ending: 07 Mar 2021	as a % of last year	Same week in March 2019	w/e 14 Mar 2021	as a % of the same week in March 2019
RC9	Bedfordshire Hospitals NHS Foundation	East of England	Bedfordshire, Luton and Milton Keynes	1,375	770	56%	1,336	917	69%	182	64	35%	203	117	58%
RGT	Cambridge University Hospitals NHS Fou	East of England	Cambridgeshire and Peterborough ST	1,552	1,009	65%	1,528	1,301	85%	292	148	51%	311	216	69%
RWH	East and North Hertfordshire NHS Trust	East of England	Hertfordshire and West Essex STP	1,278	930	73%	1,283	862	67%	133	67	50%	118	130	110%
RDE	East Suffolk and North Essex NHS Found	East of England	Suffolk and North East Essex STP	1,895	1,209	64%	1,790	1,406	79%	234	79	34%	279	116	42%
RGP	James Paget University Hospitals NHS F	East of England	Norfolk and Waveney Health & Care P	653	327	50%	618	357	58%	69	35	50%	78	23	29%
RAJ	Mid and South Essex NHS Foundation Tr	East of England	Mid and South Essex STP	2,309	1,560	68%	2,346	1,824	78%	408	140	34%	411	202	49%
RD8	Milton Keynes University Hospital NHS Fo	East of England	Bedfordshire, Luton and Milton Keynes	500	469	94%	619	546	88%	74	30	41%	80	58	73%
RM1	Norfolk and Norwich University Hospitals	East of England	Norfolk and Waveney Health & Care P	1,906	1,077	57%	1,950	1,252	64%	241	83	35%	296	85	29%
RGN	North West Anglia NHS Foundation Trust	East of England	Cambridgeshire and Peterborough ST	1,052	766	73%	1,214	812	67%	143	32	23%	216	38	18%
RGM	Royal Papworth Hospital NHS Foundation	East of England	Cambridgeshire and Peterborough ST	212	420	198%	183	165	90%	177	264	149%	181	89	49%
RQW	The Princess Alexandra Hospital NHS Tru	East of England	Hertfordshire and West Essex STP	488	307	63%	460	301	65%	77	49	63%	85	42	49%
RCX	The Queen Elizabeth Hospital, King's Lyn	East of England	Norfolk and Waveney Health & Care P	831	238	29%	858	316	37%	73	4	5%	104	4	4%
RWG	West Hertfordshire Hospitals NHS Trust	East of England	Hertfordshire and West Essex STP	883	500	57%	878	583	66%	133	75	56%	131	69	53%
RGR	West Suffolk NHS Foundation Trust	East of England	Suffolk and North East Essex STP	570	364	64%	559	399	71%	80	31	39%	78	36	46%

Source: SUS, Monthly Diagnostics (DM01) and Weekly Activity Return (WAR) *Data in this table has not been adjusted.*				First Outpatients						Follow-up Outpatients					
				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: 07 Mar 2021	as a % of last year	Same week in March 2019	w/e 14 Mar 2021	as a % of the same week in March 2019	Same weeks last year	4 weeks ending: 07 Mar 2021	as a % of last year	Same week in March 2019	w/e 14 Mar 2021	as a % of the same week in March 2019
RC9	Bedfordshire Hospitals NHS Foundation	East of England	Bedfordshire, Luton and Milton Keynes	3,857	2,931	76%	3,652	3,231	88%	7,412	6,164	83%	7,467	6,698	90%
RGT	Cambridge University Hospitals NHS Fou	East of England	Cambridgeshire and Peterborough ST	5,805	3,838	66%	6,917	4,296	62%	7,061	6,525	92%	7,430	7,033	95%
RWH	East and North Hertfordshire NHS Trust	East of England	Hertfordshire and West Essex STP	3,633	2,892	80%	3,499	2,677	77%	6,904	6,903	100%	7,215	6,865	95%
RDE	East Suffolk and North Essex NHS Found	East of England	Suffolk and North East Essex STP	4,770	4,248	89%	5,035	4,574	91%	9,519	6,584	69%	9,234	8,023	87%
RGP	James Paget University Hospitals NHS F	East of England	Norfolk and Waveney Health & Care P	1,437	1,053	73%	1,342	1,579	118%	2,593	2,255	87%	2,477	2,445	99%
RAJ	Mid and South Essex NHS Foundation Tr	East of England	Mid and South Essex STP	6,931	5,446	79%	6,517	6,381	98%	12,799	12,310	96%	12,848	14,275	111%
RD8	Milton Keynes University Hospital NHS Fo	East of England	Bedfordshire, Luton and Milton Keynes	3,371	1,500	44%	3,573	1,374	38%	2,504	2,389	95%	2,322	2,425	104%
RM1	Norfolk and Norwich University Hospitals	East of England	Norfolk and Waveney Health & Care P	4,122	2,731	66%	4,527	3,074	68%	8,971	7,933	88%	9,418	8,613	91%
RGN	North West Anglia NHS Foundation Trust	East of England	Cambridgeshire and Peterborough ST	3,238	1,512	47%	3,591	1,885	52%	5,623	2,559	46%	5,404	2,936	54%
RGM	Royal Papworth Hospital NHS Foundation	East of England	Cambridgeshire and Peterborough ST	178	196	110%	202	190	94%	501	447	89%	582	558	96%
RQW	The Princess Alexandra Hospital NHS Tru	East of England	Hertfordshire and West Essex STP	2,089	1,497	72%	1,996	1,600	80%	2,807	3,455	123%	3,011	3,567	118%
RCX	The Queen Elizabeth Hospital, King's Lyn	East of England	Norfolk and Waveney Health & Care P	1,412	981	69%	1,620	1,244	77%	3,400	2,569	76%	3,453	2,902	84%
RWG	West Hertfordshire Hospitals NHS Trust	East of England	Hertfordshire and West Essex STP	3,201	2,318	72%	3,434	2,440	71%	4,630	3,458	75%	4,536	3,885	86%
RGR	West Suffolk NHS Foundation Trust	East of England	Suffolk and North East Essex STP	2,017	1,626	81%	1,960	1,359	69%	4,538	3,730	82%	4,427	2,916	66%

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

				CT Scans						MRI Scans					
				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: 07 Mar 2021	as a % of last year	Estimated same weeks in March 2019	w/e 14 Mar 2021	as a % of the same week in March 2019	Estimated same weeks last year	4 weeks ending: 07 Mar 2021	as a % of last year	Estimated same weeks in March 2019	w/e 14 Mar 2021	as a % of the same week in March 2019
RC9	Bedfordshire Hospitals NHS Foundation	East of England	Bedfordshire, Luton and Milton Keynes	1,463	1,186	81%	1,510	1,337	89%	907	527	58%	872	475	54%
RGT	Cambridge University Hospitals NHS Fou	East of England	Cambridgeshire and Peterborough ST	913	1,095	120%	970	1,144	118%	679	580	85%	683	594	87%
RWH	East and North Hertfordshire NHS Trust	East of England	Hertfordshire and West Essex STP	1,159	784	68%	1,054	758	72%	560	422	75%	570	416	73%
RDE	East Suffolk and North Essex NHS Found	East of England	Suffolk and North East Essex STP	1,656	1,208	73%	1,572	681	43%	792	576	73%	726	319	44%
RGP	James Paget University Hospitals NHS F	East of England	Norfolk and Waveney Health & Care P	579	586	101%	553	663	120%	330	280	85%	317	335	106%
RAJ	Mid and South Essex NHS Foundation Tr	East of England	Mid and South Essex STP	3,151	2,639	84%	2,846	3,094	109%	1,289	1,027	80%	1,204	1,010	84%
RD8	Milton Keynes University Hospital NHS Fo	East of England	Bedfordshire, Luton and Milton Keynes	200	184	92%	194	167	86%	145	116	80%	172	99	58%
RM1	Norfolk and Norwich University Hospitals	East of England	Norfolk and Waveney Health & Care P	1,659	1,201	72%	1,665	1,573	94%	754	925	123%	796	581	73%
RGN	North West Anglia NHS Foundation Trust	East of England	Cambridgeshire and Peterborough ST	354	1,635	462%	1,415	1,585	112%	139	596	428%	556	562	101%
RGM	Royal Papworth Hospital NHS Foundation	East of England	Cambridgeshire and Peterborough ST	93	177	191%	85	176	207%	59	64	108%	56	61	109%
RQW	The Princess Alexandra Hospital NHS Tru	East of England	Hertfordshire and West Essex STP	1,000	635	63%	992	634	64%	343	219	64%	365	260	71%
RCX	The Queen Elizabeth Hospital, King's Lyn	East of England	Norfolk and Waveney Health & Care P	494	500	101%	474	384	81%	214	110	51%	209	80	38%
RWG	West Hertfordshire Hospitals NHS Trust	East of England	Hertfordshire and West Essex STP	668	807	121%	664	809	122%	294	299	102%	269	295	110%
RGR	West Suffolk NHS Foundation Trust	East of England	Suffolk and North East Essex STP	558	495	89%	534	460	86%	317	218	69%	306	263	86%

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

				Colonoscopies						Flexible-sigmoidoscopies						Gastroscopies					
				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: 07 Mar 2021	as a % of last year	Estimated same weeks in March 2019	w/e 14 Mar 2021	as a % of the same week in March 2019	Estimated same weeks last year	4 weeks ending: 07 Mar 2021	as a % of last year	Estimated same weeks in March 2019	w/e 14 Mar 2021	as a % of the same week in March 2019	Estimated same weeks last year	4 weeks ending: 07 Mar 2021	as a % of last year	Estimated same weeks in March 2019	w/e 14 Mar 2021	as a % of the same week in March 2019
RC9	Bedfordshire Hospitals NHS Foundation	East of England	Bedfordshire, Luton and Milton Keynes	89	90	101%	82	94	115%	107	23	21%	105	40	38%	165	108	65%	158	123	78%
RGT	Cambridge University Hospitals NHS Fou	East of England	Cambridgeshire and Peterborough ST	132	37	28%	121	53	44%	31	7	23%	31	11	35%	189	42	22%	169	121	72%
RWH	East and North Hertfordshire NHS Trust	East of England	Hertfordshire and West Essex STP	84	59	70%	80	49	61%	32	16	51%	29	9	31%	64	32	50%	58	43	74%
RDE	East Suffolk and North Essex NHS Found	East of England	Suffolk and North East Essex STP	173	26	15%	177	11	6%	57	7	12%	55	8	15%	135	20	15%	127	17	13%
RGP	James Paget University Hospitals NHS F	East of England	Norfolk and Waveney Health & Care P	33	26	79%	31	21	68%	58	14	25%	69	20	29%	31	23	75%	25	27	108%
RAJ	Mid and South Essex NHS Foundation Tr	East of England	Mid and South Essex STP	161	203	126%	134	227	169%	76	56	74%	72	56	78%	159	146	92%	147	166	113%
RD8	Milton Keynes University Hospital NHS Fo	East of England	Bedfordshire, Luton and Milton Keynes	24	0	0%	29	78	269%	13	0	0%	15	26	173%	30	0	0%	35	76	217%
RM1	Norfolk and Norwich University Hospitals	East of England	Norfolk and Waveney Health & Care P	182	123	67%	185	120	65%	175	38	21%	176	39	22%	202	88	43%	212	119	56%
RGN	North West Anglia NHS Foundation Trust	East of England	Cambridgeshire and Peterborough ST	31	65	209%	125	47	38%	14	29	211%	54	44	81%	30	85	284%	120	36	30%
RGM	Royal Papworth Hospital NHS Foundation	East of England	Cambridgeshire and Peterborough ST	0	0	n/a	0	0	n/a	0	0	n/a	0	0	n/a	0	0	n/a	0	0	n/a
RQW	The Princess Alexandra Hospital NHS Tru	East of England	Hertfordshire and West Essex STP	19	40	206%	23	1	4%	6	10	177%	7	0	0%	16	30	195%	26	2	8%
RCX	The Queen Elizabeth Hospital, King's Lyn	East of England	Norfolk and Waveney Health & Care P	45	21	47%	46	52	113%	22	10	44%	23	19	83%	54	20	36%	60	49	82%
RWG	West Hertfordshire Hospitals NHS Trust	East of England	Hertfordshire and West Essex STP	1	100	10000%	1	96	9600%	5	35	742%	4	40	1000%	7	107	1589%	6	104	1733%
RGR	West Suffolk NHS Foundation Trust	East of England	Suffolk and North East Essex STP	68	62	91%	65	15	23%	43	26	59%	41	10	24%	102	56	55%	97	35	36%

10. Integrated quality and performance report

To APPROVE a report

For Approval

Presented by Helen Beck and Susan Wilkinson

Trust Board Report

Agenda Item:	10			
Presented By:	Helen Beck & Sue Wilkinson			
Prepared By:	Information Team			
Date Prepared:	Mar-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.

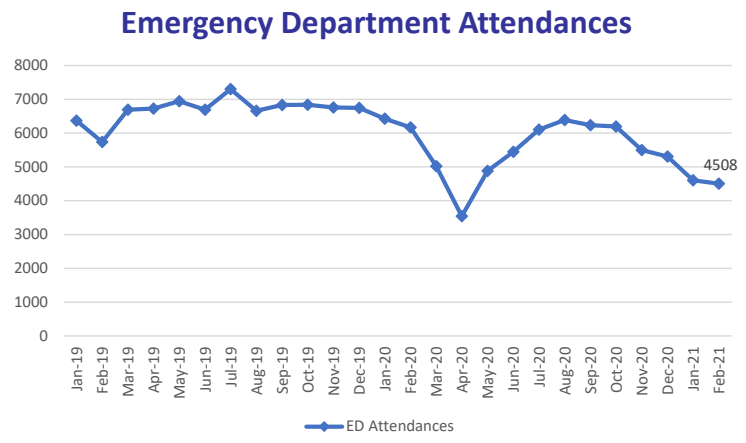
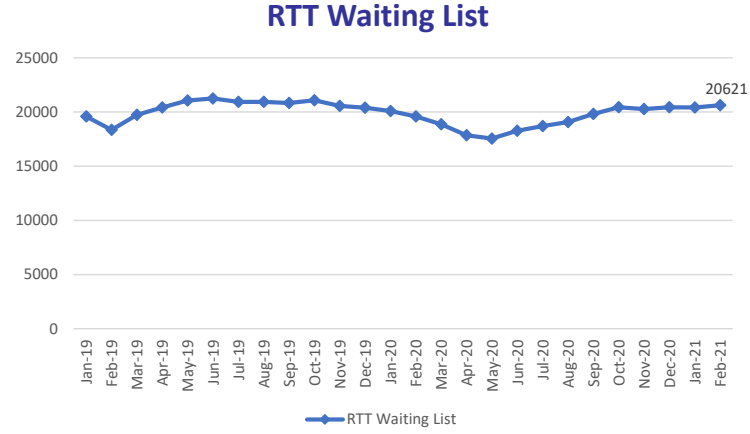
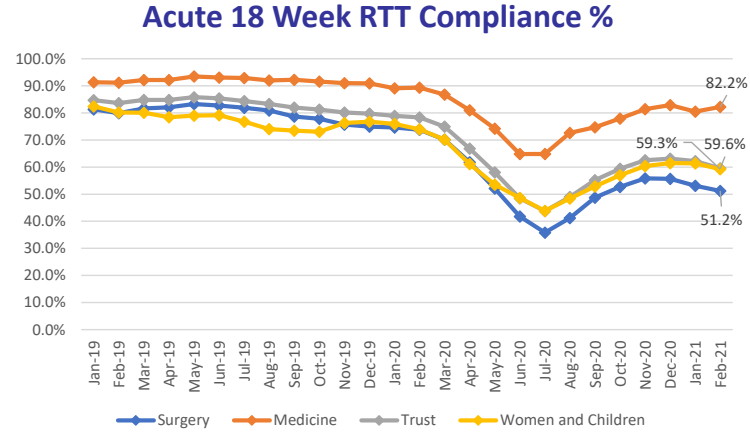
Trust Priorities [Please indicate Trust priorities relevant to the subject of the report]	**Delivery for Today**	**Invest in Quality, Staff and Clinical Leadership**	**Build a Joined-up Future**
	X		

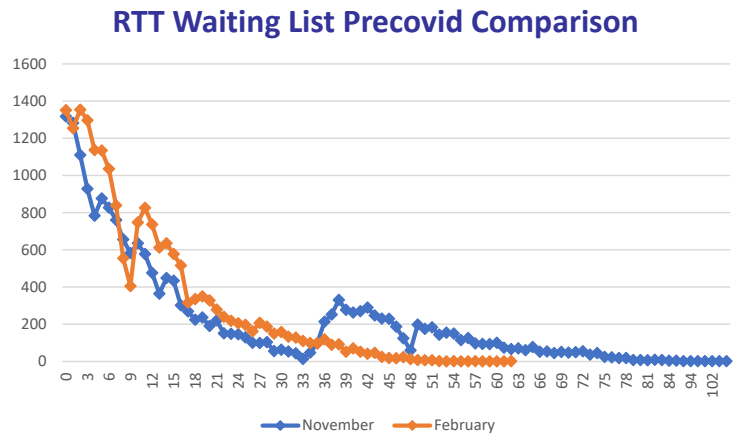
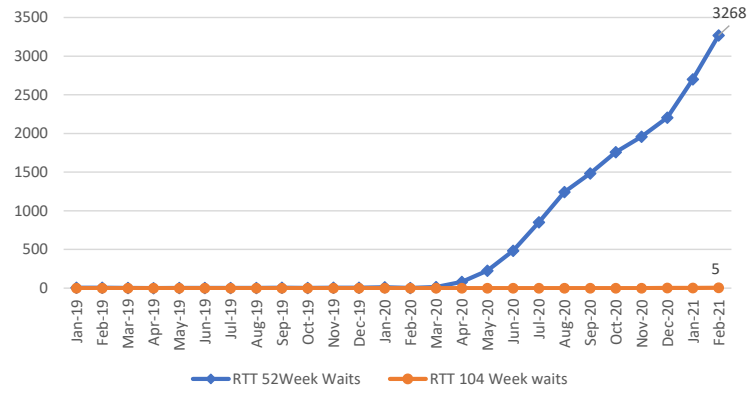
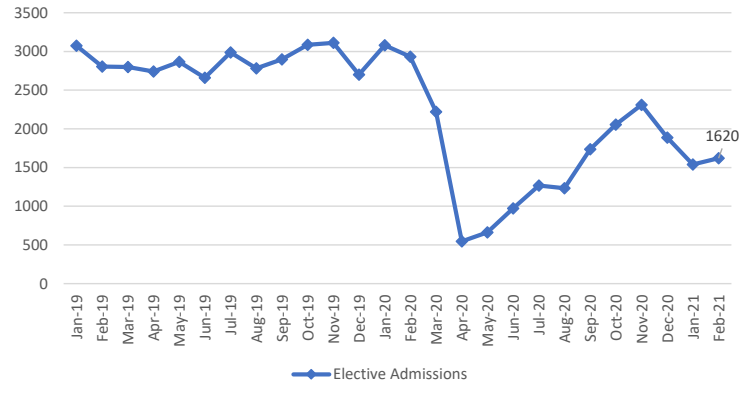
Trust Ambitions [Please indicate ambitions relevant to the subject of the report]	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
		X	**X**				**X**

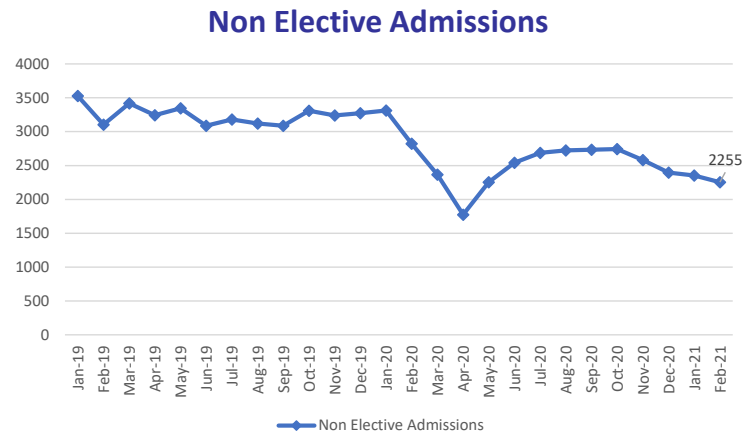
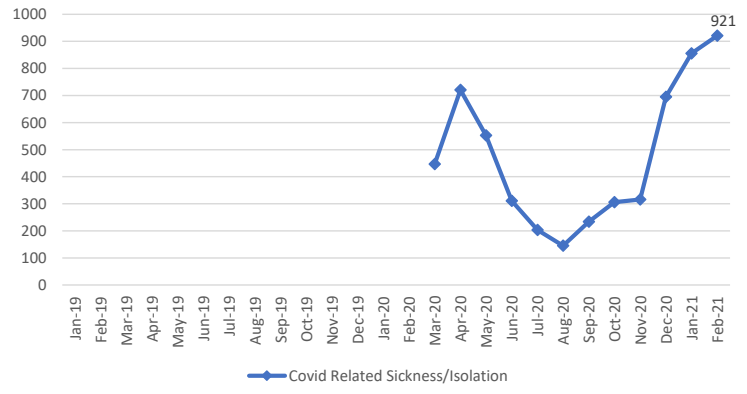
Previously Considered by:	
Risk and Assurance:	
Legislation, Regulatory, Equality, Diversity and Dignity Implications	

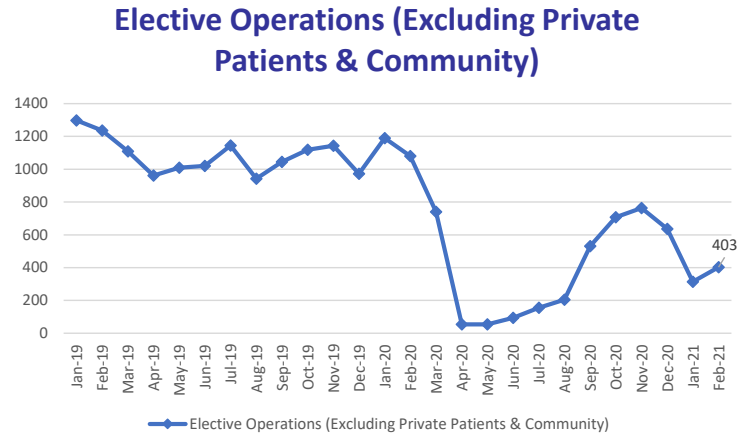
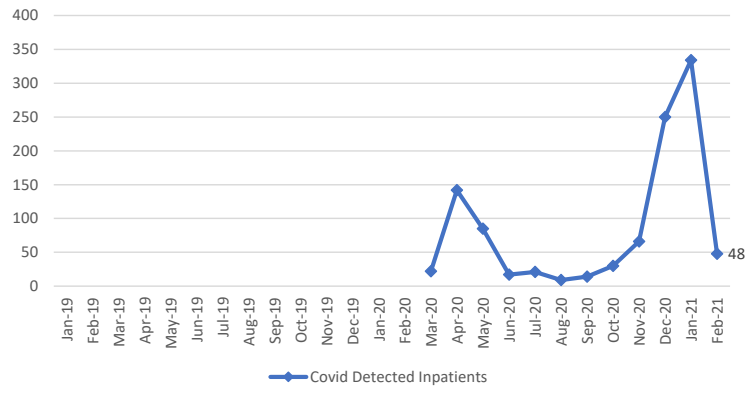
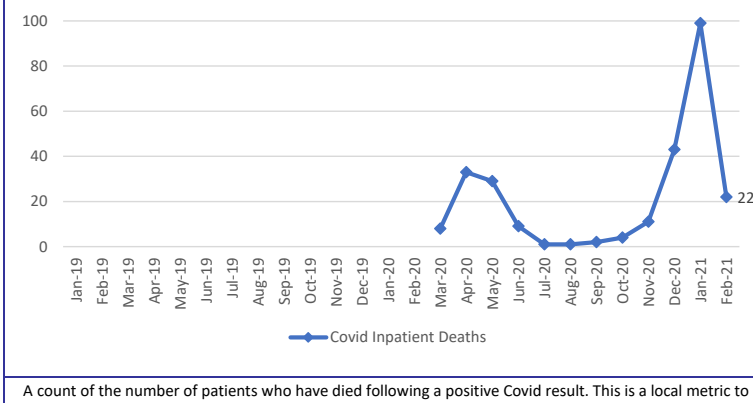
Recommendation:

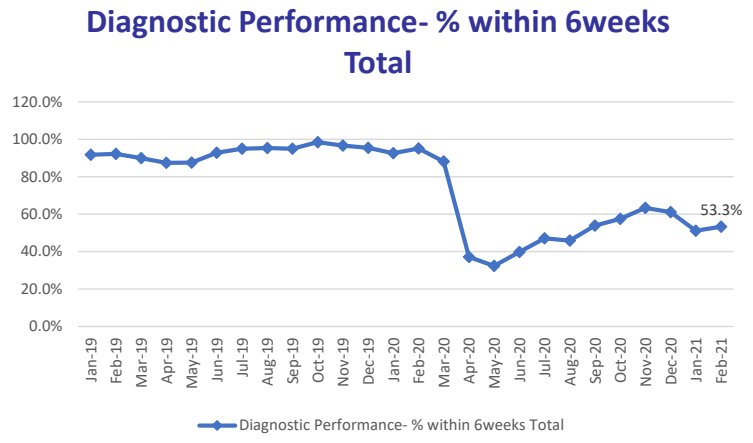
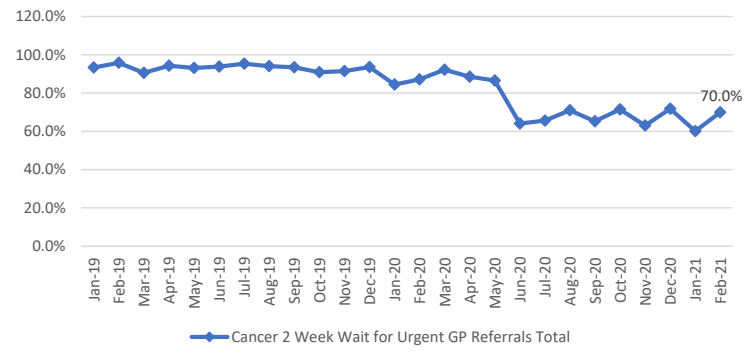
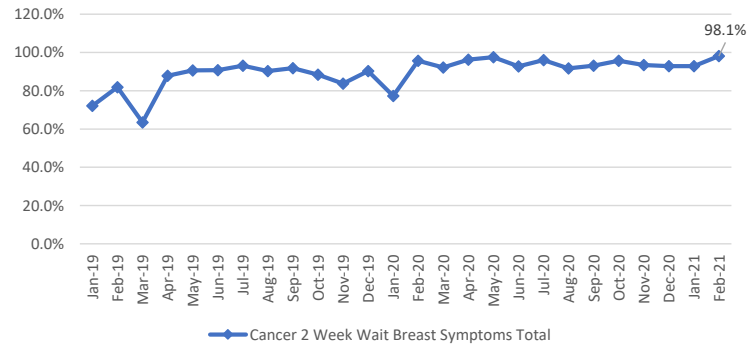
That Board note the report.

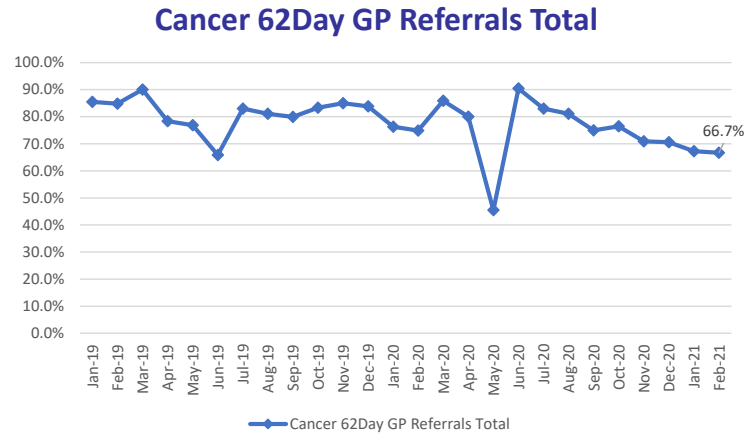
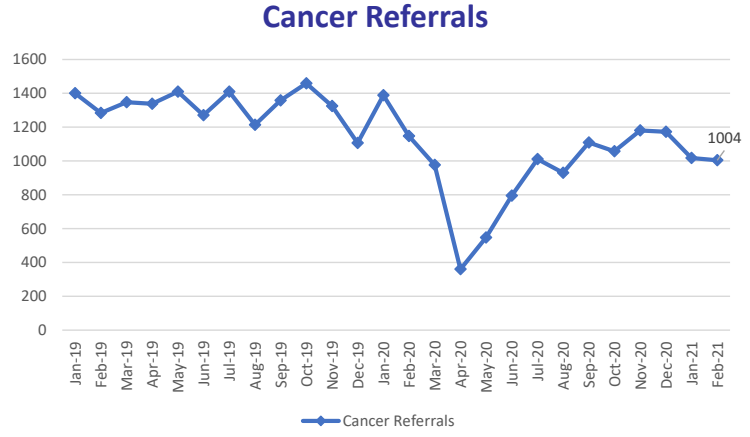
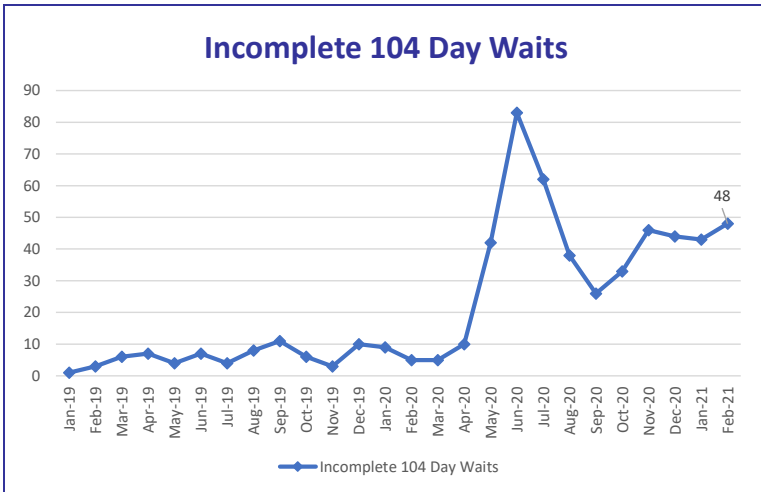
Board Report KPIs	Narratives
	There were 4508 attendances to ED in February 2021, compared with 5741 attendances in February 2020. This is a reduction of 1233 attendances (78.5%). Attendances in January 21 were 701 less than December 20. February's data shows a reduction of 95 attendances compared to January 21 which demonstrates that attendance numbers may be levelling off. This reduction continues to coincide with the second wave of Covid - resulting in patients less inclined to attend the hospital and social distancing/wearing of masks reducing the transmission of other viruses.
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.	
	Slight increase in overall waiting list size, which reflects the smaller numbers of patients being removed as completed from the pathway. Despite significantly reduced levels of activity over the past year due to the pandemic, the overall waiting list size has remained fairly stable due to a reduction in the number of referrals. There is potential that this unmet demand will result in a significant increase in referral demand over the coming months.
A count of the patients on the waiting list for treatment.	
	Medicine compliance has slightly increased again in February as clinicians has been able to pick up more clinical activity in the non-surgical pathways. Surgery and Women's and children, which are most reliant on surgical capacity have seen a continued reduction in performance as only those most clinically urgent patients have been treated.
% of patients on incomplete RTT pathways	

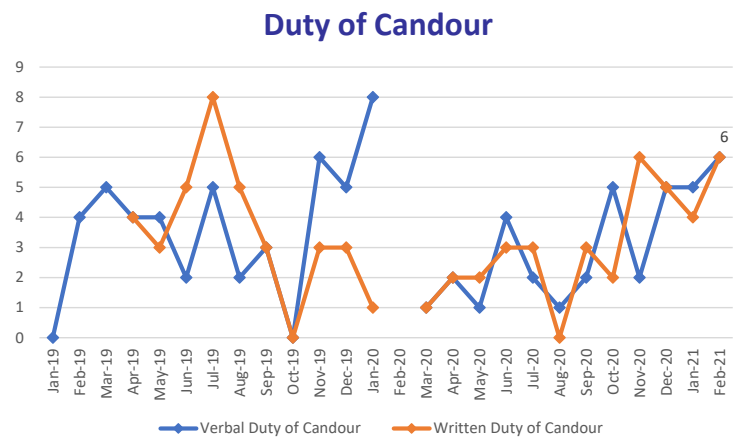
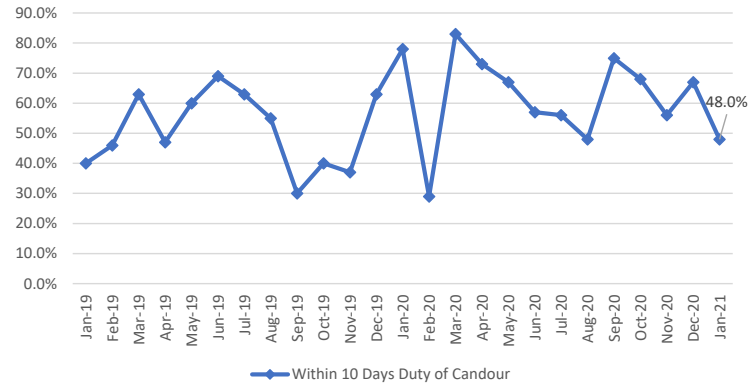
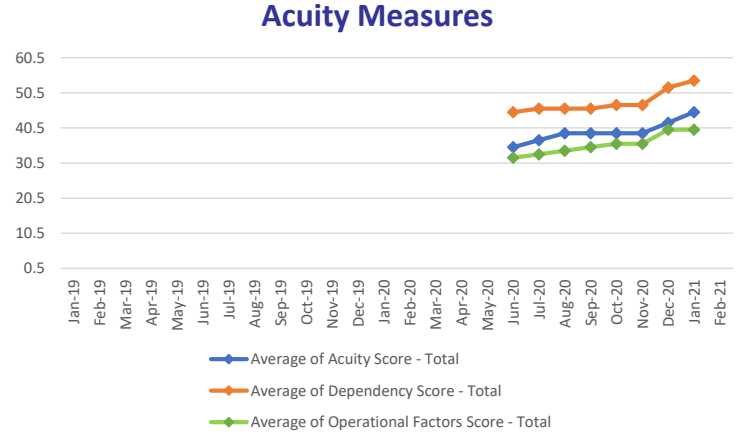
Board Report KPIs	Narratives
	As we have seen in previous months the waiting list 'tail' is significantly longer due to the restrictions in surgery as a direct impact of Covid-19 and the need to treat patients with the highest clinical priority. The waiting list shape has changed and we can see the dip at around the 48 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 amount of patients over 52 weeks. This is expected to continue to grow as more patients tip over the 52 week wait mark than we are currently able to treat. The majority of the 52 week waits are those waiting for routine surgery, which will continue to be a challenge. The current focus remains on treating patients in clinical priority order which is likely to impact the recovery of this position. There is a suggestion that 104 week waits will be the new interim backstop during the initial phase of elective restoration. There are currently 5 patients on our waiting list who have waited over 104 weeks. These are being prioritised by clinical and operational teams.
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.	
	There are been a slight increase in the amount of elective admissions in February, this will primarily be impacted by endoscopy and day surgery activity increases as staff return to their normal areas of work from Critical care/ Covid response.
A count of the number of patients that were admitted for an elective/planned procedure. This is a local metric used to monitor changes in activity.	

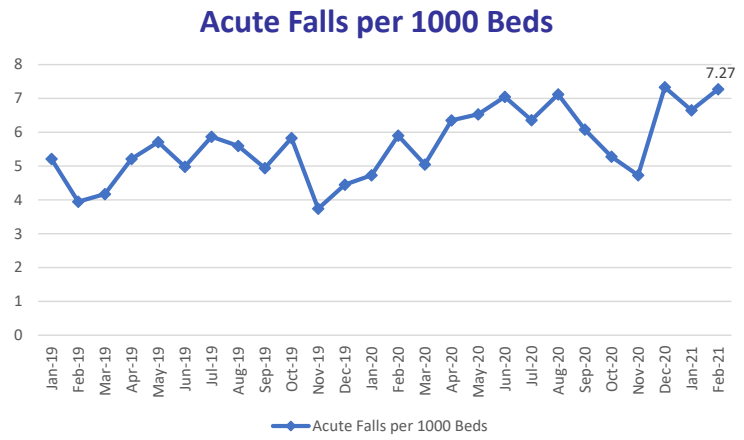
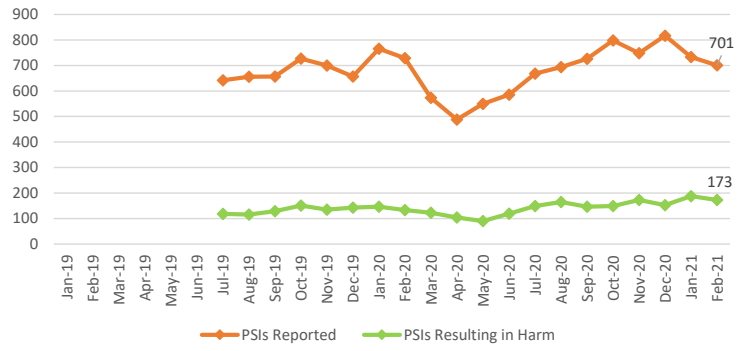
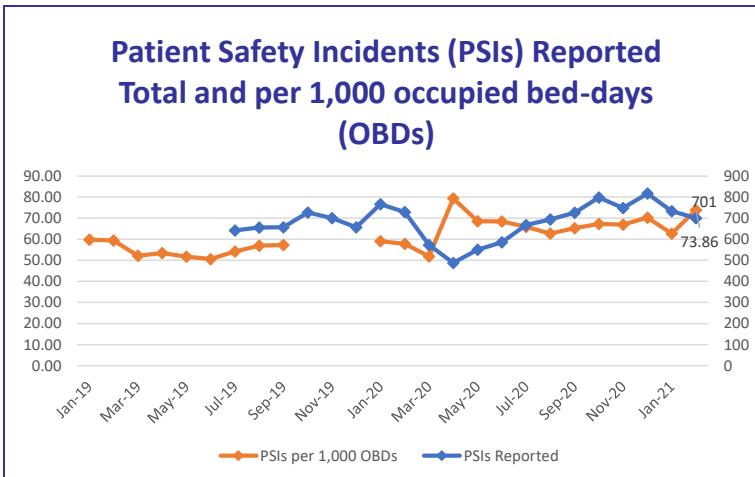
Board Report KPIs	Narratives
	There were 2255 Non-elective admissions in February 21 compared to 3103 in February 20, which represents a decrease of 848 (73.6%) non-elective admissions in month. The non-elective admissions graph is mirroring the ED attendances graph. This decrease correlates with the 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.	
	The Trust's 12-month cumulative (rolling) absence figure at the end of February 2021 was 4% which was an increase on the previous month at 3.9%. This increase is expected due to spikes in COVID-19 related absence during December 2020, January and February 2021.
A measure of staff sickness across the Trust. This includes community staff. This is a local metric to monitor the capacity of our workforce.	
	This chart illustrates the number of sickness episodes related to COVID-19. In February 2021 there were 921 episodes recorded which is an increase on January 2021 which sat at 856 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.	

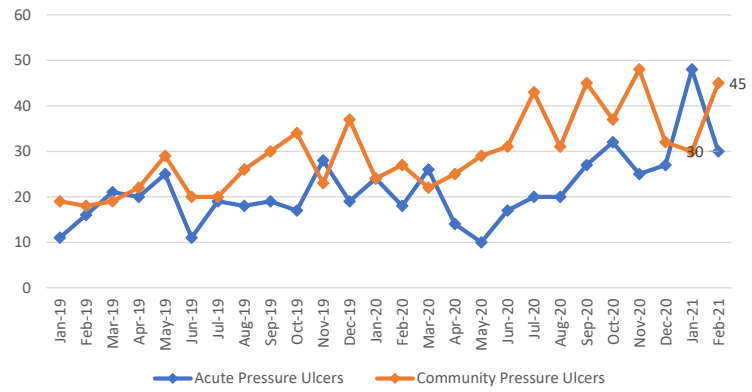
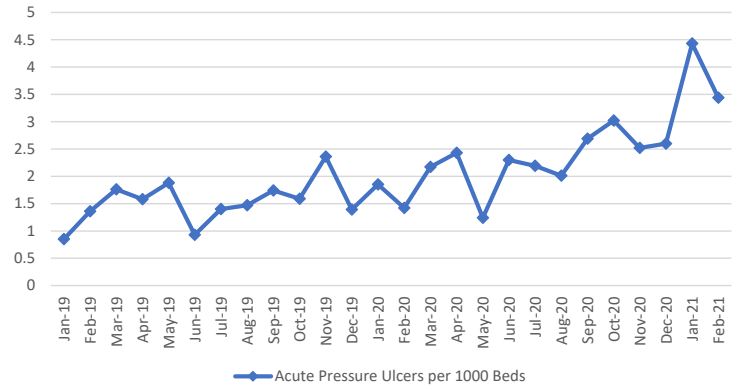
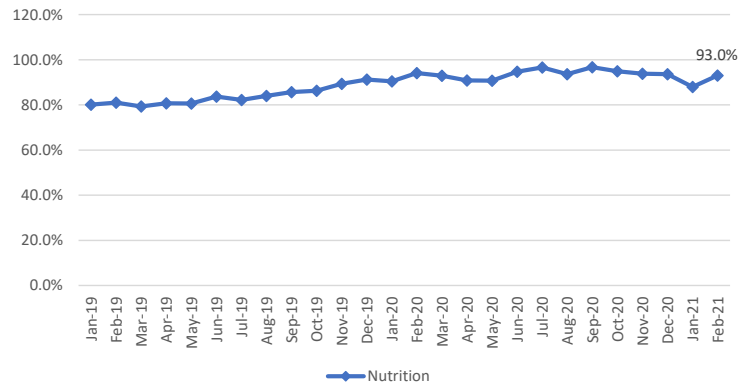
Board Report KPIs	Narratives
	Slight increase as more patients were able to be brought into the day surgery unit as a low risk site. This is expected to increase through to May 2021 as more theatre capacity becomes available prior to the roof works. We have continued to manage cancer admissions for treatment throughout.
This is a count of the number of operations that were carried out. This is a local measure to monitor our productivity and recovery from Covid.	
	There were 48 individual patients admitted during February, who had their first diagnosis of Covid-19. In February the highest number of Covid positive inpatients residing in the trust on any one day was 96, which was on 01/02/2021
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 22 patients who died within 28 days of a positive Covid result, in February. These figures are as published by NHSE.
A count of the number of patients who have died following a positive Covid result. This is a local metric to understand the local impact of Covid. This number is reported daily as part of national daily reporting requirements.	

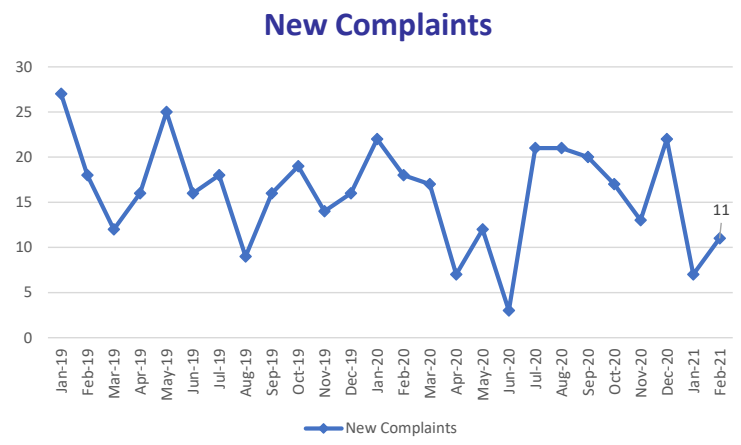
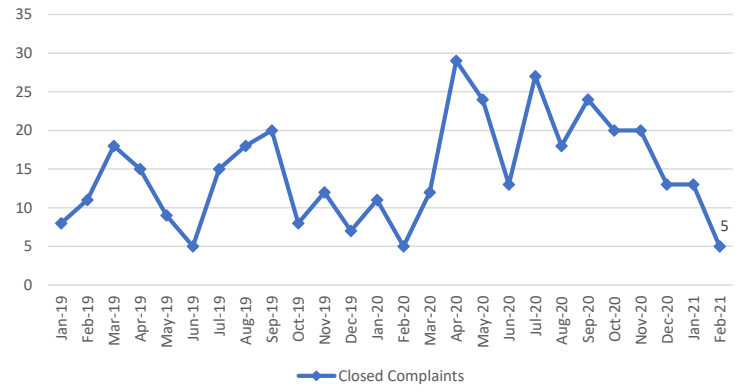
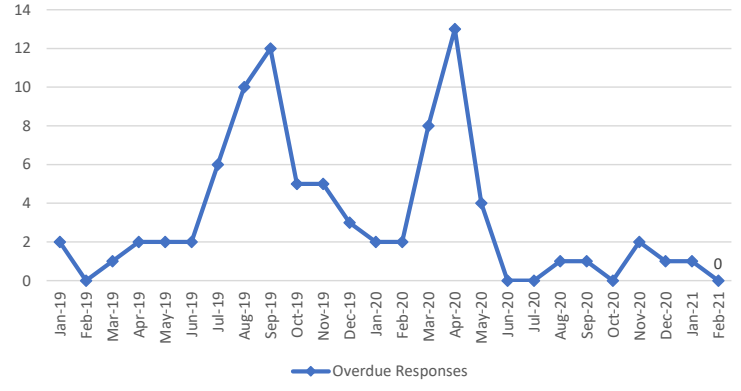
Board Report KPIs	Narratives
	Approval was given for the resumption of routine diagnostics on the 1st of March 2021. We will therefore expect to see an increase in performance against DMO1 in March as activity is restored to full capacity.
To measure compliance with the national standards for access 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 is predominantly due to patients referred to colorectal and Upper GI teams requiring endoscopic or radiological straight to test diagnostic. There have been some urology 2WW patients not seen within target due to patient choice. In addition to increasing inhouse Endoscopy capacity, including, introduction of nasal endoscopy, Cytosponge and training for use of Colon capsule technology, independent sector facility with support from ICS, is also now being utilised. The overall wait for straight to test GI patients is now getting shorter and these measures will support achieving recovery trajectory for 2 Week Wait.
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.	

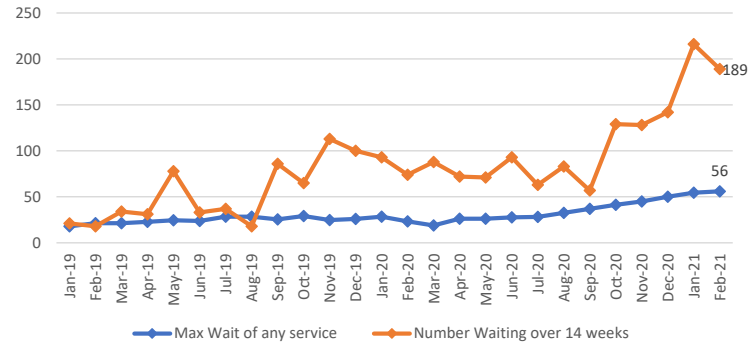
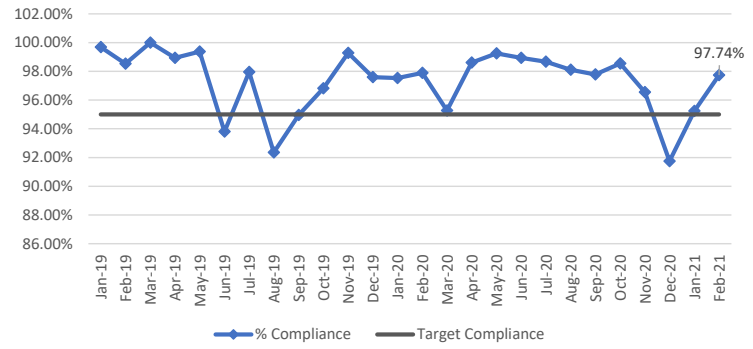
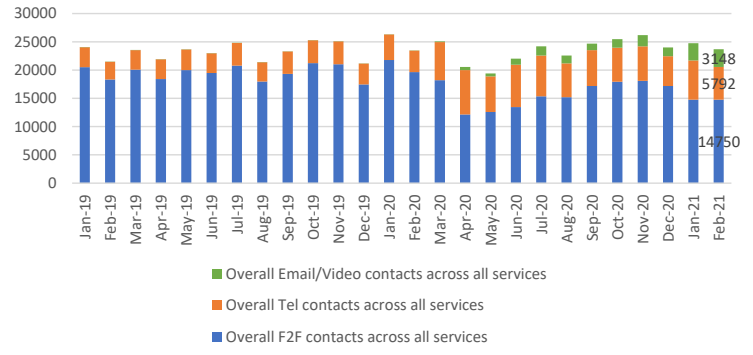
Board Report KPIs	Narratives
	Significant reduction in performance as expected due to treating patients who had been delayed for diagnostics and also the impact January wave in surgical capacity at the centre for patients on shared pathway. Once diagnosed patients are being treated promptly. RCA's and 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, potentially in line with national lockdown and seasonal referrals trends. Early data for the start of March shows that these referral numbers are now picking up again.
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 incomplete pathway has increased, this continues to remain high for the Trust. The majority of these patients are still awaiting diagnostics and the conversion rate to positive cancer diagnosis is relatively low. Most of this is a direct impact of covid-19 and diagnostic delays, including 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.	

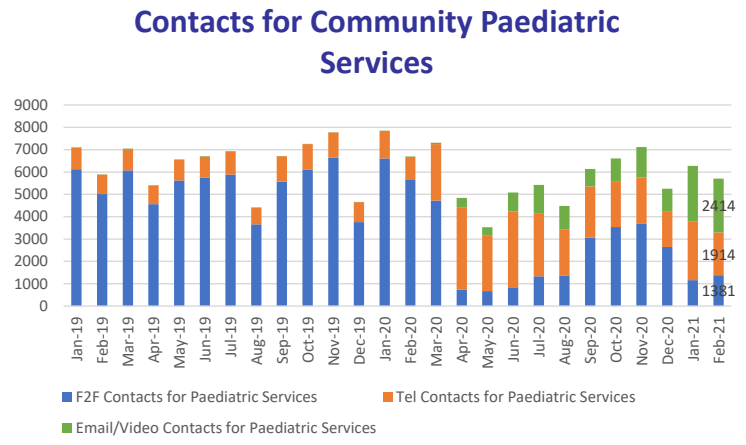
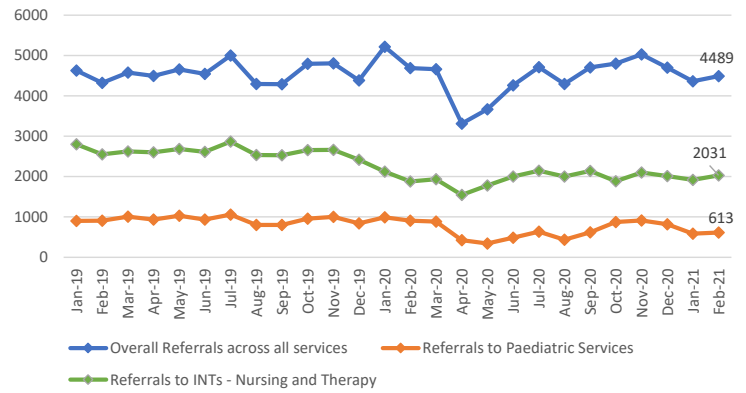
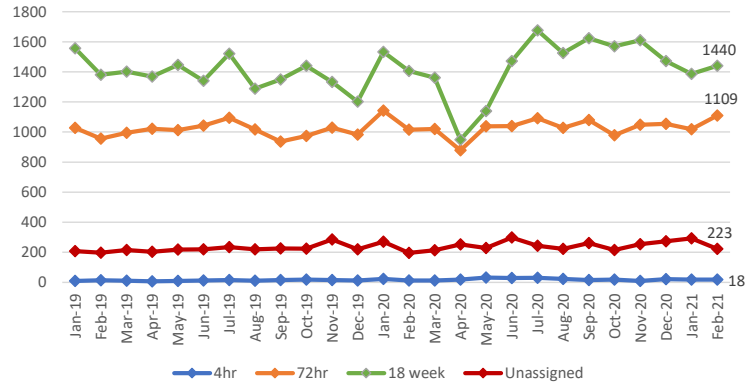
Board Report KPIs	Narratives
	The timeliness indicator demonstrates a wide variance in performance as might be expected when a small denominator indicator is reported as a percentage. The six cases reported as 'overdue' this month are made up of pressure ulcers (3) and C. difficile (3). A review of DoC processes following a report of 'healthcare acquired' C. difficile (often following antibiotics) is seeking the input of medical staff (via the Medical staffing committee forum) to co-produce supportive guidance for staff. An initial scoping meeting is taking place between patient safety, Infection prevention and the chair of the MSC in late March.
This is a count of the number of verbal and written duty of candour overdue for the reporting month (and earlier) as at the date of report issue	
	
The percentage of cases reported in that month where verbal duty of candour was completed within the nationally required 10 working day timeframe.	
	February data is not available due to data issues. In January there was 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 had 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.
A range of measures have been identified which are analysed to provide an overall acuity score, as displayed in this chart. This provides an overview of the acuity of admitted patients.	

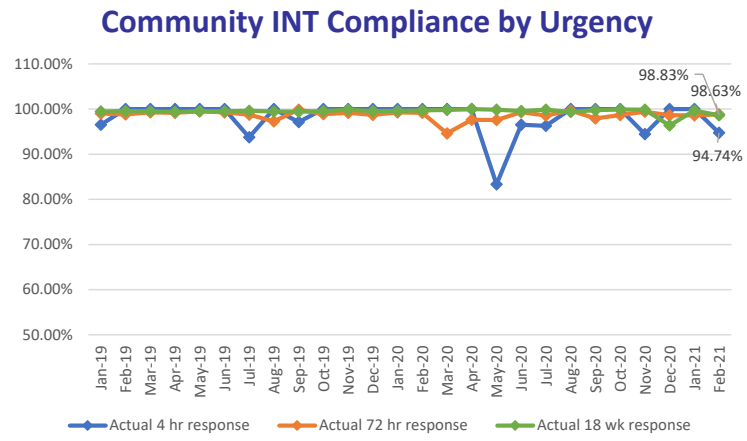
Board Report KPIs	Narratives
	The number of falls reported in February fell compared to Jan/Dec although this was a rise when expressed as falls per 1,000 bed days due to reduced bed occupancy. This is still within normal reporting limits of the longer term reporting patterns. Within February; 44 falls 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 three with major harm (2x neck of femur fractures and one open ankle fracture/dislocation) on F10, AAU and F7 respectively. There were some repeat fallers (n=6) most falling twice and one three times in the reporting month. Falls with major harm will be investigated through the new PSIRF framework and a meeting with the national PSIRF lead to discuss progress took place in February.
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 February fell compared to January but remained comparable to previous months. The number of incidents resulting in harm decreased compared to January but remained at the higher level noted in recent months. A drill-down into incident categories shows that pressure ulcers (PUs) and falls remain the main contributor to increased harm. More details on PU and Falls are contained in the specific sections of the IQPR.
A count of the number of patient safety incidents reported in total and those resulting in harm	
	The incidents reported per 1,000 bed days rose in February 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	Overall our pressure ulcer incidence as an organisation has remained fairly static during February, although acute incidence has decreased whilst community has grown. Cat 2 PU's decreased, Cat 3 remained at the same level, whilst no Cat 4 PU's were reported. An increase was also noted in the reporting of unstageable PU's, which continue to be reviewed by the Tissue Viability Team for accuracy and proactive treatment planning. Opportunistic and distant learning continues, led by the TVS. Community staffing has remained challenging over the period with increased acuity noted by colleagues, as well as increasingly complex caseloads. Whilst in the acute setting the pressures on critical care and Covid areas has reduced, which is reflected in reduced PU occurrence in these areas. Senior Matron and TVS colleagues maintain contact with national leads to review the increasing upward trend in national PU incidence, a further discussion takes place w/c 22.03.21 in order to share learning and strategies to support a reduction in patient harm. An opportunity has arisen to offer a change of role within the TVS to focus on data and thematic analysis in order to address areas for improvement, it is hoped that this may be in place in the next 3 months.
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	Compliance has improved in completing nutrition assessments within 24 hours in February up to 93%, following a significant decrease in January 2021. On review the majority of areas have demonstrated significant improvement in their compliance with only minimal areas struggling to achieve. Similar to January, the areas where compliance has not been achieved are those Wards which have been converted to Covid areas and relates to the ward receiving direct admissions, bypassing the assessment area. Theses specific areas have also seen high acuity through February. The Matron's for these areas are focussing on this with the teams involved and as the acuity in these areas is now decreasing, it is predicted the compliance will improve. It continues to be acknowledged that the vast majority of patients have a nutritional assessment completed, even if this is beyond the expected timescale, offering some assurance that patients are being assessed. There is continued focus on compliance by the Senior Matrons and Ward Managers to ensure assessments are completed on time and appropriate plans of care are put in place and assurance is being gained via the weekly Perfect Ward documentation audits.

Board Report KPIs	Narratives
	11 formal complaints received which is still around 50% below what we would receive pre-Covid. Only 4 complaints received were about the level of care received. 2 complaints were about the clinical helpline and information that was given. Both of these complaints were not upheld and the correct processes were followed. 2 complaints were relating to lost property which were initially PALS cases however wanting escalated to formal complaints.
New formal complaints received and accepted, this counts both West Suffolk Hospital and Community	
	Our attention focused on complex cases as complaints were outstanding that were part of the incident, inquest and formal complaints procedure. We focused on completing these which took additional time. We also ensured all complaints have received a holding letter if there are were any extensions or delays.
Formal complaints signed off by the CEO, this counts both West Suffolk Hospital and Community	
	0 Over due responses for February 2021
Any complaints which were sent outside of the given timeframe and no extension was agreed, this counts both West Suffolk Hospital and Community	

Board Report KPIs	Narratives
Community Non Consultant Led 18week Max Wait 	The Paediatric speech and Language service have been significantly impacted by the Covid restrictions. Initial assessment times are primarily impacted by reduced clinic/school access and needing to do more virtual appointments which require more clinical preparation time. Also use of PPE is a barrier as not all therapeutic interventions can be undertaken wearing face masks. Group therapy intervention has longer waits due to Covid restrictions meaning children are seen virtually or in single clinics (Clinics would have seen 4-6children in a group). This will not change until restrictions are lifted. Schools are now open so teams will be visiting more but there are some restrictions to the access and ongoing negotiation needed with individual schools. The Clinical Psychology Service has seen an increased demand during Covid. Referrals typically have a higher level of clinical need and associated supporting challenges with mental health and education access as other services are impacted by Covid restrictions. A Skill mix review has taken place and more therapy assistant hours put in place and the team is now nearer to expected capacity but with less senior Clinical Psychology capacity. The Team is developing a "Moodle" platform to deliver workshops virtually. Recovery is expected to take time as restrictions lift. Wheelchair Services have been impacted by Covid restrictions with most patients shielding or reluctant to attend an assessment due to Covid risks. The service also has one member of staff who is shielding representing a 50% reduction in the workforce.
Services covered: Adult SLT, Heart Failure, Neurology Service, Parkinson's Nursing, Wheelchairs, Paediatric Occupational Therapy, Paediatric Physio and Paediatric Speech and Language Therapy, There are no patients waiting over 52weeks for treatment from referral, so community look at number of patients waiting over 14 weeks. Historically, 14 weeks was agreed on as an internal measure because it gives an approx. number of patients who would breach the 18 week target at the end of the next month.	
Community Non Consultant Led 18week Compliance 	The aggregated % of patients treated within 18 weeks for all community services in February was 97.74% with the lowest individual service being Wheelchairs at 85.19%.
Services covered: Adult SLT, Heart Failure, Neurology Service, Parkinson's Nursing, Wheelchairs, Pead OT, Pead Physio and Pead SLT. RTT nationally is for consultant led services but the community services are required to report on compliance to 18 week Referral to Treatment locally to our CCG. Target is 95% of referrals are given a first definitive treatment within 18weeks	
Contacts for ALL Community Services (Adults and Paediatrics) 	The total activity for community services has returned to pre-COVID levels 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. February is a short month and historically half term has an effect on activity even though the schools are not open for usual attendance.
Activity is counted as a face to face/telephone/email/video contact with a patient/carer/parent which is clinically relevant. This means activity that a clinician carries out which is writing reports, liaising with other healthcare professionals is NOT counted as activity. This is in line with acute systems where there is an assumption that clinicians will carry out related activities that result from contact with a patient.	

Board Report KPIs	Narratives
	The Paediatric services have moved a high proportion of their activity to telephone and email/video contacts but they are still unable to carry out any group work due to social distancing requirements. There are also shortages in clinic availability in certain locations. The wearing of masks and social distancing means Speech and Language therapy is particularly hard to do. The services are reviewing all possible options. Activity has picked up again after the Christmas break. February is a short month and half term has historically had an effect.
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
	The Red (4hr) referral urgency was not met, reaching 94.74%. There were 2 breaches of the 4hr target, one patient was seen within 5hours and the other was seen in 5hrs 45mins. The Amber and Green referral targets were met.
Referrals into the Integrated Neighbourhood Teams have urgencies of Red (within 4 hours), Amber within 72hrs) and Green (within 18 weeks). These contractual urgencies are locally agreed pan Suffolk with the CCG and there is a 98% response target for Red, Amber and Green response times have a 95% threshold (These are local contractual targets)	

11. Finance and workforce report

To ACCEPT the report

For Report

Presented by Craig Black

Board of Directors – March 2021

Agenda item:	11			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	19th March 2021			
Subject:	Finance and Workforce Board Report – February 2021			
Purpose:		For information	x	For approval

Executive summary:

The reported I&E for February 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 agreed a budget for 2021-22 to deliver a deficit of £10.5m, with a Cost Improvement Programme (CIP) of 1%. 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.

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

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

Previously considered by:	*This report is produced for the monthly trust board meeting only*
Risk and assurance:	*These are highlighted within the report*
Legislation, regulatory, equality, diversity and dignity implications	*None*
Recommendation: *The Board is asked to review this report.*	

FINANCE AND WORKFORCE REPORT
February 2021 (Month 11)

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	£33.4m	adverse
EBITDA margin YTD	14%	adverse
Total PSF Received	£44.7m	
Cash at bank	£23.9m	

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 - February 2021	February 2021 Budget £m	February 2021 Actual £m	February 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	17.3	22.6	5.4	201.8	202.5	0.7	220.4	216.0	(4.4)
Other Income	2.8	1.6	(1.3)	32.4	29.7	(2.7)	35.4	31.4	(4.0)
Total Income	**20.1**	**24.2**	**4.1**	**234.2**	**232.2**	**(2.1)**	**255.8**	**247.4**	**(8.4)**
Pay Costs	16.7	20.3	(3.5)	177.2	186.6	(9.4)	204.8	202.6	2.2
Non-pay Costs	6.1	6.6	(0.4)	85.4	79.0	6.4	82.0	81.0	1.0
Operating Expenditure	**22.9**	**26.8**	**(4.0)**	**262.6**	**265.6**	**(3.0)**	**286.8**	**283.6**	**3.2**
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)**	**0.1**	**(28.4)**	**(33.4)**	**(5.0)**	**(31.1)**	**(36.2)**	**(5.2)**
Depreciation	0.7	0.6	0.1	7.4	6.5	0.9	8.1	7.0	1.1
Finance costs	0.3	0.5	(0.2)	3.6	4.9	(1.3)	3.9	5.3	(1.4)
SURPLUS/(DEFICIT)	**(3.7)**	**(3.8)**	**(0.0)**	**(39.3)**	**(44.7)**	**(5.4)**	**(43.1)**	**(48.5)**	**(5.5)**
Provider Sustainability Funding (PSF)									
PSF / FRF/ MRET/ Top Up	3.7	3.7	0.0	39.3	44.7	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 – February 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 – February 2021

Income and Expenditure Summary as at February 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 agreed a budget for 2021-22 to deliver a deficit of £10.5m, with a Cost Improvement Programme (CIP) of 1%.

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.

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	29	62	⇔	Green
YTD surplus/ (deficit)	(0)	0	5	⇔	Green
Forecast surplus/ (deficit)	(0)	0	0	⇔	Green
EBITDA (excl top-up) YTD	(3,737)	(3,771)	(34)	↑	Green
EBITDA %	(18.6%)	(15.6%)	3.0%	↑	Green
Clinical Income YTD	(212,821)	(212,649)	(172)	↓	Amber
Non-Clinical Income YTD	(60,733)	(64,219)	3,486	↓	Green
Pay YTD	177,176	186,596	(9,420)	↑	Red
Non-Pay YTD	96,371	90,261	6,110	↓	Green
CIP Target YTD	7,968	4,092	0	↑	Red

FINANCE AND WORKFORCE REPORT – February 2021

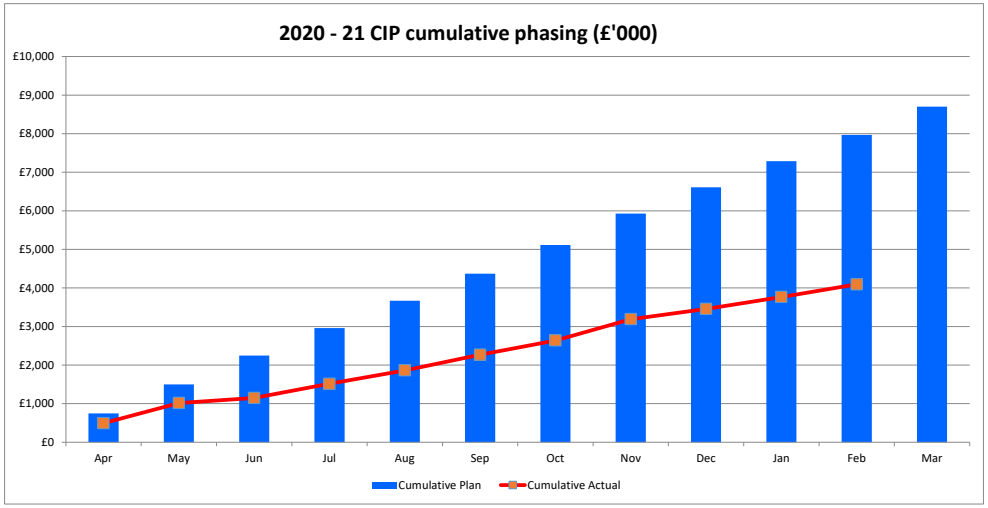
Cost Improvement Programme (CIP) 2020-21

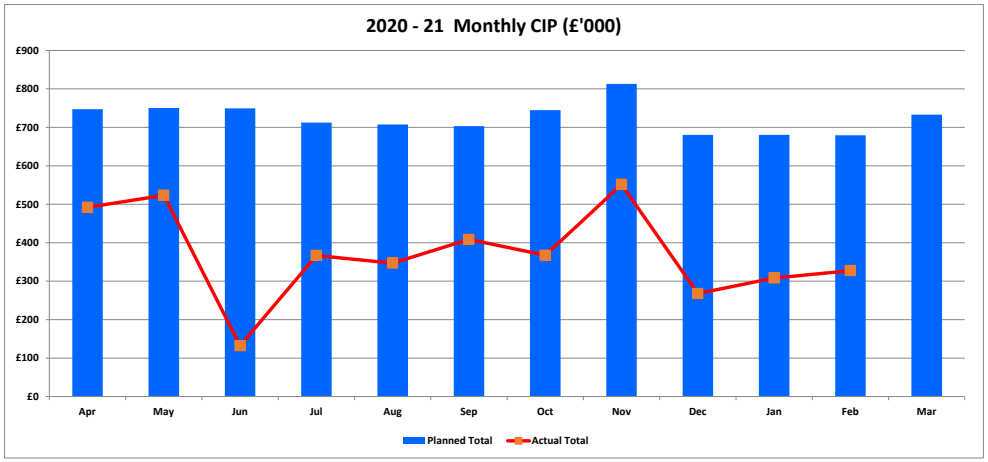
In order to deliver the Trust's control target in 2020-21 we need to deliver a CIP of £8.7m (3.4%). The plan for the year to February is £8.0m (91.6% of the annual plan) and we achieved £4.1m (47.0%). This represents a shortfall of £3.9m.

The CIP forecast is to achieve £4.4m by year end which is a shortfall of £4.3m.

Recurring/Non Recurring	2020-21 Annual Plan	Plan YTD	Actual YTD
	£'000	£'000	£'000
Recurring			
Outpatients	254	225	50
Procurement	492	451	467
Activity growth	200	183	183
Additional sessions	363	333	80
Community Equipment Service	510	468	312
Drugs	367	336	336
Estates and Facilities	187	176	94
Other	949	886	932
Other Income	493	452	154
Pay controls	327	295	178
Service Review	16	16	16
Staffing Review	819	706	618
Theatre Efficiency	302	277	-
Contract Review	50	46	9
Workforce	-	-	-
Consultant staffing	-	-	-
Agency	-	-	-
Unidentified CIP	975	890	-
Recurring Total	**6,304**	**5,739**	**3,429**
Non-Recurring			
Pay controls	580	543	519
Other	1,810	1,680	138
Estates and Facilities	6	6	6
Non-Recurring Total	**2,396**	**2,228**	**663**
Total CIP	**8,700**	**7,968**	**4,092**

Division	Divisional Target £'000	YTD Var £'000	Unidentified plan £ YTD	Unidentified plan £ year
Medicine	2,555	(1,911)	234	255
Surgery	2,029	(777)	186	203
W&C/CSS	1,847	(269)	0	0
Community	1,422	(490)	114	125
E&F	516	(360)	181	202
Corporates	331	(69)	175	191
Stretch	0	0	0	0
Total	**8,700**	**(3,876)**	**890**	**975**





FINANCE AND WORKFORCE REPORT – February 2021

Trends and Analysis

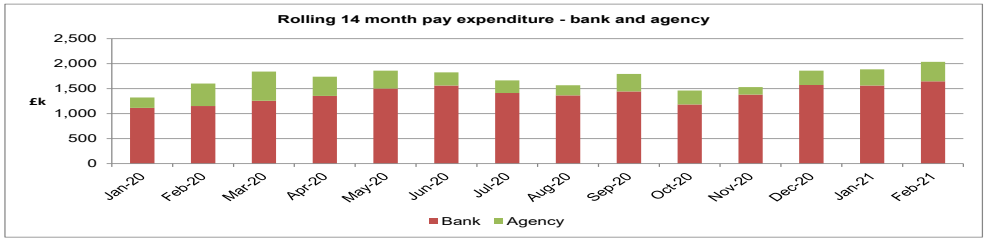
Workforce

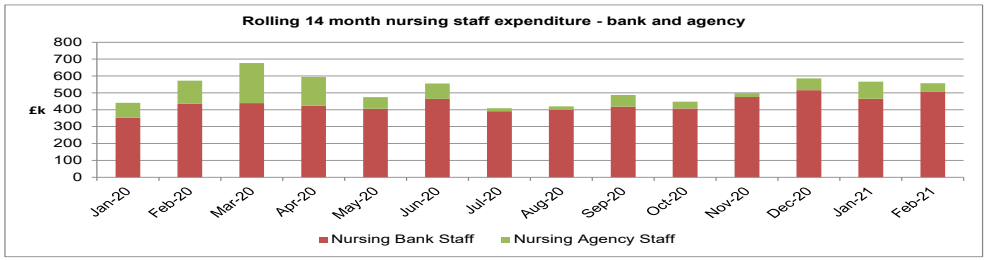
Monthly Expenditure (£)				
As at February 2021	Feb-21	Jan-21	Feb-20	YTD
	£000's	£000's	£000's	£000's
Budgeted Costs in-month	16,733	16,236	14,569	177,176
Substantive Staff	18,246	14,671	13,532	167,374
Medical Agency Staff	170	167	178	1,827
Medical Locum Staff	396	395	237	3,591
Additional Medical Sessions	114	212	173	2,729
Nursing Agency Staff	49	101	138	719
Nursing Bank Staff	509	465	435	4,875
Other Agency Staff	170	55	135	691
Other Bank Staff	294	241	170	2,434
Overtime	215	141	63	1,377
On Call	118	109	74	979
Total Temporary Expenditure	2,035	1,886	1,602	19,222
Total Expenditure on Pay	20,282	16,557	15,134	186,596
Variance (F/(A))	(3,549)	(320)	(565)	(9,420)
Temp. Staff Costs as % of Total Pay	10.0%	11.4%	10.6%	10.3%
memo: Total Agency Spend in-month	389	323	450	3,237

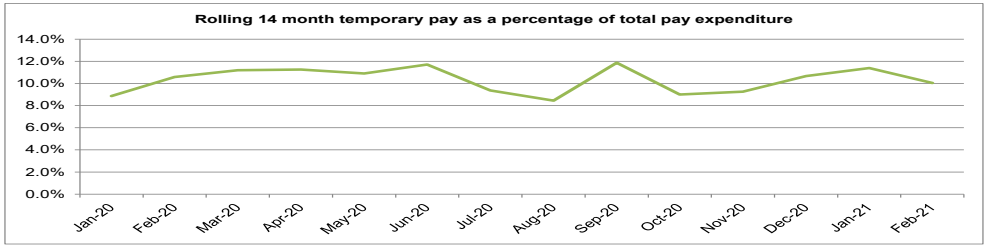
Monthly WTE			
As at February 2021	Feb-21	Jan-21	Feb-20
	£000's	£000's	£000's
Budgeted WTE in-month	4,229.4	4,227.9	3,890.3
Substantive Staff	4,004.4	3,933.0	3,674.9
Medical Agency Staff	11.2	17.9	11.7
Medical Locum Staff	34.9	33.9	27.8
Additional Medical Sessions	2.7	1.3	7.9
Nursing Agency Staff	10.1	18.0	29.1
Nursing Bank Staff	147.4	137.8	122.7
Other Agency Staff	29.8	18.1	26.1
Other Bank Staff	108.0	91.8	70.4
Overtime	56.9	36.1	15.9
On Call	9.8	9.8	6.2
Total Temporary WTE	410.7	364.7	317.8
Total WTE	4,415.1	4,297.7	3,992.7
Variance (F/(A))	(185.7)	(69.8)	(102.4)
Temp. Staff WTE as % of Total WTE	9.3%	8.5%	8.0%
memo: Total Agency WTE in-month	51.1	54.0	66.9

Pay Costs

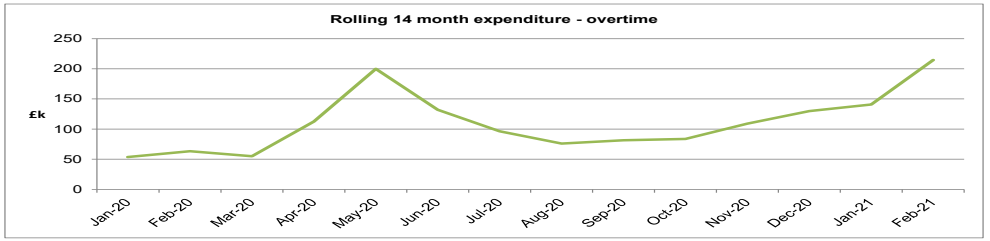
During February the Trust overspent by £3.5m on pay (£9.4m overspent YTD). This includes all COVID related pay costs and accrued leave.







Expenditure on Additional Sessions was £114k in February (£212k in January)



FINANCE AND WORKFORCE REPORT – February 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	(7,323)	(5,936)	(1,387)	(82,028)	(67,716)	(14,312)
Pay Costs	4,409	5,228	(819)	47,196	53,318	(6,122)
Non-pay Costs	1,540	1,554	(14)	17,236	17,780	(544)
Operating Expenditure	**5,949**	**6,782**	**(834)**	**64,433**	**71,099**	**(6,666)**
SURPLUS / (DEFICIT)	**1,374**	**(847)**	**(2,221)**	**17,595**	**(3,382)**	**(20,978)**
SURGERY						
Total Income	(5,324)	(2,179)	(3,145)	(59,827)	(39,605)	(20,222)
Pay Costs	3,410	3,629	(219)	37,482	39,560	(2,077)
Non-pay Costs	1,060	625	436	12,551	9,690	2,861
Operating Expenditure	**4,470**	**4,253**	**217**	**50,034**	**49,249**	**784**
SURPLUS / (DEFICIT)	**854**	**(2,074)**	**(2,928)**	**9,794**	**(9,644)**	**(19,438)**
WOMENS AND CHILDRENS						
Total Income	(1,870)	(1,579)	(291)	(21,576)	(18,275)	(3,301)
Pay Costs	1,520	1,574	(54)	15,907	15,906	0
Non-pay Costs	170	190	(20)	1,878	2,060	(182)
Operating Expenditure	**1,691**	**1,764**	**(73)**	**17,785**	**17,966**	**(181)**
SURPLUS / (DEFICIT)	**179**	**(185)**	**(364)**	**3,791**	**309**	**(3,482)**
CLINICAL SUPPORT						
Total Income	(717)	(444)	(272)	(8,846)	(6,847)	(1,999)
Pay Costs	2,033	2,100	(68)	19,617	19,311	306
Non-pay Costs	1,191	1,127	64	11,991	13,255	(1,264)
Operating Expenditure	**3,223**	**3,227**	**(4)**	**31,608**	**32,566**	**(958)**
SURPLUS / (DEFICIT)	**(2,507)**	**(2,783)**	**(276)**	**(22,762)**	**(25,720)**	**(2,958)**
COMMUNITY SERVICES						
Total Income	(3,513)	(3,498)	(15)	(38,642)	(38,718)	76
Pay Costs	2,548	2,808	(259)	27,946	29,004	(1,057)
Non-pay Costs	2,101	983	1,118	12,014	13,420	(1,406)
Operating Expenditure	**4,649**	**3,790**	**859**	**39,960**	**42,424**	**(2,464)**
SURPLUS / (DEFICIT)	**(1,137)**	**(292)**	**844**	**(1,318)**	**(3,706)**	**(2,388)**
ESTATES AND FACILITIES						
Total Income	(434)	(207)	(227)	(4,773)	(2,230)	(2,543)
Pay Costs	1,034	1,010	24	10,048	10,449	(400)
Non-pay Costs	626	496	130	6,889	7,122	(233)
Operating Expenditure	**1,660**	**1,506**	**154**	**16,937**	**17,571**	**(634)**
SURPLUS / (DEFICIT)	**(1,226)**	**(1,299)**	**(73)**	**(12,164)**	**(15,340)**	**(3,176)**
CORPORATE						
Total Income	(4,668)	(14,064)	9,396	(57,763)	(103,315)	45,552
Pay Costs	1,778	3,933	(2,155)	18,979	19,049	(70)
Non-pay Costs	(566)	1,579	(2,145)	22,795	15,604	7,191
Capital Charges and Financing Costs	993	1,071	(78)	10,925	11,179	(253)
Operating Expenditure	**2,205**	**5,512**	**(3,307)**	**52,699**	**34,653**	**18,046**
SURPLUS / (DEFICIT)	**2,463**	**8,552**	**6,089**	**5,064**	**68,662**	**63,599**
TOTAL						
Total Income	(23,847)	(27,907)	4,059	(273,455)	(276,706)	3,251
Pay Costs	16,733	20,282	(3,549)	177,176	186,596	(9,420)
Non-pay Costs	6,122	6,553	(431)	85,355	78,932	6,423
Capital Charges and Financing Costs	993	1,071	(78)	10,925	11,179	(253)
Operating Expenditure	**23,847**	**27,906**	**(4,059)**	**273,456**	**276,707**	**(3,250)**
SURPLUS / (DEFICIT)	**0**	**0**	**0**	**(0)**	**(0)**	**0**

Page 6

Medicine (Sarah Watson)

The division is behind plan in month by £2.2m and £21.0m YTD.

Clinical income is behind plan in month by £1.36m and £13.9m 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 both waves of the COVID-19 pandemic brought with it a significant reduction in activity levels across Medicine throughout the year. From April to November 2020, this reduction narrowed, only to increase again as the impact of wave 2 hit in December.

With the pressures from COVID easing in February, activity levels improved across Medicine. Elective activity is now 33% behind plan (January 39%) and Outpatient activity is 9% behind plan (January 15%). The shortfall for Non-Elective activity reduced to 24% (January 27%) in month. We anticipate that these gaps will continue to decrease as COVID driven operational issues ease further.

With the effect of Clinical Income removed, Medicine division is recording an adverse variance against budget of £861k in month (£7.0m YTD). Continuous drivers of this variance are *identified* additional costs of COVID (£380k) and unmet CIP schemes (£187k). Other factors driving this include:

- Overspends in Rheumatology for Drugs (£41k) - likely a timing difference for claiming excluded drugs and will reverse next month;
- Increased additional sessions (£118k above budget in month) – due to covering wards at short notice across medicine during wave 2
- Use of non-substantive registrars within A&E (£48k).

To date, the division has recorded £11.6m of expenditure towards COVID YTD, £4.02m is a result of additional costs being incurred due to COVID and £5.5m is using existing resources (e.g. medical wards) solely towards COVID. The remaining £2.0m relates to CIP schemes that are unable to be met due to COVID.

Surgery (Simon Taylor)

The division is behind plan by £2.9m in month (£19.4m year to date).

Clinical income performance reflects the changes the division have had to make with its operating model throughout the year in response to COVID. The division continue to treat all P2 and cancer patients as non-urgent procedures and face to

face appointments remain paused. Elective activity is 37.6% behind plan in month (48% YTD) and outpatient activity behind plan by 36% in month (39% YTD). Activity is anticipated to continue at this level until the end of the financial year. The division are currently reviewing options to mitigate the loss of theatre capacity due to the necessary work on the theatre refurb and roof failsafe works being carried out over the coming months in addition to COVID restrictions.

Pay expenditure reported an overspend of £219k in month, (£2.08m YTD). This is due to additional COVID support to wards and Critical care.

The non-pay budget is £436k underspent in month, predominantly within Prothesis and (£173k) and MSE (£172k), due to reduced elective activity.

Women and Children's (Michelle O'Donnell)
In February, the Division reported an adverse variance of £364k (£3,482k YTD).

This year COVID has depressed activity with low levels of elective activity in Gynaecology and non-elective activity in Paediatrics. Consequently, income is behind plan by £291k in-month (£3.3m YTD).

Pay reported a £54k overspend in-month (breakeven YTD). Both paediatrics and the maternity service have struggled to fill vacancies. However, the underspends have been offset by spending on COVID initiatives such as consultant cover, running additional clinics, shielding cover and increased ward staff levels.

Non-pay reported a £20k overspend in-month (£182k YTD). Non-pay costs were high in-month as the Maternity Service continued to overspend on consumables and Paediatrics settled legacy invoices. YTD, non-pay has been higher since COVID initiatives have necessitated overspends on low value equipment.

Clinical Support (Michelle O'Donnell)
In February, the Division reported an adverse variance of £276k (£2,958k YTD).

Income for Clinical Support reported £272k behind plan in-month (£1,999k 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 since January as the department has overcome many of the COVID related capacity constraints.

Pay reported a £68k overspend in-month and an underspend of £306k YTD. In-month, Radiology significantly increased the consultant additional sessions paid to complete the required number of reports. YTD, it has been difficult to fill vacancies in Radiology, Outpatients and Pharmacy.

Non-pay reported a £64k underspend in-month and an overspend of £1,264k YTD. The vast majority of the year to date overspend relates to COVID recovery expenditure with private sector suppliers.

Community Services (Michelle Glass)
In February the division reports a favourable variance of £844k (adverse variance of £2.4m YTD)

Income reported a £15k under recovery in month (£76k over recovery YTD). Where income is linked to a cost and volume contract, the division has continued to track and forecast the impact of COVID on the activity levels.

There was an in-month over spend on pay of £259k (£1,057k YTD). The overspend was incurred to support the division's response to COVID and the division has a favourable underlying pay spend 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 through winter to ensure capacity is in place to meet increasing demand for community services.

Non-pay reported a favourable variance of £1,118k in February (£1,406k adverse variance YTD), following funding from reserves in relation to Community Equipment. The YTD position primarily reflects delays in the delivery of some CIP schemes due to the impact of COVID and additional costs incurred to support the Division's COVID response. 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 and to support more than a doubling of discharges through Pathway 1 this year. Additional community equipment costs were also 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 secured.

COVID recovery planning and linked service transformation is being used to inform the forecast; whilst some additional costs continue to support our response and winter planning, we also anticipate our learning from COVID to create opportunities for the cost improvement programme, in development for the 2021-22 financial year.

FINANCE AND WORKFORCE REPORT – February 2021

Statement of Financial Position at 28 February 2021

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2020	Plan 31 March 2021	Plan YTD 28 February 2021	Actual at 28 February 2021	Variance YTD 28 February 2021
	£000	£000	£000	£000	£000
Intangible assets	40,972	48,986	47,905	45,085	(2,820)
Property, plant and equipment	110,593	142,614	138,395	129,625	(8,770)
Trade and other receivables	5,707	6,366	6,366	5,707	(659)
Total non-current assets	**157,272**	**197,966**	**192,666**	**180,417**	**(12,249)**
Inventories	2,872	3,000	3,000	3,174	174
Trade and other receivables	32,342	18,000	18,000	21,832	3,832
Cash and cash equivalents	2,441	2,005	20,005	23,916	3,911
Total current assets	**37,655**	**23,005**	**41,005**	**48,922**	**7,917**
Trade and other payables	(33,692)	(30,838)	(29,714)	(46,768)	(17,054)
Borrowing repayable within 1 year	(58,529)	(3,200)	(3,200)	(5,348)	(2,148)
Current Provisions	(67)	(70)	(70)	(61)	9
Other liabilities	(1,933)	(2,000)	(22,000)	(25,377)	(3,377)
Total current liabilities	**(94,221)**	**(36,108)**	**(54,984)**	**(77,554)**	**(22,570)**
Total assets less current liabilities	**100,706**	**184,863**	**178,687**	**151,785**	**(26,902)**
Borrowings	(52,538)	(51,358)	(51,408)	(49,842)	1,566
Provisions	(744)	(750)	(750)	(744)	6
Total non-current liabilities	**(53,282)**	**(52,108)**	**(52,158)**	**(50,586)**	**1,572**
Total assets employed	**47,424**	**132,755**	**126,529**	**101,199**	**(25,330)**
Financed by					
Public dividend capital	74,065	164,063	157,061	132,646	(24,415)
Revaluation reserve	6,942	6,900	6,900	6,942	42
Income and expenditure reserve	(33,583)	(38,208)	(37,432)	(38,389)	(957)
Total taxpayers' and others' equity	**47,424**	**132,755**	**126,529**	**101,199**	**(25,330)**

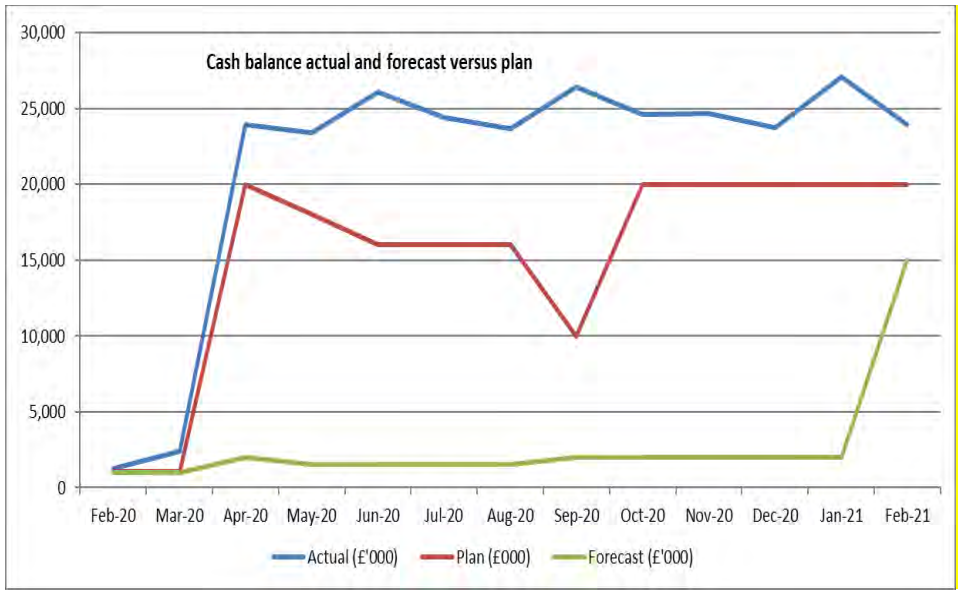
There has been a large increase in payables and this is due mainly to the increase in the annual leave accrual, which is as a result of staff being unable to take their annual leave during the pandemic.

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 February 2020. The Trust is required to keep a minimum balance of £1m.



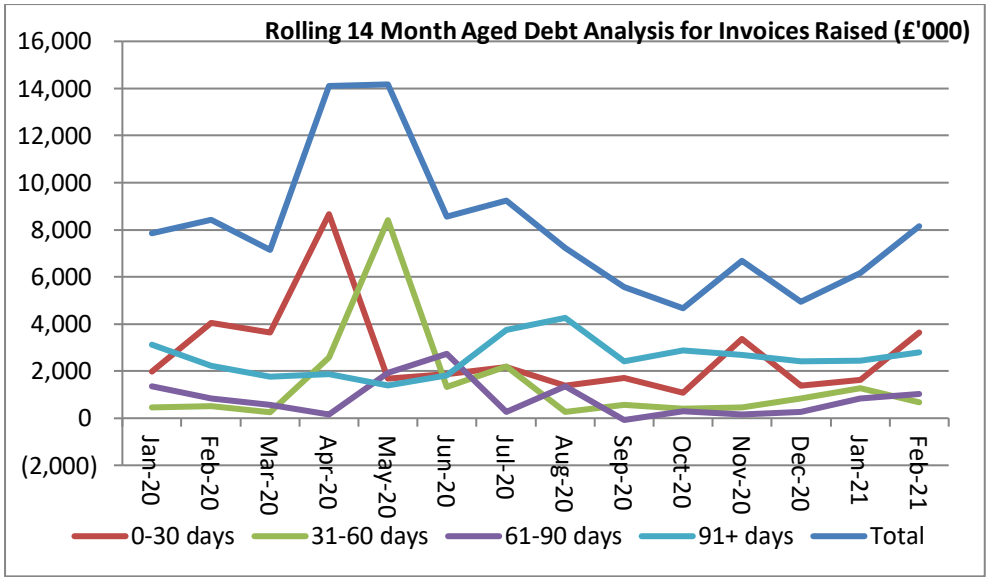
The cash balance has increased significantly and this is due to the current cash regime within the NHS. Contract payments have been paid in advance to ensure that there are adequate cash balances across the NHS and to ensure that payments to suppliers can be made quickly to keep the supply chain in full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

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

FINANCE AND WORKFORCE REPORT – February 2021

Debt Management

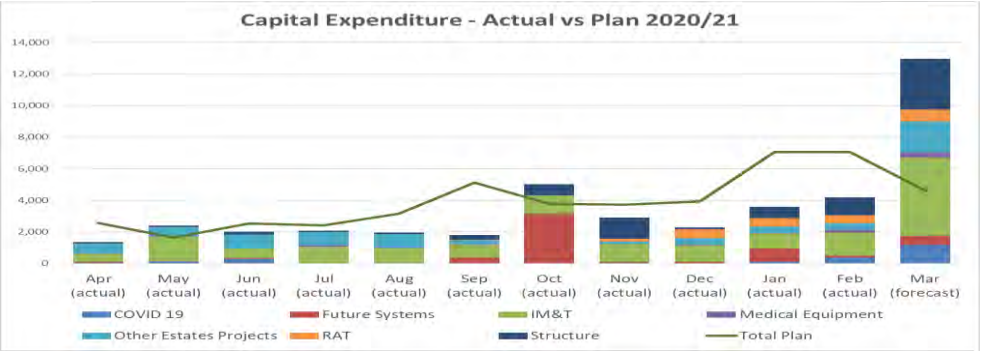
The graph below shows the level of invoiced debt based on age of debt.



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 11. The large majority of the debts outstanding are historic debts. Over 81% of these outstanding debts relate to NHS Organisations, with 31% 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 Actual £'000	Mar Forecast £'000	Total 2020-21 £'000
COVID 19	58	153	305	32	10	17	16	46	26	103	379	1,194	2,339
Future Systems	51	2	62	3	0	364	3,138	78	90	865	127	557	5,337
IM&T	520	1,541	568	1,037	988	813	1,156	1,118	1,048	934	1,447	4,965	16,135
Medical Equipment	16	16	16	75	27	16	27	16	16	16	182	337	760
Other Estates Projects	639	610	895	838	852	285	0	139	436	433	428	1,950	7,505
RAT	0	0	0	0	0	4	1	177	550	529	507	749	2,517
Structure	83	69	178	95	74	315	686	1,328	113	715	1,109	3,197	7,962
Total / Forecast	1,367	2,391	2,024	2,080	1,951	1,814	5,024	2,902	2,279	3,595	4,179	12,949	42,555
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. The forecast has increased slightly to take account of some capital expenditure within IT that has been brought forward to 2021/22. The forecast will be challenging with pressures on both the Estates team and IT that will prove difficult. Meetings have been held with both Estates and IT to assess the year end position.

Comfort Break - 10 minutes

10:30 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

12. People and organisational development (OD) highlight report

To APPROVE a report

For Approval

Presented by Jeremy Over

Board of Directors – Friday 26 March 2021

Agenda item:	12			
Presented by:	Jeremy Over, Executive Director of Workforce and Communications			
Prepared by:	Members of the Workforce & Communications directorate			
Date prepared:	15 March 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 focus:

- Putting You First Awards
- Report on the anniversary of the establishment of our staff psychology service
- Staff vaccination uptake (ethnicity)
- NHS Staff Survey 2020
- Well-being Guardian
- Gender Pay Gap – annual report
- Education Report
- 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*
		✓					✓

Putting you first

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

Putting You First – March awards

Patricia Bivins, critical care sister
Nominated by Debra Baker
Trish has been recognised for the work she has undertaken during the Covid-19 pandemic to support all staff working within critical care during what has been a challenging and difficult time.

She has, often in her own time, organised and implemented weekly meetings via Teams for staff, facilitating drop in sessions to offer time, empathy, a friendly face as well as reassurance and support. Positive feedback encouraged Trish to further develop this service and she has subsequently applied for a critical care network-supported professional nurse advocate role.

Dr Ayush Sinha added to this nomination, saying: "Trish is absolutely amazing… she is also our unit's representative as co-production lead for new hospital ITU."

Marian Nunn, breast imaging
Nominated by Jan Watson
The breast imaging unit courtyard has always been really well cared for but recently had become very unkempt due to contractors putting up scaffolding for essential roof work.

Marian, along with her daughter completely tidied and cleaned up the courtyard, all in her own time. She also added a bird feeder and a water tray and now the courtyard looks lovely. Marian undertook this work to improve the environment for patients waiting for their appointments, at what it probably a very anxious time, and also for colleagues who use the courtyard in good weather.

Jane Dallas
Nominated by Karen Ranson
During a very challenging year, Jane has maintained the standard of care we have always strived to achieve. She has also been the driver for NNU - mapping, planning and teaching, in readiness for the implementation for e-Care.

Over the 16 years that Jane has been with the team, she has helped to implement several large projects to improve the care of our babies. She led the cooling, CFM monitoring and neuroprotection project, represented the team at network meetings and taught neuroprotection at mandatory training.

Jane has been the driver for Badgernet, ensuring that data input by doctors and nurses is accurate and reflects good practice. As lead for sourcing new equipment, she has arranged trials and training of staff to ensure that they are confident and safe in their practice.

All of the above has been undertaken in addition to Jane's clinical shifts and she has always been willing to cover/swapped shifts at short notice, and to help in an emergency.

The West Suffolk Staff Psychology Support Service

Whilst it is sobering to mark the milestone of a year since the start of the global pandemic, it is also a year since we launched the rapid expansion of a staff psychology support service at West Suffolk – a hugely positive development to emerge from an unprecedented crisis.

The threat posed by the pandemic accelerated plans already in development under the leadership of Emily Baker (clinical psychologist), Paul Molyneux (deputy medical director) and Denise Pora (deputy workforce director). I am immensely grateful to Emily who has developed a detailed report for the Board, included in the papers for this agenda item, to provide in-depth analysis of the growth and impact of this service.

Emily will be in attendance at our meeting on 26 March 2021 to present her report and discuss its ramifications, and the development of our future strategy and approach for staff psychological well-being.

Staff Covid-19 Vaccination – uptake amongst Black and Minority Ethnic colleagues

There has been understandable concern raised nationally about access to and uptake of the Covid-19 vaccination amongst different demographic groups and, most notably, people who are of black and minority ethnic origin.

Here at West Suffolk we have monitored these data closely to assess any disparity in access or take-up. Through both the BAME Staff Network, and other communication channels, we have shared information about the vaccine and provided ways for staff to have any concerns addressed.

Analysis of those individuals self-reporting as WSFT staff (bank or substantive) confirmed that 13.1% of this group were of BAME origin.

Separately, looking at the total WSFT workforce (bank and substantive), 12.8% report their ethnicity as black and ethnic minority origin. This demonstrates, at the conclusion of the administration process for the first vaccine, there is no disparity in vaccine take-up amongst BAME staff at West Suffolk.

Staff Survey 2020

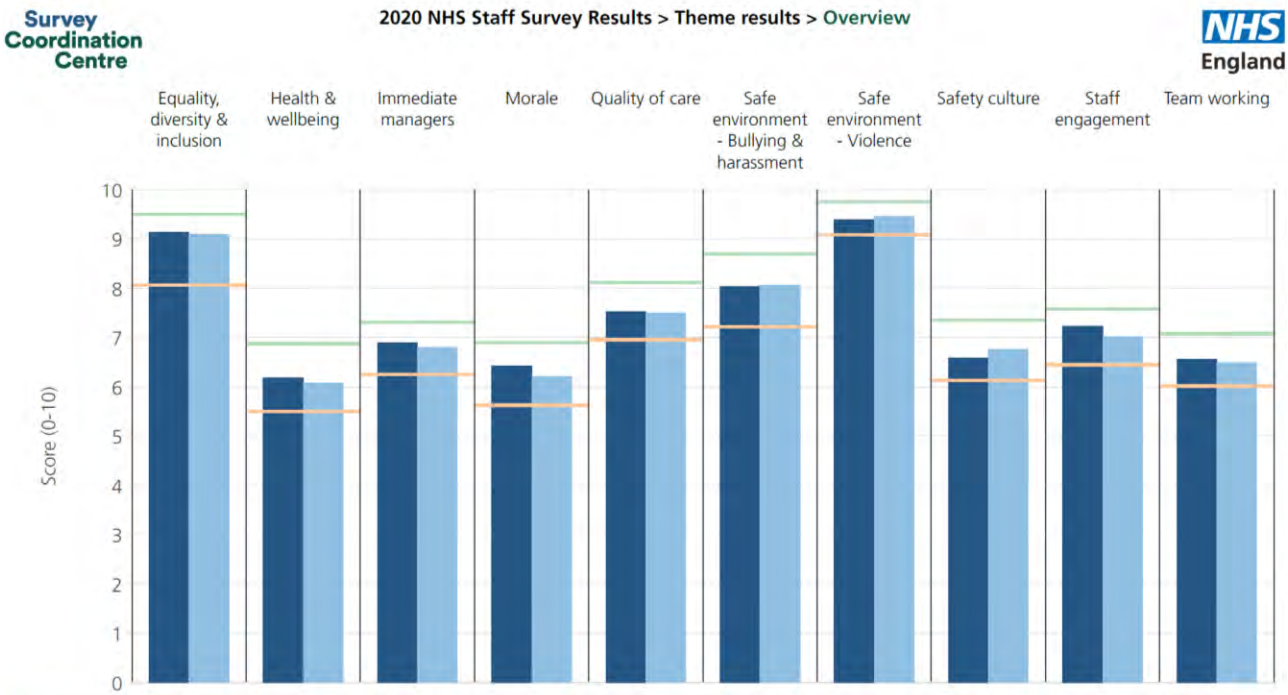
The NHS staff survey is run on an annual basis across the service in England. It is one of the largest staff feedback and benchmarking exercises for any employer in the world and provides deep insights into the views and experiences of our staff. The results provide a significant opportunity to understand our current position and involve our teams in how the report's findings are interpreted and taken forward.

The survey was undertaken during October and November 2020, as per the usual annual timetable. Rather than limiting the survey to a sample, West Suffolk again took the decision to give all staff the opportunity to take part. The Picker Institute acted as our

survey contractor. Just shy of 2,000 staff took part, a response rate of 46%. This was a 6% reduction from the previous year.

The staff survey reports contain a huge amount of data and analysis. The process of absorbing all of its insights and learning is still continuing and this initial overview of our position is just the start, with more to do over the coming days and weeks. Historically, West Suffolk's scores in the staff survey have improved over recent years, and in 2019 were amongst some of the best in the country. This year we have seen a reduction in most of our scores, although many remain well above the average for comparator organisations. In some areas the reductions are small, in others they are more significant. This is concerning and means it is more important than ever to use the survey results to learn and make improvements, together.

The survey report presents the data in a variety of formats, with these ten themes as the headline set of measures with each scored out of ten:



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.9	7.3	6.9	8.1	8.7	9.8	7.4	7.6	7.1
Your org	9.1	6.2	6.9	6.4	7.5	8.0	9.4	6.6	7.2	6.6
Average	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7.0	6.5
Worst	8.1	5.5	6.2	5.6	7.0	7.2	9.1	6.1	6.4	6.0
Responses	1,907	1,920	1,925	1,893	1,707	1,863	1,911	1,903	1,940	1,911

WSFT is above average for five of these, equal to the average for two, and below average for three. The most notable gap between the average and WSFT scores is the 0.2 difference for the 'safety culture' theme.

The safety culture theme incorporates the responses for a number of questions related to raising concerns and reporting incidents, and the level of confidence staff have in doing so, including whether or not action will be taken. There was a significant reduction in the scores for these questions. This includes:

- A 10% reduction in whether staff believe they will be treated fairly if involved in an incident, error or near miss;

- 8% reductions in two scores: staff saying they are given feedback when reporting an incident, and in whether the organisation takes action to ensure it doesn't happen again
- A 6% reduction in staff saying they feel secure to raise a concern about unsafe clinical practice, and 12% fewer staff saying they are confident the organisation would address their concern

Other areas covered by the survey where the reduction in scores is concerning include:

- *Workplace behaviours*: 3% more staff reported experiencing harassment, bullying or abuse from colleagues
- *Senior managers*: the extent staff feel communicated with, and how staff are involved in decisions. The reductions for these scores were 11 and 10% respectively and are now on par with the national average.
- *Immediate line managers*: feeling supported and valued by your line manager, and recognition for good work. These scores reduced by 4-6%.
- *Health and well-being*: the extent to which WSFT takes positive action to support staff's well-being, and feelings of stress at work. These scores reduced by 4 and 7% respectively.

We have already started to share these themes and concerns with staff in a way that does not jump to conclusions around why these changes have happened, rather in a way that invites feedback and comment from staff on this point. Many of the themes appear to resonate with the *What Matters to You* feedback and we will want to be curious as to how any of the actions already put in place and committed to will help.

We will work with different groups, including staff representatives, to ensure that the People Plan is developed further to incorporate the learning and priorities from the staff survey. HR business partners will support each division and corporate directorates to understand their own results and take action.

The Board will be updated as this crucial work progresses, and the support of individual members of the Board in making this a priority over the coming weeks would be greatly appreciated.

Improving recruitment and induction of our Healthcare Support Workers (HCSW)

In December 2020 we applied for, and were awarded, funding (circa £9.5k) to increase our capacity for recruitment activity in relation to HCSW's from NHSEI. This was to enable us to create designated HR capacity for accelerated shortlisting, interviewing and pre-employment checks.

Early indications are that this investment is reaping rewards already; some key successes are highlighted below:

- Application to interview time for HCSW's is running at around 1-2 weeks compared to 3-4 weeks last year
- Reduction in time from interview to start date from 8 weeks last year to 6 weeks this year

- Enhanced Induction capacity enabling a 50% increase in HCSW's attending Inductions held in March 2021 (30 new colleagues, compared to 20 in March 2020)

The additional support enables the recruitment to team to interview more frequently, complete documentation at pace and actively follow-up pre-employment check requirements on a daily basis.

Recent HCSW numbers at one of the Inductions in March 2021 was commented on by Dan Spooner, our Deputy Chief Nurse:

"a big thank you for your hard work as I welcomed 18 HCSW's to the Trust on their Induction yesterday. I have never seen so many new HCSW's in a room before. I know it's a huge process….."

Well-being Guardian

As part of the national NHS People Plan, NHS England have asked all NHS organisations to establish the role of Well-being Guardian. The intention behind this role is for it to provide assurance at Board level through looking at the organisation's activities through a holistic health and wellbeing lens. Their purpose is to:

- question decisions which might impact on the wellbeing of NHS staff
- challenge behaviours which are likely to be detrimental
- challenge the Board to account for its decisions and their impact on the health and wellbeing of staff
- remind the board to consider any unintended consequences of organisational actions and review them with a view to mitigating these.

NHS England state that the role is considered *"best suited to a Non-Executive Director who does not need to have specialist knowledge about wellbeing, but should be confident and competent in their ability to check and challenge the executive team on behalf of the board. Operating in an inclusive manner, the Wellbeing Guardian will actively encourage a dispersed model of wellbeing leadership which engages ownership and advocacy across the organisation, valuing and building upon existing internal resource. As this becomes routine practice for the Board, the requirement for the Wellbeing Guardian to fulfil this role should reduce over time."*

Richard Davies has kindly agreed to take on the responsibility of Well-being Guardian for West Suffolk. My team and I look forward to working closely with Richard to support him in his role and ensure he is fully appraised of all our related plans and activities to enhance and support staff health and well-being.

Gender Pay Gap – annual report

All UK employers with 250 or more employees are required by law to publish their gender pay gap each year on their own and the Government's website. The Trust must publish data for the year ending 31 March 2020 by 30 March 2021. The figures reported below show West Suffolk NHS Foundation Trust's gender pay gap in two ways – as median and mean average hourly rates:

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

In 2019/20 the average hourly rate of pay for women remained lower than that of men but the gradual trend towards narrowing the gap continued. The gap exists because we have proportionately more men in more skilled, senior, higher paying jobs than we have women; in particular amongst senior management roles and medical staff.

The Trust also reports on the gender bonus pay gap. A bonus is any remuneration that is in the form of money, vouchers, securities or options and relates to profit sharing, productivity, performance, incentive or commission. Our gender bonus pay gap was:

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

The gender bonus pay gap exists because proportionately more men than women receive the highest level of the highest paying bonuses (i.e. Clinical Excellence Awards (CEA) made to consultant medical staff). 54% of the 85 men receiving bonus payments were consultant medical staff in receipt of CEA, whilst only 18% of the 234 women receiving bonus payments were consultant medical staff in receipt of CEA. The board agreed in 2020 that the overall bonus GPG figures were not particularly helpful for identifying or monitoring the equality of payments made to men and women.

However, it was agreed that further monitoring of the award of CEA was of value. To remove the bonus gender pay gap in the award of CEA we are aiming for an equal number (consistent with the representation of males/females in the consultant workforce) and an equal spread of levels of award amongst male and female recipients. At 31.3.20 female consultants made up 47% of the consultant workforce and 47% of those receiving CEA were female. Overall, therefore, the award of CEAs to women was proportionate to their representation in the consultant workforce.

Education Report

The attached Education Report provides Board members with an overview of how West Suffolk is currently delivering against one of our key organisational priorities – that of

education, training and development for our existing people and contributing to developing the NHS workforce of the future – in line with our strategic framework.

Recent Consultant Appointments

Post:	Consultant General Surgeon (Upper GI sub-specialty)
Interview:	4 March 2021
Appointee:	Mr Krashna Patel
Start date:	26 July 2021
Current post:	Post-CCT Surgical Registrar (Oesophago-gastric cancer / Benign UGI) Mid and South Essex NHS FT: October 2020 - present
Previous Position:	
October 2019 – October 2020	
ST8 Surgical Registrar – Luton and Dunstable Hospital / Hammersmith Hospital	

Jeremy Over
Executive Director of Workforce & Communications
March 2021

Item 12 – Psych report

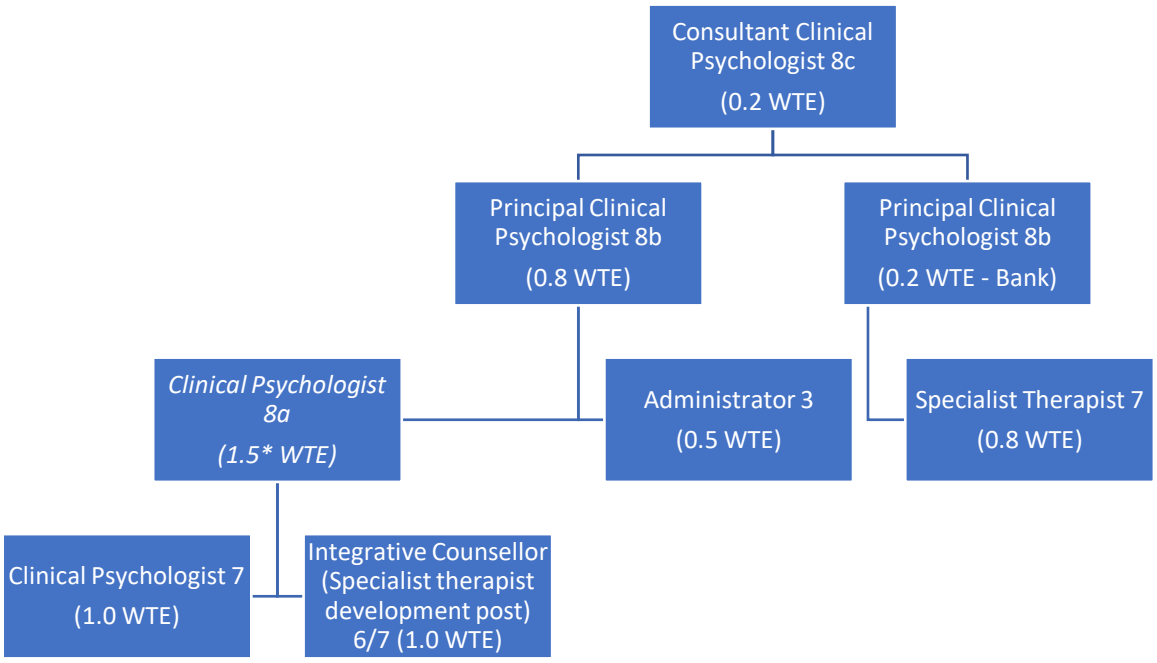
Background

The Trust has been working on a proposal for clinical psychology support for staff since June 2019 and was in a strong position to respond rapidly to the needs of staff at the start of the pandemic as it already had a model to implement. This was put in place from 1st April 2020. The team was initially staffed by 2.0 WTE clinical psychologists and clinical psychology trainees redeployed from acute paediatrics and 0.2 WTE from a clinical psychologist within the pain team.

As the scale of the impending pandemic became apparent, the need to adapt the model to take account of the acute risks of trauma and burn out on staff became clear. In July 2020, TEG agreed to fund an enhanced staff support team so redeployed staff could return to their posts and agreement was given to start recruiting to fixed term posts. From July to October 2020 the staff support team consisted of 1.6 WTE, made up of 1.0 WTE consultant clinical psychologist and 0.6 WTE trainee clinical psychologist, as other staff returned to their previous roles.

We were able to recruit additional staff via West Suffolk Professionals to support the service whilst recruitment took place to the funded posts.

Current Structure



**Includes 0.5 WTE My Wish funded post – neither are yet in post*

It was difficult to appoint to one-year fixed term posts, so all posts were converted to two-year fixed term. One Band 7 post was filled with a development post, as unable to recruit enough existing Band 7 staff.

The service has required significantly more time than the 0.2 WTE 8c time and the 8b employed through the bank has flexed upwards in hours whilst still waiting for the 8a to come into post.

In addition, we successfully bid for 1.0 WTE Band 7 post from charitable funds specifically for disadvantaged groups, but converted this to a 0.5 WTE 1 year 8a post due to difficulties recruiting to Band 7 roles. This post will be funded by My Wish as they have received the funding we bid for.

Model

The model and approach for the staff support team was based on the recommendations from the Healthcare Workers Welfare Group, the Intensive Care Society and the Trauma Group, all of whom published recommendations identifying staff who were likely to be at most risk of psychological harm and effective interventions to address this.

The staff support psychology team was one part of the overall wellbeing and staff support offer from the Trust and would not have functioned effectively without the broader offer of free parking, free hot drinks, calm rooms and break spaces, hot food available at night, free accommodation for staff needing to live apart from clinically vulnerable family members, chaplaincy and other Trusted Partners ongoing provision, Human Factors, Occupational Health and HR support. Regular wellbeing and workforce meetings were held to ensure a coherent framework was established and to avoid duplication of effort and the team were embedded within the broader health and wellbeing structure.

Summary of support offered by the Staff Support Psychology team:-

- Individual sessions for psychological first aid, advice and practical coping strategies
- Development of posters, leaflets and teaching resources to support coping strategies
- Development of resources and information for the intranet site
- Individual therapy and counselling
- Team sessions on normal responses to trauma and signposting to support available
- Support and coaching for managers to support their teams
- Proactively engaging with teams from 'at risk' groups/areas – attendance at handover, 'drop-in' sessions offered on wards, session from team as part of induction, working with the housekeeping team to deliver leaflets to all staff residences on site etc.
- Reflective practice 'team time' sessions
- Wellbeing Wednesdays webinar sessions and Green Sheet articles to maximise access to psychological advice and coping strategies
- Virtual coffee lounges aimed at reconnecting those working from home, although these were not well attended (max 6 attendees and often 0-2) and so replaced with Wellbeing Wednesday session specifically for this group
- Supporting staff to attend HR and other formal meetings
- Support following clinical incidents for teams and individuals

The initial strategy and teaching sessions on normal responses to trauma were developed from slides prepared by colleagues from CPFT based at Addenbrookes and from colleagues at NNUH, as well as from resources and literature shared by colleagues within clinical psychology professional networks.

The Trust library team also supported the development of the service by continuing to review relevant literature and pass on updates of best practice that were incorporated into the model. Learning from the Human Factors Leads and from the 'What Matters To You' work were also included in the model, with practice being adapted to meet needs and respond to feedback.

We have aimed to be a visible, accessible and effective service that promotes that it is 'okay to not be okay' and tackles the stigma around mental health and wellbeing. We have proactively sought out the groups of staff identified as being most at risk and least likely to access services and worked with all divisions across the Trust to ensure equality of access.

Who has made use of the service?

By 5th March 2021, the service had seen 550 members of staff for individual sessions (ranging from one off sessions to twice weekly appointments over a period of 6 months, depending on need). In addition, the service had delivered 135 sessions for groups, committees or teams (ranging from one off teaching sessions on normal responses to trauma to ongoing, regular team reflective practice sessions). The Wellbeing Wednesday webinars have been watched by over 600 people.

Members of the team have also run regular drop-in sessions for particular wards and areas and attended handover in ITU every weekday morning to provide on-the-spot support to staff redeployed into those areas and the leadership team.

The data below is based on the first 500 members of staff and the first 120 group sessions.

Demographics	Seen by team	Whole staff team
% of Males	12.5%	19%
% BAME	11.5%	12.6%

Professional group	% of all individuals seen by team	% of total workforce
Prof, sci and technical	7	3
Additional Clinical Services	17	21
Admin and Clerical	7	21
AHPs	9	8
Estates and ancillary	8	9
Healthcare scientists	1	1
Medical and dental	16	10
Nursing and midwifery	36	27

Professional group	% of total staff in that professional group who have been seen by team
Prof, sci and technical	17
Additional Clinical Services	10
Admin and Clerical	4
AHPs	11
Estates and ancillary	7
Healthcare scientists	5
Medical and dental	17
Nursing and midwifery	14

Division	% of total number of individuals seen by team	% of group sessions run by team	% of total workforce that are from that division
W&C	11	7	8
Surgery	24	22	17
Medicine	23	27	25
Community	17	24	20
Clinical Support	9	7	12
Corporate	10	11	10
Estates and Facilities	6	2	8

Division	% of total staff from that division who have been seen for individual sessions
W&C	16
Surgery	15
Medicine	10
Community	9
Clinical Support	7
Corporate	11
Estates and Facilities	5

Key findings:-

- We have seen staff from every division, broadly in line with the proportions of staff from each division when individual and team support is taken together.
- Clinical staff groups are slightly over-represented (particularly medical and nursing and midwifery staff) and admin and clerical staff are under-represented (possibly due to not coming into direct contact with COVID patients as more likely to be working from home).
- We have a lower ratio of men to women using the service than the ratio in the workforce but this may be explained by 42% of individuals using the service being registered nurses or nursing assistants, who are more likely to be female than male.
- W&C directorate have accessed more individual support, the vast majority of which has not been COVID related but related to service model changes as well as CQC and HSIB pressures. They also already had psychology embedded within the directorate and knew how to access support from the start of the pandemic.
- Community have accessed more team sessions than individual sessions, which broadly reflects the way they work as the whole team are involved in individual cases, rather than end of life care only being supported by an individual member of staff.
- Surgery was targeted for support in the first wave as this is where ITU sits and where staff were most likely to be redeployed (a risk factor for psychological distress)
- Medical wards that became COVID wards were also proactively targeted for support but only once staffing allowed for this
- Clinical Support make up a larger proportion of the workforce team now that pathology has come back 'in house' and team sessions are now being organised
- Estates and facilities remain under-represented and steps still need to be taken to proactively engage with some groups of staff, particularly men

Of those seen for individual appointments, approximately 20% have required therapy and approximately 50% had only a single appointment. The remainder had less than 6 appointments and often just an extended assessment with advice, or a few ad hoc sessions over the course of the year.

What have the main themes been from those using the service?

Single appointments were more common at the start of the pandemic with redeployment, panic symptoms and concerns about PPE being the most common presenting issues. Exacerbation of previous mental health difficulties caused by lockdown restrictions became more common as the first wave eased and exhaustion and moral injury have been key themes from the later stages of the pandemic. Staff have also consistently used the service to access support for issues that are unrelated to work or to seek support with non-COVID related work issues.

Presenting concerns that triggered individuals to seek support from the team fell into three broad categories:-

1) COVID related – managing panic, adapting to mask wearing, needle phobia around vaccination, having COVID themselves and fear of dying, 'long COVID' and ongoing symptoms, COVID related bereavement, trauma from treating COVID patients and witnessing increased numbers of deaths, moral injury, shielding and fear of returning to work places etc.
2) COVID plus other stressors – pre-existing mental health difficulties exacerbated by not having access to usual coping strategies due to lockdown, redeployment plus difficult homelife so loss of access to normal support structures, parents needing admitting to care homes and unable to view/visit due to COVID restrictions, juggling work and home-schooling, adjusting to own physical health and COVID changing perceptions etc.
3) Not COVID related – CQC and HSIB worries, anxiety related to state of the roof, support after non-COVID related clinical incidents, support during HR or other formal processes, pre-existing departmental challenges, non-COVID related bereavement, relationship breakdown, significant life events (road traffic accidents, relative in prison, rape, miscarriage etc.)

Whilst the vast majority of group interventions were focused on groups 1 and 2, individual sessions were 24% purely COVID related, 37% non-COVID related and 38% a mix of both.

Experience of service feedback

The public health team co-ordinated an experience of service survey via Survey Monkey, which staff were encouraged to complete through all the usual communication channels. 42 people completed the survey and key results are highlighted below. The full report is included as an appendix.

Accessibility – 79% of respondents reported that the service was easy or very easy to access, with a further 19% saying it was neither easy nor difficult. Only one respondent found it difficult to contact the team, commenting on no-one answering the telephone when they called.

"I think it's good how here are lots of different methods to access the service as one does not fit all and different people want to use different methods e.g. bleep, drop in, email"

Responsiveness – 75% reported that when they first contacted the service they got a reply either quickly or very quickly, with nearly 70% having a response either the same day or the next working

day. Only one responder thought the response was slow and reported they had a response within a week.

"Very easy to contact and they always reply and make themselves available to you"

Helpful – More than 80% of the respondents reported that their contact with the team was either helpful or very helpful. Three respondents reported that the contact was very unhelpful but of those, all three stated they would recommend the service to a friend or colleague. Two reported that although the initial contact was helpful, the wait for therapy was not. Two respondents reported they would not be at work if it were not for the support of the team.

"*They helped me during a very personally stressful time. Wonderful to get support just when I needed it"*

95% of respondents said they were likely or very likely to recommend the service to a colleague or friend. Themes included that the team were good listeners, patient and understanding and had given people practical skills and coping strategies.

Through the Trust or elsewhere? – 97% thought it was a good idea to have this support through the Trust with comments mentioning that this made it possible to fit in or around work. Responders also mentioned it was good to have support from a service that knows what it is like to work within the Trust and understands the challenges of healthcare.

The team have also received feedback from managers who report that the support has enabled staff to return to work sooner than they would have done previously:-

"*I expected x to be off for 6 months as that is what usually happens when people are signed off with stress and anxiety, but with your support they were back at work after 6 weeks*"

<u>Effectiveness</u>

Formal outcome measures for therapy are being implemented and will be available for the next report, however, some of the achievements of the team include:-

- Supporting members of staff who were off work with anxiety related sick leave or stress/burn out to return to work.
- Continuing to support 6 members of staff with 'long COVID'.
- Providing support and on-the-spot psychological first aid to enable members of staff to stay in work – particularly during the acute phases of the pandemic.
- Supporting 4 members of staff who were actively suicidal or had taken overdoses to access appropriate mental health crisis support and linking them in with ongoing MH care
- Providing evidence based therapy for staff with PTSD symptoms, depression, anxiety or OCD following their work during the pandemic
- Supporting whole teams through the challenges of having colleagues in ITU and the loss of a friend and colleague

Mental health accounts for 25% of sick days in the NHS nationally and represents 19.3% of our Trust's pre-pandemic sickness rates. During a pandemic you would anticipate that this proportion would increase. However, comparisons between sickness rates due to anxiety in January 2020 (pre-pandemic) and January 2021 (peak of pandemic) were also favourable, with 14.66% of staff being off with anxiety or stress in 2020 and 14.74% in 2021. This could be explained partly by presenteeism,

but a stable trend during the pandemic is the opposite of what might be expected during such a stressful period and therefore indicates that staff are benefitting from the provision of support from the team. This rates of sickness in medical staffing associated with mental health is also interesting in that it falls from 5.62% of the total mental health related sickness in 19-20 to 5.05% in 20-21. This is a group of staff where 17% of them have made use of the support from the team.

Next steps

The team continues to adapt to the changing phases of the pandemic. During the next few months, as we pass the end of the current wave of the pandemic, the focus will be more on the provision of therapy. People have not yet had time to reflect on their experiences and so the psychological distress and trauma symptoms are likely to increase over the next few months. Further members of the team are being trained in EMDR to be able to respond to the predicted demand.

We currently have 50 people on the therapy waiting list but anticipate this will reduce rapidly once the final members of the team are in post. Only three of those waiting for therapy would meet the criteria for the NHS Mental Health hub (which has to be purely COVID related trauma/distress).

In addition to the focus on therapy, the team are also involved in the development of the following interventions:-

- Buddy and peer support schemes (through the ICS and by making use of experts by experience)
- Establishing therapy groups to link staff with others with similar experiences (e.g long COVID)
- Schwartz rounds (together with the Human Factors team and Nursing Lead for MH)
- React training for managers (to equip managers to confidently have mental health conversations with their team)
- Support in stressful times support (jointly with the Better Working Lives group)
- Engaging with disadvantaged groups (working with newly appointed Inclusion and Diversity officer in HR)

We will also be embedding the use of pre and post therapy measures in order to provide a report on the efficacy of interventions and standardising our consent and contact details forms in line with those used by similar services across the region.

Challenges

Throughout the past year, the main challenges have been around the logistics of setting up, recruiting to and delivering a new service, in a short space of time and during a pandemic. Whilst capacity will improve as the team grows and is fully staffed, room space (both for offices and spaces in which to conduct assessments and therapy) becomes more of a challenge. Thanks go to the team at the education centre and particularly to Denise Pora for facilitating access to office space, therapy rooms and equipment. The IT team have also been incredibly supportive and enabled timely access to laptops, webcams and mobile telephones in order for the team to function efficiently.

Manning an office base whilst also responding to the needs of staff was also problematic, leading to delays in responding to a small minority of people. However, this should be resolved now that the administrator is in post.

Some staff would have struggled to access support if it were not available close to their work areas and so we were grateful for the provision of a room in the F2 corridor during the first wave of the pandemic and for the provision of an office in the operational directorate thereafter. Being centrally located and close to Time Out improved access for the majority of staff on the main hospital site but some staff felt it did not protect confidentiality as it was in the same location as senior staff offices and did not have a private waiting area.

Attempts were made to offer appointments in community basis but these were not well used as community staff spend the majority of their time out in the community. The use of Microsoft Teams and telephone support was often preferred by community staff, many of whom felt they would not wish to have appointments in their locality base in order to put some separation between the therapy and their routine work. Community managers worked hard to ensure their teams knew about the service and were encouraged to make use of it, often booking whole team reflective practice sessions following difficult clinical experiences.

Redeploying staff from acute paediatrics and the call on the consultant clinical psychologist's time in order to meet the demand within the staff support team has led to a reduction in service and support for acute paediatrics. This was highlighted in the Better Working Lives survey where wellbeing support was experienced as being less available during the pandemic for paediatrics, which was the opposite of what was reported for all other areas. This needs to be addressed if the staff support team is to be made substantive.

Decisions for the Board

As we approach the end of the first year of running the service, questions arise about what the Trust plans to do. The original bid was for a two year 'core team' plus one year of specialist therapy provision. This was converted to two years of both aspects of the service, due to challenges in recruiting to one year fixed term posts. Decisions need to be made as to whether to continue the team beyond it's initial two year term.

As we move beyond the acute phases of the pandemic, the needs of staff and the levels of demand for the service are likely to change. The provision of national and local services specifically for COVID related trauma and mental ill health of health and social care staff also changes the potential remit of the service, so as not to duplicate services that are already available within the health and social care system.

The newly established Mental Health hub for health and care staff will only deal with COVID specific challenges or trauma and so 76% of the individual work undertaken by the staff support psychology service would not have met the criteria for access to the National provision.

Suffolk Wellbeing continue to 'fast track' all health and social care staff, for support with anxiety and depression, but are only offering telephone and virtual sessions currently and is manualised treatment that does not take into account the specific needs of healthcare staff, nor understand the nuances of WSFT. Despite 'fast tracking' response times are much longer than the same day, next working day response that the staff support psychology team has been able to offer. Only approximately 20% of those seen for individual appointments required psychological therapy and so

the vast majority of individuals seen would not have met the criteria for therapeutic support from the wellbeing service.

Suffolk MIND run a 24/7 text support service and a daytime telephone support line which staff are directed to for out of hours support and NSFT runs a 24/7 acute mental health crisis service. The staff support psychology service has not aimed to replicate this provision.

Medical staff and staff at 8d and above can access psychiatric assessment and support from NHS Practitioner Health, but this is not available to other staff groups.

All staff can self-refer for counselling via Care First counselling but this is not the same as access to Clinical Psychology. Access to therapy from a clinical psychologist was previously accessed via Occupational Health and charged per session to the Trust.

Despite the increase in provision of mental health support for health and social care workers both locally and nationally, the vast majority of those seen by the staff support psychology team would not have met criteria to receive support from these services. Many also stated that they would not have wanted to be seen by mental health and wellbeing services due to perceived stigma or difficulty accessing support around their work commitments.

The numbers seen for individual appointments by our staff support service (550) are broadly in line with the 600 individuals seen by colleagues at Queen Elizabeth King's Lynn during the same time frame. QEKL had a larger clinical psychology service already established in the hospital in both adult and children's services and so were able to mobilise a larger team of staff, rather than have gaps in service whilst they recruited to staff support posts and were already embedded within more team, leading to increased uptake of the service (as is true for our W&C divisional staff).

Future Vision:-

The staff support psychology service continues to provide unique and well received support for employees of the Trust, in line with best practice guidelines for staff wellbeing. It is accessible, responsive and effective. The establishment of the team is evidence of the Trust's commitment to the health and wellbeing of its staff and was envisaged prior to the pandemic as a way of supporting staff through stressful times.

Over next 5 years, the Trust should work towards a structure that embeds psychology in to divisions as part of routine clinical care for all patients as well as meeting staff wellbeing needs. As the needs of staff decrease beyond the pandemic, the staff support psychology team could be redeployed to divisional posts that flexibly meet the needs of both patients and staff. This embeds mental health and wellbeing as part of physical health, not as a separate service, and makes the posts more attractive for clinical psychologists. This would also be in line with the strategic direction of the Trust and should be reflected in plans for the new hospital.

Item 12 - Education and Training Report

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

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

Undergraduate Medical Education

- The Cambridge Graduate Course in Medicine continues to thrive at the West Suffolk Hospital. 40 students started at the end of September 2019. The current final years are firmly embedded on the medical and surgical wards, and in the Emergency Department. After their finals in April they will return to the Hospital for their Apprenticeship Block, during which students get to practice the skills needed to transition to their Foundation jobs. This has proved a very successful attachment. Two new CGC Tutors have been appointed – Dr Jon Buckler and Dr Katie Keller.

Postgraduate Medical Education

- **Panopto & Bridge – blended learning platform**
  HEEoE has procured a suite of software packages (Panopto and Bridge) to enable the creation and storage of video lectures and to self-build online courses for all Postgraduate Medical Specialties within the EoE. Supporting Doctors in Training by giving Trainees access to resources giving them the very best tools to manage patients on the ground, in one central, secure, online space. Currently free to all FY1/2, SAS and LED Drs. A cost will be linked to this next year for SAS & LED Drs.
  Panopto is the regional teaching Video Library for trainees to view recorded training/teaching events across all specialties.
  Bridge holds material on regional teaching events for any specialty in the EoE allowing trainees a one stop shop to register for events.

- **Foundation Weekly Teaching**
  Continues to be delivered via TEAMS with a room available in Education Centre for trainees to use. 'Face to face' teaching resumes on 16.03.21 with cameras allowing simultaneous face to face - remote sessions to take place. Sessions are recorded and uploaded on to 'Bridge/Panopto' enabling trainees access at a convenient time.

- **Communication Courses**
  Discussions around local courses delivered by HEE for IMT/LEDs around communication would benefit our overseas doctors. HEE agreed this would be possible and the trust hope to initiate soon.

  The SAS College Tutor, Dr Zulieka D'Souza has already pencilled in 3 'Communication Skills/Team Working/Collaborative Working' courses to run by end of May.for our LEDs/Clinical Fellows/Senior Clinical Fellows/Non-training Grades.

- **Reporting to HEEoE**
  One incident reported on up to October 2020. This was regarding an act of conduct and professionalism. Not patient safety concerns. This is an ongoing HR investigation.

Nursing, Midwifery and Allied Health Professionals

- **Quality Performance Review (QPR) and student feedback**
  An updated report was sent to HEE in December who replied that no further actions were required at that time. The next report update is due by the 30th April.

- **Pre-registration Programmes**
  We have continued to support multi-professional pre-registration students throughout the Covid pandemic. During the first wave in 2020 the WSFT supported AHP, midwifery, adult (2nd year and 3rd year) and child students during paid placements. All of these students remained supernumerary within the workforce and were given excellent support by the clinical teams. We did not receive any concerns from students during this time. We continue to support 20 x 3rd year adult and child nursing students (to support wave 2 of the pandemic) on paid placements (as per NMC guidance). A weekly teams meeting is available to all students to provide an opportunity to talk about experiences, discuss challenges and share good practice in a safe environment.

  First year adult and child nursing student placements have been delayed and these students will commence clinical placements in April 2021. This will provide a challenge for the placement areas as all universities will commence the placements at a similar time leading to an influx of students. Capacity has been reviewed and resulted in an increase in student allocation in a few areas. We will be able to manage all students at this time but will also monitor experience and feedback from both the student and clinical teams.

  Most universities are reporting an increase in applications for healthcare courses which will hopefully result in an increase in numbers starting in September 2021 and early 2022.

- **International Registered Nurses**
  We continue to recruit nurses from Africa, the Philippines and India as well as supporting our own nursing assistants with an overseas nursing qualification (2 in early 2021)

Induction month (cohort)	Number of staff	Number who have passed OSCE
December 2020 (18)	5	4
February 2021 (19)	4	March 24th,30th and 31st
March 2021 (20)	5	TBC
April 2021 (21)	5	TBC
May 2021 (22)	5	TBC

The OSCE programme has been adapted to meet the challenges of Covid but exam pass rates remain consistent.

- **Student apprentice nurses (4 year)**
  Our cohort of 11 student apprentice nurses undertaking the 4-year programme have now completed over 50% of their programme. They are all enjoying the programme and have been well supported by the clinical areas. HEE is investing money into the 4-year programme and the organisation is scoping interest in supporting further cohorts. The WSFT has been allocated funding to support 8 new apprentices on the 4-year programme and we are currently scoping areas that have the capacity to support either an internal or

an external apprentice. Vacancies will be advertised via NHS jobs with a view to starting with the Trust in July 2021.

- **Non-registered workforce**
  As part of the HEE ambition to reduce Nursing Assistant vacancies. WSFT have received funding from HEE to support our new non-registered workforce. This funding will be used to support the secondment (6 months) of 2 x band 3 healthcare support workers to work alongside all new HCSWs to provide support, education and assess competence. This will hopefully better support our new staff and reduce attrition rates within this staff group. The band 3 HCSWs will start their secondment in April 2021. Additional HR support has also been sourced as part of this HEE ambition to improve onboarding of NAs

Support Workforce/Other Staff Groups

- **Apprenticeship levy:**
  The Trust is now able to commission apprenticeship training, which allows the education provider the opportunity to draw down the cost of the training from the Levy. We have 94 live apprenticeships and 28 apprenticeships have been paused because of COVID-19. WSFT staff are participating in19 different courses and we are working with 13 providers. 43 learners have completed their apprenticeships.

Priority 2: Invest in quality, staff and clinical leadership

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

- **Postgraduate Medical Education**
  Royal College Tutor Roles
  - MEDICINE - Dr Suresh Mohanraj replaced Dr Mark Sykes wef .
  - Assistant CT (trainee role to support CT Medicine) - Dr Preethi appointed on 01.02.2021
  - Anaesthetics – Dr Vanessa Johnston replaces Abigail Hallett wef 01.02.2021
  - Surgery – Mr Ami Mishra replaced Miss Lora Young wef 01.04.2021

- **Physician Associate Learning Facilitator**
  Dr Shubhada Sinha successfully appointed on 01.02.2021, working with Dr Wasim Huda. 3 Physicians Associates students are returning to trust on 12th April and 4 new Physician Associate students starting on 19th April. Both groups will receive an induction and placements organised at various departments within the trust. **#**Additional measures are in place, as for substantive staff, to cover COVID such as risk assessments, training, PPE, COVID induction and signposting to Psychological Support/Intranet for support.

- **Clinical Attachments/Electives**
  Reconvene on 01.04.2021 with additional measures in place (as above**#**).

- **Simulation Training for Junior Doctors**
  A mixture of simulation options is offered as part of the trainees training programme to enhance learning via the Clinical Skills Team. HEE EoE provides a day of hi-fidelity simulation, and trusts provide core skills training, as well as other simulation opportunities. Each trainee must have 3 days of simulation-based training per year, made up of Virtual Reality (VR) simulation, trust based clinical procedures sessions, hub events and hi-fidelity simulation (the 3-day requirement has been relaxed for ARCP this year due to COVID). All are available to LED F1/2 trainees which have been very well attended and feedback following sessions has been very encouraging.

- **Foundation Quality Assurance Group**
  Consists of FY1/2 and LED Drs, DME, FTPD & MEM to discuss issues, highlights, concerns and offer support/guidance whilst at the trust. This have been particularly useful for conveying information amongst trainees. These occur once a month via TEAMS.

- **HEE East of England Quality Review Report**
  From virtual visit 2020. This was triggered by the CQC report and newspaper reports about difficulty raising concerns. Further improvements will be submitted again by 30th April.

- **Re-Deployment of Trainees (18th Jan – 15th Feb 2021)**
  To assist ITU during height of pandemic an additional 5 trainees were moved into ICU with a further 5 trainees moved to backfill those posts. All received an induction and assigned a Clinical Supervisor. This was well received by trainees and departments.

- **Education/Clinical Supervisors Training**
  Is being provided online via video pack or e-learning through HEE. A spring conference by HEE starts 15th March with the first day is for ES & CS. Registration is via the HEE website

- **Educational Supervisors for Trust Grade FY2 & LED Doctors**
  Following successful implementation of Educational Supervisors for FY2 LED doctors this has been rolled out again this academic year. ESs act as a mentor, role model, careers advisor and source of support including using the electronic e-portfolio system to record evidence of competencies. Recruitment of more ES will be necessary to fulfil this role for our FY2 LED Drs moving forward.

Nursing, Midwifery and Allied Health Professionals

- **CPD funding**
  Our CPD allocation for 2020/2021 (£499,667.00) has been fully allocated and we are waiting for confirmation of funding for 2021/2022. The electronic application portal is working well and an approval group has been established to review all applications every 2 weeks.

- **In-house programmes**
  The majority of these were postponed due to Covid however these are being reorganised for 2021. The Expert Navy programme recommenced in March 2021 with further cohorts planned for April and September. The AHP Aspiring Leaders programme will start in April 2021. It has been difficult to manage the preceptorship programme for newly registered practitioners but we are utilising the HEE accelerated preceptorship programme and providing additional support in the form of drop in sessions and teams meetings.

Support Workforce/Other Staff Groups

- **Mandatory training**
  In March 2020 significant elements of mandatory training were paused due to the COVID-19 crisis. Trust overall compliance for mandatory training was 89% in March 2020 87% in March 2021. The Trust reinstated single session refresher mandatory training in August for manual handling, basic life support (BLS) and conflict resolution. All other mandatory training subjects can be completed via eLearning. All face-to-face training was stopped on 6th January 2021 and will be resumed from 5th April. E-learning options have been introduced for BLS and manual handling as a temporary alternative to face-to-face training.

  Managers are being supported to manage their staff's mandatory training compliance through notification reminders via ESR informing them when their staff's mandatory training is due to expire and has expired. This new process was introduced in September.

- **Staff, management and leadership development and talent management**

Local and national leadership development programmes were paused in March 2020 due to the COVID-19 pandemic. Some on-line development workshops are available and the range of options is being increased in the coming months. A task and finish group has been set up to ensure that, when it is restarted in full the programme will reflect the feedback from the What Matters To You staff engagement process around the importance of supporting all managers, particularly those who are new to the role.

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

The Trust continues to support the Graduate Management Training Scheme as an element of our talent management strategy. We currently have one Management Trainee from the March 2020 intake on placement in Medicine and will be bidding for a trainee to join us as part of the September 2021 intake.

The 5 O'clock club has met regularly via Microsoft teams, which is proving to be popular with staff and 60+ people are participating in sessions, which is more than generally attended when sessions were face-to-face. Speakers since October have been Dr Chris Turner who leads the 'civility saves lives' movement, Nigel Parsley, HM senior coroner for Suffolk and Professor Megan Reitz who spoke on speaking and listening up.

- **Library Services**
  The Trust library has remained open throughout the COVID-19 pandemic and provided a modified service for users, for example supporting journal clubs and providing database search training via MS Teams rather than face-to-face. Additionally, it has acted as a wellbeing hub for staff with access to free hot drinks and snacks. The Library annual report is attached.

Priority 3: Build a joined up future

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

Nursing, Midwifery and Allied Health Professionals

- ***Health and Care Academy***
  Since September 2020 the WSFT has been hosted both senior and junior academies

Cohort	Number attending	Age range	Number of different career interests
Senior 1	10	17 – 19	4
Senior 2	11	16 – 22	5
Senior 3	17	16 – 18	10
Junior 1	69	16 – 18	10

Another 3 academies are planned in partnership with Thurston Community College, Thomas Gainsborough High School and Kings Edwards School. Data is collected before, during and 1 year after attendance at the academies to track students' pathways into healthcare careers.

Next steps

- Continue to implement improvement plan and review at pre-registration meeting in April
- Scope all areas regarding possibility of further student nurse apprenticeship (4 year) cohorts

- Continue to review student placement capacity on a three-monthly basis especially areas that may be closed or reopened due to Covid
- Ensure all areas are supported with pre-registration student activity when first year placements recommence
- Continue to support overseas OSCE programme
- Continue to promote health and care academies

West Suffolk Library Annual Report April 2020 to March 2021

This report covers the period 1st April 2020 to 31st March 2021.

The Library and Information Centre is referred to as the Library, West Suffolk Foundation Trust as WSFT, Health Education England as HEE. Library and Knowledge Services are referred to as LKS.

Quality Assurance

In 2019/20 HEE replaced the Library Quality Assurance Framework with the Quality and Improvement Outcomes Framework (QIOF) which signals a step change to help LKS staff both to improve service delivery and to better articulate the positive outcome of our work.

The QIOF makes a fundamental shift in emphasis focusing on outcomes rather than process, and it places a responsibility on the organisation served to also demonstrate that it recognises the business-critical role of LKS in mobilising knowledge and evidence to enable healthcare staff to deliver the best quality care to their communities. Part of that recognition is providing adequate resourcing and senior stakeholder engagement in the strategic development of the service.

Due to the pandemic, our QIOF submission has been postponed until September 2021. We continue to gather evidence for our first baseline assessment later this year.

Impact of Covid-19 on core library services

We encountered many barriers to home working, particularly around securing remote access as we are not fully on the trust network. These issues were not suitably resolved until August 2020.

However, we continued to offer a full virtual service throughout the pandemic.

We delivered evidence summaries to key Covid teams such as the Clinical Ethics Advisory group and the Core Resilience Team (CRT), as well as to staff and students across acute and community teams.

Library users would have seen little disruption to the service, other than being requested to contact us via email only, at times.

Workforce

There were two vacant posts in 2020 which were eventually filled in October/November 2020, which necessitated the Trust Librarian and Deputy Librarian covering the vacant posts as well as their own roles for several months.

Currently, there are two members of the team on site each day, in different locations to observe social distancing and to deal with any tasks that require a person on site, the rest of the team work from home. This is rotated on a weekly basis.

HEE offered a comprehensive CPD package to all library staff in 2020 and members of the team took advantage of this free online training and continued to attend online regional meetings to stay in touch with the regional network.

Online resources

Demand for online resources increased significantly during 2020, and this is reflected in an increase in OpenAthens accounts (888) and KnowledgeShare accounts (1016).

HEE also invested in further online resources:

- Kortext – a national collection of e-books covering a wide range of clinical topics
- Confirmed the subscription for BMJ Best Practice will continue indefinitely
- Purchased a national subscription to Oxford Handbooks Online to commence April 2021
- Purchased a national discovery system, due to go live September 2021.

HEE are also in the process of procuring a new library management system and we have participated fully in all engagement sessions to ensure we receive a product which is fit for purpose. The same system will be used across several regions in England, which will significantly improve the service for our users.

Mobilisation of knowledge and evidence

We have played a central role in mobilising knowledge during the pandemic:

- Member of the Clinical Ethics Advisory group, providing evidence, drafting the Terms of Reference and contributing fully to ethical discussions.
- Collating the huge amount of government and scientific information in relation to all aspects of the pandemic and producing information updates for the Core Resilience Team, Infection Control and Tactical.
- Delivered monthly evidence bulletins for managers and leaders, equalities, nursing and mental health, and created an Advancing Practice Bulletin to support the new advancing roles programme within the Trust.
- Planned and delivered workshops for What MattersToYou.
- Supported staff across the organisation with timely evidence summaries, synthesising and ranking the evidence to save them valuable time.
- Embarked on an ambitious project with IT to migrate all Library computers to the trust network. The partial migration to the trust network and the addition of two more laptops has improved our ability to run a virtual service for users.

Financial resources

We continue to rely on the Co-Medical Education and Training Committee (CMET) for tariff funds to purchase subscriptions to online resources, such as:

- Clinical Skills
- KnowledgeShare
- MAG Online library of nursing and AHP journals
- BMJ Case Reports
- Royal Marsden online
- Anatomy TV

CMET also funded six new computers for the Library in 2020, installed with Windows 10 and Office 365 which has greatly improved the IT provision for our library users.

The Library budget was used to purchase books and journals to support clinical practice and leadership skills, but we have also focussed on our special collections this year, Health and Wellbeing, Mood Boosting and Equalities, to support staff wellbeing.

We also gratefully received new furniture from My WiSH comprising four easy chairs, a coffee table, a selection of games and four new study tables, as we are a designated wellbeing hub for staff.

Alignment of LKS to the Workforce team

Prior to 2020, the Library sat somewhat uncertainly between the Medical Director for funding and HR for line management. Now that we have been brought firmly into the Workforce team we have greater engagement with senior stakeholders, deeper involvement in workforce projects and the opportunity to invite senior stakeholder engagement in setting our future strategy.

Reset, recovery and risks, post-Covid

Resumption of face to face services – we will reintroduce a full face to face enquiry service by Easter 2021.

Students on placement – many students were unable to take up their placements during the pandemic. Preparation for their return in 2021 will include overhauling our inductions and ensuring they are suitable for online transmission.

Training - we have continued to offer online 121 search training, but our remaining courses, Health Literacy, Medical Terminology, Critical Appraisal and Writing for Publication will need to be adapted to an online format.

Evidence searches - our online search interface, known as HDAS, will cease at the end of 2021 as NICE will no longer fund its maintenance and development. This means we will have to learn how to use the native interfaces of nine databases for both our own searches and for teaching library users. HEE has arranged some training with more to follow in 2021, but this will be a step change for the library service and will coincide with the launch of two additional major IT projects for 2021.

New IT projects – a national discovery service and a new library management system. Given that we are not fully migrated into the trust network, this will mean working in partnership with the IT team to ensure minimal disruption to the service for users.

Team resilience - we are proud of the fact that we continued to offer a full library service through out the pandemic when several NHS libraries closed completely. We coped with almost constant changes to the way in which we deliver services as well as changes to the physical library with social distancing measures. This has taken a toll on our physical and mental wellbeing at times, but we will continue to access support, within the team and externally when necessary, and to provide a high-quality library service for our staff and Alliance partners.

13. Quality, safety and improvement reports

To APPROVE the reports

Presented by Susan Wilkinson and Nick Jenkins

13.1. Maternity services quality & performance report

For Approval

Trust Open Board – 26th March 2021

Agenda item:	13.1			
Presented by:	Sue Wilkinson, Executive Chief Nurse/ Karen Newbury, Head of Midwifery			
Prepared by:	Karen Newbury – Head of Midwifery/Rebecca Gibson Compliance Manager			
Date prepared:	March 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
- Maternity improvement plan
- Ockenden
- Safety champion feedback from walkabout/virtual session
- Service user feedback
- External assurance and oversight
- 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)

Strategy update

The 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 pre-approval stage (including providing a copy to the CCG and NHSE for their information following the assurance visit) and plan to present to TEG for formal approval next Month.

Maternity improvement plan

The Improvement Board now receives the updated Maternity improvement plan on a monthly basis. This has been created through an amalgamation of the original CQC improvement plan with the wider requirements of Ockenden, HSIB, external site visits and self-assessment against other national best practice (e.g. MBRRACE, Each Baby Counts, UKOSS).

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. Feedback is due in March and update included in next month's pack.

Safety Champion Walkabout feedback

In November 2015, the Secretary of State for Health announced a national ambition to halve the rate of stillbirths, maternal and neonatal deaths and brain injuries occurring during or soon after birth by 2030; a timeframe subsequently revised to 2025. In autumn 2016, the 'Safer maternity care' action plan developed the maternity safety movement further, including a strong focus on leadership. In addition, anecdotal evidence from maternity care providers that have successfully implemented the recommendations of Saving Babies' Lives; a Care Bundle were seeing a significant reduction in stillbirths, but highlighted unwarranted variation in care and outcomes. It was suggested that by implementing current best practice these variations would be addressed. It was felt that good leadership would be a key element and that designated safety champions would be central in driving down this variation

The Board-level champion undertakes a monthly walkabout in the maternity and neonatal units. Staff have the opportunity to raise any safety issues with the Board level champion and if there are any immediate actions that are required, the Board level champion will address these with the relevant person at the time. Individuals or groups of staff can raise the issues with the Board champion.

Executive safety champion walkabout on the 10/02/2020 encompassed all inpatient areas in maternity and NNU. Issued raised included; shortage of staff, however acknowledgement that midwives from other areas did help, caring for Covid positive patients, however the staff member felt supported to wear additional PPE as appropriate, issues with poor connectivity of medic bleep, incubators nearing end of service and requiring replacement and shortage of scrubs. During this walkabout it was observed that not everyone was familiar with the Safety Champion role and the agreed action is to increase the profile by including photos to the safety champions on the posters and to trial virtual walkabouts to capture more staff/community areas. The idea for Medical professionals to have fast track through switchboard also put forward on the walkabout.

Service User feedback via F&FT and maternity Facebook page

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

In February, the maternity service received 87 FFT returns.

Of these 87 respondents:
90% found staff to be professional and approachable.
90% felt they were treated with dignity and respect.
90% felt staff listened to what they had to say.

The maternity service has developed a Facebook page for information and feedback from women. The feedback has been positive, and the service is responsive in their comments back to women. During the pandemic we have acknowledged the difficulty for our families to access groups and have the opportunity to share their thoughts, feelings and concerns with other expectant families. In response to this we have developed a weekly live Q&A session via Facebook to share information but also give our families an opportunity to ask questions and have a virtual discussion with other families.

External assurance and oversight

In February the CCG and local stakeholders undertook an assurance visit. A draft report has been sent to the Trust to check for factual accuracies, which has been completed. Feedback from the visit has been overall very positive.

In addition, the CQC are undertaking a nation-wide regulatory review of Maternity services according to their new framework (which considers 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). We are awaiting to hear when the call will take place.

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 (reports can be found at https://www.npeu.ox.ac.uk/mbrrace-uk/reports)

HSIB have now issued a number of maternity national learning reports. These collate the learning from multiple investigations and require consideration of their content alongside those issued for WSFT specific cases. National reports are more likely to contain safety recommendations for national bodies (e.g. the CQC) but the impact of these national recommendations will be relevant locally. To date HSIB have issued 11 local reports for WSFT cases and the outcome of these have been presented locally in Maternity as well as within the Board quarterly quality & learning report.

Maternity MBRRACE and HSIB action plans (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 received a presentation on the annual perinatal mortality report on the 15th March 2021. No specific further actions were identified at that meeting but it provided an opportunity for wider trust wide sharing of the content. Human Factors training was identified as 'best practice' which all of the labour suite co-ordinators have been scheduled to attend.

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 February there were nine indicators categorised as Red and zero 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 (IOL) (ex pre-labour & twins)	With the full implementation of SBLCBv2 and an increase of gestational diabetes this is to be expected.

Indicators	Narrative
Emergency Caesarean Sections	Increasing trajectory however with high IOL rate this is to be expected
Total Instrumental deliveries	Variable month by month
Grade 1 section decision to delivery time	2 delays due to theatre already in use, others delay of 2 & 3 minutes.
Unit closure	Due to high acuity & number of women in labour
Supernumerary Labour Suite Co-ordinator	NHSI – Improvement Officer supporting workforce plans to resolve this issue.
Appraisal completion	Part of wider Trustwide improvement plans
Mandatory training	
Emergency equipment 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
Smoking cessation / CO checks	
Domestic violence checks	
Swab count	Compliance has remained low for December – new staff and CoC midwives. Further support regarding documentation to commence.
Drug chart completion	
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. The first iteration of this will be presented in next month's board report subject to regional sign-off

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 February 2021 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). An updated version was

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 February - two

Although the Trust introduced the new PSIRF from 1st February; this did not change the categories of incidents within Maternity that are required to be reported externally (e.g. to HSIB) although it does provide more clarity around the wider reporting pathways that were not covered within the serious incident reporting framework (predecessor to PSIRF) and these are described within the Maternity Quality and Safety Framework

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 term stillbirth: WSH-IR- 67195 which has met the HSIB requirement and one antepartum stillbirth reported in February; WSH-IR-67876. The latter case did not meet the requirement for reporting to HSIB.

As per protocol 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.

An external thematic review which will review all maternity's serious incidents including HSIB cases for the last two years has just been commissioned and terms of reference have been agreed.

<table>
<tr><td rowspan="2">Trust priorities</td><td colspan="2">Deliver for today</td><td colspan="2">Invest in quality, staff and clinical leadership</td><td colspan="3">Build a joined-up future</td></tr>
<tr><td colspan="2">X</td><td colspan="2">X</td><td colspan="3">X</td></tr>
<tr><td rowspan="2">Trust ambitions</td><td>Deliver personal care</td><td>Deliver safe care</td><td>Deliver joined-up care</td><td>Support a healthy start</td><td>Support a healthy life</td><td>Support ageing well</td><td>Support all our staff</td></tr>
<tr><td></td><td>X</td><td>X</td><td>X</td><td></td><td></td><td></td></tr>
<tr><td colspan="3">Previously considered by:</td><td colspan="5">Women's Health Governance</td></tr>
<tr><td colspan="3">Risk and assurance:</td><td colspan="5"></td></tr>
<tr><td colspan="3">Legislation, regulatory, equality, diversity and dignity implications</td><td colspan="5"></td></tr>
<tr><td colspan="8">Recommendation:
The Board to discuss content</td></tr>
</table>

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	Feb20
Total Women Delivered	>208 or <216	>216 or <208	> 224 or <2 00	178	180	187	174	183	202	203	178	159	181	166
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	169
Twins		No target		1	2	3	1	4	2	3	3	1	2	3
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%	6 3.6%
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%	13 7.8%
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%	147 88.6%
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%	49 29.5%
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%	13 7.8%
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%	36 21.7%
Grade 1 Caesarean Section (Decision to Delivery Time met)	100%	96 - 99%	95% or less	100%	100%	100%	100%	100%	91%	100%	n/a	100%	100%	67%
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%	15.7%
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%	47.6%
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%	1.8%
Shoulder Dystocia	2	3-4	5 or more	3	7	4	4	5	2	2	3	5	1	2
Unit Closures	0		1	0	0	0	0	0	1	0	0	0	0	1

West Suffolk NHSFT		MIDWIFERY SERVICE: QUALITY DASHBOARD											
QUALITY TOPIC		Denominators											
		RAG	GREEN	= Standard or above	AMBER	≥5% below standard	RED	> 5% below standard					
STAFF SUPPORT & DEVELOPMENT													
Appraisal completion	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Midwives Hospital % in date	90%				94.0%	97%	97%	97%	100%	89%	82%	87%	
Midwives Community & ANC % in date	90%				83.0%	90%	80%	100%	98.50%	98.50%	95%	98%	
Support Staff Hospital % in date	90%				90.0%	90%	88%	84%	72%	76%	81%	83%	
Support Staff Community & ANC % in date	90%				100.0%	100%	No data	93%	91.50%	91.50%	91.5%	87%	
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	Feb	March
Midwives: % compliance for all training	90%		70.3%	74.8%	77.6%	78.3%	79.9%	80.1%	81.9%	92.2%	93.4%	92.1%	
Midwives: % compliance with PROMPT training	90%		52.7%	75.0%	75.9%	77.2%	81.4%	85.5%	93.3%	89.7%	86.4%	87.3%	
Midwives: % compliance with GAP training	90%			79.0%	91.0%	92.0%	98.0%	96.0%	96.0%	96.0%	96%	89.0%	
Midwives: % compliance with Safeguarding Children training	90%					99.3%	No data	99.0%	94.0%	94.0%	97%	96.0%	
Midwives: % compliance with Fetal Monitoring training	90%										68.6%	75.9%	
ANC Midwives: % compliance with Fetal Monitoring training											40%	71.4%	
MCA: % compliance for all training	90%		81.5%	83.2%	84.9%	85.6%	81.2%	85.7%	86.0%	92.8%	92.5%	94.1%	
MCA: % compliance with PROMPT training	90%		58.8%	72.2%	72.2%	72.2%	57.1%	65.0%	80.0%	83.3%	87.5%	87.5%	
MCA: % compliance with Safeguarding Children training	90%					99.4%	No data	100.0%	94.0%	91.0%	97%	100.0%	
Obstetric Medical Staff: compliance with PROMPT training	90%			70.0%	70.0%	73.3%	57.1%	69.6%	76.0%	79.2%	84%	84.6%	
Obstetric medical staff: % compliance with GAP training	90%			88.0%	83.0%	58.0%	92.0%	87.0%	83.0%	86.0%	83%	79.0%	
Obstetric Medical Staff: compliance with Safeguarding Children training	90%						No data	84.0%	50.0%	84.0%	90%	80.0%	
Obstetric Medical Staff: % compliance with Fetal Monitoring training											89.5%	76.2%	
Anaesthetic compliance with PROMPT training	90%						No data	50.0%	53.9%	53.9%	60%	64.3%	
Theatre staff compliance with PROMPT training	90%						No data	34.3%	47.4%	47.4%	50%	50.0%	
Sonographer: % compliance with GAP training	90%			93.0%	93.0%	79.0%	86.0%	79.0%	86.0%	93.0%	93%	86.0%	
EQUIPMENT SAFETY													
Checking of Emergency Equipment	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Labour Suite: Adult Trolley	100%			86%	100%	100%	100%	100%	100%	100%	100%	100%	
Labour Suite: Resuscitaires				73%	86%	76%	88%	96%	98%	97%	92%	98%	

Ward F11: Adult Trolley					97%	100%	97%	100%	100%	100%	100%	100%	
Ward F11: Resuscitaire					77%	84%	93%	97%	100%	100%	100%	100%	
MLBU: Resuscitaires	100%				95%	100%	93%	94%	97%	97%	96%	93%	
Community: Emergency Bags					89%	98%	95%	84%	82%	100%	96%	100%	
Checking of Fridge Temperatures	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Labour Suite	100%				97%	100%	100%	100%	93%	97%	97%	96%	
Ward F11					100%	100%	93%	100%	100%	97%	100%	100%	
MLBU					97%	100%	100%	100%	100%	100%	100%	100%	
ANC					100%	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	Feb	March
Labour Suite	100%				97.0%	100.0%	100%	100%	93%	97%	97%	96%	
Ward F11					100.0%	100.0%	97%	100%	97%	97%	1005	100%	
MLBU					97.0%	100.0%	100%	100%	100%	100%	100%	100%	
ANC					100.0%	100.0%	100%	100%	100%	100%	100%	100%	
Checking of CD's	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Labour Suite	100%				100.0%	98.0%	100%	100%	100%	100%	100%	100%	
Ward F11					100.0%	100.0%	97%	100%	100%	97%	100%	100%	
MLBU					97.0%	100.0%	100%	100%	100%	100%	100%	100%	
MONTHLY QUALITY & SAFETY AUDITS:													
	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Supernumerary Status of LS Coordinator	100%				84%	74%	No data	83%	70%	91%	90%	92%	
1-1 Care in Labour	100%	97.4%	100.0%	100.0%	100.0%	100.0%	99.5%	100.00%	100%	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	1:27	
No. Red Flags reported				3	4	2	1	14	12	12	4	6	
DOCUMENTATION & CARE AUDITS	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Compliance with MEOWS completion	100%			98.0%	99.5%	99.0%	99. 8%	99%	99.3%	99.40%	99.6%	99.50%	
Compliance with NEWTT completion	100%	97.0%	97.0%	96.0%	95.0%	99.0%	100%	100%	100%	97.50%	98%	99%	

Carbon Monoxide Monitoring													
Smoking at booking recorded	95%	Audit suspended due to Covid-19				100.0%	100%	100%	100%	100%	97.5%	100%	
Smoking at 36 weeks recorded	95%					45.0%	78%	74%	85%	97.50%	93%	90%	
Compliance with DV questions													
Antenatal period	100%					95.0%	100%	98%	98%	100%	98%	100%	
Postnatal period	100%					97.5%	95%	90%	80%	94%	90%	98%	
Swab Count Compliance													
Birth	100%				56.0%	85.0%	87%	93%	100%	73%	85%	80%	
Suturing	100%				54.0%	90.0%	87%	96%	92%	66%	78%	70%	
Compliance with completing WHO checklist @ CS	95%	No audit		93.0%	96.0%	96.0%	90%	96%	100%	96%	96%	92%	
Recording of Pain Score													
Labour Suite	100%					99.0%	100%	100%	98%	100%	100%	100%	
Triage						100.0%	100%	100%	100%	100%	100 %	100%	
MLBU						100.0%	100%	100%	100%	100%	100%	96%	
Ward F11						97.0%	100%	100%	98%	100%	100%	100%	
MDAU						100.0%	100%	100%	100%	100%	100%	100%	
Completed Drug chart information: weight and allergies	100%						7.00%	73%	76%	60%	48%	76%	
Fresh Eyes													
Labour Suite	100%						20%	100%	80%	100%	100%	67%	
Fresh Ears													
MLBU	100%					80.0%	50%	80%	88.80%	88%	89%	100%	
Epidural response <30 min	90%					92%	98%	87%	98%	Data per 1/4	Data per 1/4	awaiting data	
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%	78.1%
Unicef baby friendly audits	10, 8, 6		0	0	0	0	40	0	0	0	9	0
LSCS decision to delivery time met												
Grade I LSCS	95%		100%	100%	100%	100%	91%	100%	None	100.0%	100%	67.0%
Grade 2 LSCS	80%		81%	67%	95%	78%	83%	82.3%	68%	75%	58%	81%
Neonatal Outcomes												
Mag Sulpate for preterm infants												1 of 1
Pre-term infants birth in right place												100%
Continuity of Care Outcomes												
Women Booked onto the continuity pathway	Number									415	473	542
	%									18%	20.6%	
Women who received 70% of care	Number									31	36	26
	%									1.30%	2.9%	15.60%
Governance												
Outstanding Datix (last day of the month)												4
Out of date guidelines										0	0	2
Number of serious incidents										1	2	2

13.2. Infection prevention and control assurance framework

For Approval

Board of Directors – 26th March 2021

Item	13.2			
Presented by:	Sue Wilkinson, Exec Chief nurse			
Prepared by:	Rebecca Gibson – Compliance Manager			
Date prepared:	March 2021			
Subject:	NHSE ICT assurance framework			
Purpose:	x	For information		For approval

Executive summary:

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

This month's report contains

- Dashboard
- Integrated 'learning from outbreaks' plan (Appendix 1)
- Asymptomatic staff testing evaluation (Appendix 2)
- Self-assessment against the Feb 21 updates to the NHSE BAF (Appendix 3)

The 'learning from outbreaks' update from last month's Board meeting has been shared with all staff through the weekly staff briefing session (available to join live or watch after the broadcast).

In March the Health & Safety Executive published the findings of a spot-check inspection of 17 acute hospitals (not WSH) which identified seven recommendations for organisations (see Appendix 4). There is a high degree of confidence in a statement of compliance with these recommendations. To provide additional assurance a full self-assessment will be included in next month's paper. This will include a cross-reference of the full list of findings against the outbreak/cluster RCA reports to look for any commonality.

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

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

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

Trust ambitions *[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	

Putting you first

Dashboard

Measure	Time period reported	Data		
		Previous	Last period	This period
Compliance to Antimicrobial stewardship (AMS) standards	91.7% (Q2)		No Data	
AMS ProTectis compliance	85.8% (Q2)		No Data	
Nosocomial C19 (probable + definite)	Feb 21	91	60	0 ↓
Staff work-related C19 cases reported to RIDDOR	Feb 21	0	0	0
Incidents relating to C19 management	Feb 21	47	79	27 ↓
Admissions swabs within 24 hours of DTA	Feb 21	95%	97%	97% →
C19 clusters / outbreaks	Feb 21	6	3	0 ↓
Staff sickness / absence due to C19	Feb 21	695	856	921 ↑
Staff uptake of lateral flow test	To date	3205	3354	3408 ↑

Associated charts / tables / narrative

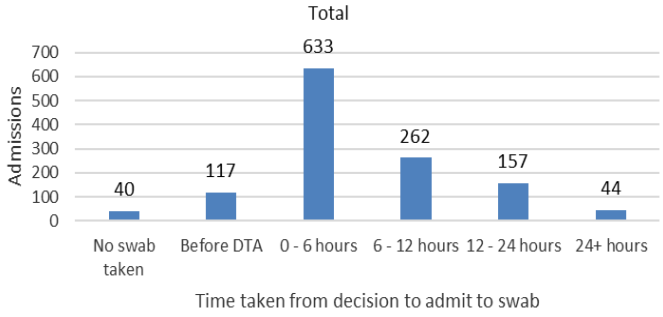
Antimicrobial audits are currently on hold whilst infection prevention resource is focussed on the pandemic. AMT intend to resume antimicrobial stewardship audits as staffing allows (probably April/May). In the interim the AMT has worked with the biochemistry department to allow PCT (procalcitonin) testing for all patients admitted with coronavirus to help guide antibiotic treatment in this group of patients with an observational retrospective analysis being undertaken.

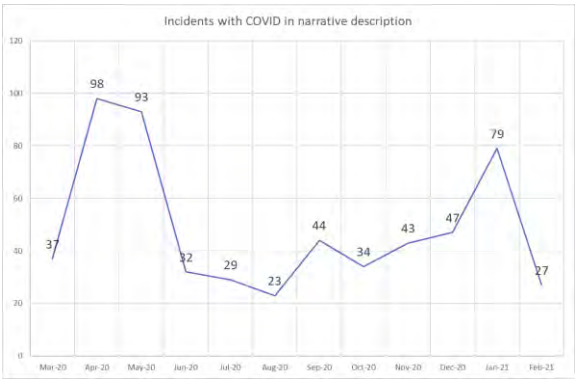
C-19 admission swabs

93% of patients had a swab taken within 24 hours of the DTA in January and 97% in total.

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

The updated NHSE IPC BAF requires oversight of the requirements for emergency admissions who test negative on admission to be retested on day 3 of admission, and again between 5-7 days post admission. The information team are working to develop a report to show this.

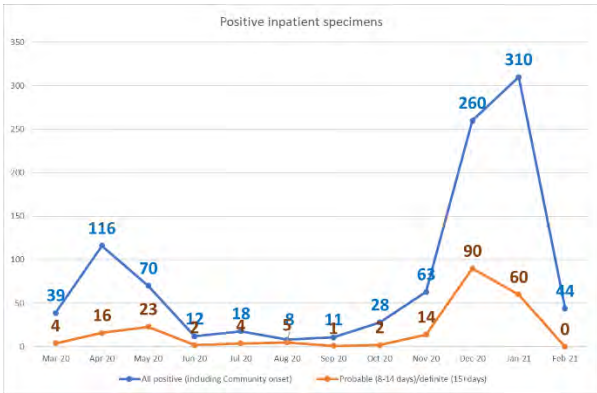




The number of **incidents relating to C-19** recorded in February fell considerably to similar levels in Jun-Aug months.

26/27 February reported incidents were green and there was one amber and no reds:

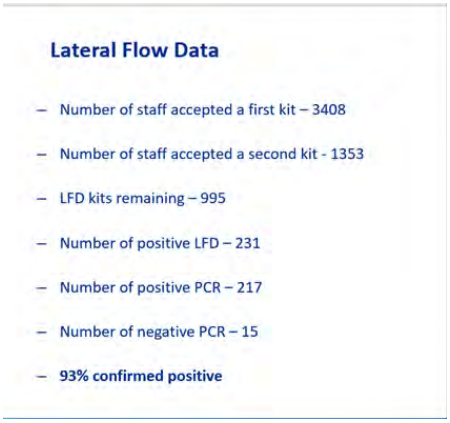
The one amber was a delay in treatment (of a C19 patient) whilst in the care of the ambulance service. The incident has been forwarded to the ambulance trust as per the trust's 'other organisation incidents' pathway.



Nosocomial (Hospital-Onset) C19

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

There were no cases identified as probable/definite in February. This mirrors the decrease in community prevalence over the same period.

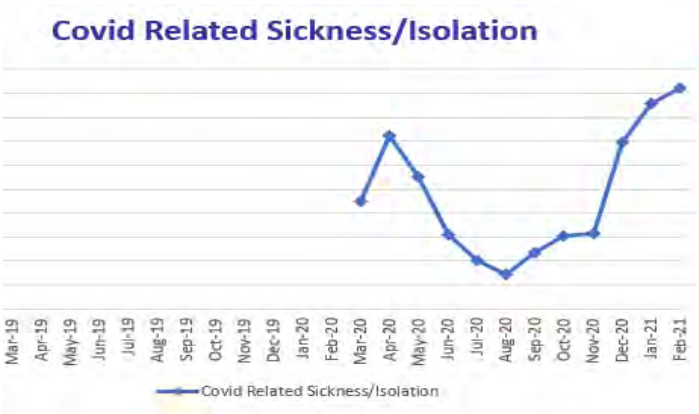


Staff uptake of lateral flow test

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 (93%) 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 February 2021 there were 921 episodes recorded, a slight increase from January (856 episodes).

Appendix 1 - 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. There were none reported in February.

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

'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 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
- 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
- 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 (Rosemary ward)
- Adapted process for collecting patient's meal trays after use without IPC guidance

Since last month's report

One additional report noted some similar themes to the above and in addition:

- 2m spacing between patients not possible on G5 increasing likelihood of transmission by droplet spread.
- Patients sharing belongings (e.g. toiletries, magazines)

It was also reported that there may have been occasions where full PPE was not able to be donned by staff before attending to prevent patients from falling which again may have led to possible transmission

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

- Lateral flow rapid tests / SAMBA machines for all admitted patients enables prompt confirmation of infection status on adm / throughout hospital stay.
- Daily review of patients in each ward by Matrons to identify on eCare individuals "suitable to outlie" in the event of operational pressure.
- Robust Test and Trace system in place coordinated by Tactical team including on-call arrangement for weekends.
- Lateral flow testing kits available for all staff (on voluntary basis) with results submitted centrally.
- All respiratory patients requiring AGPs on F7, G9 or ITU. In exceptional cases, consultant review beforehand to make sure low suspicion of C-19 and then nursed in a dedicated side-room.
- Staff COVID vaccination programme
- Inpatients wearing masks when moving about shared areas and, if able / comfortable, whilst sitting in bed. Supported by posters and patient information leaflet.
- Increased frequency of PPE / environmental audits
- Discourage patients from sharing belongings and encourage to remain in bed space 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 discouraged (recognising that demand for beds may override this practice. Where this occurs risk assessment should be completed and recorded by IPC).
- COVID curtains/screening installed to help mitigate where social distancing is breached.
- All food trays collected and transported via trolley.

New since last month's report

- Asymptomatic staff swabbing SOP to be enacted (see Appendix 2)

Appendix 2 - Asymptomatic staff testing

NHSE's IPC BAF states that systems should be in place to ensure that "*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 is no national guidance on when staff that do not have symptoms should receive a PCR test if they are identified as possibly involved in an outbreak of COVID-19 in a hospital setting. In WSFT asymptomatic staff testing is in place but requires a service evaluation to establish whether it is fit for purpose.

PCR testing is resource intensive, requiring significant staff time to identify the relevant staff, arrange testing, undertake testing, record and communicate the results, as well as the cost of the test itself. Furthermore, there is an opportunity cost (these resources could be deployed elsewhere if not focused on this) and there is the risk of testing fatigue among staff who are being routinely subjected to an unpleasant procedure. For these reasons, it is important that we understand the value of undertaking asymptomatic staff testing.

The Public Health team will be running an evaluation of the asymptomatic staff testing process, to determine the impact that such testing is having. If there is an outbreak, the staff who have been on the ward will be tested for covid twice (once asap after the outbreak is declared, and a second time a week after their first).

The agreed process is that asymptomatic staff associated with an outbreak should receive two PCR test; one as soon as possible after identification of the outbreak and a second 5-7 days after their first.

Staff will be invited to complete a questionnaire about their symptoms 1) for the past week at the time of the first test and 2) for the past week at the time of the second test. Staff will be provided with a unique identifier (i.e. will not need to input any personal details but will be able to be linked up with their test results, so we'll know whether they became positive or not).

A full evaluation protocol has been prepared with the following objectives:

1. Does testing of asymptomatic staff in ward that has a COVID-19 outbreak result in cases that would otherwise have gone undetected?
2. Determine the characteristics of staff involved in an outbreak and by test result, including whether they develop symptoms (& if so, which), vaccination status and staff role.
3. Assess the staff experience of asymptomatic testing in the context of an outbreak

The findings will be reported to the Covid Strategic group with a view to deciding the most appropriate methods for continuing asymptomatic staff testing in an outbreak setting. Report findings will also be shared with the Trust staff through Green Sheet as reporting back to all staff will be an important step for ensuring they know how their data has been used.

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 patient moves policy in place 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. policies and procedures in place • Monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice on: o staff adherence to hand hygiene Hand hygiene audit undertaken monthly (data to be included in dashboard next month) o staff social distancing across the workplace *[TBC]* o staff adherence to wearing fluid resistant surgical facemasks o ▪ a) clinical *[TBC]* o ▪ b) non-clinical setting *[TBC]* o staff compliance with wearing appropriate PPE, within the clinical setting *[TBC]* • 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 In place and reported monthly to Board • 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. During outbreaks/clusters, targeted staff testing takes place as part of the IMT process as and when required. • 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 Poster in place throughout WSFT buildings including non-clinical areas • 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 The Daily COVID SitRep is signed off during the week by either COO or Deputy COO (Head of Information & Contracting deputises), and at weekends it is signed off by GOLD command. It is also checked daily by the Executive Chief Nurse (Director of Infection prevention & control – DIPC) • This Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board Reported monthly to Board (this report)

Standard	Additional prompts in Feb21 update (underline is where an addition to a current prompt has been added)
	• There are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas *[TBC]*
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 *[TBC]* • Monitor adherence to the decontamination of shared equipment *[TBC]*
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 Posters and leaflets provide this advice • Monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so) *[TBC]* • 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 *[TBC]*
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 *[TBC]* • 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 *[TBC]* • clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas *[TBC]*
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. Compliance with admission swab reported monthly in trust IPC dashboard • Those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise. *[TBC]* • Those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission. Compliance with Day 3 and Day 7 swab to be reported in future trust IPC dashboard (Information team currently designing this report) • Sites with high nosocomial rates should consider testing COVID negative patients daily.

Standard	Additional prompts in Feb21 update (underline is where an addition to a current prompt has been added)
	Will be built into testing SOP • 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 Unable to provide automated reporting of this from eCare. A spot check audit of February patient discharges is to be undertaken • 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. *[TBC]* • 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. Information team reviewing a possible option to report upon this

Appendix 4 – HSE hospital spot check inspections – COVID-19. Recommended actions for NHS Trusts and Boards

Review detailed findings of the inspections and take the following actions to reassure that adequate COVID control measures are in place and remain so during the pandemic:

1. Review their risk management arrangements to ensure they are adequately resourced.

2. Consider how well the various parts of the risk management system coordinate with each other, including the health and safety team, departmental managers, infection control and occupational health colleagues and whether they could be improved.

3. Ensure compliance with their legal obligations to consult with trade unions and employee representatives by ensuring they are engaged in the risk assessment process. Worker engagement in this process is critical to establishing workable control measures.

4. Review all non-patient facing areas to ensure a suitable and sufficient risk assessment has been carried out and the control measures identified have been implemented – in line with relevant guidance, including - *Making your workplace COVID-secure during the coronavirus pandemic* (hse.gov.uk). Consider how well the risk assessments for these areas have applied the hierarchy of control and have they:

- Identified the maximum room occupancy numbers and the optimum layout and seating arrangements in all areas? For example, in libraries, the laundry, porters lodge, clinical records, rest rooms, toilets, locker rooms, post rooms, changing rooms, offices, canteens, training rooms, doctors' common rooms
- Considered how ventilation could be improved in all areas? Could windows be unsealed to open, are doors left open, how are rooms with no windows or air conditioning being ventilated?
- Implemented mitigating measures where it is not possible to maintain social 2m distancing? For example, by proving physical barriers (screens), one-way systems or rearranging /modifying layout.
- Checked the adequacy of their cleaning regimes in non–clinical areas? Have they consistently considered high touch surfaces, for example printers, vending machines, kettles, photocopiers, door handles etc?

5. Review the provision of lockers and welfare facilities to ensure they can accommodate the number staff on shift in a COVID secure manner.

6. Establish routine monitoring and supervision arrangements to ensure control measures identified in the risk assessment are implemented and are being maintained.

7. Review your arrangements regularly to ensure they remain valid and act on any findings.

13.3. Nursing staffing report

For Approval

Trust Board – March 2021

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

Executive summary:
This paper reports on safe staffing fill rates and mitigations for inpatient areas for February 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

- Overall Trust fill rates have improved in all shifts (days and nights)
- Sickness rates have improved compared to previous months falling below rates seen in Autumn 2020
- Nurse quality indicators have improved further illustrating the link with fill rates and patient safety
- RSM final report received
- Significantly fewer staffing incidences reported this month

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

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

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

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

	Day		Night	
	Registered	Care Staff	Registered	Care staff
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%
Average fill rate for February 2021	96%	86%	97%	101%

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

Day shift fill rates for registered nurses (RNs) has improved markedly this month with only four wards falling below 90%. Nursing assistant fill rates in the day has also improved but the majority of wards are below 90%. A full list of ward by ward fill rates can be found in appendix 1. The matron of the day (MOD) mitigates short notice staffing shortfalls and the Trust has mobilised additional staff to support inpatient areas during February.

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

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 were higher than in the first wave of this pandemic. Sickness within nursing and care staff, in February, is much improved compared with previous months, with both registered and unregistered staff falling below levels seen in the autumn of 2020.

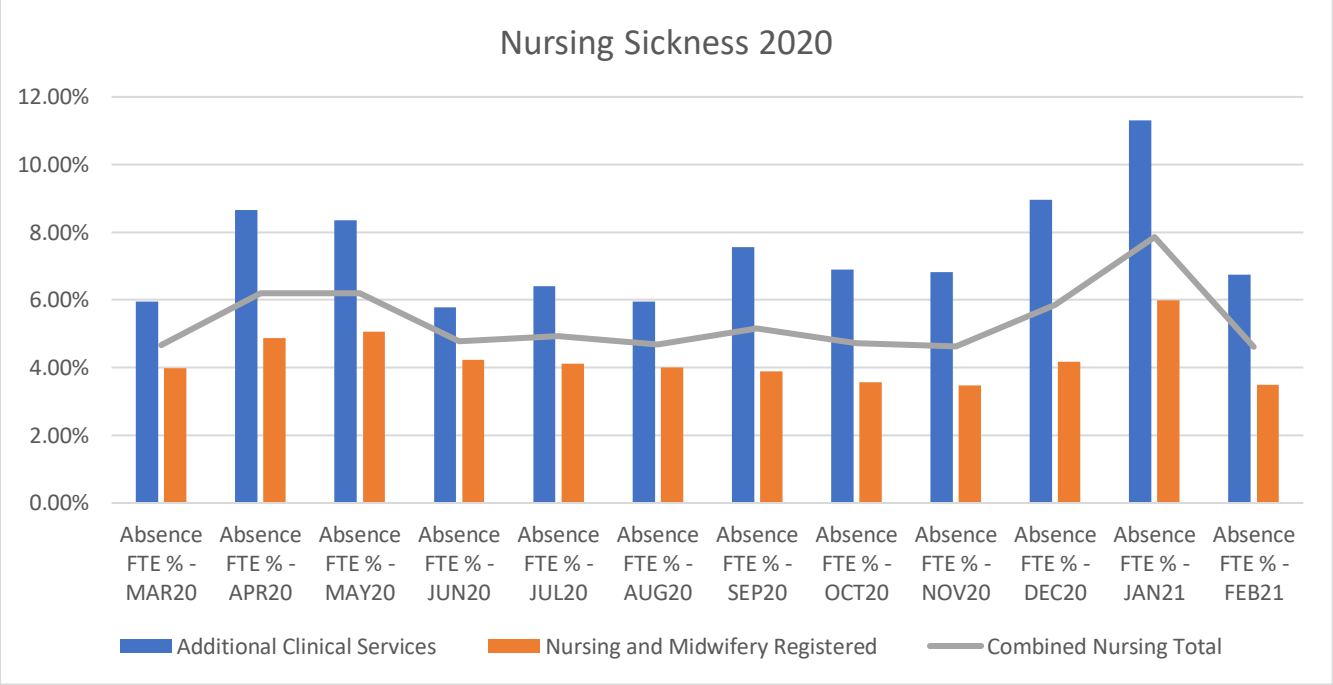


Chart 2.

	Aug	Sept	Oct	Nov	Dec	Jan 21	Feb 21
Unregistered staff (support workers)	5.95%	7.56%	6.90%	6.83%	8.97%	11.30%	6.75%
Registered Nurse/Midwives	4.01%	3.89%	3.57%	3.47%	4.16%	5.99%	3.49%
Combined Registered/Unregistered	**4.69%**	**5.15%**	**4.72%**	**4.64%**	**5.86%**	**7.86%**	**4.61%**

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). Self-isolation incidences have also reduced compared to January.

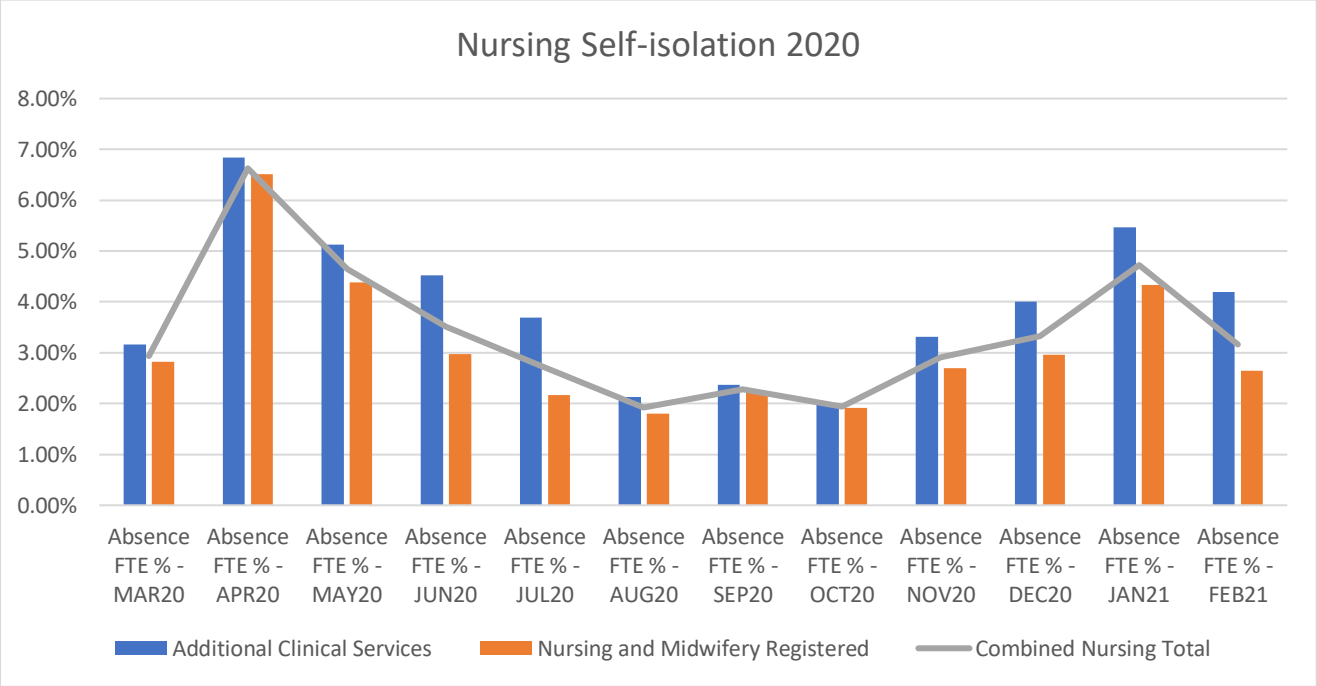


Chart 3

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. In addition, no wards were closed during this period due to any covid19 outbreaks. Some wards had bays closed to admissions following identification of asymptotic positive cases which would inhibit patient flow but the closed beds have enabled further mitigation of any staffing shortfall seen this month. Areas where bays have been closed are as follows;

- 11/02 – G3 bay 2
- 11/02 – G5 bay 4
- 16/02 – F9 bay 1
- 16/02 - G3 bay 4
- 27/02 – G3 bay 1

6. Recruitment and retention

Vacancies: Registered nursing (RN):
The vacancies have marginally increased from 65.1 WTE to 66.8WTE this month. Using this data, the percentage vacancy rate for RN/RM has remained static this month at 9%. 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.

Previous papers have highlighted high maternity vacancies. However, on further scrutiny of the midwifery services budgets, it is evident that continuity or carer and community midwives have not previously been included. These roles work peripatetically in both the acute and community sector and should be included in overall vacancy factors (Appendix 2). Midwifery recruitment is slowly improving is currently at 15.4WTE, with a 16% vacancy rate.

	Ward Nursing	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 Actual Period 11 (Feb)	Sum of CURRENT MONTH VARIANCE
RN/RM Substantive	Ward	576.7	587.4	609.4	603.9	609.8	610.2	66.7
	CV19 Costs	8.5	6.0	11.4	10.3	2.0	(0.1)	0.1
Total: RN Substantive		**585.2**	**593.4**	**620.8**	**614.2**	**611.8**	**610.2**	**66.8**

Table 4

Vacancies: Unregistered Nursing assistants (NAs): The vacancy rate of unregistered support staff is demonstrating an over establishment of 5.8 WTE. This is driven by additional Covid support costs. Data reviewed on a ward by ward analysis shows this is more likely to be a vacancy rate of 7%. 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. This has already proved effective and having a positive effect on recruitment processes.

	Ward Nursing	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 Budget Period 11 (Feb)	Sum of CURRENT MONTH VARIANCE
Nursing Unregistered Substantive	Ward	355.3	355.9	363.4	375.1	380.6	386.2	11.1
	CV19 Costs	17.8	8.1	8.4	9.0	0.0	16.9	(16.9)
Total: NA Substantive		**373.2**	**364.0**	**371.9**	**384.0**	**380.6**	**403.0**	**(5.8)**

Table 5

Overseas Nurse (OSN) recruitment:

Six nurses arrived from the OSN pipeline including critical care nurses as part of the NHSE initiative to support critical care provision during the pandemic. Interviews continue to ensure that our pipeline ambition of five arrivals a month continues.

New starters

	December	January	February
Registered Nurses	10	16	17
Non-Registered	11	11	17

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

In February 2021 seventeen RNs completed induction; of these; five community nurses, one midwife, two WSP and nine for the acute trust.

In February seventeen NAs completed induction; of these five NAs six in the community, one in midwifery, one for WSP and nine for the acute Trust.

7. Quality Indicators

Falls

Overall falls this month have reduced from 81 to 74. However due to low bed occupancy the falls per thousand bed days has increased (Chart 6). A full list of falls and locations can be found in appendix 3.

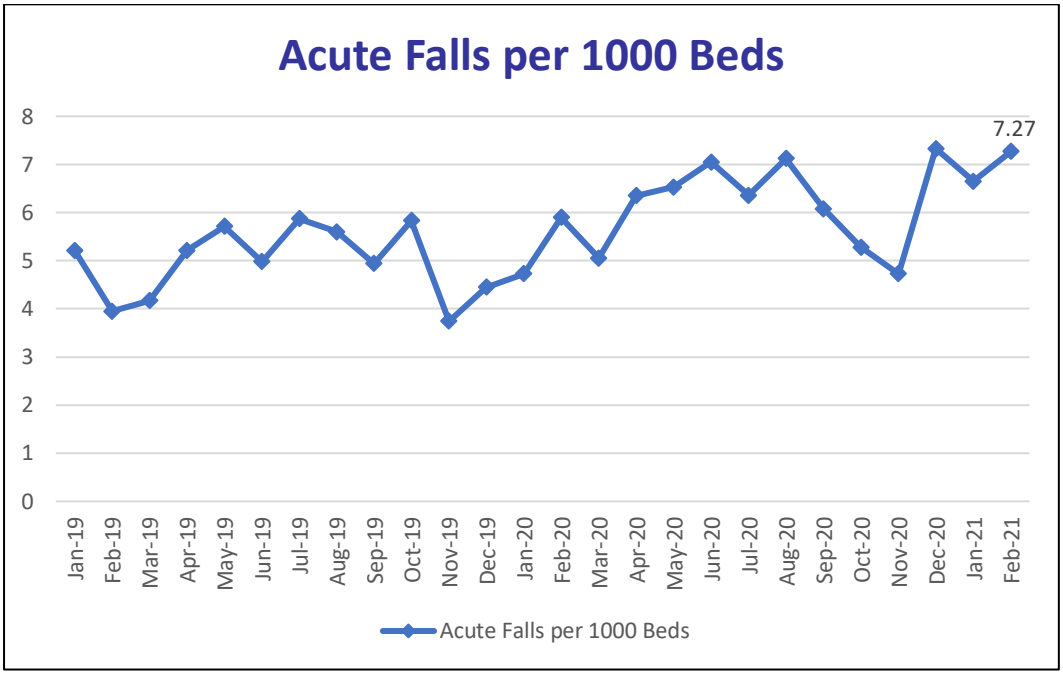


Chart 6

Pressure Ulcers

This month saw an improvement in the incidences of HAPU in the acute trust and also by using the per 1000 bed days measure. This may be driven to the improving staffing picture this month.

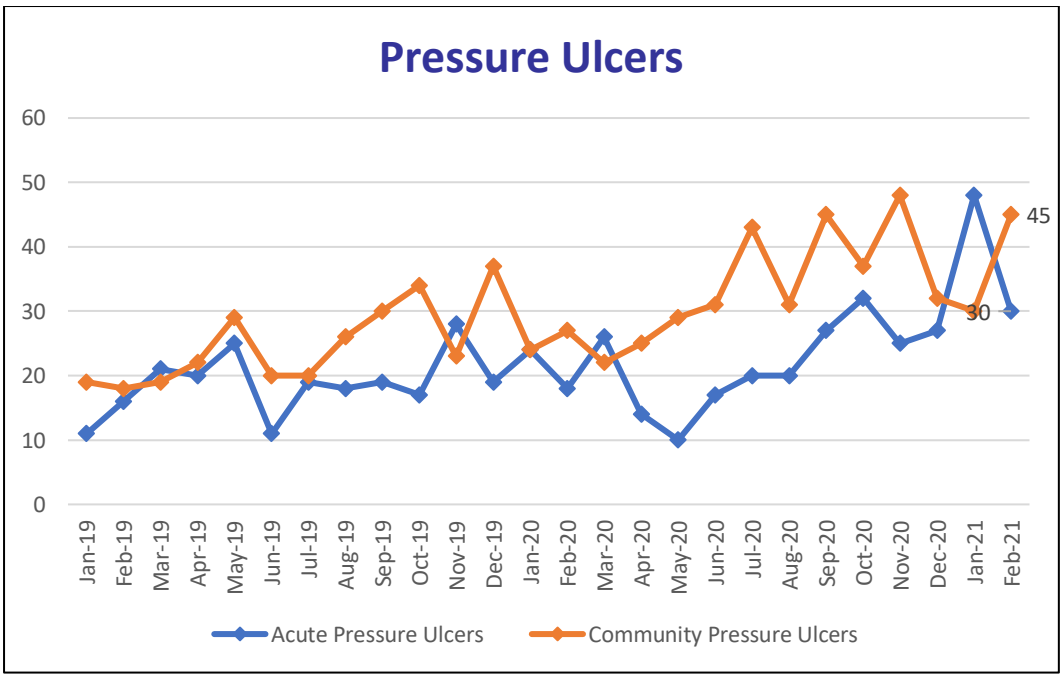


Chart 7a

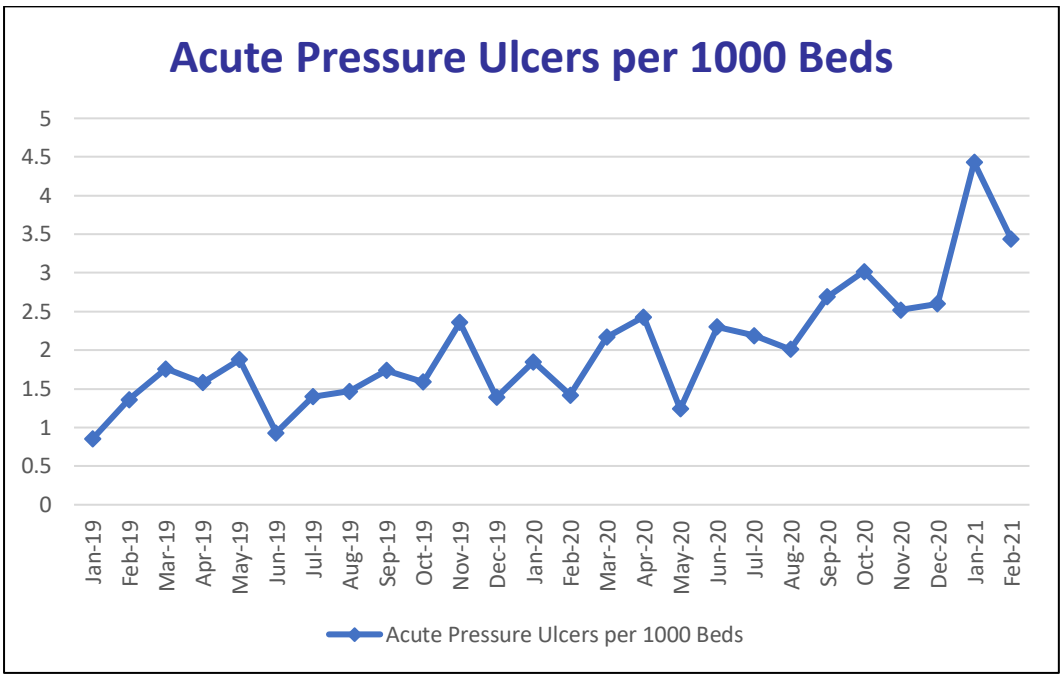


Chart 7b

8. Compliments and Complaints

Table 8 demonstrates the incidence of complaints and compliments for this period. As lockdown measures have continued in February low incidences of complaints continue. A rise of four complaints against the previous month has been observed. Positively in increase in compliments was also seen.

The clinical helpline has been maintained and an average of 152 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
February	17	11

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 February there were 6 Datixs recorded for nurse staffing. This is a significant reduction from the previous two months (see table 9.)

Red Flag	Nov 20	Dec 20	Jan 21	Feb 21
Registered nursing shortfall of more than 8 hours or >25% of planned nursing hours	4	11	11	0
>30-minute delay in providing pain relief	1	2	3	1
Delay or omission of intention rounding	8	17	17	4
<2 RNs on a shift	1	2	6	1
Vital signs not recorded as indicated on care plan	3	10	3	0
Unplanned omissions in providing patient medication	0	4	4	0
Total	17	46	44	6

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 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 six red flag incidents reported in February 2021: One unit closure due to high demand, two delayed observation and medication due to low staffing levels (F11), two delays in commencing induction of labour, one labour suite co-ordinator had to provide 1:1 care for a woman due to high capacity.

Midwife to Birth ratio

In February 2021 the Midwife to Birth ratio was 1:27 Birthrate+ recommend a Midwife to Birth ratio of 1:27.7.

Supernumerary status of the labour suite co-ordinator

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

In February we achieved 92% compliance. 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 start dates have been confirmed for May 2021.

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. The recommendations of this review were presented to the Trust public board in January 2021. The review will have an impact on nursing vacancies in April 2021 as funding becomes available. The review will provide a net increase of approx. 19 RNs and a net reduction of 4 NAs.

The amendments to budget and roster templates will be included in budget setting ready for use in April. The ward teams are actively recruiting into any uplifts to reduce the time taken to rely on temporary staff fill.

The audit has been completed again in February to commence the biannual review to capture seasonal variations. It is unlikely that the second audit will require additional investment given the most recent review, but it will allow surveillance of acuity and dependency.

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, and the relaunch of the SafeCare risk assessment module. The rapid response pool payment has now been confirmed, operational deployment of this process is now being worked through to ensure maximum efficiency. The SafeCare deployment has been intentionally delayed to avoid overlap with phase four e-Care down time, so that staff can focus on the training requirements for the next phase of e-Care.

In December, a nursing resource management audit was completed by RSM. The final report was received in early March. The report indicates overall partial assurance of robust rostering practices. Robust assurances were found in the following area;

- Roster production and oversight
- Trend analysis of temporary staff utilisation
- Board oversight
- Nursing resource improvement plan

Weakness in process where judged to include

- Rostering policy out of date. NB. This has been intentionally delayed to reflect new ways of working in relation to escalation and risk assessment.
- Requesting and authorisation of bank staff. This will be captured in the rostering policy
- Agency time sheets. WSP currently scoping an electronic solution to this
- Out of hours sourcing of temporary staff.
- Evidence of overtime authorisation.

The majority of the improvement actions have already been identified following the Deputy Chief Nurse's and WSP lead process reviews and are in train. Actions not already articulated within the nursing resource improvement plan will be included to maintain oversight of completion and assurance to the board. Actions will be monitored through audit committee. A summary of these action can be found in appendix 6.

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. Although this pressure began to reduce towards the end of February, all additional actions for providing staffing support continued. Actions to further strengthen and support staffing have included;

- Extension of agency lead time to encourage temporary staff fill continued in February
- 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.
- Bank incentive scheme continued during February to address RN shortfall
- Sixteen third year nursing students joined the substantive workforce in early February, with three more scheduled to join in March.

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

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each day	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	840	847.5	1337.25	976	724.5	713	829	784	101%	73%	98%	95%	452	3.5	3.9	7.3
Glastonbury Court	644.75	655.25	950.75	907	644	644	492	544	102%	95%	100%	111%	384	3.4	3.8	7.2
Acute Assessmen	1932	1791.25	2254	1687.25	1610	1461	1288	1219	93%	75%	91%	95%	761	4.3	3.8	8.1
Cardiac Centre	2505.317	2363.5	1119.5	1200	1610	1449	635.5	616	94%	107%	90%	97%	632	6.0	2.9	8.9
F10	1278.5	1156	1283	1227	964.5	950	966	1165	90%	96%	98%	121%	707	3.0	3.4	6.4
G9	1288	1289.75	1279.5	1172.75	1288	1230.5	966	1069.5	100%	92%	96%	111%	752	3.4	3.0	6.3
F12	500.5	593.5	318	339.5	644	632.5	322	351.75	119%	107%	98%	109%	240	5.1	2.9	8.0
F7	1288	1173.5	1891.75	1595.75	1288	1093.5	1610	1207	91%	84%	85%	75%	683	3.3	4.1	7.4
F9	1288	1186	1922.5	1622.75	966	933	1280.833	1337.25	92%	84%	97%	104%	744	2.8	4.0	6.8
G1	2160.367	2021.15	925.1667	751.5	644	645.25	322	306	94%	81%	100%	95%	361	7.4	2.9	10.3
G3	1288	1196	1923.5	1625.25	966	925	962	1165.167	93%	84%	96%	121%	864	2.5	3.2	5.7
G4	1285	1132	1891.5	1533.5	966	826	1281.5	1089	88%	81%	86%	85%	896	2.2	2.9	5.1
G5	1610	1294.25	1575.5	1232.25	954.5	880.75	1282.5	1167	80%	78%	92%	91%	760	2.9	3.2	6.0
G8	1913	1766.817	1652.5	1449	1288	1292.917	966	930	92%	88%	100%	96%	615	5.0	3.9	8.8
F8	1288	1237.5	1927	1520.5	966	828	1288	1213.5	96%	79%	86%	94%	723	2.9	3.8	6.6
Critical Care	2434.5	3279.75	301.5	738.5	2517.5	2861.517	0	446.5	135%	245%	114%	N/A	388	15.8	3.1	18.9
F3	1590.5	1202	1926	1545.5	966	805	1288	1058	76%	80%	83%	82%	732	2.7	3.6	6.3
F4	782	714.75	718	547	540.5	553	608.5	759	91%	76%	102%	125%	602	2.1	2.2	4.3
F5	1610	1225.5	1260.5	1121.25	962	876	644	667	76%	89%	91%	104%	698	3.0	2.6	5.6
F6	1821.583	1726.833	1503	1143.5	975.25	965	644	747.5	95%	76%	99%	116%	939	2.9	2.0	4.9
Neonatal Unit	974.5	938.5	324	259	984	936	288	168	96%	80%	95%	58%	116	16.2	3.7	19.8
F1	1056.5	1305.5	474.75	543.75	966	1238.75	0	46	124%	115%	128%	100%	115	22.1	5.1	27.3
F14	672	696.75	132	132	672	660	0	0	104%	100%	98%	100%	106	12.8	1.2	14.0
Total	32,051.02	30,793.55	28,891.17	24,870.50	24,106.75	23,399.68	17,963.83	18,056.17	**96%**	**86%**	**97%**	**101%**	**13270**	**4.1**	**3.2**	**7.3**

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

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

Ward/Department	Registered Nursing (RN)				Ward/Department	Non Registered Nursing (HCSW)			
	Budgetted establishment	Actual establishmet	Vacancy rate (WTE)	Vacancy percentage		Budgeted Establishment	Actual Establishment	Vacancy rate (WTE)	Percentage Vacancy rate
AAU	30.1	25.5	4.7	15.4%	AAU	28.3	23.2	5.2	18%
Accident & Emergency	64.0	60.2	3.8	6.0%	Accident & Emergency	26.5	23.9	2.6	10%
Cardiac Centre	40.7	36.8	3.9	9.6%	Cardiac Centre	15.7	17.0	(1.3)	-8%
Community - Glastonbury Court	11.7	11.6	0.1	1.1%	Community - Glastonbu	12.6	10.7	1.9	15%
Critical Care Services	45.0	44.4	0.6	1.3%	Critical Care Services	1.9	4.3	(2.5)	-131%
Day Surgery Wards	11.0	7.6	3.4	30.5%	Day Surgery Wards	3.9	3.7	0.2	4%
Gynae Ward (On F14)	12.8	11.3	1.5	11.7%	Gynae Ward (On F14)	1.0	1.0	0.0	0%
Neonatal Unit	20.8	19.5	1.3	6.2%	Neonatal Unit	4.3	4.8	(0.5)	-11%
Newmarket Hosp-Rosemary ward	12.4	14.9	(2.4)	-19.5%	Newmarket Hosp-Rose	13.5	17.3	(3.8)	-28%
Recovery Unit	21.9	20.6	1.3	6.0%	Recovery Unit	0.9	0.9	0.0	1%
Ward F1 Paediatrics	26.2	21.4	4.8	18.3%	Ward F1 Paediatrics	7.2	7.2	(0.1)	-1%
Ward F12	10.2	11.0	(0.8)	-7.7%	Ward F12	5.9	3.5	2.3	40%
Ward F3	22.2	20.1	2.1	9.4%	Ward F3	25.8	22.5	3.3	13%
Ward F4	14.2	13.9	0.3	2.3%	Ward F4	13.9	10.7	3.3	23%
Ward F5	22.2	17.8	4.4	19.8%	Ward F5	12.9	14.0	(1.0)	-8%
Ward F6	24.0	18.9	5.1	21.2%	Ward F6	14.8	14.0	0.8	5%
Ward F7 Short Stay	22.3	21.1	1.2	5.5%	Ward F7 Short Stay	28.3	23.0	5.3	19%
Ward F9	19.3	14.6	4.7	24.5%	Ward F9	25.8	23.2	2.5	10%
Ward G1 Hardwick Unit	28.7	23.1	5.6	19.4%	Ward G1 Hardwick Uni	10.5	9.9	0.6	6%
Ward G3	19.5	15.7	3.8	19.5%	Ward G3	25.6	25.5	0.0	0%
Ward G4	19.5	18.0	1.5	7.7%	Ward G4	25.4	22.7	2.7	11%
Ward G8	27.5	23.5	4.0	14.7%	Ward G8	20.6	19.1	1.5	7%
Renal Ward - F8	19.4	17.0	2.4	12.2%	Renal Ward - F8	25.8	25.0	0.7	3%
Winter Escalation 20/21 - G5	22.5	11.8	10.7	47.7%	Winter Escalation 20/2	12.7	12.1	0.7	5%
Ward F10*	19.2	17.4	1.8	9.4%	Ward F10*	18.0	19.0	(1.0)	-6%
Respiratory Ward - G9	23.7	19.9	3.8	15.9%	Respiratory Ward - G9	18.0	14.6	3.4	19%
Total	**611.1**	**537.5**	**73.6**	**12.0%**	**Total**	**399.7**	**372.9**	**26.8**	**7%**
Hospital Midwifery	57.7	42.3	15.4	26.7%	Hospital Midwifery	15.6	13.3	2.3	15%
Continuity of Carer Midwifery	27.3	30.5	(3.2)	-11.6%	Continuity of Carer Mid	0	0	0.0	
Community Midwifery	11.2	8.1	3.1	27.9%	Community Midwifery	3.8	3.6	0.2	5%
Total	**96.2**	**80.8**	**15.4**	**16.0%**	**Total**	**19.4**	**16.9**	**2.5**	**13%**

*current ward not budgeted (figured used based on roster establishment to represent vacancy)

Appendix 3:

Ward by Ward breakdown of Falls and Pressure ulcers February 2020

HAPU

	Cat 2	Cat 3	Unstageable	Total
Total	24	1	5	30
G8 - ward	4	0	1	5
F8 Renal Ward	4	0	0	4
F9 - ward	2	0	1	3
Cardiac Centre - Ward	2	0	0	2
Critical Care Unit	2	0	0	2
F4 - ward	2	0	0	2
F6 - ward	1	0	1	2
F7	1	0	1	2
F10	0	0	1	1
F12 Isolation Ward	1	0	0	1
F3 - ward	1	0	0	1
F5 - ward	1	0	0	1
G1 - ward	1	0	0	1
G4 - ward	1	0	0	1
Respiratory Ward	1	0	0	1
G5	0	1	0	1

Falls

	Feb 2021
Total	74
Glastonbury Court	10
Acute Assessment unit (AAU)	9
F5 - ward	6
G8 - ward	6
G1 - ward	5
F10	4
F3 - ward	4
G3 - Endocrine and General Medicine	4
Rosemary Ward	4
G5 - ward	4
F7	4
Cardiac Centre - Ward	3
F8 - Renal Ward	3
Emergency Department	2
F6 - ward	2
F9 - ward	2
F12 Ward	1
G4 - ward	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: 19.3.2021 V2.6**

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		1.4.21		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 19.3.21: Final report landed. completion extended to April 2021 to include recommnendations
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 19.3.21: Final report landed. completion extended to April 2021 to include recommnendations
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 electrionic 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 19.3.21. Training delivered in March. go live extended to April to avoid clash with eCare go live phase 4
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

Appendix 6: Summary of RSM audit actions

RSM audit actions						
Mgnt Action No	Priority	Finding	Action	Progress	completion date	date completed
1	Medium	Ensure that the rostering policy is reviewed, revised and communicated to relevent staff	Roster to be updated as per RSM audit and nursing resource improvement plan	19.3.2021: Roster policy intentionally overdue to ensure that all actions and recommnedtaions in the RSM are captured. On track for completion in April	1st April 2021	
2	Low	Ensure that staffing escalation policy is reveiwed and updated and clarify out of hours of temporary	Roster to be updated as per RSM audit and nursing resource improvement plan	19.3.2021: Roster policy intentionally overdue to ensure that all actions and recommnedtaions in the RSM are captured. On track for completion in April	1st April 2021	
3	Medium	Ensure that the accuracy and timeliness of bank and agency shifts within healthroster	email sent to all ward mangers and matrons requesting cessation of all local agency bookings	19.3.2021 sent on 3.3.21	1st April 2021	3.3.2021
			Review electronic sign off of agency shifts that will drive and eliminate retrospective bookings	19.3.2021, being scoped by WSP lead	2nd April 2021	
4	Low	Monitor lead times for bank staff booking in roster review meetings	Bank shift lead time to be added to TOR of 'check and challenge' meetings	19.3.21 Added to TOR first iteration of roster reviews in	1st April 2021	
5	Low	ensure bank staff are sought in the first instance before agency	Process to be included in staffing escalation roster	19.3.2021: Roster policy intentionally overdue to ensure that all actions and recommendations in the RSM are captured. On track for completion in April	1st May 2021	
6	Medium	Ensure bank time sheets are completed and approved electronically	electronic time sheet for bank shifts to be introduced	implemented in 1.12.2020	N/A	1.12.2020
7	Medium	To ensure that out of hours requests are appropriately authorised and supported by electronic audit trails	OOH process to be articulated in staff escalation policy (see action 2)	19.3.2021: Roster policy intentionally overdue to ensure that all actions and recommendations in the RSM are	1st April 2021	
			deliver training and QRG to 888 team for OOH requests and temporary staffing fill	19.3.2021: being scoped with tactical lead given these staff are all OOH workers	1st April 2021	
8	High	Ensure O/T authorisation is able to be demonstrated and authorised	procedure to authorise O/T to be introduced that is auditable and ensures net hours used	19.3.2021: No functionality within eRoster to complete this. Hard copy request to be considered	1st July 2021	
9	Low	Check and Challenge TOR are formally circulated and approved	To update and recirculate TOR	19.3.2021: completed	1st April 2021	19.3.2021

13.4. Improvement programme board report

For Approval

Trust Open Board – March 2021

Agenda item:	13.4			
Presented by:	Sue Wilkinson, Executive Chief Nurse			
Prepared by:	John Connelly, Head of PMO			
Date prepared:	19 March 2021			
Subject:	Improvement programme board report			
Purpose:		For information	X	For approval

The Improvement programme board meeting, held on 8th **March 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 last two IPB meetings have reflected on the RAG rating with agreement to build further improvement narrative in the improvement plan to reflect the learning from external and internal sources

Trust approach emphasis to provide a greater focus on improvement and learning activities with an escalation framework was explained with benefit of reducing time spent on transactional matters

Current Status Report

- 75% of CQC must plans are now BAU (Blue), Complete (Black) or On track (Green)

RAG	Red	Amber	Green	Black	Blue
No Plans	5	3	1	10	14
%	15%	9%	3%	30%	42%

Fifteen change requests submitted for approval at March IPB were approved including:

1. One Plan moves from Black to BAU
- Plan No 15: Equipment / Medication checks

2. Four plans move from Green to Black:
- Plan No 1: Culture
- Plan No 11: Fit & Proper Persons
- Plan No 43: Displaying healthier lives information
- Plan No 57: Friends and Family Data

3. One Plan moves from Amber to Blue
- Plan No 69: Acuity Tool / Safer Staffing Levels

4. Two plans move from Amber to Green:
- Plan No 47: Supernumerary Labour Suite Co-ordinator
- Plan No 48: Mandatory Training & Prompt

5. One plan moves from Amber to Red:
- Plan No 7: Data Quality Management

6. One plan moves from Green to Red:
- Plan No 2: Freedom to Speak Up

7. One Plan moves from no rating to Blue
- Plan No 72: Personalised care plans

8. One plan moves from no rating to Black:
- Plan No 36: Infection Prevention

9. The completion dates for two plans were extended:
- Plan No 4.1: Clinical Audit extended by 4 months to 31.07.21
- Plan No 33: Pathology extended by 2 months to 31.05.21

10. The completion dates for one plan was brought forward:
- Plan No 43: Displaying Healthier Lives information brought forward by 3 months from 31.05.21 to 28.02.21

One change request submitted for approval at March IPB was not approved:

1. One plan moving from Amber to Green:
- Plan No 4.1: Clinical Audit. The project end date extension 31.07.21 was agreed, however it was deemed more appropriate for the RAG to remain at Amber until the outstanding actions were progressed further.

Other information:

- External Maternity assurance report was presented based on follow up visit undertaken 17.02.21

- WSFT approach to progress Plan No. 31 (Recording Pain Assessments in Community) was supported by CCG Chief Nurse following engagement with WSFT Community Head of Nursing

Trust priorities	**Deliver for today**		**Invest in quality, staff and clinical leadership**		**Build a joined-up future**		
	X		X		X		
Trust ambitions	*Deliver personal*	*Deliver*	*Deliver joined-up*	*Support a healthy*	*Support a healthy*	*Support ageing*	*Support all our*
	X	X	X	X	X	X	X
Previously considered by:							
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 A – Improvement Plan

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale	Origin / Source
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	Black	**28.02.21** ~~31.03.21~~ ~~30.11.20~~	**IPB Update 08.03.21: Plan moves to Black. Key actions presented below (1 - 9) all complete 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, Just Culture and national People Plan developed and presented to Board of Directors, and endorsed, 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. Exec 360 feedback process underway and due to complete by mid-March.** **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. It has been incorporated into WSFT People Plan action plan and thus will be taken forward through that route.** **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 to learn from our model and approach as part of a wider system-wide bid for resources.** **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. Implementation of agreed action plan complete. To be reviewed for assurance purposes with H.E.E. at planned meeting in April.**	

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	Red	**28.02.21** ~~31.03.21~~ ~~30.11.20~~	**IPB Update 08.03.21: Plan moves to Red** **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 arrangements in place.** **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. Decision to incorporate into ToR of new Involvement Committee, which will be established in early 2021/22.** **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 plan to implement ACSA recommendations in place and in delivery.** **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.**

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**	**31.07.21** ~~31.03.21~~ ~~01.07.20~~ ~~31.12.20~~	**IPB Update (Out): Plan moves to Amber from Green due to number of outstanding actions. The plan has been revised but actions not yet progressed with newly appointed coordinator starting on 08.03.21** **IPB Update 08.03.21: Request to IPB is to move plan from Amber to Green and to extend completion date to 31.07.21 as 21/22 plan refreshed by Compliance Manager and newly appointed Clinical Audit Coordinator, prioritising actions as preparation to hit ground running from start date 08.03.21.** **- Plan will move to Black (complete) at point when Q1 divisional clinical audit programmes progress is reported in July 2021** **- Updating plan was action taken from Feb SRO Cluster meeting ensuring carry forward of any outstanding actions from previous plan** **- Associate Medical Director (Quality & Safety) out to advert** **- Potential to further strengthen central clinical audit function with B4 support for Audit Coordinator in budget setting mix**

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 08.03.21: Plan remains on track.** **- Policies being reviewed and rewritten by HRBP's and wider HR team** **- A standard foreword for all policies has been drafted to explain the meaning and aims of a just and learning restorative culture and approach**

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 08.03.21+S70:** **- Internal Audit of Surveillance process due to complete 31st March with findings presented at April IPB** **- Training scheduled for ESR upload 22.02.21 delayed due to staffing constraints.** **- Project target completion date risk 31.03.31 due to training roll out delay escalated.** 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 March and implementation of any changes to practice to begin 1st April 2021. 1st April 2021 will 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 function. 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 feed into the performance review meetings. 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.

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	Red	**28.02.21** ~~31.12.20~~	**IPB Update 08.03.2+S161: Plan moves to Amber to Red. Data Quality actions are outstanding including:** **1. Data Quality Manager Recruitment process** **2. Completion of the DQ Strategy for approval via TEG. Medical feedback is still awaited. Completion timeframes are to be confirmed.**

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	**Black**	**28.02.21** ~~30.11.20~~	**IPB update 08.03.21: Plan moves to Black. Audit actions complete and BAU process will involve review of Chief Nurse file.**
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 08.03.21:** **- MT recovery plan will be managed with divisional input at joint PRM.** **- Recovery plans will be gauged with comparative organisations.**

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	**Blue**	**31.11.20** ~~31.10.20~~ ~~30.09.20~~ ~~31.03.20~~	**IPB Update 08.03.21: Plan moves to Blue (BAU) as compliant data is being received consistently**
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**

31	The trust must ensure staff complete and record patient pain assessments in patient records.	1. CCG Chief Nursing Officer to meet with WSFT Community Service Head of Nursing 2. Update the SOP for the clinicians First Assessment to reflect that pain assessments must be done 3. Factsheet to be given to each member of staff about pain tools/evidence 4. Trial to investigate if the Abbey Pain tool can work in the SystmOne Mobile app 5. Standardise the pain assessment pages in SystmOne, so that these are unified and fit for purpose 6. Revisit membership of Task & Finish Group to include Dawn Pretty (Lead Pain Nurse) and other relevant leads to be added 7. Informatics to provide report to measure compliance rates to the Team leads, senior matrons etc 8. Consultation between East and West Suffolk regarding user changes to SystemOne clinical system, re: embedding pain tool into care plans into SystemOne 9. District nurse sisters and end of life link nurses to identify compliant and non compliant assessments, and to discuss findings with nurses / staff 10. Barriers to be reported back to senior matrons and S Webb 11. Ensure community therapists are included in the baseline 12. Driver diagrams to be used as additional Quality Improvement tools to support evidencing the project 13. Robust training support to staff in use of SystemOne, in particular in the use and recording of pain assessments in a unified way 14. Quarterly 'deep dive' process to be launched by 31.03.21 driven by HoN to review clinical care delivered for complex patients, including consideration of pain. SOP to follow. 15. HoN and Senior Matrons to meet 03.03.21 to consider how to manage HealthWatch request for securing patient feedback re: monitoring of pain.	Helen Beck	Michelle Glass	Red	**31.03.21** ~~31.03.21~~ ~~31.12.20~~ ~~01.03.20~~	**IPB Update 08.03.21:** **Trust will monitor pain assessments of patient group with syringe driver care plans** **• Quarterly 'deep dive' launch 31.03.21 driven by HoN to review clinical care delivered for complex patients, including pain with SOP to follow** **Monthly monitoring ongoing via Information Team**

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.	Updated Improvement Plan (27.02.21) post Attain Plan review: - Review off site commercial options - Undertake feasibility studies - Consult with staff regarding process to identify preferred location - Complete Operational Plan by 31.05.21	Nick Jenkins	Fiona Berry	**Green**	**31.05.21** ~~31.03.21~~ ~~31.01.21~~ ~~31.12.20~~ ~~01.03.20~~	**IPB Update 08.03.21: Request to IPB is to review and agree revised improvement required.** **Trust extended project end date to 31.05.21 when Operational Plan will be available as plan has been updated since last IPB reflecting scope change as Attain Report not identified realistic on site option.** **Project focus moved to consider off site commercial options with plan to develop feasibility studies for potential sites and to engage staff in consultation process to identify a preferred location.** **- Review of LIMS has been undertaken with plan on track to present recommended option to Board on 16.03.21 regarding replacement of LIMS** **- Potential for digitising pathology services has been reviewed. This is again an additional piece of work that will be added to the Trust Improvement Plan.**

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	Black	**31.10.20** ~~11.02.20~~	**IPB Update 08.03.21: Plan moves to Black (complete) as all actions complete. Infection Control audits will be used to evidence BAU.**
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	**Green**	**31.07.21** ~~31.03.21~~ ~~01.07.20~~ ~~31.12.20~~	**See Plan No 4.1**

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	**Black**	**28.02.21** ~~**31.05.21**~~ ~~31.12.20~~	**IPB Update 08.03.21: Request to IPB is to move the plan to Black as final audit was completed 10.02.21 and there is good visibility of outcomes in the audit report.**

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 08.03.21: Improving Everyone's Experience action plan is complete with exception of FTSU NGO review report which is national / external - out of Trust control.**
47	The trust should ensure that the labour suite coordinator is supernumerary.		Susan Wilkinson	Karen Newbury	**Green**	**31.03.21** ~~08.02.20~~	**IPB Update 08.03.21: Plan moves to Green. All supernumerary labour suite coordinators have been appointed, but some will not be in post until May.**
48	The trust should ensure a higher percentage of staff complete mandatory training including PROMPT.		Susan Wilkinson	Karen Newbury	**Green**	**30.04.21** ~~31.12.20~~	**IPB Update 08.03.21: Plan moves to Green. All actions complete bar decision on status of PROMPT as Mandatory Training**

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**	**31/12/20**	**Update 08.03.21:** **- Recovery Plan will be managed with divisional input at joint PRM. -- Recovery plans will be gauged with comparative organisations.**
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 08.03.21: Guidance requested from IPB as to how to demonstrate BAU.**
57	The trust should ensure the collection of friends and family data in all areas.		Susan Wilkinson	Karen Newbury	**Black**	**28.02.21**	**IPB Update 08.03.21: Plan moves to Black (complete) as all actions are now complete.**
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 08.03.21: Discussions around Trust-wide action have not yet taken place. All other items complete.**

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 08.03.21: Guidelines for the new pathways are still in the final stages** 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.
61	The trust should consider security enabled doors in the paediatric outpatient department.		Helen Beck	Michelle O'Donnell	**Red**	**30.04.21** ~~31.12.20~~ ~~01.05.20~~	**IPB Update (Out) 08.03.21: Agreed to extend completion date to 30.04.21** **IPB Update 08.03.21:** **Financial approval received for Mag Locked doors solution with automated opening. 8 week lead in team for maintenance team to fit.**
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**
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 08.03.21: Two identified risks need mitigating to complete plan:** **- Community Paediatrics audit facilitation capacity. No supernumery resource as with community adult nursing and no case for additional post given audit levels. Current mitigation is that staff absorb audit facilitation in to substantive roles.** **- Community Paediatrics Clinical Audit reporting risk mitigated with start of audit coordinator in central clinical audit team 08.03.21 providing direct reporting link in to the organisation.** **Community Paediatrics Consultant Clinical Audit Plan and risk mitigation to be shared with Medical Director at March SRO Cluster**

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 / Sharon Basson	**Blue**	**31.12.20**	**IPB Update 08.03.21: Plan moves to BAU.** **- Shelford Acuity / Safer Staffing Tool in place reporting on 6 monthly basis (1 Winter + 1 Summer) with October figures compliant. Shelford covers Harm.** **- Monthly Roster Review meeting also in place with ward managers, HoN's and DDN**
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	**Blue**	**31.12.20** ~~30.04.20~~	**IPB Update 08.03.21: Plan moves to Blue (BAU). Personalised care plans available in e-Care and in use for some time. Every patient can have tailored care plan.** **Over and above the original ask, implementation of the following is being pursued to further improve the personalisation of care plans:** **- 'My Care Wishes' paperwork for patients in the last 12 months of life** **- 'This Is Me' paperwork for dementia patients and their families** **- 'Hospital Passport' tailored for patients with learning disabilities** **- Patients' and relatives' paperwork being trialled in IT**

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 08.03.21: Plan will complete when:** **Trust information team confirm e-Care can provide relevant reports** **Reporting agreement with CCG in place.**
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 08.03.21: Plan remains on track.** **- Therapists using individual goals and outcome measures.** **- Training roll-out to nursing staff has commenced and will continue over the coming weeks via MDT Team meetings, at which point the plan is expected to move to Black (Complete).**

WS FT_ 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** - Update 20.01.21: Awaiting Guidance from National Team/LMNS before implementation can be completed - Trust Response 29.12.20: Trust already prepare statement of commitment and plan to follow by 31.01.21 - 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 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.	Ockenden Report

WS FT_ 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** • Update 20.01.21: Delay is due to job planning. Mitigating actions are expected to be agreed at meeting 20.01.21 • 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 submission if not already available as part of annual audit cycle). • 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 remaining 2nd ward rounds at the weekend are being worked on, but require job plan changes.	Ockenden Report
WS FT_ 003	MDT Training Scheduled	3. Staff training and working together (Ockenden Report)	Susan Wilkinson	Karen Newbury	**Complete**	**31.03.21**	**• Trust Response 21.12.20: MDT Training schedule is in place.**	Ockenden Report

WS FT_ 004	MDT Training Implemented	3. Staff training and working together (Ockenden Report)	Susan Wilkinson	Karen Newbury	**Green**	**31.03.21**	**Update 02.02.21: Training has been scheduled but completion of training is at risk due to lack of anaesthetist availability** • Update 20.01.21: Need to ensure 90 percent compliance • Regional Response 23.12.20: One spot check audit undertaken by 15th January 2020 • Trust Response 21.12.20: MDT Training schedule is in place.	Ockenden Report
WS FT_ 005	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** • Update 20.01.21: This is currently being reviewed • 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 • 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	Ockenden Report

WSFT_006	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 29.12.20: Trust has care pathway SOP in place available for external view via Internet • 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. Commitment to support regional maternal medicine networks once established and what steps have been taken • Trust Response 21.12.20: WSH commits to complying with the developments of maternal medicine specialist centres.	Ockenden Report
WSFT_007	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 29.12.20: A statement will be made to commit to the national risk assessment process when it is available • 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 signup to the National Risk Assessment process when available. • 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.	Ockenden Report

WS FT_ 008	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** • Update 20.01.21: Guidelines need to be added to website and leaflets reproduced in top 5 languages • 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. • 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 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 information leaflets regarding choices. Trust reviewing to ensure that these are available in our top 5 languages. 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.	Ockenden Report
WS FT_ 009	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	West Suffolk Site Visit Summary Report 06.01.21

WSFT_010	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	West Suffolk Site Visit Summary Report 06.01.21
WSFT_O11	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**	West Suffolk Site Visit Summary Report 06.01.21
WSFT_012	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. These roles need to be embedded to ensure there is medical engagement and oversight of the governance processes and MDT training**	West Suffolk Site Visit Summary Report 06.01.21
WSFT_013	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	West Suffolk Site Visit Summary Report 06.01.21

WS FT_ 014	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	West Suffolk Site Visit Summary Report 06.01.21
WS FT_ 015	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 Board in March** Update 06.01.21: Midwifery led birth centre criteria pathway has not been completed	West Suffolk Site Visit Summary Report 06.01.21
WS FT_ 016	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**	West Suffolk Site Visit Summary Report 06.01.21
WS FT_ 017	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**	West Suffolk Site Visit Summary Report 06.01.21
WS FT_ 018	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**	West Suffolk Site Visit Summary Report 06.01.21

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	Black	**28.02.21** ~~31.03.21~~ ~~30.11.20~~	**IPB Update 08.03.21: Plan moves to Black. Key actions presented below (1 - 9) all complete 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, Just Culture and national People Plan developed and presented to Board of Directors, and endorsed, 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. Exec 360 feedback process underway and due to complete by mid-March.** **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. It has been incorporated into WSFT People Plan action plan and thus will be taken forward through that route.** **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 to learn from our model and approach as part of a wider system-wide bid for resources.** **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. Implementation of agreed action plan complete. To be reviewed for assurance purposes with H.E.E. at planned meeting in April.**
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 08.03.21: Plan moves to Red** **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 arrangements in place.** **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. Decision to incorporate into ToR of new Involvement Committee, which will be established in early 2021/22.** **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 plan to implement ACSA recommendations in place and in delivery.** **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.**
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**	**31.07.21** ~~31.03.21~~ ~~01.07.20~~ ~~31.12.20~~	**IPB Update (Out): Plan moves to Amber from Green due to number of outstanding actions. The plan has been revised but actions not yet progressed with newly appointed coordinator starting on 08.03.21** **IPB Update 08.03.21: Request to IPB is to move plan from Amber to Green and to extend completion date to 31.07.21 as 21/22 plan refreshed by Compliance Manager and newly appointed Clinical Audit Coordinator, prioritising actions as preparation to hit ground running from start date 08.03.21.** **- Plan will move to Black (complete) at point when Q1 divisional clinical audit programmes progress is reported in July 2021** **- Updating plan was action taken from Feb SRO Cluster meeting ensuring carry forward of any outstanding actions from previous plan** **- Associate Medical Director (Quality & Safety) out to advert** **- Potential to further strengthen central clinical audit function with B4 support for Audit Coordinator in budget setting mix**
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 08.03.21: Plan remains on track.** **- Policies being reviewed and rewritten by HRBP's and wider HR team** **- A standard foreword for all policies has been drafted to explain the meaning and aims of a just and learning restorative culture and approach**

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale
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 08.03.21+S70:** **- Internal Audit of Surveillance process due to complete 31st March with findings presented at April IPB - Training scheduled for ESR upload 22.02.21 delayed due to staffing constraints. - Project target completion date risk 31.03.31 due to training roll out delay escalated.** 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 March and implementation of any changes to practice to begin 1st April 2021. 1st April 2021 will 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 function. 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 feed into the performance review meetings. 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.
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	Red	**28.02.21** ~~31.12.20~~	**IPB Update 08.03.2+S161: Plan moves to Amber to Red. Data Quality actions are outstanding including:** **1. Data Quality Manager Recruitment process** **2. Completion of the DQ Strategy for approval via TEG. Medical feedback is still awaited. Completion timeframes are to be confirmed.**
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	**Black**	**28.02.21** ~~30.11.20~~	**IPB update 08.03.21: Plan moves to Black. Audit actions complete and BAU process will involve review of Chief Nurse file.**
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 08.03.21:** **- MT recovery plan will be managed with divisional input at joint PRM.** **- Recovery plans will be gauged with comparative organisations.**

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale
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	**Blue**	**31.11.20** ~~31.10.20~~ ~~30.09.20~~ ~~31.03.20~~	**IPB Update 08.03.21: Plan moves to Blue (BAU) as compliant data is being received consistently**
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**
31	The trust must ensure staff complete and record patient pain assessments in patient records.	1. CCG Chief Nursing Officer to meet with WSFT Community Service Head of Nursing 2. Update the SOP for the clinicians First Assessment to reflect that pain assessments must be done 3. Factsheet to be given to each member of staff about pain tools/evidence 4. Trial to investigate if the Abbey Pain tool can work in the SystmOne Mobile app 5. Standardise the pain assessment pages in SystmOne, so that these are unified and fit for purpose 6. Revisit membership of Task & Finish Group to include Dawn Pretty (Lead Pain Nurse) and other relevant leads to be added 7. Informatics to provide report to measure compliance rates to the Team leads, senior matrons etc 8. Consultation between East and West Suffolk regarding user changes to SystemOne clinical system, re: embedding pain tool into care plans into SystemOne 9. District nurse sisters and end of life link nurses to identify compliant and non compliant assessments, and to discuss findings with nurses / staff 10. Barriers to be reported back to senior matrons and S Webb 11. Ensure community therapists are included in the baseline	Helen Beck	Michelle Glass	Red	**31.03.21** ~~31.03.21~~ ~~31.12.20~~ ~~01.03.20~~	**IPB Update 08.03.21:** **Trust will monitor pain assessments of patient group with syringe driver care plans** **• Quarterly 'deep dive' launch 31.03.21 driven by HoN to review clinical care delivered for complex patients, including pain with SOP to follow** **Monthly monitoring ongoing via Information Team**
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**

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale
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.	Updated Improvement Plan (27.02.21) post Attain Plan review: - Review off site commercial options - Undertake feasibility studies - Consult with staff regarding process to identify preferred location - Complete Operational Plan by 31.05.21	Nick Jenkins	Fiona Berry	**Green**	**31.05.21** ~~31.03.21~~ ~~31.01.21~~ ~~31.12.20~~ ~~01.03.20~~	**IPB Update 08.03.21: Request to IPB is to review and agree revised improvement required.** **Trust extended project end date to 31.05.21 when Operational Plan will be available as plan has been updated since last IPB reflecting scope change as Attain Report not identified realistic on site option.** **Project focus moved to consider off site commercial options with plan to develop feasibility studies for potential sites and to engage staff in consultation process to identify a preferred location. - Review of LIMS has been undertaken with plan on track to present recommended option to Board on 16.03.21 regarding replacement of LIMS - Potential for digitising pathology services has been reviewed. This is again an additional piece of work that will be added to the Trust Improvement Plan.**
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	Black	**31.10.20** ~~11.02.20~~	**IPB Update 08.03.21: Plan moves to Black (complete) as all actions complete. Infection Control audits will be used to evidence BAU.**
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	**Green**	**31.07.21** ~~31.03.21~~ ~~01.07.20~~ ~~31.12.20~~	**See Plan No 4.1**
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	**Black**	**28.02.21** ~~31.05.21~~ ~~31.12.20~~	**IPB Update 08.03.21: Request to IPB is to move the plan to Black as final audit was completed 10.02.21 and there is good visibility of outcomes in the audit report.**

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale
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 08.03.21: Improving Everyone's Experience action plan is complete with exception of FTSU NGO review report which is national / external - out of Trust control.**
47	The trust should ensure that the labour suite coordinator is supernumerary.		Susan Wilkinson	Karen Newbury	**Green**	**31.03.21** ~~08.02.20~~	**IPB Update 08.03.21: Plan moves to Green. All supernumerary labour suite coordinators have been appointed, but some will not be in post until May.**
48	The trust should ensure a higher percentage of staff complete mandatory training including PROMPT.		Susan Wilkinson	Karen Newbury	**Green**	**30.04.21** ~~31.12.20~~	**IPB Update 08.03.21: Plan moves to Green. All actions complete bar decision on status of PROMPT as Mandatory Training**
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**	**31/12/20**	**Update 08.03.21:** **- Recovery Plan will be managed with divisional input at joint PRM. -- Recovery plans will be gauged with comparative organisations.**
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 08.03.21: Guidance requested from IPB as to how to demonstrate BAU.**
57	The trust should ensure the collection of friends and family data in all areas.		Susan Wilkinson	Karen Newbury	**Black**	**28.02.21**	**IPB Update 08.03.21: Plan moves to Black (complete) as all actions are now complete.**
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 08.03.21: Discussions around Trust-wide action have not yet taken place. All other items complete.**
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 08.03.21: Guidelines for the new pathways are still in the final stages** 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.
61	The trust should consider security enabled doors in the paediatric outpatient department.		Helen Beck	Michelle O' Donnell	**Red**	**30.04.21** ~~31.12.20~~ ~~01.05.20~~	**IPB Update (Out) 08.03.21: Agreed to extend completion date to 30.04.21** **IPB Update 08.03.21:** **Financial approval received for Mag Locked doors solution with automated opening.** **8 week lead in team for maintenance team to fit.**

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale
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**
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 08.03.21: Two identified risks need mitigating to complete plan:** **- Community Paediatrics audit facilitation capacity. No supernumery resource as with community adult nursing and no case for additional post given audit levels. Current mitigation is that staff absorb audit facilitation in to substantive roles.** **- Community Paediatrics Clinical Audit reporting risk mitigated with start of audit coordinator in central clinical audit team 08.03.21 providing direct reporting link in to the organisation.** **Community Paediatrics Consultant Clinical Audit Plan and risk mitigation to be shared with Medical Director at March SRO Cluster**
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 audit positions.** 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 flagged. 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 item on the agenda at all relevant management and service meetings which could form part of the evidence base. Update 26.10.20: Action 3: October SMG meeting agenda and presentation provided to evidence guidance work.

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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 08.03.21: BAU evidence will be submitted to the April IPB.** 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 prevail and audits are visible in each room with weekly authorisation programme with audits. 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
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 / Sharon Basson	**Blue**	**31.12.20**	**IPB Update 08.03.21: Plan moves to BAU.** **- Shelford Acuity / Safer Staffing Tool in place reporting on 6 monthly basis (1 Winter + 1 Summer) with October figures compliant. Shelford covers Harm.** **- Monthly Roster Review meeting also in place with ward managers, HoN's and DDN**
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	**Blue**	**31.12.20** ~~30.04.20~~	**IPB Update 08.03.21: Plan moves to Blue (BAU). Personalised care plans available in e-Care and in use for some time. Every patient can have tailored care plan.** **Over and above the original ask, implementation of the following is being pursued to further improve the personalisation of care plans:** **- 'My Care Wishes' paperwork for patients in the last 12 months of life** **- 'This Is Me' paperwork for dementia patients and their families** **- 'Hospital Passport' tailored for patients with learning disabilities** **- Patients' and relatives' paperwork being trialled in IT**

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 08.03.21: Plan will complete when:** **Trust information team confirm e-Care can provide relevant reports** **Reporting agreement with CCG in place.**
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 08.03.21: Plan remains on track.** **- Therapists using individual goals and outcome measures.** **- Training roll-out to nursing staff has commenced and will continue over the coming weeks via MDT Team meetings, at which point the plan is expected to move to Black (Complete).**
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** - Update 20.01.21: Awaiting Guidance from National Team/LMNS before implementation can be completed - Trust Response 29.12.20: Trust already prepare statement of commitment and plan to follow by 31.01.21 - 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 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.
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** •Update 20.01.21: Delay is due to job planning. Mitigating actions are expected to be agreed at meeting 20.01.21 •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 submission if not already available as part of annual audit cycle). •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 remaining 2nd ward rounds at the weekend are being worked on, but require job plan changes.
WSFT_003	MDT Training Scheduled	3. Staff training and working together (Ockenden Report)	Susan Wilkinson	Karen Newbury	**Complete**	**31.03.21**	**•Trust Response 21.12.20: MDT Training schedule is in place.**
WSFT_004	MDT Training Implemented	3. Staff training and working together (Ockenden Report)	Susan Wilkinson	Karen Newbury	**Green**	**31.03.21**	**Update 02.02.21: Training has been scheduled but completion of training is at risk due to lack of anaesthetist availability** •Update 20.01.21: Need to ensure 90 percent compliance •Regional Response 23.12.20: One spot check audit undertaken by 15th January 2020 •Trust Response 21.12.20: MDT Training schedule is in place.
WSFT_005	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** •Update 20.01.21: This is currently being reviewed •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 •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
WSFT_006	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 29.12.20: Trust has care pathway SOP in place available for external view via Internet •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. Commitment to support regional maternal medicine networks once established and what steps have been taken •Trust Response 21.12.20: WSH commits to complying with the developments of maternal medicine specialist centres.
WSFT_007	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 29.12.20: A statement will be made to commit to the national risk assessment process when it is available •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 National Risk Assessment process when available. •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.

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale
WSFT_008	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** •Update 20.01.21: Guidelines need to be added to website and leaflets reproduced in top 5 languages •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. •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 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 information leaflets regarding choices. Trust reviewing to ensure that these are available in our top 5 languages. 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.
WSFT_009	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_010	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_O11	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_012	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. These roles need to be embedded to ensure there is medical engagement and oversight of the governance processes and MDT training**
WSFT_013	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_014	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_015	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 Board in March** Update 06.01.21: Midwifery led birth centre criteria pathway has not been completed
WSFT_016	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_017	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**
WSFT_018	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**

11:10 BUILD A JOINED-UP FUTURE

14. Digital programme board report

To approve report

For Approval

Presented by Craig Black

Trust Board Meeting – 26 March 2021

Agenda item:	14			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Sarah Jane Relf, Head of Digital Transformation			
Date prepared:	21 March 2021			
Subject:	To receive update from Digital Board			
Purpose:		For information		For approval

Executive summary:
This paper confirms key points of interest raised and discussed at the Digital Board on 9 March 2021.The focus of the meeting was assurance for the forthcoming go live.

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:	*Separate pillar group meetings and Digital Board.*
Risk and assurance:	*Full risks are reviewed at each meeting with any high level risks reported through to board assurance framework as appropriate.*
Legislation, regulatory, equality, diversity and dignity implications	*GDPR consideration is applied to all projects.*

Recommendation:
The Board is asked to note the update.

1. Background

1.1 In May 2016, the trust embarked on a major change programme to introduce a new electronic patient record (EPR). The EPR was built around the Cerner Millennium product and was locally branded e-Care. Over time we have significantly enhanced the original e-Care offer with the introduction of new Cerner modules, implementation of other complimentary digital solutions and the extension of e-Care to other departments.

1.2 As part of this expansion the trust was bringing live the following enhanchements within e-Care.

- Maternity and neonates moving from paper to e-Care.
- An update to the drugs directory within e-Care.
- Introducing enhancements to the medicines administration processes. Currently the nurses scan the patients wrist band when doing their drugs rounds. In the future they will also scan the medication box to ensure that they are giving the correct drug to the right patient. This will bring significant safety improvements around medicines management.
- A new way for wards to request medication. Historically this has been completed on paper forms. This process is now automated within e-Care.
- Warfarin prescribing and administration moving from paper to e-Care.

These enhancements went live over the weekend of 19/20/21 March.

1.3 The above is the fourth phase of e-Care development since the original go live in May 2016.

2. Assurance process

2.1 Every major go live requires the Digital Board to sign off that the new functionality is safe. This is a statutory requirement and all significant changes to e-Care are required to have a dedicated safety case developed. This outlines any safety risks around the new functionality and confirms the mitigations that are in place to address this.

2.2 The Digital Board received three safety cases which covered all elements of the new functionality as described in section 1.2.

Maternity and neonates safety case
All risks had been appropriately mitigated with no safety concerns remaining outstanding.

Warfarin safety case
There was one risk around training numbers that the Digital Board required additional assurance around. At the time the safety case was presented the training numbers were lower than required. The Digital Board stated that Warfarin could only go live if the training numbers achieved the required threshold. After the meeting continued training was offered to staff and the threshold was exceeded. All other risks on the safety case had been appropriately mitigated.

Other medicines changes safety case
All other medicines changes were covered in the third safety case presented to Digital Board. All risks had been appropriately mitigated with no safety concerns remaining outstanding.

3. Safety case for go live

3.1 Whenever we add new functionality to e-Care we usually have to take the system down for a period of time. For this particular go live we were required to take the system down for 9 hours. Safety cases are usually only required for new functionality or systems. However because of length of time for the downtime, it was agreed to present a safety case covering

how the trust would work without e-Care. It was noted that all risks around the downtime had been appropriately mitigated with no safety concerns remaining outstanding.

4. Recommendation

4.1 The trust board is asked to note the report.

Sarah Jane Relf
Head of Digital Transformation

15. Future system board report

To APPROVE report

For Approval

Presented by Craig Black

Trust Board Meeting – 26 March 2021

Agenda item:	15			
Presented by:	Craig Black, Executive Director for Resources & Deputy CEO			
Prepared by:	Gary Norgate, Programme Director			
Date prepared:	15/03/2021			
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. 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 – As discussed last month, the Future System team had the opportunity to present its case to the newly formed, central, New Hospital Programme (NHP) on 5th February.

Since the round table we have worked with senior regional colleagues to conduct a "deep dive" into the core assumptions that underpin our costs. The session was extremely useful and identified the following as areas for further exploration:

1) Take a more detailed look backwards to test assumptions on future growth
2) Model an 85% bed utilisation rate (90% at present)
3) Model an increased percentage of digital outpatient work (increasing from the 20% in our SOC to 70% medical and 30% surgical)
4) Take account of the work underway on virtual hospitals
5) Model the revenue benefits of 70% single occupancy rooms (recognising our conclusions that the capital cost differential between 100% and 70% is marginal)
6) Remove staff accommodation from our space waterfall
7) Model the effect of reducing the cost of generic rooms (given the current small differential between the low cost and super high cost / sqm)
8) Consider how to present the need for essential maintenance funding as part of the overall case
9) Conduct an options appraisal for car parking
10) Revisit the residual value of the existing site

The strategic outline case has, in its entirety, been shared with the leader of the NHP and with NHSI/E colleagues who have agreed to 'informally' review the case against the essential business case criteria. This informal review is very welcome and will ensure that we get a "running start" at the formal appraisal once the NHP have completed the round-table events and are able to establish their priorities.

In preparation for the next phase of the business case process (the outline business case), the core members of the Future System team are all undertaking elements of a centrally administered training program aimed at "building better business cases.

Estates Workstream

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 application for planning permission on Hardwick Manor. In the last month work has centred upon the definition and

scoping of a detailed Environmental Impact Assessment which is on course to be submitted to the Local Planning Authority (LPA) w/c 22nd March 2021. Upon issue, the LPA have a statutory period of 5 weeks to provide opinion on the proposals which will then be reflected in the final scope of the formal EIA. To maintain momentum, the early activities of the EIA (e.g. tree, wildlife and traffic surveys) will progress concurrently with the provision of the scoping opinion. The EIA is scheduled for completion and issue by October / November 2021 to support an outline planning application in December 2021.

In addition, the Estates workstream is focussed on a number of research initiatives aimed at understanding the options, benefits and challenges associated with; achieving a net zero carbon design, utilising modern methods of construction and the impact of our digital blueprint. This activity is integrated with the other workstreams and contributes to the following master programme:

- Clinical brief development – January to May 2021
- Development of generic / best practice design – January to May 2021
- Development of whole hospital design strategy and site masterplan (including MMC, Net Zero,
- Carbon and Digital strategies) – January to May 2021
- Issue of whole hospital Schedule of Accommodation – July 2021
- Development of Whole Hospital design (1:500 and 1:200 layout plans) – July to November 2021
- Completion of EIA – November 2021
- Outline planning application submission – December 2021

Clinical Workstream

The physical infrastructure of any new facility must, ultimately, be designed to support the services conducted at that site. To this end, the clinical workstream continues at pace and is focussed upon the following key areas:

- Co-production of the service visions and accompanying documents for 28 subgroups of hospital care
- Definition and development of the complementary integrated community model of care
- Design of generic rooms and standard wards
- Discussion of optimum ward configuration
- Digital and clinical alignment
- Emotional and mental wellbeing
- Provider collaboration

Progress since last month:

Training for the co-production leads on the purpose and content of the outline business case is now complete (see Annex). A number of additional staff from across the organisation have been asked to help facilitate the co-production for the Outline Business Case and have kindly agreed. This is bringing extra capacity and expertise into some of the more complex workstreams.

The co-production activities for the hospital workstreams are largely planned and in many workstreams are already underway.

Discussions about the right way to develop the enhanced community model are underway with the alliance team, the alliance partners and a wider group of GP leaders.

The work on designing generic rooms continues. Three of the nine workshops with the architects have been held. The workshop schedule will continue through to mid-May.

Within that schedule, the option for different bed configurations will be looked at on 27th April and the topic will also be considered by the first meeting of the co-production community engagement panel on 24th March. Wider public feedback is being sought via the online survey about patient's experience of clinical services. Following the initial co-production community engagement panel discussion we will be able to determine whether any wider public discussion forums would be appropriate and plan for it immediately after the local elections on 6th May. A formal recommendation on preferred ward

configuration will be brought to the Future Systems Programme Board on 15th June.

The planning for a 'digital fortnight' is progressing well and is on track to take place between 12th and 23rd April. During this period, clinical and digital leads will assess the latest technological advancements review the current clinical workflows and bring the two areas together into a co-produced view of the full digital opportunity. This work will build on the generic suggestions of the digital blueprint produced for the strategic outline case and apply them to the specifics of our health and care system.

James Butcher, our senior operational lead, is working with Suffolk Mind to lead an exploration into how we can comprehensively address emotional and mental wellbeing in the clinical model.

Building on the strong foundations created in the last 3-5 years of the West Suffolk Alliance, collaboration opportunities for enhancing the community model actively being sought and explored.

Similarly, work continues with East Suffolk and North East Essex NHS Foundation Trust and our clinical commissioning groups to define the methodology that will allow the clinically lead, data driven analysis of opportunities to collaborate at a system level. That said, given the depth and extent of the conversations that would be required to design anything which would have a material impact on the Future System clinical model, this specific strand of work will not deliver any outputs in time to contribute to the outline business case.

Communications and Engagement Workstream

At last month's Board meeting we introduced the concept of a co-production community engagement group (CCEG) which would ensure ALL of our community had an opportunity shape the design and operation of the new health and care facility.

As a reminder, it was proposed that the group would meet on a monthly basis and comprise the following;

- A local resident
- A representative for vulnerable groups Inc. homeless, sex workers, prisoners and those with severe mental illnesses / their representatives
- Those with caring responsibilities
- BAME and LGBT representatives
- Recruited project lay members
- Patient VOICE reps
- Independent expert such as;
  - Disability and accessibility advocates
  - Union representatives
- Youth Council member
- Governing body engagement group member
- Future system patient voice reps
- Members of the general public
- Voluntary sector member
- Community group representative

To date we have received interest from more than 100 members of the community who wish to join the co-production community engagement group (not every member will attend each meeting). The attendance of each meeting will be determined by the subject matter being discussed to ensure those most relevant are at the table however the wider members will have an opportunity to have input by feeding their comments online via quantitative measures such as surveys.

The introduction of the CCEG complements existing internal groups and procedures.

A member of the West Suffolk Governors Engagement Committee will attend each meeting, using the forum as a listening exercise to aid understanding and hear patients' views. The engagement committee Governors will represent the wider Governing Body and act as a conduit between the project and the wider board.

The Patient Advice and Liaison (PALs) team who run the VOICE patient engagement group have been involved in the development of the co-production community engagement group. The four dedicated Future System VOICE representatives as well as the general VOICE reps are invited to attend the meetings, bringing with them the experience of their own patient engagement activities.
Feedback and discussion gathered from each meeting will be recorded and shared with both existing and future system colleagues, ensuring the timely introduction of new ideas and enhancements (the process for governing this feedback is currently being defined by Cassia Nice, Head of Patient Experience and Engagement).

The first meeting of the co-production community engagement group is on Wednesday 24th March. The subject to be discussed will be single rooms vs multi-bedded bays and optimum ward configuration.

Other communication and engagement updates:

The preferred site engagement is on-going. The next public meeting will be held after local elections. The event will be used to gather further feedback around the preferred site and provide any site updates if possible. We are in discussions with Healthwatch Suffolk regarding the analysis and evaluation of the feedback gathered. This will allow a fresh unbiased perspective on the comments received and the mitigations presented.

The Future System communications and engagement strategy has been signed off by NHS England / NHS Improvement regional communications colleagues as well as the Department for Health and Social Care New Hospital Programme communications team.

Public engagement sessions with the Bury Assembly of Associations and the Disability Forum were held in March and resulted in rich feedback relating to sustainability, traffic, parking, the involvement of pharmacists, maintaining WSFTs status as a teaching hospital and the accessibility of our materials.

A presentation relating to possible ward configurations was delivered to the Health Scrutiny Committee task and finish group and facilitated a very useful discussion.

Finance and Economic Workstream – As mentioned above, the key assumptions underpinning our cost build have been scrutinised by our Regional colleagues and remain materially unchanged, however, we will continue to review costs as we develop our clinical model and the ways in which it moderates demand and capacity. A budget for the development of the Outline Business Case has been agreed with the West Suffolk Board and will allow the team to maintain its momentum while we wait for the national "New Hospital Programme" team to complete their cycle of roundtables and define a schedule for the 40 different projects.

All in all, a month in which the strategic outline case has been published, phase 2 of the clinical design has commenced, tangible progress has been made towards de-risking our planning application 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 central NHP team.

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.							

Annex: Co-production lead study material

The following paper was prepared by Dr.Helena Jopling as a means of sharing and agreeing the conclusions and recommendations that emerged during the training of the Future System's teams co-production leads. The training may have relevance in the wider context of WSFT and how it operates. However, it is included here to inform the Board on the way in which the Future System ethos is developing and to communicate the decisions taken by the Programme Board:

In short, the Programme Board:

1. noted the learning and reflections from the co-production lead study day
2. acknowledged and accepted that the outputs of work on acute collaboration are not going to be achieved in time to inform the outline business case
3. agreed to use 'gradients of agreement' tool when taking substantive decisions
4. agreed to take four actions to improve the psychological safety within the programme:

- co-production leads would have a rolling invite to attend the Programme Board
- the Programme Board would "hold the line" on co-production as the method we have subscribed to is to think and talk honestly about how psychologically safe they themselves feel and the impact that their own perception of safety could have on the programme and how they can work together explicitly to help keep the programme team in the learning zone
- reduce the impact that the programme faces in terms of timescales, budget, etc on the clinical workstream's psychological safety and empower it to work on the basis of blue sky thinking until such time as clear directions or decisions are issued by the national team.

Background

A professional development programme has been designed for the co-production leads to support them to develop the knowledge, skills and confidence they need to do their roles well. The programme has been launched this month. It will combine formal study days with self-directed learning and informal group activities. The learning objectives for the programme were co-produced with the team in December.

We kicked off with a study day on 3rd March facilitated by Gareth Corser from NHS Elect. The day focussed on 3 objectives with direct application to the second phase of co-production that is currently underway:

1. Chairing and facilitation skills – what are the differences and how to do both well
2. Speaking truth to power / speaking bravely / difficult conversations – how to communicate effectively with colleagues at all levels of the organisation, especially when there are constraints to explain / expectations cannot be met
3. Representation – how to summarise and represent diverse views, e.g. finding the common themes and not applying one's own bias.

Gareth helped us tackle these topics with two frameworks: liberating structures and psychological safety.

Following is an account of some of the learning points and reflections from the day. This section is written in the first person from HJ's perspective, to make clear that this is a personal account of learning and reflections rather than necessarily representative of the whole group.

It is important to state that I am including these reflections in this paper with solution-finding in mind. Prof Megan Reitz recently spoke to the WSFT 5 O'Clock Club about speaking up and how power silences truth, and one of my take-home messages from her talk was that we spend a lot of time talking about *what* we're doing, and very rarely talk about *how* we're doing it.

All images are credited to Gareth Corser at NHS Elect.

Systems thinking, and its application to the topic of acute collaboration
In the morning we learned about systems thinking and the components of the system that either support or impair our ability to work towards common goals. Systems thinking encourages us to understand that we are all part of the system and as such we share responsibility for its successes and failures. The structures in the pyramid below are all constructed by us collectively; none of them exists independently. Some of the components are explicit, some are implicit. How fit for purpose each component is will have a strong and direct bearing on our success as a system.

There is a strong application to collaboration with ESNEFT here. For example:

1. The policies, practices and resources to support acute collaboration are not in place. Where it does happen at the moment it is adhoc rather than systematic and people's experiences of collaboration, vary.

2. The relationships between the organisations are perceived as being poor, despite the fact that when I have asked WSFT people individually about their relationship with their counterpart in ESNEFT, often they report a good relationship 1:1. In many cases the relationships are considered to be poor but actually, just don't exist, which is different.

3. The power dynamics in system working are complex, not least because the policy context for integrated care is still evolving. Some of the complexity is real, some of it is not. As a result the dynamics are difficult to understand and to navigate and people feel apprehensive about trying to.

4. The mental model which has been expressed most prominently as I've gone about conversations within WSFT is that collaboration between WSFT and ESNEFT is either unnecessary or undesirable or both. The mental model that has been expressed most prominently outside the trust is that collaboration between WSFT and ESNEFT is desirable, but the forms that collaboration can/should take and the reasons why it is desirable are not well-developed or consistently understood.

What this adds up to, as I see it, is a situation where:

- We need to put policies, practices and resources in place to facilitate more collaboration, and broadly speaking we are starting from scratch on this.
- Those policies, practices and resources will be easily undermined if the relationships (real or perceived) do not improve and the power dynamics do not become more straightforward.
- Even with both of those layers in place, the mental model underlying them needs to shift from one of looking back to one of looking forward. Getting the two layers above in place will help shift the mental model, but the shift also needs to be led for in and of itself.
- That shift in mental model will be made a great deal easier if we can describe what

problem(s) we are trying to solve with acute collaboration. At the moment it feels like the FS programme is being told to pursue it as an end in itself.

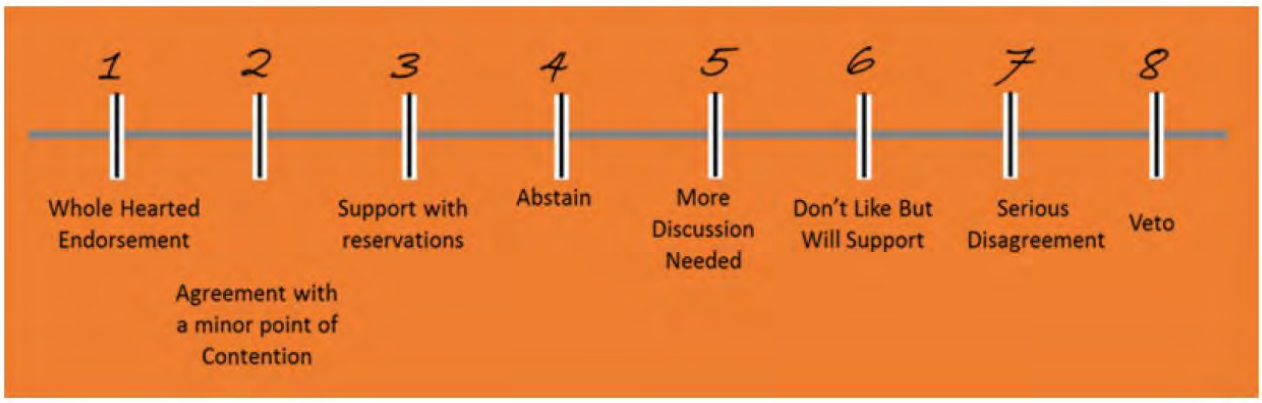
Going through the conversations on this topic over the last few weeks I have had to reflect honestly on the fact I have begun to become encultured and I have had to challenge myself to maintain the public health principles that collaboration should be the default and that passive resistance is rarely in the best interests of the population's health. Truly though, the route to well-worked up plans to do things differently between the two trusts is a long one, and good decision-making on this topic is much more complicated and involved than it might at first seem. The FS clinical workstream team can resource a work package on acute collaboration for the programme's purposes, but it cannot lead for collaboration in isolation. This is the substance of the paper which will go to the trust executive group on 15th March. The programme board has a role to play as well.

Please can the programme board:

1. consider its role in leading for acute collaboration
2. acknowledge and accept that the outputs of work on acute collaboration are not going to be achieved in time to inform the outline business case

Gradients of agreement

In the section on liberating structures we were introduced to gradients of agreement, a model which
allows the non-binary nature of agreement to be made explicit when we are trying to reach a consensus.



This feels like such a useful tool. A retrospective example of its application would have been when we took the assumptions that the SOC demand and capacity model was based on to the peer review panel. Two of the six members of the panel were wary/reluctant/qualified in their support for the assumptions, but we didn't have a way of quantifying or describing their position to the programme board. This tool would have allowed us to do just that and I anticipate it will have use throughout the co-production workshops.

I propose we adopt it for use in the programme board, the co-production community engagement panel and the peer review panel whenever substantive decisions are being made.

Psychological safety, and its application to the clinical workstream in general

In the afternoon, we learned about psychological safety, which is a concept that some people in the trust are already familiar with as it features in teaching about both human factors and a just culture.

Psychological safety is described[1] as:

> *"the willingness of people to express an opinion, admit mistakes or unsafe behaviours, without fear of being embarrassed, rejected or punished"*

We heard about the interaction between accountability and psychological safety and the four zones that people can find themselves in; apathy, comfort, anxiety and learning.

The co-production leads were invited to consider which zone they felt were in

1. within the co-production team
2. with the board (people interpreted this as the trust board or the programme board depending on which they were most familiar with)
3. within their own workstream, working with their stakeholders and colleagues

The main learning points I took away from the discussion were:

1. By and large the co-production leads feel that they are in the learning zone within the co-production team. The leads feel a high degree of accountability for their workstreams and mostly feel psychologically safe, although this varies and a sense of safety is impeded by the uncertainty that the programme in general is dealing with (see more discussion below).
2. Several commented that the study day itself was helping to increase their sense of safety, as it was emphasising that everyone was in the same boat, everyone was learning and people were enjoying learning together and getting to know each other better.
3. By and large the co-production leads do not feel a strong relation to the programme board or trust board or they feel in the anxiety zone. In some cases, people's relationships with the trust board in their main role was carrying over to inform their sense of safety within this role, whether that was good or bad.
4. There are mixed messages and mixed expectations being passed on by the programme team and by others close to the programme. Examples included:
    a. whether we are doing blue-sky thinking or whether we are working within tight constraints
    b. whether the co-production process really can determine the outcome or whether in fact it is all already decided.

    This inconsistency and uncertainty impair the co-production leads' sense of safety.

[1] Edmondson, A. C. 1999. Psychological Safety and Learning Behaviour in Work Teams. Administrative Science Quarterly, Vol. 44, 350–383

5. Within their own workstreams, the experience is more varied. Co-production leads feel variously in the learning zone, the anxiety zone, or the comfort zone, depending on the prevailing quality of relationships or the prevailing level of psychological safety.
6. It was also noted that in some cases people are trying or managing to circumvent the co-production process and have their views heard outside of the process, or more loudly. This has been created both by good intentions, e.g. by encouraging a flexible approach to how stakeholders can be involved, and bad intentions, e.g. individuals exerting managerial influence. Either way it undermines the principles of co-production if everyone is not heard equally and it undermines the co-production leads in doing the important role we have asked of them.

A number of these reflections will be picked up and acted on within the clinical workstream. The points I want to pull out for the programme board to consider are as follows:

1. I suspect people throughout the HIP programme nationally are in the anxiety zone – the programme teams and trust boards in many of the 40 trusts, the regional teams and the national team – because at each of our levels this programme is something that none of us has ever done before. Yet the accountability for everyone involved is very high; and the relationship with the level above will often not feel psychologically safe. My observation is that this is about the prevailing culture within the NHS. **A reflective discussion** about how the members of the board feel and the impact this could have on the programme would be welcome. Who feels accountable and who doesn't? Who feels psychologically safe and who doesn't?
2. There is a large amount of uncertainty across the national programme and in our relation to it: the timescales, the budget, the sequencing of builds, whether national directions are going to be issued and on what topics, what tasks might be pulled into the national team and when e.g. procurement. This creates an unstable platform on which to try to co-produce our future clinical model. Different people have different experiences of how much self-determination is typically possible in the end in projects of this scale. Blue sky thinking is difficult if only 75% of the sky is allowed to be blue. Until the national team has made firm decisions, **please can you empower the clinical workstream to continue to work on an assumption of 100% blue sky.** That way we can define together the perfect future scenario, and then work together openly and collaboratively to reduce it to a shape and size that fits when we know, with certainty, what that size and shape is. This does not disregard the need for ideas to be affordable and achievable; we will address those realities thoroughly through the OBC work up. It will allow us to continue to be ambitious though and to get the best out of the workstream discussions.
3. Please can we all note the risk of people circumnavigating the co-production processes and **commit to holding the line** so that everyone is redirected back into the agreed method.
4. To develop the relationship between the co-production leads and the board, to improve their sense of mandate and the support they feel in their roles, I suggest **a rolling invite to attend** the programme board and direct contributions on the emerging content of the clinical visions. This will also bring the visions to life for the board and help build a shared understanding of the quality of the thinking that has underpinned them.

11:30 GOVERNANCE

16. Governance report

To APPROVE the report, including subcommittee activities

For Approval

Presented by Richard Jones

Board of Directors – 26 March 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 March 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 March considered:

   - Operational challenges, including Covid and reset
   - the future developments and consultation regarding West Suffolk Community Health
   - Review and refresh of the Trust's strategy, including options for engagement with staff and partners
   - Preliminary findings from the national staff survey
   - Future system progress for the new health and care facility, including review of the strategic outline case

   The **red risk report** includes update of the 'top risks' which reflect the strategic risks captured in the board assurance framework (BAF):

   - **Staff engagement and raising concerns** - the CQC identified that staff do not always feel able to raise concerns and it is clear that we need to listen more to our colleagues, be informed by their views, offer specific support to teams and have a greater focus on leadership and continuous learning. We are reviewing our culture and openness to make sure everyone – including our patients, our staff and our commissioners – can contribute to our improvement.

   - **Failure to manage elective and emergency capacity and demand in the context of Covid activity and delivery of the RAAC remediation plan** – command and control structure put in place to manage the Trust's response in line with national emergency response.

   - **WSH building structure and provision of suitable estate** – risk assessment and remedial work plans agreed and being undertaken. This includes external assessment of the Trust's response through 'ALARP' (as low as is reasonably practical) and legal opinion.

A full summary of the strategic risk is provided below.

	Residual Risk	Target Risk
1. Quality, governance or service failure, leading to reputation damage, reduced activity/income and/or regulatory action	Quarterly x Major = Red	Annual x Major = Amber
2. Failure to manage emergency capacity and demand in the context of Covid activity and delivery of the RAAC remediation plan	Quarterly x Major = Red	Quarterly x Moderate = Amber
3. Failure to deliver the national access standards *(emergency standard is considered separate BAF entry)*	Weekly x Major = Red	Quarterly x Moderate = Amber
1. Implementation of estates strategy to provide a building environment suitable for patient care and adequately maintained with regard to backlog maintenance incorporating the acute and community estate. (BAF ref 4.1) *[Linked to structural risk assessment (ref. 24) rated as Red]*	Quarterly x Major = Red	5-yearly x Major = Amber
2. Failure to identify and deliver cost improvement and transformation plans that ensure sustainable clinical and non-clinical services while delivering the agreed control total	Quarterly x Major = Red	Annual x Major = Amber
3. Provision of sustainable pathology services	Annual x Major = Amber	5-yearly x Major = Amber
4. Digital adoption, transformation and benefits realisation	Annual X Major = Amber	Annual x Major = Amber
5. Delivery of the workforce plan with an engaged and motivated workforce	Quarterly x Major = Red	Annual x Major = Amber
6. External financial constraints impact on Trust's sustainability through tariff, contract and pattern of service provision in the west Suffolk system	Annual X Major = Amber	Annual X Major = Amber
7. Development and delivery of the West Suffolk Alliance way of working as the local delivery unit for the STP	Quarterly x Major = Red	Annual x Major = Amber

4. Quality report 2019/20 (Annex B)

Preparation of last year's quality report has been very challenging during the pandemic and the requirement was removed from the requirement for our annual report and accounts. We are about to start production of the 2020/21 annual quality report and we will follow our full engagement process in their production.

The attached quality report has been prepared based on drafting prepared following the year end. The document has been shared with a non-executive director, governors and external partners, including Suffolk Healthwatch. Recognising that due to the extreme circumstances we have been unable to follow the normal reporting cycle the Board is asked to approve the document.

5. Well led review

The following provides a context for undertaking well led developmental reviews based on the NHS Foundation Trusts regulatory guidance.

The boards of NHS foundation trusts and NHS trusts are responsible for all aspects of the leadership of their organisations. They have a duty to conduct their affairs effectively and demonstrate measurable outcomes that build patient, public and stakeholder confidence that their organisations are providing high quality, sustainable care.

Robust governance processes should give the leaders of organisations, those who work in them, and those who regulate them, confidence about their capability to maintain and continuously improve services. In-depth, regular and externally facilitated developmental reviews of leadership and governance are good practice across all industries. Rather than assessing current

performance, these reviews should identify the areas of leadership and governance of organisations that would benefit from further targeted development work to secure and sustain future performance.

The external input is vital to safeguard against the optimism bias and group think to which even the best organisations may be susceptible. We therefore strongly encourage all providers to carry out externally facilitated, developmental reviews of their leadership and governance using the well-led framework every three to five years, according to their circumstances.

Recognising that the Trust is due a review and following review with NHSE/I it is proposed that the Trust tender a two stage scope for a development review with a focus to include the introduction (stage 1) and embeddedness (stage 2) of the new governance committee structure being introduced from April 2021. We would expect the body undertaking the review to have experience in this field and use a range of approaches to gather information and assess delivery.

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:

1. **Note** the contents of the report
2. **Approve** the Quality report for 2019/20
3. **Approve** the proposed approach to a well led development review

Annex A: Scheduled draft agenda items for next meeting – 30 April 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: - 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 - Speaking-up report to include focus on "listening-up" - National staff survey response - Mandatory 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 - Review QI and safety strategies	✓		Written	Matrix	SW / NJ
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	SW
Build a joined-up future					
Pathology laboratory information management systems (LIMS) business case report	✓	✓	Written	Matrix	CB/NJ
Future system board report	✓	✓	Written	Matrix	CB
Strategic update, including Alliance, System Executive Group and Integrated Care System (ICS)	✓	✓	Written	Matrix	KV / SD
Integration report (Q4)	✓		Written	Matrix	KV / BH
Governance					
Governance report, including - Agenda items for next meeting - Use of Trust's seal	✓		Written	Matrix	RJ

- TEG report - Charitable funds committee report - Annual report and operational planning guidance - Risk appetite statement - Scope for well led developmental review - NED responsibilities					
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

NHS
West Suffolk
NHS Foundation Trust

Annual Quality Report

2019/20

Putting you first

Contents

Throughout this document the organisation West Suffolk NHS Foundation Trust is referred to as WSFT and West Suffolk Hospital as WSH.

1. Chief executive's statement

I am delighted to introduce this year's quality report on behalf of the West Suffolk NHS Foundation Trust (WSFT).

This report is published during a year in which the National Health Service is being called upon to meet the greatest challenge in the 72 years of its existence due to the coronavirus pandemic. Our colleagues across the WSFT are daily proving their resilience and their commitment to providing excellent and compassionate care for the people of Suffolk.

In our acute and community services, frontline staff are showing their courage, skill and professionalism in safely treating every patient according to their individual need. Supporting them are cleaners and catering teams, technicians and IT colleagues, administrators and educators. Now, more than ever, we know that our greatest asset is our workforce.

Responding to the pandemic has shown the value of all the work we have done to take an alliance approach with our partners across all public services throughout Suffolk and north Essex. The close ties we have forged have enabled us to join up care where it is needed, closer to home, making the best use of all our resources and improving patient experience. More and more people are able to be cared for where they live, achieving greater independence and better quality of life for as long as possible.

Even before the coronavirus crisis, the Trust had experienced a turbulent year which caused us to examine the culture of our organisation while at the same time celebrating the commitment of our staff. A full inspection by the Care Quality Commission (CQC) resulted in our being given a rating of "requires improvement". As we had previously been rated "outstanding" this was a great disappointment and as leaders we have offered our sincere apologies.

The CQC sought action on things the Trust must do and where improvement is needed. These included some areas not fully managing infection risks, medicines management or record keeping, and staff not always feeling able to raise concerns. It is important to note that the CQC rated many of our services as good or outstanding and found that across the board patients were treated with compassion and respect.

All our employees were invited to respond to this year's NHS staff survey, which brought encouraging findings, as did the staff friends and family test, with positive comparisons regionally and nationally. At the same time it is clear we need to listen more to our colleagues, be informed by their views, offer specific support to teams and have a greater focus on leadership and continuous learning.

We are reviewing our culture and openness to make sure everyone – including our patients, our staff and our commissioners – can contribute to our improvement. We are supporting staff conversations, reviewing our HR policies and pursuing the Better Working Lives initiative. We have developed a robust improvement plan, and progress on this will be monitored by our Board and reported to the CQC. We welcome and will fully co-operate with the independent review commissioned by the Department of Health into whistleblowing concerns.

Across the year we have seen an average increase of ten per cent in attendance at the hospital, and a consequent increase in admissions. This has been alleviated by using patient pathways joining up acute and community care; and learning from the experiences of previous years, we managed our winter pressures and the opening of escalation beds more efficiently. Our annual flu vaccination campaign was well-supported by staff, which again helped us to meet the challenges of the busiest season.

The success of our recruitment and training programme in the Philippines meant we were able to meet all our nursing vacancies, and these nurses have proved a most welcome and valuable addition to our workforce.

As a global digital exemplar (internationally recognised NHS provider delivering improvements in the quality of care, through the world-class use of digital technologies and information), we have continued our work to improve working lives and our efficiency through digital solutions such as the rollout of Medic Bleep, and investment in the hardware, software and connectivity needed by our community staff.

The increase in activity brought financial challenges that were met with cost improvement programmes suggested and supported by colleagues across the Trust which put us in a good position at the end of the financial year. Nevertheless, we welcome the Department of Health decision to write off the Trust's interim loans in the wake of the pandemic.

At the acute hospital site, we have celebrated the expansion and official opening of the acute assessment unit; first anniversary of the cardiac centre; the opening of a new accommodation block; and the 25th anniversary of the day surgery unit. Through a change in legislation, we were also able to transfer Newmarket Community Hospital to the Trust from NHS Property Services. This investment represents our commitment to a future that will see our Trust expand, develop and build ever greater links with our community.

As COVID-19 levels have become more stable we are starting to think about moving to a recovery phase. This is where normally you would aim to get things back to where they were before an incident occurred. However, we want to make sure we don't lose the good work we have achieved and just go back to 'how it was before'. We think this is an opportunity to learn collectively from our experiences and try to build an improved future as a Trust and as a workplace. We will use information and suggestions gathered from staff and stakeholders to inform and feed into multiple work streams, including the refresh of our future strategy, our COVID recovery plans, quality improvement, and our focus on wellbeing. It will even influence how we work on the plans for the new hospital.

Dr Stephen Dunn
Chief executive
23 June 2020

2. Quality structure and accountabilities

The quality report highlights the action WSFT is taking to improve the quality of services we provide. We have structured our priorities and measures according to the three domains of quality defined in 'High Quality Care for All', published in June 2008.

Our vision and priorities align with our partners, including West Suffolk Clinical Commissioning Group, whose mission is to deliver the highest quality health service in the west of Suffolk through integrated working. Through this vision, we put quality at the heart of everything we do.

The Board monitors quality through its **performance management arrangements** on a monthly basis. The Board also receives assurance regarding quality within the organisation through the quality and risk committee and its three subcommittees, which ensure quality is delivered in a coordinated way to support safe, effective and patient-focused healthcare. The subcommittees are:

(a) **Clinical safety and effectiveness committee** – ensuring clinical procedures and practices are effective in protecting patients, visitors and staff. This is achieved through reviewing compliance with national requirements, promoting best practice and ensuring effective identification and elimination or reduction of clinical risk

(b) **Corporate risk committee** – ensuring risk management, financial and workforce procedures are effective in promoting good business standards, protect the organisation, patients, visitors and staff, and comply with national standards and guidance

(c) **Patient experience committee** – ensuring exemplary customer and patient experience through the implementation of the improvement strategy and Patients First initiative.

3. Performance against priorities for 2019-20 and the priorities for improvement 2020-21

The quality priorities for 2019-21 were agreed as a two-year model and described at a high level with the expectation that projects across the Trust will form **part of the coordinated programme** to support their delivery.

The quality priorities and programme has been informed by the changing shape and nature of the organisation and by asking our specialists, listening to what our partners and community tell us, and looking outwards for how we can help other organisations achieve their own goals

Patient flow	The Trust has made significant improvement to patient flow through a range of initiatives and focus on improvement; ('Red2Green' / SAFER). The challenge of winter 18/19 highlighted the importance of maintaining focus and ensuring that all recommended processes are fully embedded across the Trust.
Human factors	Research, case studies and national guidance illustrate how implementing the consideration of human factors in healthcare can reduce harm and improve both patient and staff safety, providing invaluable insights for all concerned with clinical quality.
Quality improvement	In 2018 WSFT co-designed a QI framework with staff, to implement a structured approach to the use of QI methods to drive continuous improvement in quality and outcomes throughout the Trust. One year on, we are making QI a quality priority to accelerate dissemination and adoption of improvement science knowledge, skills and application

Two of the three 2019/20 quality priorities continue into their second year:

- Human factors

- Quality improvement

The third has been recognised as meeting the requirements of 'business as usual' and thus removed from the quality priorities list.

- Patient flow

The organisation therefore agreed to include a third priority for 2020/21:

- Staff engagement

This prioritisation reflects the developments already set out within the Trust's CQC improvement plan and wider work that has been identified to support our staff.

4. Statements of assurance from the Board

This section of the quality report is prescribed by regulation. It provides a series of mandated statements from the Board which directly relate to the drive for quality improvement. These statements provide assurance in three key areas:

- Our performance against essential standards and delivery of high quality care, for example our registration status with the Care Quality Commission (CQC)
- Measuring our clinical processes and performance, such as participation in national clinical audit
- Providing a wider perspective of how we improve quality, for instance through participation in clinical trials.

Review of services

During 2019/20, WSFT provided and/or sub-contracted **65 relevant health services**. WSFT has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2019/20 was **£229.5m**, which represents **89.1% of the total income** generated from the provision of relevant health services by WSFT for 2019/20.

Information about the quality of these services is obtained from a range of sources, which address the three quality domains described earlier (safety, effectiveness and experience). Key sources of intelligence are summarised in table A. Many of these sources of information provide an indication of quality across more than one domain.

Table A: Sources of quality intelligence

Deliver personal care	Deliver safe care

• CQC self-assessment and CQC visits
• Trust-wide compliance monitoring including:
  ◦ patient environment
  ◦ patient experience
  ◦ same sex accommodation
  ◦ pain management
  ◦ nutrition
• Complaints and PALS thematic analysis
• Patient and staff feedback, including local and national surveys and patient/staff forums and communication
• Quality walkabouts and 'back to the floor' visits by Board members and governors
• Feedback from FT members and governors
• 'Freedom to Speak Up' patient feedback day
• Community conversations.
	• CQC self-assessment and CQC visits
	• Trust-wide compliance monitoring including: infection control, which includes hand hygiene; pressure ulcers, falls and venous thromboembolism (VTE); stroke care; learning from deaths; and re-admission
	• Incident and claims analysis and national benchmarking
	• External regulatory and assessment body inspections and reviews, such as peer reviews
	• National safety alerts
	• Infection control, including high impact interventions
	• Quality walkabouts
	• Clinical benchmarking
	• National and local clinical audits
	• Self-assessment against national standards and reports, for example National Institute for Health and Care Excellence (NICE) guidance
	• Patient reported outcome measures (PROMs).

Participation in clinical audits and confidential enquiries

During 2019/20 51 national clinical audits and seven national confidential enquiries covered NHS services that WSFT provides.

During 2019/20 WSFT participated in 94% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that WSFT participated in, and for which the data was completed during 2019/20, are listed alongside the number of the cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry listed in Annex A.

The reports of 35 national clinical audits and 64 local clinical audits were reviewed by the provider in 2019/20 and WSFT intends to take the actions detailed in Annex A to improve the quality of health care provided.

Research and development

The number of patients receiving relevant health services provided or sub-contracted by West Suffolk NHS Foundation Trust, who were recruited during 2019/20 to participate in National Institute for Health Research (NIHR) Portfolio or commercially adopted research studies approved by a research ethics committee, exceeded 1,600 participants (an increase from 1,500 in 2018/19).

Seven-day services

The Trust has a well-represented seven-day services group leading the service development and improvement plan. The Trust already operates a full seven-day service for both the emergency department (ED) and inpatients across a wide range of clinical areas in order to manage weekend admissions. Quality improvement is focused on the four standards identified as priorities on the basis of their potential to positively affect patient outcomes:

- Standard 2: time to consultant review – compliance with the standard of all patients seeing a consultant within 14 hours of admission has increased to 80% with 90% seen within 17 hours. Work continues to improve this standard and developments in the delivery of front of house services, such as surgical ambulatory care, will support sustained delivery in the coming years
- We already achieve standards 5 (access to diagnostics) and 6 (access to consultant-directed interventions) and expect to maintain this compliance
- Standard 8: on-going review – 84% of patients who require a once daily consultant directed review receive such a review. Our focus for the coming year is ensuring reviews continue at the weekend if they are required.

The Trust has robust processes in place to comply with the revised reporting framework for seven-day services. In order to provide full assurance, the Trust is fully compliant with the national audit methodology as used for the spring 2018 audit. This allows for accurate comparison with previous audit results. It is expected that the audit will run bi-annually with both the framework template and detailed analysis presented to the board for assurance.

Consolidating vacancies and rota issues

The human resources department aims to fill staffing gaps via new appointments, so there can be a delay in this process. New 'locally employed doctors' (LEDs), have been employed specifically for service developments, including the emergency department, general surgery and general medicine. These appointments support the work to ensure that we can safely fill our rotas and staff the wards, and ensure safer working hours for all doctors.

Staff who speak up (including whistle blowers)

The Trust uses the integrated policy recommended by Sir Robert Francis to support staff to raise concerns about patient care and other healthcare related matters. This policy is available to all staff on the intranet.

The Trust offers a range of services available within the organisation to support Trust staff with concerns about patient safety, bullying and harassment and/or inclusion issues. These services supplement and support the role of Freedom to Speak Up Guardian and the Trust strategy of 'freedom to speak up, freedom to improve'. They are collectively promoted within the organisation as 'Staff Supporters' and as part of our health and wellbeing offer. The policy also clearly outlines the external routes available to raise concerns, should this be more appropriate.

Ways in which staff can speak up

- **Freedom to Speak Up Guardian** - this is an important role identified in the Freedom to Speak Up review to act as an independent and impartial source of advice to staff at any stage of raising a concern, with access to anyone in the organisation, including the chief executive, or if necessary, outside the organisation
- **Designated executives, specified non–executive director and other senior staff** - the Trust policy outlines specific individuals who have a role to support any member of staff who wishes to speak up. This includes a non-executive director who acts as Senior Independent Director and has the lead for whistle blowing.
- **Trusted partners** - these are volunteer members of staff who provide confidential, independent advice and a listening ear for issues such as bullying and harassment, and equality and diversity. There are currently 18 trusted partners from a range of clinical and non-clinical, and senior and junior roles. The role has existed in the Trust for some years as a resource to support those who feel bullied or harassed. In 2018 the role was extended to include staff who have lived experience of one or more of the characteristics protected by the Equality Act 2010 and who are willing to support others who have similar experience or by sharing knowledge and information.

- **Tea and empathy** - on-call emotional support for anyone having a really bad day is provided by volunteer members of staff (clinical and non-clinical). Any member of staff can access the service by calling the switchboard.
- **Chaplaincy service** - regardless of whether staff are religious, the chaplaincy team provides a listening ear in times of difficulty or crisis, whether personal or work-related, a space to talk about life, the purpose or the meaning of things, and pastoral counselling. For staff who have a faith, the chaplaincy service can also provide support with: practicing a faith or spiritual tradition, making contact with representatives of other faith communities and prayer support.
- **Trust executive open door** - executive directors are in the Time Out restaurant from 8.00am to 9.00am every Wednesday and staff are invited to drop by to talk informally to members of the executive team. This arrangement has been in place for a number of years.
- **Anonymous reporting –** there is a dedicated telephone line and web link to allow staff to report concerns. If they so wish they can raise concerns through these routes anonymously and these mechanisms are promoted as options for those who may wish to raise concerns anonymously. This route was introduced in September 2019.
- **Other support mechanisms** - as part of our approach to partnership working with staff-side organisations we actively promote trade unions as a source of support for staff for health and safety advice, education support and member support for disciplinary issues. A lesbian, gay, bisexual and transgender + (LGBT+) network was set up in the Trust in the autumn of 2018 comprising members of the LGBT+ community working in the organisation and allies. A Staff Disability Network was set up in the summer of 2019.

In addition, staff are encouraged to seek the support of their line manager, the human resources team and specialist departments (e.g. health, safety and risk office, postgraduate medical education team and governance support).

Staff can access support through the Trust and community intranets through a single staff supporters landing page that has links to all services. 'Staff Supporters' are advertised widely throughout the Trust on posters. Staff who do not have ready access to our intranet are signposted to the Human Resources team who can provide contact details. Services are also advertised in the weekly staff information publication Green Sheet, at Trust induction by the executive director of workforce and communications and the Freedom to Speak Up Guardian in the Trust. Where possible, evidence of use and the types of issues raised by staff are captured for monitoring purposes.

How we provide feedback to staff who speak up
Feedback depends on the mechanism used to report the concern and may be written or verbal. The individual with whom the concern is raised will provide feedback. Where concerns are reported anonymously feedback can be provided through general trust communication routes.

How we ensure staff who speak up do not suffer detriment
Our Freedom to Speak Up policy emphasises that staff raising concerns should not suffer any detriment and training has been provided to support our policy.

Goals agreed with commissioners

A proportion of WSFT income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between WSFT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services through the Commissioning for Quality and Innovation (CQUIN) payment framework.

The ten national CQUIN goals for 2019/20 were:
- **Antimicrobial Resistance**: a) Lower UTI - Antibiotic prescriptions in older patients (65 & over) meeting guidance and four criteria; and b) Elective colorectal surgery - Antibiotic prophylaxis being a single dose and prescribed in accordance with guidelines.
- **Staff health and wellbeing:** staff flu vaccination uptake.
- **Preventing ill health:** inpatient tobacco & alcohol a) screening, b) advice, c) refer/treat.
- **Preventing hospital falls occurring in older patients**: three falls prevention actions.

- **Adults managed in the same day:** who have confirmed a) Pulmonary Embolus, b) Tachycardia with Atrial Fibrillation or c) Community Acquired Pneumonia.

For 2020/21 the eight national CQUINs will be:

- **Antimicrobial Resistance**: UTI in patients aged 16 & over - Antibiotic prescriptions meeting guidance, criteria including documented diagnosis symptoms, urine sample sent to microbiology plus any catheter use.
- **Preventing ill health:** cirrhosis and fibrosis tests for alcohol dependent patients.
- **Staff health and wellbeing:** staff flu vaccination uptake.
- **Patient Safety:**
    - Recording of NEWS2 score, escalation and response time for unplanned critical care admissions
    - Advance screening and treatment of iron deficiency anaemia in patients listed for major elective blood loss surgery.
- **Best Practice Pathways:**
    - Treatment of community acquired pneumonia in line with British Thoracic Society care bundle (chest x-ray timings, severity documented plus antibiotics criteria)
    - Rapid rule out protocol: time between first and second Troponin tests, for ED patients with suspected acute myocardial infarction, excluding segment elevation myocardial infarction (STEMI)
    - Adherence to evidence-based interventions rules (category 2 procedures only carried out if the patient meets set clinical criteria).

The total CQUIN funding value for 2019/20 was £2,021,443 (compared with £3,511,673 for 2018/19). Note: whereas CQUIN was worth 2.5% of the total contract (1.25% national and 1.25% local schemes) up to 2018/19: From 1 April 2019, NHS England advised the CCG schemes were all national so "1.25% with a corresponding increase in core prices, allowing more certainty around funding to invest in agreed local priorities".

What others say about us

WSFT is required to register with the Care Quality Commission (CQC) and its current registration status is conditional. The conditional status relates to the extension of registration in May 2020 to include a General Practice (GP) surgery and the requirement for a named individual from that practice to be named on the registration certificate.

During 2019/20, the Trust was the subject of an inspection of the following core services:

- Urgent and Emergency care
- Medical care (including older people's care)
- Surgery
- Maternity
- Outpatients
- Community health services for adults
- Community health services for children and young people
- Community health inpatient services

The CQC also undertook a 'Well-led' and a 'Use of Resources' review of the trust during the inspection process. The outcome of the inspection was to rate the trust as 'Requires Improvement' according to the matrix set out below

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement ↓ Jan 2020	Good ↓ Jan 2020	Good ↓ Jan 2020	Requires improvement ↓ Jan 2020	Requires improvement ↓ Jan 2020	Requires improvement ↓↓ Jan 2020
Community	Good Jan 2020	Requires improvement Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020
Overall trust	Requires improvement Jan 2020	Good Jan 2020	Good Jan 2020	Requires improvement Jan 2020	Requires improvement Jan 2020	Requires improvement Jan 2020

The report listed 32 breaches of legal requirements (MUST) and 45 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality (SHOULD).

In addition, the CQC issued five requirement notices to the trust and undertook enforcement action in relation to significant concerns within the maternity and midwifery service. This required the Trust to provide a report saying what action it would take to meet these requirements. This was issued through a warning notice under Section 29A of the Health and Social Care Act 2008.

The CQC also highlighted three areas of outstanding practice in the Community health services for children and young people:

- An emotional well-being care pathway developed, in conjunction with other services.
- Multi-disciplinary and multi-agency working was particularly strong.
- Physiotherapists linking with sports gyms in the locality to jointly provide gym groups for five to 11 year olds and 11 to 18 year olds with cerebral palsy.

A detailed improvement plan has been developed and its progress is overseen by an improvement programme board with membership including local commissioners. Regular updates on progress against this plan as well as specific detail around the subjects covered by the Section 29A are provided to the CQC via the trust's local CQC relationship manager and inspection lead.

Highlights of the year

Looking back over this challenging year, there is much of which to be proud. In our comprehensive Care Quality Commission (CQC) report, the inspectors found that staff across the board: "treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions" and that they "gave patients and those close to them help, emotional support and advice when they needed it to minimise their distress."

In a national survey, the CQC also reported that our emergency department is performing better than most in the country in several areas of urgent and emergency care. The WSFT matched the highest score in England for the availability of help from members of staff while patients were waiting in the emergency department, and also the overall score for waiting times. The survey scored us highly across categories including respect and dignity for our patients, their experience with doctors and nurses, and their overall care and treatment.

We were named one of 40 CHKS Top Hospitals for 2019 in the leading data-driven awards that have been running for 18 years. CHKS is a provider of healthcare intelligence and quality improvement services and the awards recognise hospitals that are safer for patients, more effective, more efficient and have lower mortality when compared with the performance of all hospitals in England, Wales and Northern Ireland.

The Royal College of Physicians' national lung cancer audit reported that WSFT demonstrated a 40.1% one-year survival rate for this serious disease, a higher average rate than the regional and

national rates of 34.6% and 37% respectively. This report also highlighted the importance of early diagnosis if people are to survive, and we are working with all our partners to facilitate this.

Our role was also acknowledged by our commissioners, the West Suffolk Clinical Commissioning Group, in its achievement of the best cancer survival rates in the east of England. The figures from Public Health England showed that the one-year survival rate for patients in west Suffolk diagnosed with cancer is 74.9%, higher than any other CCG area in the east and above the national average of 73.3%. This survival rate has been increasing every year in west Suffolk.

The Macmillan Unit, which cares for people with cancer, has scored highly in its Macmillan Quality Environment Mark (MQEM) accreditation reassessment, maintaining an overall score of 4 (very good) and retaining its high standards. While the overall score has remained the same, some of the inspected areas have improved.

This year we have marked two significant milestones – the first anniversary of our cardiac centre; and 25 years since the opening of our day surgery unit. In one year, thousands of diagnostic tests have been run at the cardiac centre, and hundreds of cardiac patients have benefited from the procedures that can be performed on site. With its six operating theatres, the day surgery unit, which also houses the eye treatment centre, sees thousands of operations carried out every year for patients, most of whom go home on the same day.

Our state-of-the art acute assessment unit (AAU) is now fully completed and was officially opened by Jo Churchill, MP. The unit has transformed the way patients who do not need major emergency department care are observed, diagnosed and treated. We have expanded the ambulatory emergency care space and monitored bay, and assigned the unit a dedicated ambulance entrance. This allows us to provide better care while maximising our resources.

A change in legislation allowed the ownership of Newmarket Community Hospital to be transferred to the WSFT from NHS Property Services this year. The Trust provides a number of community services at the hospital, including an inpatient unit, X-Ray, outpatients department and community health team; and other providers including a GP surgery are based there. This helps us to offer joined-up, targeted care to the local population as a health provider in west Suffolk, and better manage the treatment pathway for patients between acute and community services.

The NHS workforce is, of course, our most valuable asset and we are committed to doing everything we can to support our staff wherever they work across Suffolk, to ensure they can provide care safely and efficiently, develop their skills, and know how much they are appreciated.

That is why we chose to offer every WSFT employee the chance to complete the annual NHS staff survey. We were pleased that the percentage of people responding increased by four per cent to 52%, which is also above the national average of 48%. There were many positive indicators for us, with a staff engagement score equal to the best in the country; and the morale and safety culture scores close to the highest national scores. Eight of the 11 themes in the survey had an improved score, three of those showing significant improvement, three were unchanged, and our community staff expressed the highest level of satisfaction across the Trust, a tribute to their leaders.

We have also acknowledged that 48 per cent of our colleagues chose not to respond, some reported worse experiences and significant challenges. We are using the findings alongside those of our CQC report to see what we can learn to bring lasting improvements throughout the Trust.

Our staff gave us a vote of confidence in the NHS Staff Friends and Family Test, with 92% of staff surveyed saying they would recommend the WSFT as a place to receive treatment, the seventh highest percentage in England. In addition, 79% said they would recommend it as a place to work, which is the tenth highest percentage in the country. These are both well above the national averages of 81% and 66% respectively.

As part of our commitment to staff welfare, we opened three new accommodation blocks at the Bury St Edmunds site. This £12.7 million scheme replaced the 40-year-old hospital residences with modern, five-storey buildings, providing 160 en-suite bedrooms complete with communal kitchen and living areas, including accessible facilities.

This year we made significant strides in managing the many nursing vacancies we had across the hospital, which was putting added pressure on staff to maintain quality, safe patient care. Our recruitment and subsequent in-house training programme for nurses from the Philippines has seen more than a hundred of these committed nurses joining our ward staff, meaning we are effectively fully staffed for nursing.

Our vacancy rate was also addressed by the launch of our imaginative, responsive #BeKnown recruitment campaign, which is a long-term project to attract people to apply to us in any professional capacity and ensure the work of the Trust is fully supported.

Our training and education team has been recognised in two national award schemes this year. Once again we achieved the highest score in the east of England for doctors' overall training satisfaction in acute trusts. The doctors at our Trust surveyed in the General Medical Council's (GMC) national training survey 2019 rated their overall satisfaction at 82%, a three per cent increase on last year.

A longstanding partnership between WSFT and West Suffolk College has seen us shortlisted for health and science apprenticeship provider of the year category in the FE Week (further education publication) and Association of Employment and Learning Providers (AELP) annual apprenticeship conference awards 2020. We were nominated by the college for our role in the joint training of senior healthcare support worker apprentices working at the hospital.

Our Putting You First citations and Shining Lights peer-nominated annual staff awards ensure that we can acknowledge those who go above and beyond even that which is demanded of everyone in the NHS. The efforts and achievements of these people are as always an inspiration to everyone at the Trust, and we appreciate those who take the time to put their colleagues forward.

Six staff who had been recognised in Shining Lights were nominated by us to attend a tea party for NHS staff at No 10 Downing Street, attended by the Prime Minister. We were also delighted that the retirement of our long-serving HR director and now Trust ambassador, Jan Bloomfield, was marked by her being given the lifetime achievement award at the Healthcare People Management Association excellence in healthcare human resource management awards.

Our overall CQC report highlighted the work we do to ensure we have an inclusive culture at the WSFT, with LGBTQ, BAME and disability fora all working to help us support every staff member and tackle discrimination at source.

Data quality

WSFT submitted records during 2019/20 to the Secondary Uses Service (SUS) for inclusion in the hospital episode statistics (HES) which are included in the latest published data. The percentage of records in the published data which included the patients' valid NHS number was:

Valid NHS number	WSFT	Midlands and East (East)	National
Admitted patient care	**99.8%**	99.6%	99.5%
Outpatient care	**99.9%**	99.9%	99.7%
Accident and emergency care	**98.9%**	98.3%	97.8%

(The above figures cover April 2019 to March 2020 inclusive – taken from NHS Digital)

The percentage of records in the published data which included the patients' valid general medical practice code was:

Valid general medical practice code	WSFT	Midlands and East (East)	National

Admitted patient care	**99.9%**	99.9%	99.8%
Outpatient care	**99.9%**	99.7%	99.8%
Accident and emergency care	**99.9%**	99.4%	98.2%

(The above figures cover April 2019 to March 2020 inclusive – taken from NHS Digital)

WSFT's **information governance assessment** report overall score for 2019/20 was 44/44 assertions met. All 118 mandatory evidence items were provided. WSFT will be taking the following actions to improve data quality:

- Continue to conduct data quality audits on WSFT data to ensure its completeness and accuracy, and feedback audit results to the clinicians involved in the recording of that data
- Continue to increase awareness of the importance of accurate data recording throughout WSFT
- Working with our digital partner, Cerner, to improve reporting from e-Care (our electronic patient record).

WSFT was not subject to the payment by results (PbR) clinical coding external audit during the reporting period 2019/20. A local audit was undertaken and the error rates reported in the latest published audit for that period for diagnosis and treatments coding (clinical coding) were:

Data field - inpatients	Error rate
Primary diagnosis	4.5%
Secondary diagnosis	5.2%
Primary procedure	2.7%
Secondary procedure	3.1%

The audit sample was 200 finished consultant episodes (FCEs) from medical, surgical and woman and child health services. The results of this audit should not be extrapolated further than the actual sample audited.

5. Other quality indicators

WSFT has a comprehensive quality reporting framework that includes an array of quality indicators that are monitored and reported on a monthly basis. These include priorities identified by patients and staff, issues arising from national guidance and research, and other stakeholders such as West Suffolk CCG. Performance against agreed indicators is monitored by the Board on a regular basis. A range of nationally-mandated quality indicators is reported in Annex B.

National targets

	2019/20 Target	2019/20 Actual	2018/19 Actual	2017/18 Actual	2016/17 Actual	2015/16 Actual
C. *difficile* - Hospital onset health care associated [1]	20	25	12 (2)	19 (7)	23 (5)	22 (10)
18-week maximum wait from point of referral to treatment (patients on an incomplete pathway) [2]	92%	81.6%	88.8%	86.42%	92.55%	96.25%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge [3]	95%	-	90.7%	89.33%	86.89%	94.26%
62-day urgent GP referral-to-treatment wait for first treatment - all cancers	85%	79.5%	84.6%	86.68%	85.92%	88.05%
62-day wait for first treatment from NHS cancer screening service referral	90%	92.6%	92.4%	94.90%	97.85%	95.68%
31-day wait for second or subsequent treatment - surgery	94%	99.6%	99.5%	100%	100%	100%
31-day wait for second or subsequent treatment - anti-cancer drug treatments	98%	100%	99.8%	100%	100%	99.87%
31-day diagnosis-to-treatment wait for first treatment - all cancers	96%	99.6%	99.8%	99.94%	99.92%	100%
Two-week wait from referral to date first seen comprising all urgent referrals (cancer suspected)	93%	92.0%	90.7%	94.62%	94.78%	98.46%
Two-week wait from referral to date first seen comprising all urgent referrals for symptomatic breast patients (cancer not initially suspected)	93%	89.2%	82.2%	96.66%	88.54%	98.28%
Maximum six-week wait for diagnostic procedures	99%	93.3%	97.3%	99.92%	96.40%	91.68%

[1] Figures in brackets exclude cases that West Suffolk CCG deemed to be non-trajectory (no identified lapses in care). One case for 2018/19 is pending CCG final opinion

[2] 2016/17 and April 2017 data is based on estimated performance

[3] 2016/17 data covers a 50-week period as excludes two weeks in May 2016 when e-Care was implemented.

During 2019/20 we continued to work through plans to recover sustainable cancer performance. Prior to the response to the COVID-19 emergency we were on track to deliver in accordance with the integrated care system (ICS) cancer alliance plans. To achieve this, we have worked with NHSI's intensive support team (IST) to review our systems and processes for the management of cancer pathways and working with the clinical teams had delivered pathway changes across the first phase of tumour sites (colorectal, lung and prostate). In the early stages of the COVID pandemic in response to advice and guidance from the Royal Colleges all non-emergency endoscopy activity ceased and capacity in radiology was significantly reduced. While we continued to run services to treat patients

diagnosed with cancer we have built up a significant backlog of patients on cancer pathways awaiting diagnostics to determine their care pathway.

All of these patients were clinically reviewed, triaged and have been carefully monitored. We are now opening up services to address the backlog based on clinical prioritisation. The order in which we treat patients will also be determined by the clinical prioritisation, rather than waiting time until we have addressed the backlog and returned to a normal service delivery model.

The context of our waiting list position is a significant reduction in referrals from primary care as well as cessation of normal surveillance programmes such as breast screening. Therefore, as these activities return to normal levels we expect to see an increase in patients presenting late in their pathway adding further pressure to an already stretched service.

In terms of referral to treatment (RTT) we completed detailed capacity and demand analysis at a specialty level using the national intensive support team (IST) model. We had clearly articulated our capacity gaps and in conjunction with the CCG were developing detailed plans to recover performance to agreed levels. But these plans recognised that we would be unable to achieve the national 92% access standard within 2019/20.

In order to prepare to treat the anticipated demand for COVID-19 all non-urgent and non-cancer activity which required patients to attend the hospital was cancelled. We rapidly enabled clinicians to undertake telephone and video consultation with patients where clinically appropriate. All patients who were cancelled by the Trust or cancelled themselves as a result of the COVID pandemic were appropriately coded and held on waiting lists with open pathways (the time to access their required treatment still being counted).

The number of routine referrals has significantly reduced as a result of the pandemic and those referrals that were received have been accepted and held by the Trust. As a result of the changes, fewer referrals and long-standing referrals, the profile of the waiting list has changed significantly with an increase in patients experiencing long waits (over 18-weeks and over 52-weeks) but an overall reduction in the size of the waiting list. This exacerbates the deterioration in reported performance.

As activities return to normal we anticipate seeing a surge in unmet demand.

The requirements of social distancing, enhanced infection control and personal protective equipment (PPE) will have a negative impact on the capacity of all services. This will lead to a reduction in the number of cases treated within our existing capacity. In response to this we are working through our COVID recovery plans with the CCG and the regional team to consider the following options to mitigate this risk:

- Continuing use of the independent sector
- Use of our stand-alone day surgery unit as an elective inpatient facility
- Capital bids for additional theatre and inpatient ward capacity
- Consideration of the workforce implications for extended hours.

Incident reporting and learning

WSFT has continued to build upon and further strengthen the arrangements for managing serious incidents requiring investigation (SIRIs). The Board takes the lead on this process and all SIRIs have an executive sign-off. The Board receives a monthly summary of all newly-reported SIRIs and, on a quarterly basis an update on the outcome of each case as well as more thematic learning and actions arising.

The total number of SIRIs reported during 2018/19 was 42 (46* in 2017/18). These were reported in the following categories:

	2018/19	2017/18
Slips/trips/falls	9	7
Maternity/obstetric/neonatal incident	7	7
Confidential information leak/information governance breach	6	3
Diagnostic incident including delay	3	3
Healthcare associated infection	3	7
Medication	3	2
Treatment delay	3	8
Surgical/invasive procedure	2	1
Sub-optimal care of the deteriorating patient	2	8
Other	4	0
	42	46

* *In 2017/18 the Trust reported pressure ulcers through the serious incidents framework. However, in 2018/19 the framework was updated to reflect national guidance and following clarification from the CCG, excluded all but the most severe pressure ulcers. In order to provide a suitable comparison between years the total for 2017/18 has been given excluding non-reportable pressure ulcers under the new guidance.*

By reviewing the SIRI cases and their respective investigations, key learning can be identified and actions put into place. Examples from 2018/19 include:

- Ward safety assessments to be completed on a regular basis even if the patient is mobile and independent
- Wash hand basins at the entrances to ward areas reduce the risk of cross-contamination when a ward/bay is closed due to, for example, norovirus and emphasised the importance of not moving staff from infected areas
- Early senior review and involvement should be sought if the patient is not responding to treatment or is deteriorating
- Ensure all staff are aware of the correct method of requesting assistance and the importance of the correct procedure to be used to summon specialist help
- The need to have all Trust resuscitation trolleys equipped with surgical airway equipment
- All staff to be involved in checking the emergency equipment stored on a unit/ward in order that items are easy to find/locate in an emergency
- Consider allergic reaction with any ambiguous patient history and consider anaphylaxis as a differential diagnosis
- Importance of recording lying and standing blood pressures in line with the Trust falls policy and the importance of pre/post fall care planning as well as regular fall risk reassessment
- The need to ensure that verbal conversations between both interprofessional teams and patients are recorded accurately on e-Care
- The need for greater staff awareness of the principles of information governance, emphasising the importance of not accessing patient records unless they have a clinical need to
- e-Care, and IT systems in general, play an important role in mitigating against human error through automation, computerisation and functions within systems
- Importance of listening to the information given to staff from both patients and their families regarding previous medical history, treatment and concerns they may have.

During 2018/19, there were two **never events** reported (one in 2017/18) and subject to detailed investigation.

(a) Wrong site (anaesthetic) block - prior to surgery for a left hip hemiarthroplasty it was identified that the anaesthetist had administered the anaesthetic block to the wrong side. Following identification of error, the operation continued as planned. The patient did not come to any additional harm as a consequence of the incident apart from a requirement of additional opioids for pain relief.

The National Safety Standards for Invasive Procedures (NatSSIPs) guidance states '*Immediately before the insertion of a regional anaesthetic, the anaesthetist and anaesthetic assistant must simultaneously check the surgical site marking and the site and side of the block*'. In addition, the local WSFT safer surgical pathway guidance states '*Where an anaesthetist is planning to perform a regional anaesthetic block whether as part of the anaesthetic technique or as a sole means of anaesthesia, it will be the responsibility of the anaesthetist to mark the site of the proposed block (correct side and site) and document it on the anaesthetic chart. To be done prior to 'sign in'*. Neither guidance was followed on this occasion which was a significant departure from the accepted procedure and directly contributed to the incident. The incident highlighted the need to ensure that there are two people to check the anaesthetic block site, the anaesthetist and the anaesthetic assistant.

It has been agreed that block sites will be marked after the patient has entered the anaesthetic room whilst the World Health Organisation (WHO) check 1 is being read out and then checked again by two members of staff as part of the 'stop before you block' process.

Lessons learned include:

- 'Stop before you block' posters have been reintroduced to all anaesthetic rooms
- Green permanent marker pens have been sourced for anaesthetic use in the anaesthetic room
- Block sites will be marked after the patient has entered the anaesthetic room whilst the WHO check 1 is being read out and then checked again by two members of staff as part of the 'stop before you block' process.

(b) Wrong side breast biopsy - the patient did not suffer any harm as a result of the incident apart from the associated discomfort of the procedure itself which needed to be repeated on the correct side.

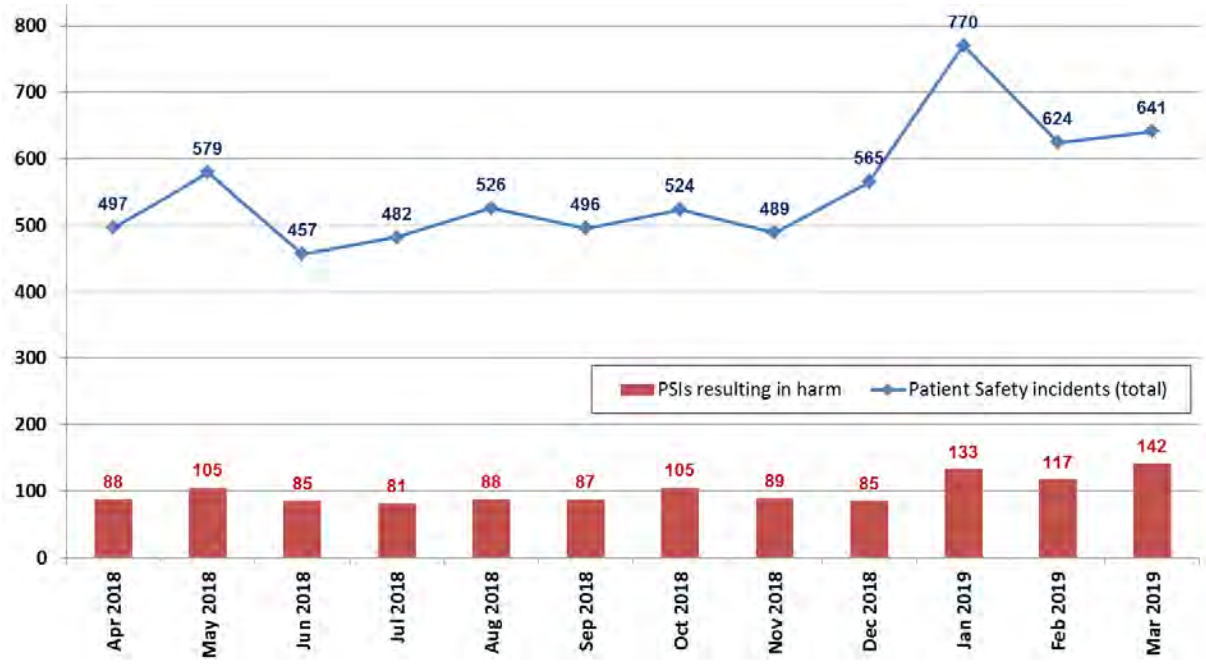
The investigation is ongoing. However immediate mitigating actions included:

- Email to all consultants to remind their respective teams that, prior to any procedure, a minimum of two points of clinical reference (i.e. diagnostic report, referral letter, patients notes) should be reviewed in order to ensure the correct site is identified
- Review roadmap in relation to the publishing of the latest safer surgery pathway
- Review National Safety Standards for Invasive Procedures (NasSSIPs) in relation to this incident and Local Safety Standards for Invasive Procedures (LocSSIPS)
- Explore if a second nurse checker is required.

Patient safety incident (PSI) reporting

The Trust's web-based electronic incident reporting system (Datix) supports multidisciplinary incident reporting which includes a high level of reporting near misses, no harm and minor harm incidents. Reporting of these 'green' incidents is seen as a key driver for identification and management of risks to prevent more serious harm incidents.

Patient safety incidents total (line chart) and resulting in harm (bar chart)



Source: Datix

The Board reviews this data on a monthly basis and recognises the increased reporting rate as a positive reflection of an open culture within the organisation which supports learning from incidents.

The Trust is required to upload all patient safety incidents (PSIs) to the national reporting and learning system (NRLS). This is used to benchmark our performance against other NHS providers. Further data is provided in Annex B of this report.

Duty of candour (DOC)

The DOC is a direct response to recommendation 181 of the Francis Inquiry report into the Mid-Staffordshire NHS Foundation Trust. DOC is required for all safety incidents which have resulted in moderate harm, severe harm or death and prolonged psychological harm. In November 2014, DOC was legislated and required NHS organisations to:

a) Have a face-to-face discussion with the patient or relevant person following a safety incident resulting in moderate harm or above
b) Provide written communication following the face-to-face discussion with the patient, to include:
   - an account of the known facts about the incident
   - details of any enquiries to be undertaken
   - the results of any enquiries into the incident
   - an apology.

The aim of this regulation is to ensure health service bodies are open and transparent when an incident happens.

WSFT's incident system (Datix) is used to record patient safety incidents and automatically notifies key members of staff when an incident of moderate harm or above is reported. These incidents are reviewed by senior nursing and medical staff to confirm the grading and to ensure DOC is achieved.

The compliance with achieving verbal DOC is monitored through the clinical governance team and reported on a monthly basis to the Board. The written element of DOC is monitored through the clinical governance team and captured within the incident record.

Quality walkabouts and executive-led table-top audits

WSFT has a well-established schedule of quality walkabouts attended by executive and non-executive members of the Board and representation from the Trust governors and the CCG.

The walkabouts serve to observe and review real-time care and service delivery in a multitude of settings, including community services, whilst providing staff, patients and visitors with the opportunity to raise issues, concerns or indeed compliments. Formal feedback is provided to the ward manager, service manager and matron. Areas are asked to provide action plans to address issues identified and enable follow-up as part of the quality walkabout process.

As part of the quality walkabout, a number of key areas are consistently reviewed. These include:

- Medication security
- Cleanliness and infection control
- Resuscitation trolley checks
- Checking of compliance and displaying up-to-date information
- Escalation plan and resuscitation status (EPARS) completion
- Fluid storage.

Issues identified can range from equipment to staffing skill mix, signage to improvement in documentation and infection prevention to estates. These issues are fed back to the areas, with a view to resolving many issues immediately and escalating any more serious concerns or thematic issues. The quality walkabout process enables staff to raise concerns directly with senior leaders and governors. This has received positive feedback from staff and we continue to plan the programme on a quarterly basis. As well as feeding back the findings to the areas visited, the Board and governors receive a quarterly summary of walkabout activity and learning.

Complementing the walkabouts is an executive-led table-top audit and assurance programme which allows a ‘deep dive’ approach to key patient safety themes and subjects. During 2018/19 these included pressure ulcers, falls, sepsis, mental health and maternity. In 2019/20 this schedule will continue with plans to encompass areas such as VTE (venous thromboembolism), nutrition, AKI (acute kidney injury) and patients with learning disabilities.

Perfect Ward app

WSFT uses the Perfect Ward app for local ward/department inspections. This use of digital technology allows quick, easy and more effective scoring of questions, capture of photographs and free-text comments straight into the app, meaning information is quick to record and up-to-date. Information is stored in the app rather than on the phone used, so it is always secure. Capturing the information directly with phones or tablets means there is no longer a need to write up and send reports afterwards, saving valuable time. As soon as an inspection is complete, everyone with the app can be alerted and see the results. With automated reporting, it is also much easier to compare performance and track improvements at ward level. There are five different audits available in the app; documentation, observation, patient experience, staff and infection prevention and control.

Matrons, ward managers, service managers, general managers, pharmacy, executive directors and the infection prevention team all have access to the Perfect Ward app, and are using it to complete all ward audits at the WSH, Rosemary Ward at Newmarket Community Hospital and the Kings Suite at Glastonbury Court. In 2019/20 this is also being rolled out to the community teams.

Learning from deaths

During 2018/19, 900 WSFT patients died (of which three were neonatal death, four were stillbirths, nine were people with learning disabilities and 13 had a severe mental illness). This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 213 in the first quarter (of which one was a neonatal death, two were stillbirths, one was a person with learning disabilities and two had a severe mental illness)
- 209 in the second quarter (of which zero were neonatal deaths, one was a stillbirth, two were people with learning disabilities and two had a severe mental illness)
- 219 in the third quarter (of which zero were neonatal deaths, zero were stillbirths, three were people with learning disabilities and three had a severe mental illness)
- 259 in the fourth quarter (of which two were neonatal deaths, one was a stillbirth, three were people with learning disabilities and six had a severe mental illness).

As of 10 May 2019, 774 case record reviews and 31 investigations have been carried out in relation to these 900 deaths. In 31 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 213 case record reviews (seven investigations) in the first quarter
- 209 case record reviews (13 investigations) in the second quarter
- 218 case record reviews (eight investigations) in the third quarter
- 114 case record reviews (three investigations) in the fourth quarter.

One death, representing 0.11% of the patient deaths during the reporting period, was judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- None [0%] for the first quarter
- One [0.48%] for the second quarter
- None [0%] for the third quarter
- None [0%] for the fourth quarter.

No case record reviews and no investigations were completed after 31/03/2018 which related to deaths which took place before the start of the reporting period. These numbers have been estimated using the following pathways: all inpatient deaths excluding neonatal death and stillbirths are collated via the Trust's electronic patient record and recorded on a bespoke mortality database (Rhapsody). Neonatal deaths and stillbirths are collated via the MBRRACE-UK perinatal mortality surveillance system. Deaths of patients with a learning disability are recorded on Rhapsody but also reported to the national learning disabilities mortality review programme (LeDeR). Maternal deaths are also reported to the Healthcare Safety Investigation Branch (HSIB) for external review.

A case record review is undertaken using the Royal College of Physicians' structured judgement review (SJR) method. The objective of the SJR method is to look for strengths and weaknesses in the caring process, to provide information about what can be learned about the hospital systems where care goes well, and to identify points where there may be omissions or errors in the care process. Bereaved families are invited to give feedback on the care their relative received. In a small number of cases a further investigation is warranted and this is undertaken via the Trust's incident reporting pathway. Case record reviews and investigations conducted have highlighted the following themes:

- Many examples of excellent communication with family and relatives by junior doctors, when explaining care and treatment
- Regular comment upon the excellent care provided by the palliative care team
- Delayed recognition that a patient is reaching the end of their life, such that active treatment continues when, with the benefit of hindsight, it was likely to be futile
- Continuing active treatment also when it has been recognised that the patient is dying, and they and their family have agreed a plan for palliative care with the ward team. Unfortunately, sometimes active treatment still continues, which could impact on the patient's quality of life in their last few days
- In addition, the publication in 2018 of the 2016 National MBRRACE summary report and UK Perinatal Mortality Report noted a slightly increased stillbirth rate at WSFT. This trend had

already been identified internally in 2016 and been the subject of thematic review with changes implemented at the time and subsequently in 2017-19 including:
    - Actions to address the issues of women who smoke in pregnancy, including participation in the national 'MatNeo' patient safety initiative (see 'Performance against 2018/19 priorities' section for more details)
    - Checks undertaken at routine antenatal appointments such as urine testing and confirmation that women are taking folic acid
    - Implement multiple pregnancy clinic in line with the guidance of NICE (CG129 *Multiple pregnancy: antenatal care for twin and triplet pregnancies*)
    - Guidance on referral pathway to fetal medicine.

The Trust identified its first case of a maternal death for review by the HSIB in 2018/19. The investigation is still ongoing at the time of this report.

Whilst the Trust records and reviews deaths of patients with a learning disability, it does not currently receive feedback from the external LeDeR review and will be actively seeking this to enhance wider learning in 2019/20. Actions taken in 2018/19 as a consequence of what has been learned during 2018/19 include:

- Audit of completion of escalation plan and resuscitation status (EPARS) forms in the electronic patient record
- Quality improvement project on the importance of maintaining steroid medication
- Last days rounding tool to be included in the Trust-wide nursing documentation review
- Service user involvement in learning from deaths committee, ensuring learning into action is progressed
- Trust-wide, multidisciplinary, quarterly learning events including cases identified by learning from deaths
- Positive feedback for excellent care at ward and individual level.

Actions proposed to be taken in 2019/20 as a consequence of what has been learned during 2018/19 include:

- Quality improvement project on the implementation of the amber care bundle for end-of-life care, supported by the hospice
- Improvement of EPARS completion will be addressed as part of a suite of interventions to improve patient flow, as a Trust-wide quality priority
- Continue to work on ways to improve serial scans for women who smoke
- Development of the opportunities for learning from external reviews from LeDeR
- Widen the involvement of service users in the learning from deaths committee
- Continue to develop wider shared learning pathways including electronic newsletters, case presentation to committees and ward folders (led by the patient safety team).

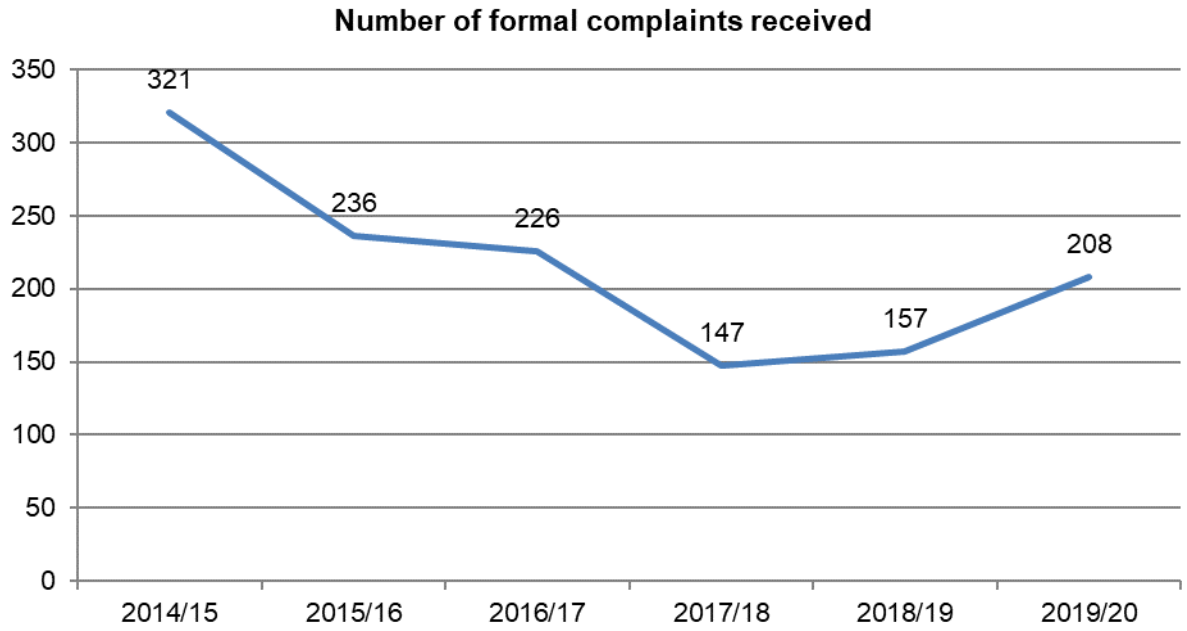
Reflecting on the actions taken in 2018/19, our approach to learning from deaths continues to evolve and we are actively looking for ways in which to measure impact. In particular, we are looking for ways to measure improvements more agilely and less resource intensively than relying on manual audits. It is likely that our electronic patient record system can support this. We are also working with our family representative and patient experience manager to consider how family members could help us measure impact, and how we could employ qualitative methods when numbers would not be informative.

Complaints management

WSFT is committed to providing an accessible, fair and effective means of communication for those persons who wish to express their concerns with regard to the care, treatment or service provided by the Trust. In responding to and reviewing complaints, WSFT adheres to the six principles for remedy as published in October 2007 by the Parliamentary and Health Service Ombudsman (PHSO).

Complaints are reviewed with service managers, associate directors, clinical directors and the senior nursing team to ensure that learning takes place, issues are addressed and trends identified. Examples of learning are detailed below. Themes and lessons learned are also reviewed by the patient and carer experience group and patient experience committee.

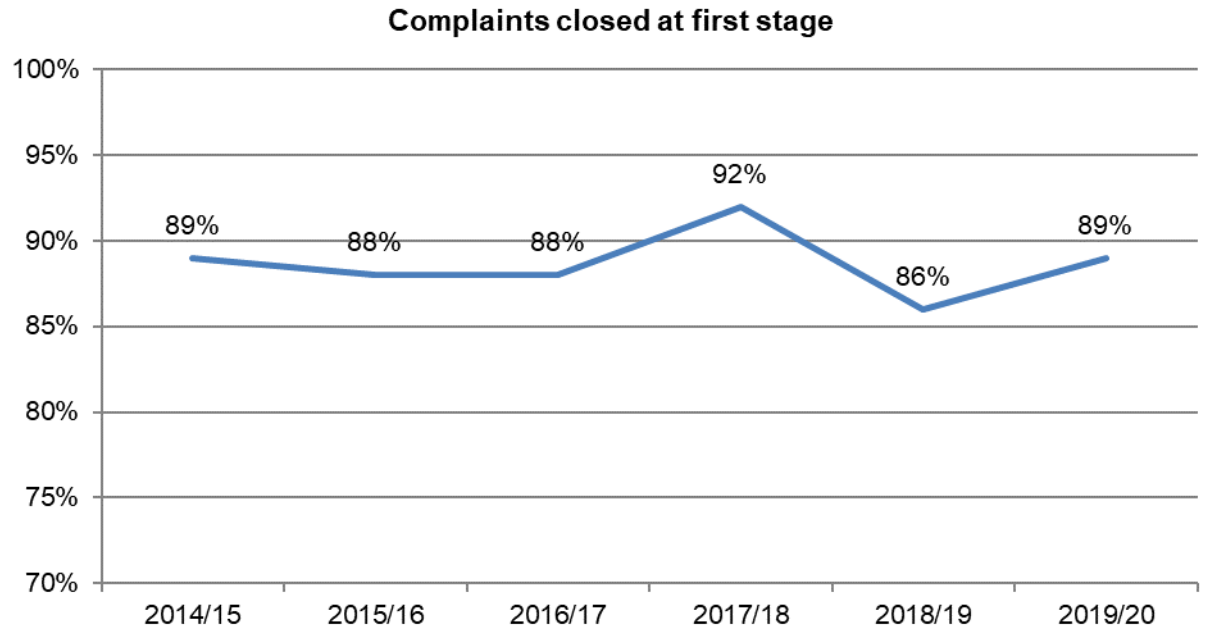
WSFT received 208 formal complaints during 2019/20 The Board monitors complaints and learning on a monthly basis as part of the quality reporting arrangements.



Source: Datix

As a Trust we aim to resolve complaints at first stage, resolving a person's concerns upon receipt of their first contact. On occasions people are dissatisfied with the outcome of our investigations and request a review; at this stage we would consider this to have gone beyond the first stage.

In 2019/20 the Trust successfully resolved 184 complaints at first stage, with 24 investigations escalating to second stage throughout the year.



Source: Datix

Complainants who are dissatisfied with the Trust's response can refer their concerns directly to the PHSO for an independent review. During 2019/20, one complaint was referred to the PHSO, compared to four during 2018/19.

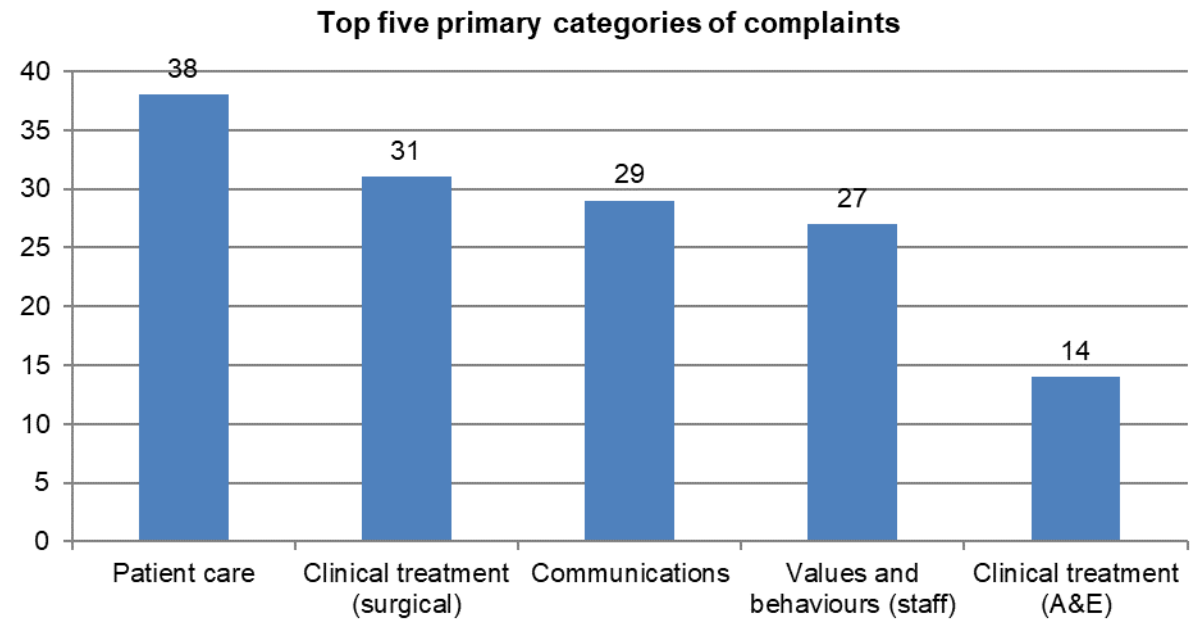
In 2019/20, the PHSO completed its review of five complaints:

- Two were partially upheld
- One was closed with no further action
- Two were not upheld

Recommendations made included:

- Write to complainant and apologise for complaint handling
- Write and acknowledge failings in patient care
- Produce action plans for reassurance about lessons learned

This decrease of complaints accepted for investigation by the PHSO in 2019/20 demonstrates quality investigation processes at local level.



Source: Datix

The numbers identified in the chart above list only primary concerns; many complaints have multiple categories. The top five categories remain the same as the previous financial year, with patient care still being the top category for concern. Clinical treatment in surgery increased from 19 complaints in 2018/19 to 31 in 2019/20, as well as communications also deteriorating. Values and behaviours made up a higher percentage of complaints over 2019/20, and clinical treatment in the emergency department remained at 14 despite increased attendances.

As well as responding to and learning from individual complaints, WSFT identifies themes and trends from local complaints and national publications such as the PHSO. Learning from complaints has supported WSFT's quality priorities and other service improvements including:

- Improvements made to the process around administration of expressed breast milk
- Information regarding cremation form process and contact details added to bereavement booklet
- Patient information leaflet developed to explain process in place to support patients with unresolved delirium who are ready for discharge from hospital.
- Reviewed training levels on eCare prior to agency staff starting their ward shifts.
- New appointment system installed to log and monitor appointments for wheelchair services.
- Ward has changed their ward round process so that the daily check regarding the status of patients and their Heparin injections are carried out

There were some complaints that were also investigated simultaneously with serious incident investigations and the actions identified through these investigations are being progressed and reported via this route.

Managing compliments

A total of 510 compliments have been formally received by WSFT. This figure only includes thank you correspondence shared with or sent directly to the patient experience team.

National CQC patient surveys

The CQC carries out a variety of patient surveys, the most frequent of which occurs annually. Feedback from national as well as local surveys is used to monitor service performance and focus on quality improvement.

Inpatient survey 2019

Inpatient services scored significantly better than most Trusts on three questions:

- How would you rate the hospital food?
- Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?
- Did you feel well looked after by the non-clinical staff e.g. cleaners, porters, catering staff?

In comparison to our own results in 2018, performance was significantly better than previously for patients' feeling well looked after by non-clinical staff.

Overall experience of care was as follows. Full details can be found on the CQC website.

Question	Respondents	2019 Score	2019 Band	2018 Score	Change from 2018
68. Overall... I had a very good experience	565	8.4		8.2	

Section	2019 Score	Band
1. The accident and emergency department	8.5	
2. Waiting list or planned admission	8.8	
3. Waiting to get to a bed on a ward	7.4	
4. The hospital and ward	8.1	
5. Doctors	8.7	
6. Nurses	8.1	
7. Your care and treatment	8.2	
8. Operations and procedures	8.6	Better
9. Leaving hospital	7.1	
10. Feedback on care and research participation	1.3	
11. Respect and dignity	9.3	
12. Overall experience	8.4	

Maternity survey 2019

Maternity services were categorised as 'worse' than most Trusts on two questions:

- Did you get enough information from either a midwife or doctor to help you decide where to have your baby?
- In the six weeks after the birth of your baby did you receive help and advice from a midwife or health visitor about feeding your baby?

In comparison to our own results in 2018, performance was significantly worse on the following question:

- During your pregnancy, did you have a telephone number for a member of the midwifery team that you could contact?

We performed 'about the same' compared with other trusts for labour and birth, staff during labour and birth and care in hospital after the birth. Full details can be found on the CQC website.

National staff survey 2019

The WSFT has moved to a full census of staff and has seen an increase in the response rate of 3.4%. The Trust has also seen an increase in staff engagement to 7.5 which is the best national score for acute trusts.

There have been significant improvements in those who experienced physical violence and reported the incident has increased from 49% to 71%; as well as those who don't work any additional paid hours per week for the organisation, over and above contracted hours, which has increased from 58% to 68%; satisfied with opportunities for flexible working patterns, which has increased from 52% to 60%; and last experience of harassment/bullying/abuse reported has increased from 37% to 45%.

There are areas which have deteriorated, such as in the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public has increased from 3% to 5.6%. There has also been a reduction in staff feeling that there are frequent opportunities for them to show initiative in their role has reduced from 77% to 75.6%, and the team I work in has a set of shared objectives has reduced from 77% to 75.7%.

Workforce Race Equality Standard (WRES)

The scores presented below are the unweighted scores for indicators 5, 6, 7 and 8 split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

		WSFT 2019	Average (median) for acute trusts	WSFT 2018
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	**25%**	28%	27%
	BME	**28%**	30%	21%

Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	**22%**	26%	23%
	BME	**22%**	29%	34%
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	**90%**	87%	90%
	BME	**85%**	74%	79%
In the last 12 months have you personally experienced discrimination at work from any of the following – Manager/team leader or other colleagues?	White	**6%**	6%	7%
	BME	12%	14%	11%

6. Development of the quality report

WSFT has continued its commitment to listening to the views of our service users and Trust members in developing the priorities set out in the quality report and its format and content.

During 2019/20 we have built on our understanding of the views of Trust members' and users' quality priorities through FT membership engagement events. The results of this feedback are reflected in the format and content of this quality report.

Preparation of our quality report has been very challenging during the pandemic and the requirement was removed from the requirement for our annual report and accounts. The global Covid pandemic limited the extent to which views of West Suffolk CCG, Suffolk Health Scrutiny Committee, Healthwatch Suffolk and our governors could be gathered in a timely way to include in the report.

Annex A: Participation in clinical audit

This annex provides detailed information to support the clinical audit section of the quality report.

Table A: National clinical audits

National clinical audit	Host organisation	Eligible	Participated	%
Assessing Cognitive Impairment in Older People (Care in Emergency Departments)	Royal College of Emergency Medicine	Yes	Yes	100%
Cystectomy	British Association of Urological Surgeons	No	N/A	-
Female Stress Urinary	British Association of Urological Surgeons	Yes	Yes	Ongoing[1]
Incontinence Audit	British Association of Urological Surgeons	Yes	Yes	Ongoing[1]
Nephrectomy Audit	British Association of Urological Surgeons	Yes	Yes	Ongoing[1]
Percutaneous Nephrolithotomy (PCNL)	British Association of Urological Surgeons	Yes	Yes	Ongoing[1]
Radical Prostatectomy Audit	British Association of Urological Surgeons	No	N/A	-
Care of Children (Care in Emergency Departments)	Royal College of Emergency Medicine	Yes	Yes	100%
Intensive Care National Audit and Research Centre (ICNARC)	Intensive Care National Audit and Research Centre (ICNARC)	Yes	Yes	Ongoing[1]
Long-term ventilation in children, young people and young adults	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	No	N/A	-
Elective Surgery (National PROMs Programme)	NHS Digital	Yes	Yes	Ongoing[1]
Endocrine and Thyroid National Audit	British Association of Endocrine and Thyroid Surgeons	Yes	Yes	Ongoing[1]
Fracture Liaison Service Database	Royal College of Physicians	Yes	Yes	Ongoing[1]
National Audit of Inpatient Falls	Royal College of Physicians	Yes	Yes	Ongoing[1]
National Hip Fracture Database	Royal College of Physicians	Yes	Yes	Ongoing[1]
Inflammatory Bowel Disease (IBD) Audit	IBD Registry	Yes	No	0%[2]
Trauma Audit & Research Network (TARN)	The Trauma Audit and Research Network (TARN)	Yes	Yes	Ongoing[1]
Mandatory Surveillance of HCAI	Public Health England	Yes	Yes	Ongoing[1]
Mental Health (Care in Emergency Departments)	Royal College of Emergency Medicine	Yes	Yes	100%
Mental Health Care Pathway - CYP Urgent & Emergency Mental Health Care and Intensive C i S	National Collaborating Centre for Mental Health (NCCMH)	No	N/A	-
Paediatric Asthma Secondary Care	Royal College of Physicians	Yes	Yes	Ongoing[1]
Adult Asthma Secondary Care	Royal College of Physicians	Yes	Yes	Ongoing[1]
Pulmonary rehabilitation-organisational and clinical audit	Royal College of Physicians	No	N/A	-
Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	Royal College of Physicians	Yes	Yes	Ongoing[1]
National Audit of Breast Cancer in Older People (NABCOP)	Clinical Effectiveness Unit - Royal College of Surgeons	Yes	Yes	Ongoing[1]
National Audit of Cardiac Rehabilitation (NACR)	University of York	Yes	Yes	Ongoing[1]

National clinical audit	Host organisation	Eligible	Participated	%
National Audit of Care at the End of Life (NACEL)	NHS Benchmarking Network	Yes	Yes	100%
National Audit of Dementia - Prescription of psychotropic medication spotlight audit	Royal College of Physicians	No	N/A	-
National Audit of Pulmonary Hypertension (NAPH)	NHS Digital	No	N/A	-
National Audit of Seizure management in Hospitals (NASH)	University of Liverpool	Yes	Yes	100%
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Royal College of Paediatrics and Child Health	Yes	Yes	Ongoing[1]
National Bariatric Surgery Registry (NBSR)	British Obesity and Metabolic Surgery Society (BOMSS)	No	N/A	-
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre (ICNARC) / Resuscitation Council UK	Yes	Yes	Ongoing[1]
National Audit of Cardiac Rhythm Management (CRM)	Barts Health NHS Trust	No	N/A	-
Myocardial Ischaemia National Audit Project (MINAP)	Barts Health NHS Trust	Yes	Yes	Ongoing[1]
National Adult Cardiac Surgery Audit	Barts Health NHS Trust	No	N/A	-
National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Barts Health NHS Trust	No	N/A	-
National Heart Failure Audit	Barts Health NHS Trust	Yes	Yes	Ongoing[1]
National Congenital Heart Disease (CHD)	Barts Health NHS Trust	No	N/A	-
Early Intervention Psychosis (EIP) Audit 2019/2020	Royal College of Psychiatrists	No	N/A	-
National Diabetes Foot Care Audit	NHS Digital	Yes	Yes	Ongoing[1]
National Diabetes Inpatient Audit (NaDIA)	NHS Digital	Yes	Yes	100%
National Diabetes Inpatient Audit (NaDIA) Harms	NHS Digital	Yes	Yes	Ongoing[1]
National Core Diabetes Audit	NHS Digital	Yes	Yes	Ongoing[1]
National Pregnancy in Diabetes Audit	NHS Digital	Yes	Yes	Ongoing[1]
National Early Inflammatory Arthritis Audit (NEIAA)	British Society for Rheumatology	Yes	Yes	Ongoing[1]
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists	Yes	Yes	Ongoing[1]
National Bowel Cancer Audit (NBOCA)	NHS Digital	Yes	Yes	Ongoing[1]
National Oesophago-gastric Cancer (NOGCA)	NHS Digital	Yes	Yes	Ongoing[1]
National Joint Registry (NJR)	Healthcare Quality Improvement Partnership (HQIP)	Yes	Yes	Ongoing[1]
National Lung Cancer Audit (NLCA)	Royal College of Physicians	Yes	Yes	Ongoing[1]
National Maternity and Perinatal Audit (NMPA)	Royal College of Obstetricians and Gynaecologists	Yes	Yes	Ongoing[1]
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Royal College of Paediatrics and Child Health	Yes	Yes	Ongoing[1]
National Ophthalmology Audit (NOD)	Royal College of Ophthalmologists	Yes	Yes	Ongoing[1]

National clinical audit	Host organisation	Eligible	Participated	%
National Paediatric Diabetes Audit (NPDA)	Royal College of Paediatrics and Child Health	Yes	Yes	Ongoing[1]
National Prostate Cancer Audit	Royal College of Surgeons	Yes	Yes	Ongoing[1]
National Smoking Cessation Audit 2019	British Thoracic Society	Yes	No	0%[3]
National Vascular Registry	Royal College of Surgeons	Yes	Yes	Ongoing[1]
Neurosurgical National Audit Programme	Society of British Neurological Surgeons	No	N/A	-
Paediatric Intensive Care Audit Network (PICANet)	University of Leeds and University of Leicester	No	N/A	-
Perioperative Quality Improvement Programme (PQIP)	Royal College of Anaesthetists	No	N/A	-
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Public Health England (PHE)	Yes	Yes	Ongoing[1]
Sentinel Stroke National Audit programme (SSNAP)	King's College London	Yes	Yes	Ongoing[1]
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Serious Hazards of Transfusion (SHOT)	Yes	Yes	Ongoing[1]
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Society for Acute Medicine	Yes	No	0%[4]
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Public Health England	Yes	Yes	Ongoing[1]
UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	No	N/A	-
UK Parkinson's Audit	Parkinson's UK	Yes	Yes	100%

1 Data collection is ongoing therefore the percentage of cases submitted against registered cases required in 2019/20 is currently unavailable
2 Inflammatory Bowel Disease (IBD) team awaiting administrative support to participate in the IBD Audit
3 WSFT are participating in the Alcohol and Tobacco CQUIN, which records screening and advice
4 Society for Acute Medicine's Benchmarking Audit (SAMBA) has been running since 2012, previously as a non-mandatory audit. WSFT currently does not participate but this status will be reviewed as part of the annual clinical audit programme plan

Table B: Clinical outcome review programmes participation

Clinical outcome review programme	Host organisation	Eligible	Participated	%
Perinatal Mortality Surveillance	MBRRACE-UK, National Perinatal Epidemiology Unit, University of Oxford	Yes	Yes	Ongoing[1]
Perinatal morbidity and mortality confidential enquiries	MBRRACE-UK, National Perinatal Epidemiology Unit, University of Oxford	Yes	Yes	Ongoing[1]
Maternal Mortality surveillance and mortality confidential enquiries	MBRRACE-UK, National Perinatal Epidemiology Unit, University of Oxford	Yes	Yes	Ongoing[1]
Maternal morbidity confidential enquiries	MBRRACE-UK, National Perinatal Epidemiology Unit, University of Oxford	Yes	Yes	Ongoing[1]
Dysphagia in Parkinson's Disease	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Yes	60%
In-hospital management of out-of-hospital cardiac arrest	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Yes	43%
Physical Health in Mental Health Hospitals	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Yes	Ongoing[1]

Clinical outcome review programme	Host organisation	Eligible	Participated	%
Suicide by children and young people in England (CYP)	National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) - University of Manchester	No	N/A	-
Suicide and Homicide	National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) - University of Manchester	No	N/A	-
The Assessment of Risk and Safety in Mental Health Services	National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) - University of Manchester	No	N/A	-
Suicide by middle-aged men	National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) - University of Manchester	No	N/A	-

1 Data collection is ongoing therefore the percentage of cases submitted against registered cases required in 2019/20 is currently unavailable

Table C: Action from national clinical audit reports

National clinical audit	Summary of actions taken
National Asthma and COPD Audit Programme (NACAP): Outcomes of patients included in 2017 COPD clinical audit	Action to appoint an inpatient COPD team to reduce the risk of readmission and conduct annual reviews.
National Audit of Dementia (NAD): Assessment of Delirium in Hospital for People with Dementia Spotlight Audit 2017/18	Actions to: • Provide more accessible cognitive screening and assessment for doctors • Set up a daily dementia and delirium report based on diagnosis entries • Set up a monthly report identifying AMTS and 4AT scoring • Provide dementia and delirium training to relevant staff
National Audit of Dementia (NAD) Care in General Hospitals 2018-19 Round 4 Audit Report	Actions to: • Improve eCare alerting for junior doctors to complete dementia and delirium assessment with direct link to tool • Provide easy access to complete 4AT form in tasks • Include how to complete dementia and delirium screening in junior doctor training sessions • Collate data from monthly snapshot surveys to compare with daily reports to demonstrate discrepancies and highlight the need to record diagnosis
National Comparative Audit of Blood Transfusion 2018 Survey of Group O D Negative Red Cell Use	Actions to: • Maintain ongoing audit of O D negative use and present to Hospital Transfusion Team annually • Continue to monitor major haemorrhage activations to identify if delay in sample receipt impacts on use of O D negative • Update Trust policy & SOP to reflect female >50 with no immune anti-D should receive O D positive blood • Review & reduce stock levels of O D negative blood to avoid inappropriate use & implement procedure for ordering mixed expiry date stock
National COPD Audit Programme: Clinical Audit of COPD Exacerbations Admitted to Acute Hospitals 2017 / Secondary Care Clinical Audit 2017 Working Together	Action to appoint an inpatient COPD team.
National COPD Audit Programme: Resources and Organisation of Care in Hospitals 2017	Action to appoint an inpatient COPD team.
NCEPOD Mental Healthcare in Young People and Young Adults	Action to work with commissioners to implement a system wide tool for assessing and managing risk across the local clinical network and making sure mental health is included in statutory and mandatory training for all staff.

National clinical audit	Summary of actions taken
National Lung Cancer Audit (NLCA) Report 2017	Actions to: • Record FEV1 and FEV1% in the clinic letter for all patients • Review lower-than-expected surgical resection rates for NSCLC at annual meeting with representative from surgical centre • Review job plan of core MDT members to reflect need for dedicated time to attend weekly MDT meeting
Pain in Children RCEM 2017-18 Audit	Action to amend paediatric safety checklist on eCare to ensure re-evaluation of pain after analgesia.
Procedural Sedation in Adults RCEM 2017-18 Audit	Action to incorporate discharge leaflets into e-Care so that they can be printed and dispensed to patients.
Sentinel Stroke National Audit Programme (SSNAP) Sixth Annual Report	Actions to: • Reviewing provision and referral to CT scanning overnight • Review thrombolysis rates • Review overnight nursing assessments e.g. swallow • Trust working on improving nutrition and continence assessment rates

Local audit report summary actions are detailed on the WSFT website:
https://www.wsh.nhs.uk/Corporate-information/Information-we-publish/Annual-reports.aspx**Annex**

Annex B: Nationally-mandated quality indicators

This section sets out the data made available to WSFT by the Health and Social Care Information Centre (HSCIC) for a range of nationally-mandated quality indicators.

(a) Preventing people dying and enhancing quality of life for people with long-term conditions

Summary hospital-level mortality indicator (SHMI)

	Jul 16 – Jun 17	Jul 17 – Jun 18	Jul 18 – Jun 19	Jul 19 – Jun 20
WSFT (control limits)	89.29 (92.48 to 89.05)	87.89 (107.71 to 92.69)	0.9183 (1.0802 to 0.8834)	0.9266 (1.0804 to 0.9239
Banding [a b]	2	3	As expected	As expected
National average	100	100	100	100
Highest NHS trust	122.77	125.72	No longer reported nationally	
Lowest NHS trust	72.61	69.82		

Source: Dr Foster up to June 17, NHS Digital July 17 onwards

(*2020 guidance*) The England average SHMI is 1.0 by definition, and this corresponds to a SHMI banding of 'as expected'. For the SHMI, a comparison should not be made with the highest and lowest trust level SHMIs because the SHMI cannot be used to directly compare mortality outcomes between trusts and, in particular, it is inappropriate to rank trusts according to their SHMI. Trusts are advised to use the banding descriptions i.e. 'higher than expected', 'as expected', or 'lower than expected' in their Quality Account rather than the numerical codes which correspond to these bandings. This is because, on their own, the numerical codes are not meaningful and cannot be readily understood by readers.

WSFT considers that this data is as described as the SHMI rates are reported to the Learning from deaths group along with an analysis of other mortality information. These indicate that WSFT is performing well in regard to maintaining mortality below the expected level.

Patient deaths with palliative care coded at either diagnosis or specialty level

	Jul 15 – Jun 16	Jul 16 – Jun 17	Oct 17 – Sep 18	Jul 18 – Jun 19	Jul 19 – Jun 20
WSFT	32.54%	31.1%	41.0%	45%	46%
National average	29.56%	35.9%	33.6%	36%	36%

Source: Dr Foster to June 17, NHS Digital October 17 onwards

WSFT considers that this data is as described and shows WSFT's rate is slightly above the national average. WSFT intends to take, and has taken, a range of actions to monitor and improve performance in this area as part of our mortality reviews, and so the quality of our services. These are described in the 'Other quality indicators' section of this report.

(b) Patient reported outcome measures scores (PROMS)

	2016/17	2017/18	2018/19	2019/20
Hip replacement surgery (primary) EQ-5D adjusted health gain				
WSFT	0.441	0.479	0.448	0.403*
Comparison	Not an outlier	Not an outlier	Not an outlier	Not yet available
National average	0.445	0.468	0.46	Not yet available
Knee replacement surgery (primary) EQ-5D adjusted health gain				
WSFT	0.338	0.427	0.327	0.269*
Comparison	Not an outlier	Positive outlier	Not an outlier	Not yet available
National average	0.324	0.338	0.34	Not yet available

*2019-20 is provisional data. All previous years are final

(c) Emergency readmissions within 30 days of discharge from hospital

		2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
WSFT	Aged 0 to 15	11.1	12.8	12.9	12.5	13.0	Not yet available
National average		11.4	11.5	11.6	11.9	12.5	
WSFT	Aged 16 or over	12.5	12.5	12.2	12.1	12.7	Not yet available
National average		13.0	13.4	13.6	14.1	14.6	

(2020 update) There is an ongoing review by NHS Digital of emergency readmission indicators across Compendium and the framework publications (NHS OF & CCG OIS), many of which until last year, had not been published since 2014. Phase one of this review was completed in early 2019 and involved the publication of two indicators: CCG Outcomes Indicator Set indicator 3.2 and NHS Outcomes Framework indicator 3b – Emergency readmissions within 30 days of discharge from hospital. This was followed by a subsequent publication in May 2019 of the Compendium emergency readmission indicators.

(d) Responsiveness to the personal needs of its patients

	2016	2017	2018	2019
WSFT	72.9	69.7	68.6	67.4
National average	69.6	68.1	68.6	67.2
Highest NHS trust	86.2	85.2	85.0	85.0
Lowest NHS trust	58.9	60.0	60.5	58.9

Source: NHS Digital

WSFT considers that this data is as described as each year WSFT participates in a national inpatient survey. Review of this data shows that WSFT is performing at the national average and has performed at or better than the national average in all of the last four years.

(e) Staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their friends or family

If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	2017	2018	2019
WSFT (agree + strongly agree)	85.3	82.9	86.2
England: acute trusts (agree + strongly agree)	70.8	71.3	70.5
Benchmark group best result (agree + strongly agree)	85.3	87.3	87.4
Benchmark group worst result (agree + strongly agree)	46.7	39.8	39.7

Source: National NHS Staff Survey Co-ordination Centre - Picker Institute

WSFT considers that this data is as described as the data is analysed independently. Each year WSFT participates in a national staff survey. WSFT receives a benchmark report that compares the results with those of other trusts. When given the statement “if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation”, the percentage of staff employed by, or under contract to the Trust during the reporting period who indicated they agreed or strongly agreed scored higher than the England average for acute trusts. Review of this data shows that WSFT is performing better than the national average each year.

(f) Patients who were admitted to hospital and who were risk assessed for venous thromboembolism

	2016/17	2017/18	2018/19	Q3 2019/20*

WSFT	86.62%	92.12%	94.94%	94.39
National average	95.61%	95.27%	95.59%	95.53

Source: NHS England

*VTE data collection and publication is currently suspended to release capacity in providers and commissioners to manage the COVID-19 pandemic. Data is reported for Q3 only.

(g) Rate per 100,000 bed days of cases of C. *difficile* infection reported within the Trust amongst patients aged 2 or over

	2015/16	2016/17	2017/18	2018/19	2019/20
WSFT	16.4	17.3	13.4	8.6	16.9
National average	14.9	13.2	13.7	12.2	13.6

Source: NHS Digital

WSFT considers that this data is as described as the *C. difficile* infection cases is consistent with the data reported to the Board on a monthly basis and described in the 'Other quality indicators' section of this report.

(h) Number and, where available, rate of patient safety incidents reported within the Trust, and the number and percentage of such patient safety incidents that resulted in severe harm or death

Patient safety incidents (total)

	WSFT number and rate/1000 bed days	Median (all acute non-specialist trusts) Rate/1000 bed days	Comparison to peer group
Apr 2016 – Sept 2016	2,517 (36.2 / 1000 bed days)	40.02 / 1000 bed days	Middle 50% of trusts
Oct 2016 – Mar 2017	2,617 (36.39 / 1000 bed days)	40.14 / 1000 bed days	Middle 50% of trusts
Apr 2017 – Sept 2017	2,541 (35.78 / 1000 bed days)	42.84 / 1000 bed days	Middle 50% of trusts
Oct 2017 – Mar 2018	2,877 (39.53 / 1000 bed days)	42.55 / 1000 bed days	Middle 50% of trusts
Apr 2018 – Sept 2018	2,642 (39.3 / 1000 bed days)	44.52 / 1000 bed days	Middle 50% of trusts
Oct 2018 – Mar 2019	3,624*	Not yet published	Not yet published

Data sources: NHS Improvement (NRLS) and *Local incident system

In October 2017 the Trust took on responsibility for the delivery of community services, this has contributed to an increase in the number of reported patient safety incidents.

Patient safety incidents resulting in severe harm or death

	WSFT number and % of total reported	Average (all acute non-specialist trusts) % of total reported	Comparison to peer group
Apr 2016 – Sept 2016	12 (0.5%)	0.4%	Above peer group average
Oct 2016 – Mar 2017	20 (0.7%)	0.4%	Above peer group average
Apr 2017 – Sept 2017	13 (0.5%)	0.35%	Above peer group average
Oct 2017 – Mar	16 (0.5%)	0.3%	Above peer group

2018			average
Apr 2018 – Sept 2018	15 (0.6%)	0.34%	Above peer group average
Oct 2018 – Mar 2019	15 (0.4%)*	Not yet published	Not yet published

Data source: NHS Improvement (NRLS) and *Local incident system

WSFT considers that this data is as described as the reporting rates are consistent with the data received by the Board on a monthly basis and described in this report within the summary on *Incident reporting and learning*.

WSFT intends to take and has taken a range of actions to improve the rate and percentage for these indicators, and so the quality of its services. These are described in the report within the summary on *Incident reporting and learning*.

Annex C: Glossary

Acute Kidney Injury (AKI)

Acute Kidney Injury (AKI) has now replaced the term acute renal failure and a universal definition and staging system has been proposed to allow earlier detection and management of AKI.

Clostridium *difficile*

C. difficile is a spore-forming bacterium which is present as one of the normal bacteria in the gut of up to 3% of healthy adults. People over the age of 65 are more susceptible to developing illness due to these bacteria.

C. difficile diarrhoea occurs when the normal gut flora is altered, allowing *C. difficile* bacteria to flourish and produce a toxin that causes a watery diarrhoea. Procedures such as enemas and gut surgery, and drugs such as antibiotics and laxatives cause disruption of the normal gut bacteria in this way and therefore increase the risk of developing *C. difficile* diarrhoea.

CQC

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England.

The CQC's purpose is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and to encourage care services to improve.

The CQC's role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety, and to publish findings, including performance ratings to help people choose care.

CQUIN

The Commissioning for Quality and Innovation (CQUIN) payment framework enables our commissioner, NHS Suffolk, to reward excellence by linking a proportion of the Trust's income to the achievement of local quality improvement goals.

DEXA (DXA) scan

DEXA (DXA) scans are used to measure bone density and assess the risk of bone fractures. They're often used to help diagnose bone-related conditions, such as osteoporosis, or assess the risk of developing them.

Total body DEXA scans can also be used to measure body composition (the amount of bone, fat and muscle in the body). This type of scan is routinely used in children, but is still a research application in adults.

Dr Foster Intelligence

Dr Foster Intelligence provides comparative information on health and social care services.

EPARS

The purpose of the EPARS (Escalation Plan and Resuscitation Status) form is to ensure that patients admitted to the Trust (with the exception of day case patients), all have an escalation and treatment plan in place. This ensures that all healthcare professionals are aware of patient's treatment and degree of escalation and de-escalation when coming into contact with the patient.

EPRO	EPRO is a web-based clinical information management system which supports deployment of discharge summaries while also managing patient records and providing reporting capabilities.
HSMR	Hospital standardised mortality ratio (HSMR) is calculated as a ratio of the actual number of deaths to the expected number of deaths among patients in acute care hospitals. An HSMR equal to 100 suggests that there is no difference between the hospital's mortality rate and the overall average rate; greater than 100 suggests that the local mortality rate is higher than the overall average; and less than 100 suggests that the local mortality rate is lower than the overall average.
MEWS	Modified early warning score (MEWS) is a simple physiological scoring system suitable for use at the bedside that allows the identification of patients at risk of deterioration.
NHSI	NHS Improvement (NHSI) is the sector regulator for health services in England. NHSI's job is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit. NHSI exercises a range of powers granted by Parliament which includes setting and enforcing a framework of rules for providers and commissioners, implemented in part through licences issued to NHS-funded providers.
MRSA	MRSA (*Methicillin Resistant Staphylococcus Aureus*) is an antibiotic-resistant form of a common bacterium called Staphylococcus aureus. *Staphylococcus aureus* is found growing harmlessly on the skin in the nose in around one in three people in the UK.
NCEPOD	National confidential enquiry into patient outcome and death (NCEPOD). NCEPOD promotes improvements in healthcare. They publish reports derived from a vast array of information about the practical management of patients.
Never event	Never events are a sub-set of SIRIs and are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.
NRLS	The national reporting and learning system is a national database of confidentially-reported patient safety incidents from healthcare staff across England and Wales. Clinicians and safety experts analyse these reports to identify common risks to patients and opportunities to improve patient safety.
PROMs	Patient Reported Outcome Measures (PROMs) measure quality from the patient perspective. Initially covering four clinical procedures, PROMs calculate the health gain after surgical treatment using pre- and post-operative surveys.
Quality Walkabouts	A programme of weekly visits to wards and departments by Board members and governors. These provide an opportunity to talk to

staff about quality and test arrangements to deliver WSFT's quality priorities.

RCA

A root cause analysis (RCA) is a structured investigation of an incident to ensure effective learning to prevent a similar event happening.

Red2Green

Sometimes patients spend days in hospital that do not directly contribute towards their discharge. We believe that by working better together we can reduce the number of these 'red days' in favour of value-adding 'green days'.

SAFER

The SAFER patient flow bundle blends five elements of best practice. It is important to implement all five together for cumulative benefits and it works particularly well when used with the 'Red2Green days' approach. The five elements of the SAFER patient flow bundle are:

S – Senior review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.
A – All patients will have an expected discharge date and clinical criteria for discharge. This is set assuming ideal recovery and assuming no unnecessary waiting.
F – Flow of patients will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10 am.
E – Early discharge. 33% of patients will be discharged from base inpatient wards before midday.
R – Review. A systematic multi-disciplinary team review of patients with extended lengths of stay (>7 days – 'stranded patients') with a clear 'home first' mindset.

Safety Thermometer

The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and harm-free care. As well as recording pressure ulcers, falls, catheters with urinary tract infections (UTIs) and VTEs, additional local information can be recorded and analysed.

Sepsis

In sepsis, the body's immune system goes into overdrive, setting off a series of reactions including widespread inflammation, swelling and blood clotting. This can lead to a significant decrease in blood pressure, which can mean the blood supply to vital organs such as the brain, heart and kidneys is reduced.

If not treated quickly, sepsis can eventually lead to multiple organ failure and death.

'**Sepsis Six'** is a set of six tasks including oxygen, cultures, antibiotics, fluids, lactate measurement and urine output monitoring - to be instituted within one hour by non-specialist practitioners at the front line.

SHMI

Summary hospital-level mortality indicator (SHMI) is the ratio between the actual number of patients who die following treatment at an acute care hospital and the number that would be expected

	to die on the basis of average figures across England, given the characteristics of the patients treated there. It covers all deaths reported of patients who were admitted to non-specialist acute trusts in England and either die while in hospital or within 30 days of discharge.
SIRI	Serious incidents requiring investigation (SIRIs) in healthcare are rare, but when they do occur, everyone must make sure that there are systematic measures in place to respond to them. These measures must protect patients and ensure that robust investigations are carried out, which result in organisations learning from serious incidents to minimise the risk of the incident happening again. When an incident occurs, it must be reported to all relevant bodies.
VTE	Venous thromboembolism, or blood clots, are a complication of immobility and surgery.

11:45 ITEMS FOR INFORMATION

17. Any other business

To consider any matters which, in the opinion of the Chair, should be considered as a matter of urgency

For Reference

Presented by Sheila Childerhouse

18. Date of next meeting

To NOTE that the next meeting will be held on Friday, 30 April 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