Board of Directors (In Public)

Schedule	Friday 28 May 2021, 9:15 AM — 12:00 PM BST
Venue	Via video conferencing
Description	A meeting of the Board of Directors will take place on Friday, 28 May 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 05 28 May.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: Dr Richard Davies, Alan Rose, Richard Jones, 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 30 April 2021
   For Approval - Presented by Sheila Childerhouse

   Item 6 - Open Board Minutes 2021 04 30 April Draft.docx

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

   Item 7 - Matters arising action sheet - open board.doc

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

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

   Item 9 - CEO Board report May 2021.docx

10:00 DELIVER FOR TODAY

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

    Item 10 - Operational Board update May 2021.doc

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11. Report from 3i Committees: Insight, Improvement & Involvement
To APPROVE the report
For Approval - Presented by Craig Black, David Wilkes and Jeremy Over

- Item 11 - 3i committee reports v2.docx
- Item 11 - Trust IQPR - March 2021 v1.pdf

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

- Item 12 - Board report Cover sheet - M01.docx
- Item 12 - Finance Report- April 2021 Final.pdf

Comfort Break - 10 minutes

11:00 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

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

- Item 13 - People OD highlight report May 2021.doc
- Item 13 Appendix 1 - FTSU_Board_review_tool v1.docx

13.1. Guardian of safe working annual report
For Approval - Presented by Francesca Crawley

- Item 13.1 - Safe staffing guardian annual report 2020_21.doc

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

14.1. Maternity services quality & performance report
For Approval

- Item 14.1 - Maternity Quality and performance report May 2021v2.docx
- Item 14.1 Annex B - RPQOG Safety HLR v13 28.04.21 Final.pptx

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14.2. Infection prevention and control assurance framework
For Approval

- Item 14.2 - COVID IPC assurance framework May 2021.docx

14.3. Nursing staffing report
For Approval

- Item 14.3 - Nurse Staffing Report May 21.docx

14.4. Quality and learning report – learning from deaths, quality priorities
For Approval

- Item 14.4 - Quality and Learning report - May 21.docx

11:25 BUILD A JOINED-UP FUTURE

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

- Item 15 - Future system public board report May 2021.doc

11:35 GOVERNANCE

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

- Item 16 - Governance report.doc

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 TBC 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, 28 May 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: Richard Davies, Richard Jones & Kate Vaughton	Sheila Childerhouse
3.	**Declaration of interests for items on the agenda** To note any declarations of interest for items on the agenda	Sheila Childerhouse
4.	**Questions from the public relating to matters on the agenda** (verbal) To receive questions from members of the public of information or clarification relating only to matters on the agenda	Sheila Childerhouse
5.	**Review of agenda** To agree any alterations to the timing of the agenda.	Sheila Childerhouse
6.	**Minutes of the previous meeting (attached)** To approve the minutes of the meeting held on 30 April 2021	Sheila Childerhouse
7.	**Matters arising action sheet (attached)** To accept updates on actions not covered elsewhere on the agenda	Sheila Childerhouse
8.	**Patient or staff story (verbal)** To reflect on the experience shared with the Trust	Sue Wilkinson
9.	**CEO report (attached)** To receive an introduction on current issues	Steve Dunn
10:00 DELIVER FOR TODAY		
10.	**Operational report (attached)** To approve the report	Helen Beck
11.	**Report from 3i Committees: Insight, Improvement & Involvement (attached)** To approve the report	Craig Black/ David Wilkes / Alan Rose
12.	**Finance and workforce report (attached)** To approve report	Craig Black

	Comfort break – 10 minutes	
11:00 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP		
13.	**People and OD:** To approve the report **13.1 Guardian of safe working annual report (attached)**	Jeremy Over Francesca Crawley
14.	**Quality and safety reports** To approve reports: 14.1 Maternity services quality and performance report (attached) 14.2 Infection prevention and control assurance framework (attached) 14.3 Nurse staffing report (attached) 14.4 Quality and learning report – learning from deaths, quality priorities (attached)	Sue Wilkinson / Nick Jenkins
11:25 BUILD A JOINED-UP FUTURE		
15.	**Future system board report (attached)** To approve report	Craig Black
11:35 GOVERNANCE		
16.	**Governance report (attached)** To approve report, including subcommittee activities	Sue Wilkinson
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 TBC 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

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6. Minutes of the previous meeting

To APPROVE the minutes of the meeting held on 30 April 2021

For Approval

Presented by Sheila Childerhouse

DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 30 APRIL 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		
Kate Vaughton	Director of Integration and Partnerships		
Governors in attendance (observation only): Allen Drain, Florence Bevan, Adrian Osborne, Joe Pajak, Liz Steele, Clive Wilson,			

Action

GENERAL BUSINESS

21/062 RESOLUTION

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

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

21/063 APOLOGIES FOR ABSENCE

There were no apologies for absence.

21/064 DECLARATION OF INTERESTS FOR ITEMS ON THE AGENDA

No declarations of interest were received.

21/065 QUESTIONS FROM THE PUBLIC RELATING TO MATTERS ON THE AGENDA

Q I have a question relating to the Trust's priorities, and its work in delivering more integrated services, together with its local (Alliance) partners. The question has relevance to current work (e.g., agenda item 10 West Suffolk Integration Update), and to the treatment of patients affected by health issues, ranging from asthma to cardiovascular disease and lung cancer.

The Health and Social Care Secretary, Matt Hancock, has said that; *Air pollution is a health issue: it harms the health of the nation. For each of us, our health is unavoidably shaped by the environment we live in. Environmental factors determine around 30% of our healthy life expectancy. Air pollution poses the single greatest environmental threat to human health.*

Breathing dirty air is associated with a host of health problems, from asthma to cardiovascular disease and lung cancer, and all too often it is the most vulnerable – children, older people, and those from poorer backgrounds, who are hit hardest. In short: clean air helps you live longer."
(Reference: https://www.gov.uk/government/news/government-launches-world-leading-plan-to-tackle-air-pollution)

Given the above, what evidence and data, does the Trust have in relation to the negative impact of air pollution on our local community: in terms of admissions and the treatment of patients which has been caused, or aggravated, by poor quality of air? In addition, what action is the Trust undertaking to address these risks, through its focus on integrated working, education, and development of resources?

A This question would be addressed under agenda item 10, integration report.

Q Re. Item 11. Operations Update. Appendix 1. As Covid necessitated the almost complete cessation of endoscopy procedures, it is clearly a vital part of recovery. It would appear from the statistics (on p. 55-56 of Convene) that the figures for all three types of procedures that began to recover last month have dropped to very low levels in comparison with the prior four weekly average, and also in comparison to other hospitals.

Can we be assured that the reasons for this are understood and are being addressed?

A This question would be addressed under agenda item 11, operation report.

Q It is quite understandable that appraisals will have been difficult to carry out when dealing with COVID however Page 74 Convene. Appraisal figures have historically moved slowly upwards, appraisal is a vital part of professional development. Can we be assured that checks are made to ensure that there is not a consistent avoidance by the same members of staff and that there is not a set pattern of no appraisal by certain areas within the hospital.

A This question would be addressed under agenda item 13, people and OD highlight report.

21/066 REVIEW OF AGENDA

The agenda was reviewed and it was explained that item 13.1 would be net on the agenda due to the clinical commitments of the presenters (see minute 74.1).

21/067 MINUTES OF MEETING HELD ON 26 MARCH 2021

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

Item 21/054 (page 7); names of staff members nominated for Putting You First Awards to be included in minutes.

21/068 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 noted that the target date was now 28 May 21.

Ref 1944; Consider how to develop information on the quality of training provided in the 6-monthly education report. It was confirmed that the target date was October 21 as this was the date that the next six-monthly report was due.

The completed actions were reviewed and there were no issues.

21/069 PATIENT OR STAFF STORY

- A letter was read out from a lady and her partner who attended the maternity department at WSFT in November 2020.
- This was an IVF pregnancy and throughout her pregnancy she had received excellent care. She had hoped for a natural home birth but this was not possible due to complications. She had to have a caesarean and as a result of problems with the anaesthetic she had to be resuscitated.
- Despite all the problems both her and her partner felt that they had received the best care. The staff had ensured that they were fully involved in the decisions that were made and even when she was anaesthetised she felt she was in safe hands.
- The whole medical team carried out their jobs with great skill and everyone in the organisation went above and beyond the basic standard. Every professional introduced themselves and provided them with information they required to make decisions.
- The postnatal care had also been excellent and very supportive in helping her to breast feed which was something that she had not initially intended to do. She now realised the benefits and was very grateful for the encouragement and support she had been given.
- This letter had been shared with the team who had looked after this lady, her partner and baby. It highlighted that it was not just about what the staff did but also about how they did it.
- It was noted that verbal feedback following the recent CQC visit to the maternity department had been good. They were pleased with the significant progress that being made by the team in trying make services safer and more responsive.

21/070 CHIEF EXECUTIVE'S REPORT

- Simon Stephens had announced yesterday that he would be stepping down as Chief Executive of the NHS and the board recorded its thanks to him for his leadership.
- Locally the response to the pandemic had been very strong, including the vaccination programme.
- Helen Beck would be retiring at the end of the year. Nick Jenkins would be stepping down as medical director at the end of May for personal reasons, but would remain

in the organisation. Both had made a significant contribution to the organisation, particularly during the pandemic.

- Yesterday Ian Stuchbury, estates manager retired after 41 years in the NHS and 33 years at WSFT. He and his team had made a considerable contribution during the pandemic including the management of oxygen supplies, effective infection control and supporting the housekeeping teams.
- There were currently no Covid patients in the Trust, however this was not the case in Ipswich. The issues being experienced internationally highlighted the importance of not being complacent; the Trust was supporting colleagues with families in the affected areas.
- The focus was now on recovery and the Trust was trying to secure additional resources in the system to assist with this. There was also a need to ensure that staff were given time to recuperate from the pressures and challenges of the pandemic.
- The orthopaedic team were commended for having again delivered some of the best hip fracture repair performance in the country. Andrew Dunn would be leading some of the regional work on orthopaedics.
- This week the new modular ward (G10) would start to arrive on site. The additional capacity it provided would help to mitigate the work being done in response to the structural issues.
- The delivery of the modules for the ward would result in some disruption to traffic and to local residents. The preparation and management of this highlighted the Trust's close working relationship with public partners, particularly the police. Local residents had been communicated with about the likely disruption over the next few days.

70.1 Vaccination close down report

- The board received and noted the content of this report.

Q Was there any early indication that the Trust would have to reproduce the approach to vaccinations on site in the autumn?

A It was not yet known but this could be likely.

DELIVER FOR TODAY

21/071 INTEGRATION REPORT

- In response to the governor's question Kate Vaughton explained that she had recently met with the ICS sustainability lead. A Suffolk wide board had been set up to look at this type of issue and understand the environmental impact of services and the impact this has on health and wellbeing and what needed to be done differently. Further information on west Suffolk's footprint would be brought back to the board when this was available.

ACTION: provide further information on west Suffolk's footprint for environmental sustainability. **K Vaughton**

- Partnership working had accelerated as a result of the Covid crisis and a number of staff from Abbeycroft Leisure had been deployed during this period to provide support to the community. This had been a key part of the system wide response and as a result conversations had taken place around an integrated model and how

to work differently with Abbeycroft Leisure as a provider for the health and wellbeing of patients.

- There had been very good engagement from clinicians who had worked with the team to develop exercise and rehabilitation programmes to support people. They were also looking at cancer pathways and helping patients to deal with their journey both mentally and physically.
- This linked with ongoing work around social prescribing, health coaching etc within the community to improve health and wellbeing.
- Additional roles in primary care had been well received by the primary care networks. This would help the development of clinical models and provide additional capacity within primary care, as well as linking with other elements of integrated care teams.
- There had been an excellent response to the community vaccination programme; at one stage west Suffolk was leading nationally in terms of the percentage of the population who had been vaccinated. This was a credit to all elements across the whole system.
- The work undertaken around the vaccination programme had also enabled a greater understanding of areas of inequality and of organisations and initiatives that could influence and support these areas moving forward, ie taking the vaccination bus to the Mosque in Newmarket and clinics for staff working in the racing industry.
- A significant piece of work was being undertaken around homelessness in west Suffolk which was being supported by the quality improvement team. A system wide decision was made to focus initial work around the homeless and this was being led by Ian Gallin, CEO of West Suffolk Council.
- This work showed that everyone involved in the provision of a care package needed to be able to collaborate and to be empowered to work differently.

Q Re the ongoing journey of integration, ie pace and the obligation for provider collaboration; had the ICS, CCG or alliance considered how best to achieve this?

A A lot of work was already going on in this area. Helen Beck recently joined a regional meeting around this topic which was attended by the quality team. The national lead had offered to come and speak about this. It was proposed that this could be a board workshop.

Currently a broad range of options was being looked at, recognising that a lot of collaboration already existed. This included clinical networks outside the ICS; the ICS were supportive of this and understood that networks were a different type of collaboration.

Q What was the process for prioritising different initiatives; how difficult was it to reach agreement across all partners?

A This process required more development and structure but there were currently four priorities which mirrored the ICS and aligned with the Trust's strategy. The alliance was about an agreement to work in partnership. When making a decision around priorities, eg homelessness, there was a short list that the system executive group signed up to and then further information was presented. All decisions went through a governance process which included the system executive group.

A community and localities model was also being developed, together with changing ways of working to make this an integrated model.

Q Re development of integrated teams; table 2.8 showed that all seven primary care networks had signed up to the mental health practitioner role. How would this be taken forward and was there the capacity and resources to meet the requirements?

A The system was now in a new phase in terms of mental health provision which was becoming more closely aligned with primary care and understanding the workload and what would be required. A recruitment process was currently taking place but demand was higher than ever before and the workforce in this area would need to be prioritised which would be a challenge.

Q Was it understood which of the different models for social prescribing across the county worked best?

A The west had a different model for social prescribing to the east. This was hosted by the district borough council who had agreed to look at the model and understand what the need was and what the funding requirement would if this part of the workforce was expanded.

Q Re the early supportive discharge package which was Suffolk wide; were there other examples where the two alliances would work together and if so was there governance around this, ie whole Suffolk alliance?

A This was a specialist piece of activity which was tendered for by the CCG to provide a county wide service and WSFT had put in a joint bid with ESNEFT to bring this back into the county. WSFT was the principle contract holder but the service was delivered by ESNEFT in the east and WSFT in the west. Therefore, there was overarching governance but with different teams delivering in each local alliance.

Where possible and appropriate services should be provided locally but there was also a need to do this at the right level, ie ICS, alliance or across two alliances.

21/072 OPERATIONAL REPORT

- As previously reported, WSFT had no Covid positives inpatients. However, Ipswich hospital had recently had a local outbreak and it was very important not be complacent and everyone needed to continue to adhere to all infection control procedures.
- Having no Covid patients allowed for improvement in flow through the organisation, ie reinstated short stay medical ward; teams focussing on previous effective ways of working which had resulted in positive results. This was the reason that things had worked well with the recent increase in emergency department attendances, ie 200.
- Early Sage data suggested that there was likely to be another surge in Covid cases between June and September; this was likely to be a surge in the local population but with less impact on healthcare.
- The RAAC plank issue and the impact on operational plans had to be responded to. Therefore, by next week critical care would be decanted into the critical care area on F2 that was created during the pandemic, in order to enable failsafe work to be undertaken.
- Work was already being undertaken in two wards and by the end of next week this would be extended to three wards. This was a significant challenge for the operational teams together with the need to react to change very swiftly. The estates and operational teams were commended for their joint working on this.

- Briefings had taken place to try to alert staff to the fact that this was a rapidly changing programme with a level of uncertainty and disruption and that plans may suddenly need to change.
- The core resilience team had been re-established with key operational people, emergency planning resources and business support to assist the team in managing changes as quickly as possible.
- Elective restoration was progressing well and planning guidance had set out the core requirement to deliver 70% of 2019/20 baseline activity in April and then increase this by 5% per month to 80% in July. However, this would not be sufficient to clear waiting lists and demand was expected to increase again.
- The Trust was working hard to secure additional resources to enable it to move forward more quickly whilst realising the need to balance patient care/treatment with the effect the pandemic had had on staff.
- Conversations were taking place in order to get some recognition of the issues that the organisation would be facing during the theatre closure programme and not being able to deliver the same levels of inpatient activity during this period. The regional team were very supportive and were trying to get national recognition of this.
- With reference to the governor question re the weekly activity return which showed a reduction in endoscopy performance over the last four weeks compared to the previous four weeks; the first figure was the four week rolling average and the second figure was the provisional previous weeks data which would improve over time as the reporting caught up.
- There were likely to be data quality issues from some Trusts and it would be more realistic to compare WSFT with other organisations with similar estate issues. There were also Trusts that would be using a considerable amount of private sector resource, eg ESNEFT. The local BMI did not have the facilities to do this amount of work.
- Last week's data and the cumulative rolling picture for April to date was very encouraging in terms of the level of activity that had been delivered in the month. The Trust would continue to deliver as much activity as possible until it was impacted by the failsafe programme.

Q How was the organisation communicating with patients about the timing of different treatment pathways due to the challenges it was facing?

A This was very challenging and a number of initiatives were being tried. There was a very detailed communications plan about the RAAC plank issues which overlaid the waiting list issues. The Trust was awaiting final regional approval of this plan.

There was a GP section on the Trust's website which was updated monthly across every speciality and diagnostic. Some GPs were communicating this information to their patients. Funding had also been secured for additional resource in the PALs team to help react to issues, but recruitment was still ongoing. Currently the longest waiting patients were being telephoned, but this was very time consuming.

The Trust had deployed the DrDr platform; this had a quick question facility which was a way of quickly interacting with patients and would enable them to be updated in terms of waiting times. Discussions were also taking place with clinical teams about specific communication on the DrDr platform but this was being finalised.

Media coverage was also being looked at alongside individual patient communication and communication through various teams, eg PALs. Therefore, there was a mix of proactive and reactive communication.

Q Re pressure to speed up to recovery plans above and beyond what was realistic and reasonable and the opportunity for the ICS to bid to become an "accelerator system"; what was being done to protect tired staff from this pressure? Were plans to speed up the recovery programme being developed by the teams who would have to deliver this, rather than top down pressure?

A There was a fine balance between how to protect staff and how to manage disparity in waiting times between the east and west of the county. Further detail on the acceleration programme would be provided to the board when there was more clarity around this.

ACTION: provide further information on acceleration programme to board. **H Beck**

- One of the key drivers was looking at bringing additional people into the system and using any additional funding made available for this. A decision would also need to be made around transformation of delivery of services in the future.
- Clinical teams had been asked what opportunities there were to accelerate activity if the capacity and funding was available. A lot of initiatives were being put forward from different specialities about what they could do more of if they had the resources.
- An outpatient transformation programme was already in place to look at how to reduce unnecessary outpatient activity.
- It was very important to look at this as a system, not just in the acute setting.
- The board thanked the operational team for all the work they were undertaking to manage the challenges from both the failsafe programme and waiting lists.

21/073 FINANCE AND WORKFORCE REPORT

- The finance team had produced a full set of accounts within three weeks of the year end and these had been submitted to the auditors earlier this week. This was a genuine achievement in the current circumstances.
- The Trust had finished the financial year in a breakeven position with a small surplus of £145k, subject to audit.
- The most significant element was capital expenditure in the final month of the year. WSFT was one of a small number of organisations across the east of England which had achieved its capital target; this had been done with the benefit of patients firmly in mind.
- The cash balance remained high as expenditure had not yet been delivered in cash. The cash position would reduce this month when bills were paid, therefore cash would return to being a significant focus as the organisation moved through next year.
- The board had approved a financial plan for 2021/22 based on a significant assumption around income and work was being undertaken with the ICS and NHSEI on what the income position would look like.
- The income figure for the first half of the year had been confirmed and the impact of this and the likely financial position was being worked through. This was looking better than the position that had been signed off by the board but there was still a degree of uncertainty.

- The ability to deliver the cost improvement programme (CIP) during last year had been constrained by the impact of the pandemic and this was likely to continue into the first half of 2021/22. Therefore, the CIP related to the second half of 2021/22 and was likely to change.

Q Considering the RAAC plank issue and a new hospital in five or six years the organisation would not want to spend unnecessary capital on the building that would be closing. What would the general approach be in terms of capital expenditure on the current premises other than to address safety issues?

A Expenditure on the existing building would be inefficient to a certain extent. Therefore, the approach was to only spend money in order to maintain the safety of the building and to carefully scrutinise any other expenditure. Where there was a need to spend money on equipment the aim was to ensure that this could be transferred to the new facility, ie pathology equipment could be moved, although this would not be without a cost to move it.

The principals were to minimise expenditure where possible and ensure that expenditure was sustainable taking into account the new facility. However, the Trust was likely to be in a position where the quality of the building would be deteriorating as it got nearer to the date for moving into the new facility.

ACTION: Consider future capital programme and the balance between safety and a limited building life. **C Black**

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

21/074 PEOPLE AND ORGANISATIONAL DEVELOPMENT (OD) HIGHLIGHT REPORT

Freedom to Speak Up Guardians' Report

- James Barrett and Amanda Bennett, who had been employed as Freedom to Speak Up (FTSU) guardians since November 2020, joined the meeting to present this report.
- They considered it to be very helpful to have two people in this role and were very grateful for the support they had received from senior management.
- There had been a considerable increase in the number of concerns raised over the last six months, with a total of 27 cases.
- It was difficult to establish any themes but the importance of good line managers had been highlighted, which correlated with information from What Matters to You (WMTY). A number of concerns related to lack of communication between middle managers and staff.
- The guardians were looking at how to gain more information about people in the workplace and develop FTSU ambassadors; the National Guardian's office had just issued guidance on this.
- Trusted partners were being asked how they thought their role was working and this information would be used when looking at what to do next.
- Discussions had taken place about training and the recommendation from the National Guardian's office was that everyone in the organisation should have some sort of training around FTSU. There was also a module for managers and it was recommended that this was undertaken by all managers in the Trust.

Q Could the next report provide information on the impact or outcome of interaction with staff members and if people felt that their concern/issue had been resolved.

A It was agreed to include this information in the next report.

ACTION: include information on outcomes of interaction with FTSU guardians in next quarterly report. **J Over**

Q This report provided greater reassurance compared to reports in the past. It included a number of 'even better if' suggestions for each of the eight key workstreams that the guardians had identified. Was the organisation clear on what concerted actions were being taken in response to these suggestions?

A A number of workshops would be taking place in May to co-ordinate and strengthen the people plan around safety culture and speaking up. All of the ideas and proposals in this report would be included in this process.

ACTION: confirm how 'even better if' suggestions would be reflected in the people plan. **J Over**

Q The information in this report around "even better if" could be part of the response to further embed speaking up as part of the culture of the organisation. Did Amanda or James have any additional ideas including support for line managers and extension of FTSU ambassadors and how could the board support this?

A The board could provide support around the ambassador role; the Guardian's office proposed that there should be protected time for individuals in this role, ie training, ongoing support, discussion groups etc.

Q Was there any plan to link FTSU with the just and learning culture work as one cohesive programme?

A Discussions had already taken place with senior managers and it was recognised that it would be better if these were linked so that everyone was working together under one structure for both.

There were a number of overlapping cultural priorities and one of the aims of the workshops in May was to try and obtain a single narrative around priorities and the west Suffolk approach and to convey this in a way that made sense to everyone. The safety culture work would be embedded into this.

Q Would it be appropriate at some time in the future to repeat the WMTY survey so that the organisation could identify where further action needs to be taken?

A Information was available from the staff survey and FTSU and this would continue to be analysed and actions taken. Repeating WMTY would be a decision of the board and a discussion would take place with staff representatives about the most appropriate time to do this.

ACTION: Consider most appropriate time to repeat WMTY. **J Over**

- The board congratulated Olly Best, Lucy Webb and the MyWiSH Charity fundraising team who had been nominated for Putting You First awards in April.
- An update was provided on the staff wellbeing plan.
- The board received and noted the quarterly mandatory training and appraisal update.

- In response to the question from a governor, ie 'can we be assured that checks are made to ensure that there is not a consistent avoidance by the same members of staff and that there is not a set pattern of no appraisal by certain areas within the hospital?' HR business partners worked with the divisions to improve appraisal performance and prioritised staff who had gone for a long period without an appraisal
- Prior to allocation of HR business partners to divisions a lot of work had been undertaken on appraisals with the operational team including using the waiting list approach, ie focussing on those who had waited longer or did not have any record of having an appraisal.

74.1 Development of One Clinical Community for West Suffolk

- The one clinical community was about building a network that had previously existed but no longer had the impact it used to. Therefore, clinical leaders from across the area had been being brought together to develop and work on issues as a group, ie a one team approach.
- They were working together to look at current challenges and opportunities that would come out of the white paper.
- Andrew Dunn, Amanda Takavarasha and Shelley Lee joined the meeting for this item and explained what they had learned and the ways in which each of them had benefited from being part of this programme.
- It had provided the opportunity to meet and collaborate with other professionals who they would not normally have worked with. Everyone had a common goal and the programme had enabled them to understand each other's individual challenges and pressures within their roles and provided ways of understanding how they could work collaboratively.
- This highlighted the importance of professional leadership development. This was particularly relevant to the future system programme and the many individuals who were involved in its strategy and planning. It was important that they were supported and developed and the learning from the one clinical approach could be very helpful over the next few years.
- Leadership programmes were valuable in helping individuals to deal with the many changes they were facing. Strategic direction was very much around collaboration across the system and removing barriers that existed between organisations.
- The board thanked Andrew, Emma and Shelley for attending the meeting and helping the board an insight into the difference this was making.

21/075 QUALITY SAFETY AND IMPROVEMENT REPORT

75.1 Maternity services quality and performance report, including Ockenden report

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

- It was explained that there had been a delay in producing data which meant that some of the information in the dashboard was not available this month due to the eCare go live and establishing the new reporting arrangements.
- eCare went live in maternity on 21 March and would provide a number of benefits, including enhancement of continuity of care and accessibility of documentation across community and hospital settings
- Changes in the senior team were noted including Karen Green, Clinical Quality & Governance Senior Midwifery Matron and a Deputy Head of Midwifery who would be taking up their role at the end of July.

- The Ockendon report highlighted the importance of a perinatal surveillance model and that Trust boards should have oversight of quality in maternity services. Therefore, this report would include a quality dashboard, safety champion walkabout feedback, staff survey results and service user feedback.
- The team was still submitting data to the CQC following their recent visit and it was hoped to have their final report by the end of May.

Q There had been increasing pressure on the maternity team over the last few months; how was morale?

A Morale had not been good due to the previous CQC report and warning, as well as Covid. This had taken its toll and the maternity team had accessed the Trust's wellbeing service more than any other division. Receiving positive feedback from the CQC's recent visit had been fantastic and helped to lift morale. Staff were now starting to feel better and for the first time the division had employed more staff than it lost, however this was also the national picture.

75.2 Infection prevention and control assurance framework

- The infection prevention and control (IPC) guidance continued to be monitored and the Board Assurance Framework updated. A full gap analysis had also been undertaken in relation to Covid and infection control.
- Despite there currently being no Covid positive patients in the hospital there was still Covid in the community and the Trust remained very alert and monitored every patient coming through the organisation.
- The Trust had been without a lead IPC nurse since August last year but the team had managed the situation. A recruitment process was currently being undertaken however it was difficult to recruit to this position.
- Duty of candour letters were currently being sent out in relation to the nosocomial infection outbreak. It was anticipated that there were would be some feedback on this which was likely to be national as well as relating to WSFT.

Q Re infection control and learning from the pandemic, was there a specific IPC workstream which was providing feedback in relation to the new hospital building?

A The IPC team was very engaged in this process and the issues with the current building were recognised.

75.3 Nurse staffing report

- Over all fill rates continued to be positive for registered nurses with sickness rates reducing. Nursing quality indicators had also improved this month.
- The vacancy rate for registered nurses remained static at around 9%, however there were some individual areas of concern and these were being supported with a recruitment plan, eg F6.
- Nursing assistant vacancies had improved from 7% to 4%. It was hoped that this would continue to reduce over the next few months with the reduced establishment for nursing assistants.
- The supernumery status of a labour suite coordinator also continued to improve.

Q At the recent monthly business meeting of Glastonbury Court and Rosemary ward it was explained that Rosemary ward had become the Covid recovery area for a period of time and the number of beds had also increased to 33. This had put additional pressure on staff as it was difficult to recruit people with the appropriate skills to care

for this type of patient. How was the Trust ensuring that patient safety was monitored where there was an increase in patient numbers and acuity and a shortage of qualified staff?

A Rosemary ward had been an area of specific focus over the last few months due to the increase in the number of higher dependency patients. Work was currently being undertaken to look at the staffing establishment and a number of actions had been in put place to support this area.

A review of staff would take place to look at this against the new nurse staffing plan. Currently when there was a larger number of high dependency patients than anticipated the ward was supported by staff from the acute hospital.

It was important that 33 beds had not been opened due the staffing deficit and this ward as being maintained at previous bed numbers. The aim was to work on a plan to gradually increase the number of beds to 33 by August.

Q How was data on retention of new starters managed and analysed and what was the retention rate; was this included in the figures for new recruits?

A This level of data was currently being looked at. There were a number of staff in the recruitment pipeline who had not worked in healthcare before and sometimes this turned out to be not what they had anticipated. Therefore, additional staff had been put in the education team to support these individuals and help them achieve their qualifications.

ACTION: provide information on retention of new starters. **J Over**

Q Looking forward in 12 months' time at the recruitment market, how difficult might it be to recruit to what was currently in the Trust's plans? It would be helpful to have more information on this in future reports and the likely changes.

A This information could be provided in future reports.

ACTION: provide information on future recruitment pipeline. **J Over / S Wilkinson**

Q Was there a version of the safe staffing tool that could be used across all staff in the community as well as Rosemary ward and Glastonbury Court?

A A tool was being developed nationally but this was yet to be accredited by NICE. Currently community teams were working with a capacity and demand model and this was being developed further.

ACTION: provide information on a national safe staffing tool for the community. **S Wilkinson**

75.4 Improvement programme board report

- As of next month the Trust would be moving to the 3i committee structure, ie improvement, insight and involvement. Any outstanding actions on this plan would be transferred to the relevant committee which would continue to monitor progress.
- Through the 3i committees the intention was to use the PSIRF priorities as a baseline and structure. As well as focussing on the CQC requirements the committees would be focussing on the Trust's quality and safety plan and looking forward rather than in the past.

21/076 CAR PARKING TARIFFS AND CONCESSIONS 2020/21

- This proposal conformed with government guidance which continued to be updated.
- There was no significant change and the current guidance was designed to last for the duration of the pandemic.
- The board approved the following recommendations in the report:
  1. the proposal to comply with the government guidance for the 4 groups
  2. hold the current tariffs and concessions until further details of the government's plans are received.
  3. 2021-22 tariff review for patients, visitors & staff when staff charges are reinstated.

BUILD A JOINED-UP FUTURE

21/077 FUTURE SYSTEM BOARD REPORT

- A meeting had recently taken place with the construction industry council around 46 different aspects of the planned new facility. It had been a very good session and one of the aspects that had been considered at length was around sustainability and the need to meet the government's zero carbon target. WSFT was committed to delivering a sustainable development across the whole programme.
- An imminent indication from the department of health was expected in terms of a formal response to the deep dive meeting around the stage of the process that the Trust was at. Very good informal feedback had been received following the meeting and it was clear that WSFT was progressing well through the process in comparison to other projects.
- This would continue to be driven forward for reasons that had previously been discussed. A lot of work was going on and there had been lots of good progress.

Q Re the digital agenda, were digital costs included in the project plan and would this come out of the Trust's capital programme in future years?

A The assumption was that the final scheme would include £20m for digital capital.

A digital fortnight was completed at the end of last week to look at potential technology to improve the Future System programme. This included aspects of digital exclusion within the population which would remain a significant focus. Investment in technology was currently being treated separately but would be included in the final figure.

GOVERNANCE

21/078 GOVERNANCE REPORT

- The 3i committee structure was noted. This was a new structure which would evolve over the coming months and the new way of working and its effectiveness would be reviewed during the year.

ITEMS FOR INFORMATION

21/079 ANY OTHER BUSINESS

There was no further business.

21/080 DATE OF NEXT MEETING

Friday 28 May 2021, 9.15am

RESOLUTION TO MOVE TO CLOSED SESSION

21/081 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 – 28 May 2021

Agenda item:	7			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Ruth Williamson, Trust Office Manager			
Date prepared:	24 May 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	At April meeting it was proposed that this action should remain open as community metrics had not yet been fully resolved. It was noted that this was work in progress and updates would be provided to the board - update scheduled for May (or timing for completion). Working group of community team members established and work is progressing. **Work on-going.**	HB	28/5/21 26/3/21	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	IQPR pack being developed but the revision (taking out) and update (adding in) will take more time. This is also impacted changes in roles and options being considered. Unfortunately we have again needed to second a key member of the team to support CRT for the RAAC works. We are actively looking for external support to backfill this gap. **Matter on-going.**	HB	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. On track as part of Trust safer staffing review.	SW	28/06/21	Green

1943	Open	26/3/21	Item 10	Set timeline for develop SPC charts at Trust, division and specialty level	Reviewed date proposed following review with information team and head of performance. Potential for some earlier iterations as the Insight work progresses as we as some different/additional metrics to be reported to the Board.	CB	30/04/2021 31/07/21	Red
1944	Open	26/3/21	Item 12	Consider how to develop information on the quality of training provided in the 6-monthly education report		JMO	31/10/21	Green
1950	Open	30/4/21	Item 5	Discussion in open session that considers the point of when to report in public.	**To be covered under Item 5 of today's agenda.**	RJ	28/05/21	Green
1954	Open	30/4/21	Item 13	Develop report to include an indication of outcome for issues raised to FTSUGs		JO	31/07/21	Green
1955	Open	30/4/21	Item 13	Confirm how "even better if" issues from FTSU report have been reflected in plans		JO	31/07/21	Green
1957	Open	30/4/21	Item 14.3	Staff retention and attrition rates (particularly for new staff) – develop indicators to support visibility of this indicator	**Data for turnover received and is included in this month's board paper. Data for new staff still being scoped.**	JO / SW	28/05/21	Green
1958	Open	30/4/21	Item 14.3	Provide visibility for future recruitment pipeline within report	**Future pipeline being created by DCN and DHRD likely to be complete in time for July board.**	JO / SW	31/07/21	Green
1959	Open	30/4/21	Item 14.3	Provide visibility of the developing national safety nursing care tool for community	**National Development detail awaited.**	SW	31/07/21	Green

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1927	Open	26/2/21	Item 8	Consider future provision of keeping in touch service for acute and community services	At April meeting it was proposed to extend the target date as this was likely to be a long-term project. The board would be updated on progress. We have the keeping in touch (KIT) service in our community inpatient areas.	SW	25/6/21 30/4/21	Complete
1931	Open	26/2/21	Item 11	Consider use of SPC charts within maternity (prior to reintroduction within wider IQPR)	Review by information team and head of performance and agreed target for inclusion in IQPR by end of May. This will be reviewed through Insight and reported to the Board. Provision of data was reviewed at the insight committee and a report is due to come back to the next meeting. Will be reported to the board in due course. - Action closed	CB	30/04/2021 31/05/21	Complete
1951	Open	30/4/21	Item 10	Provide further information on West Suffolk's footprint for environmental sustainability.	A green action plan is being developed for the CCGs which, will in turn inform the future Green Plan (sustainability strategy). The current focus is on gathering data to evaluate environmental impacts and includes understanding the carbon footprint. Some key areas will be focused on over the second half of 2021 including reducing environmental impact of travel and transport, addressing the carbon impact of Estates and Facilities	KV	28/05/21	Complete

					and activities that reduce the carbon impact of medicines. Work with partners will continue including developing social value within the Anchors programme, green spaces and social prescribing and, numerous engagement/ partnership activities to promote the Greener NHS vision to 'deliver a net zero carbon NHS.			
1952	Open	30/4/21	Item 11	Bring back more detail on the accelerator site initiative	Detail to be given at Scrutiny Committee.	HB	28/05/21	Complete
1953	Open	30/4/21	Item 12	Capital programme for 2021/22 – balance between safety and future write-off	This will be a constant consideration when determining the capital programme. Will next be formally considered when determining the 22/23 capital programme.	CB	28/05/21	Complete
1956	Open	30/4/21	Item 13	Consider timing of future more regular staff surveys	NHS England introducing quarterly staff surveys – to commence in 2021/22	JO	28/05/21	Complete

8. Patient or staff story (verbal)

To reflect on the experience shared with the Trust

For Report

Presented by Susan Wilkinson

9. Chief Executive’s report

To RECEIVE an introduction on current issues

For Report

Presented by Stephen Dunn

Board of Directors – 28 May 2021

Agenda item:	9			
Presented by:	Steve Dunn, Chief Executive Officer			
Prepared by:	Helen Davies, Head of Communications			
Date prepared:	18 May 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

On Wednesday, 12 May we celebrated **International Nurses Day** and the 201st anniversary of Florence Nightingale's birth. Florence believed nursing to be a call to service and she set out to change the work for the better, setting an example of compassion, commitment to patient care and continuous quality improvement.

The theme for the anniversary was "nursing the world back to health". Our wonderful nurses, along with all of their dedicated colleagues across the Trust, have played a superb role looking after some of the sickest and most vulnerable in our community throughout the pandemic. They have responded magnificently and gone above and beyond looking after people with care and compassion day after day in hugely stressful circumstances.

It was fantastic to be able to use International Nurses Day to celebrate our nurses and tell some of their stories. We heard from one of our student nurses, Molly, who is studying at university whilst also working full time at the Trust with the goal of becoming a paediatric nurse. It was also wonderful to hear from Amanda, one of our senior matrons in our community team, who has been with us since 1988. Being able to shine a light on the profession and celebrate the vital role nurses play in the Trust was humbling and it was touching to be involved in a special service of celebration and commemoration in our chapel.

It was good for some of our nurses on F7 and F8 to be able to chat to **local MPs Matt Hancock and Jo Churchill** when we welcomed them to West Suffolk Hospital earlier this month. As well as hearing how it has been to work on the frontline through the pandemic, we also took them to see Hardwick Manor, which is our preferred site for our new healthcare facility. We spoke to the MPs about how we are engaging our community on our plans - so we can truly co-produce the new healthcare facility with our local population. We also talked about our ambitions for it to be environmentally sustainable and the potential for us, should we go ahead with this site, to maintain as far as possible, the beautiful natural surroundings, which would benefit staff and patient well-being.

We were also able to show them the 'here and now' of the structural challenges we are facing and the efforts we are undertaking to address these issues to try to keep our patients and staff safe. We took them to see wards F11 and our ITU, which are some of the areas currently undergoing works to help mitigate our **RAAC issues**. We also took them to see the construction of our decant ward "G10", which we expect to complete on time and under budget in July. This new ward will allow us to accelerate the installation of essential fail-safes and bearing point extensions, thus extending the effective life of our hospital while we plan for its replacement. I think we left our guests with a strong sense of the momentum and excitement and I am sure they will support us to ensure this continues.

The intensive structural works across the hospital, and the complex planning and organisation it is taking to keep the hospital running whilst doing these necessary works, is a testament to the hard work of all our staff involved. From the estates team organising the contractors, to the clinical staff who are affected by wards moving around the hospital, this is an enormous team effort. I also want to thank West Suffolk Council and Suffolk Constabulary and local residents for their help and forbearance facilitating 92 deliveries to the site to help with the construction of the new ward over the May bank holiday weekend. Our goal is to make our building as safe as possible whilst trying to maintain healthcare services for our local community – and all being done in the midst of a pandemic. This is no mean feat and my thanks go to everyone involved.

Of course, these works are unsettling for staff and with the backdrop of the pandemic, it is more important than ever for us to look after our colleagues. I hope the **Abbeycroft Leisure offer** we have organised, entitling all WSFT staff free gym membership at Abbeycroft centres, will go some way to help people to relax and look after themselves. Over 1,600 of our staff have taken up the

offer and nearly 1400 activities were undertaken in the month of April alone. We have received really positive feedback from staff who say they value the membership.

Despite our best efforts to look after our staff's well-being, we know that Covid-19 is still the cause of huge amounts of stress and uncertainty. The terrible situation in India is a reminder that whilst Covid-19 is abated in West Suffolk and figures are low across the UK, that we must not be complacent. Many of our colleagues have family and friends in countries where Covid-19 is rampant and healthcare systems are struggling. As such, our **staff support team hosted an online support session for anyone affected by Covid-19 abroad.** We will continue to do all we can to help our staff through this period and look after their health and welfare.

In mid-April we **introduced new visiting arrangements.** In most inpatient areas, including Newmarket Hospital and Glastonbury Court, we are now permitting one visitor per patient per day for up to an hour. We know our patients have struggled without seeing their loved one's face to face, so being able to re-introduce visiting has been a key milestone in our pandemic journey. In maternity, one partner can attend scans, appointment and labour or planned caesarean section. Again, we know this will bring much needed comfort and support to those we are caring for.

As life returns more back to normal in the UK, we are seeing increasing demands on our services. In recent weeks we have seen a surge in the numbers of people coming to our Emergency Department. Our system partners have also reported an increase in demand and work is ongoing to understand why we're seeing this rise in numbers. We also continue to care for high numbers of vulnerable patients in the community, many of whom have been directly affected by Covid-19 and have multiple health conditions requiring complex care plans.

In order to make sure we see patients as quickly as possible and to get through our waiting lists, we have signed up to be one of 12 integrated care systems to lead a £160 million initiative to **tackle waiting lists and develop a blueprint for elective recovery.** These 'elective accelerators' will each receive a share of the funding alongside support to implement and evaluate innovative ways of working to ensure services are sustainable for the future.

As part of the Suffolk and North East Essex Integrated care system we are working closely with ESNEFT to look at how we can transform our services. We know there are mixed feelings amongst staff about going full steam into recovery just as we've all been through such busy and stressful times. However, we also know that our teams really care about their patients and many want to get on with delivering the care patients need. The concept of the accelerator is not just to go harder and faster, but to look at how we can work differently and more sustainably in the future.

Having had national confirmation of the funding, we are in conversations with the ICS about how the money will be used locally. Initiatives likely to be part of the scheme include a Vanguard mobile operating theatre, sited at Ipswich but with capacity reserved for West Suffolk patients; new facilities, equipment and staffing to support improved day surgery; and using technology to help patients to be assessed remotely. There will also be a focus on the recommendations of the national "Getting It Right First Time" (GIRFT) programme and how we can further integrate them into our ways of working to improve outcomes and efficiencies.

Finding ways to improve services is something our staff are always striving to achieve. It was really good to see that patients at our West Suffolk Hospital site are receiving some of the **best hip fracture care in the country,** according to data released by the National Hip Fracture Database. Their data puts us at the top of all hospitals in England, Wales and Northern Ireland for meeting best practice criteria when assessing patients with a hip fracture.

The hospital achieved the top rank by being marked on a wide array of criteria including achieving 100% scores on providing nutritional risk assessments and mental test scores for patients when they were admitted. All patients also received a physiotherapist assessment the day after surgery

was complete. Overall, the hospital achieved a 94.3% score, compared to a national average of 54.9%. Hip fractures can be frightening for the patient so it's great for the residents of west Suffolk to know that they are in some of the best hands if they have to come into our hospital for treatment.

We are also **improving services for young patients coming into our emergency department**. Claire Thompson has joined us as a play specialist. Based in our Emergency Department, Claire is working with children up to the age of 16 and can also attend patients in the neonatal unit or day surgery. Her role involves preparing children for procedures such as imaging, blood tests and theatres, helping them to deal with anxieties and worries. The role has been funded by the My WiSH charity and will support the post for two years.

Of course, the brilliant work our staff and charity do across the Trust is only part of our story. We are delighted to be able to **welcome some of our volunteers back into the Trust**. Our volunteers undertake hugely valuable roles across our many teams and they have been hugely missed throughout the pandemic. We are beginning to welcome those who wish to return back into our sites - albeit with the necessary protocols and risk assessments in place to keep them, our staff and our patients as safe as possible.

10:00 DELIVER FOR TODAY

10. Operational report

To APPROVE a report

For Approval

Presented by Helen Beck

Trust Board – 28 May 2021

Agenda item:	10			
Presented by:	Helen Beck, Executive Chief Operating Officer			
Prepared by:	Helen Beck, Executive Chief Operating Officer Alex Baldwin, Deputy Chief Operating Officer			
Date prepared:	18 May 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, the impact of RAAC remedial work and updates on reset and recovery planning.

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

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

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

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

Operational update

General activity and COVID

Over the past four weeks the trust has seen a notable increase in general and acute demand, largely driven by increased ED attendance. Whilst we had, through March and April, seen reduced demand this has now changed and we are starting to see acute activity comparable to pre-pandemic levels.

General and acute capacity is now more stretched and we have regularly used surge capacity (such as AAU, AEC and DWA) to manage flow. This is despite continued focus which has reduced the volume of medically optimised patients and low numbers of stranded patients (length of stay longer than seven days). We are starting to see the impact of reduced capacity and can expect to use escalation and surge capacity until the bearing extension programme concludes in the autumn.

At the time of writing there is one patient with a confirmed COVID result in the organisation. We continue to have isolation capacity for COVID patients and patients requiring NIV support and have robust plans in place for any future COVID surge. Data suggests we may expect a third peak sometime between August and September and we are monitoring developments with the newest variant closely. Additional capacity on G10 will increase our ability to manage isolated patients within the hospital and we remain on track to open the ward in mid-July.

Although spring is yet to finish early thoughts are turning to winter planning and a full winter plan will be presented to board in due course.

RAAC bearing extension and operational impact

As previously reported bearing extension work has been completed on F9 with that area now in service as a decant facility (currently for F11). Work is ongoing on F10 and F11 with completion due by the end of May.

The critical care decant was delivered as planned and the service is currently based on F2. There have been three none clinical transfers out of the organisation but generally capacity has been sufficient to meet demand. The ITU failsafe work is scheduled to be completed by mid-June and currently good progress is being made.

The planned closure of F3, detailed in the last board report, was postponed due to unplanned delays with the theatre failsafe programme (and thus rendering the scheduled ward closure unfeasible). A programme adjustment allows the reduction in surgical beds to coincide with the theatre failsafe programme with little overall impact on the overall project timescales.

Since the last board meeting the RAAC core resilience team (CRT) has been established to provide oversight and operational planning capacity for the bearing extension and failsafe programmes. Brining together the technical estates, clinical, business support and operational teams has already seen benefit and there is good cross function working in place.

Elective restoration and accelerator plans

Elective restoration continues at pace. The current position is positive and we benchmark well regionally (see appendix 1.) Activity levels remain ahead of the national guideline thresholds (75% From May) in all points of delivery. April data has shown a consistent level of delivery with first

outpatients (89%), follow ups (95%), inpatient electives (89%), day cases (96%), MRI (97%), CT (116%) and Endoscopy (86%).

Additional funding (ERF) available for activity above 19/20 baseline subject to achievement of a number of gateways as described in image 1. Each of these form a component of the system recovery plan which is delivered via the SNEE Elective Care Recovery and Adaptation Board.

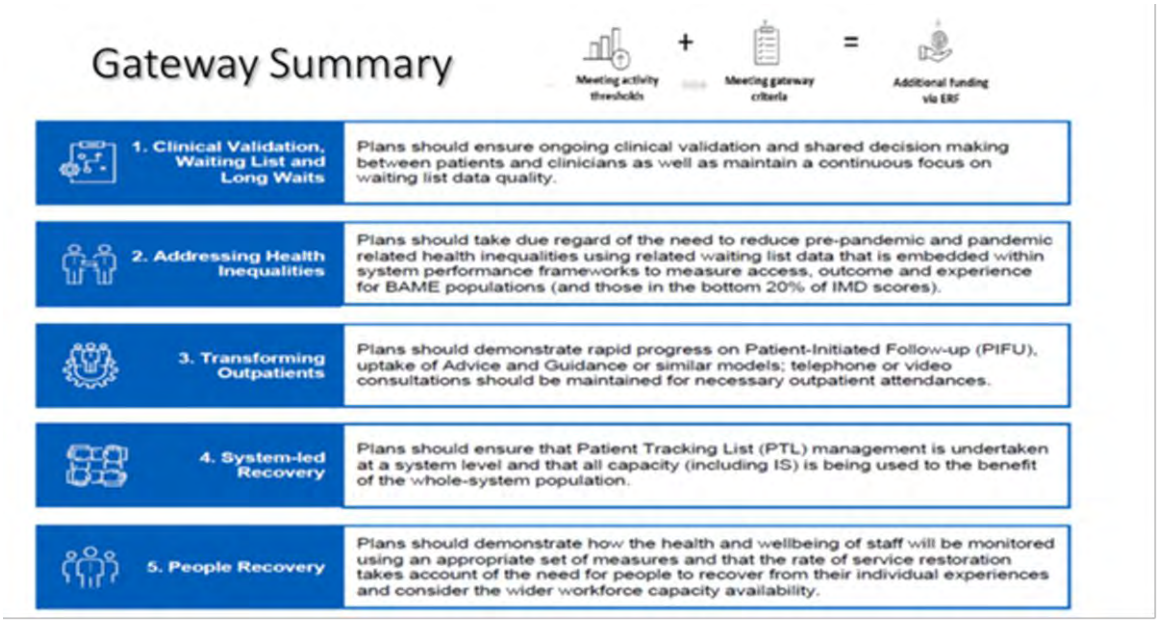


Image 1: ERF gateway summary.

A number of reduced theatre capacity mitigations are in development and these are now largely at an advanced stage. In summary these are as follows;

Independent sector

- Use of the BMI in Bury St Edmunds is limited, but we do run some breast sessions, endoscopy and ad hoc plastic surgery from this location. We have been given the opportunity to send up to 20 General Surgery cases with immediate effect and this will be actioned. There is the option to use BMI theatres at the weekend during our own closures if we can provide staff and this is being explored.
- Newmedica have capacity to take up to 200 cataracts per month subject to patient choice. We have agreed with system partners that this falls within our commissioned capacity and patients will be encourage to accept an offer for surgery at this location.
- Capacity at the Nuffield Hospital in Ipswich is being explored and may provide a small amount of additional T&O capacity.

Maximising use of theatres

- Increased use of DSU where we had historic opportunities in terms of utilisation.
- Weekend working where possible and staff are willing.
- An options appraisal is underway to provide an additional injection room in the eye treatment centre and thus release an additional theatre for cataracts and other surgical procedures.
- On completion of the theatre failsafe programme theatre One will be recommissioned providing additional IP theatre capacity.

Additional modular theatres

- The option to place a vanguard unit on this site is not possible due to lack of space to site a unit and power infrastructure constraints. SNEE has reserved 2 units, one theatre and one ward to be located on the Ipswich site. The unit has laminar flow and can be used for IP as well as DC activity, although we plan to mainly use it for DC activity. The units are staffed and we are looking to utilise up to 10 sessions per week for the 16-week failsafe programme.
- We expect the unit to be operational from mid-July.

- A multi-disciplinary working group has been established to work through the clinical, operational, HR and governance issues related to this.

Activity transfer

- Where appropriate we are in conversation with system partners about offering choice of NHS provider. This will commence with Ophthalmology where there is a significant differential in waiting times between the trust and ESNEFT for cataract surgery. Positive dialogue between the relevant clinical leads from WSFT and ESNEFT is taking place.

Elective Reset and Accelerator Programme – Accelerator programme

SNEE has been successful in bidding to become and elective accelerator programme. This provides the system with an opportunity to provide 100% of 19/20 baseline activity by July and 120% by September. The bid recognises our RAAC issues as the national ask is 120% in July.

Acceptance to the programme provides £10m additional system funding over an above the ERF funding associated with achievement of the planning guidance activity thresholds.

There are two broad elements to the plan – deliver activity to clear backlogs and service transformation to reduce demand and improve sustainability. The transformational change will focus on well-worn priorities such as;

- outpatients where initiatives such as advice and guidance, patient initiated follow up and virtual pathways will be the focus,
- high volume, low acuity pathways (HVLA) such as Ophthalmology, general surgery, T&O, urology, ENT – endorsed by the royal colleges and advocated by GIRFT.

There will also be opportunities to put forward ideas for service transformation or where small capital investment may make a bigger pathway change, such as transferring services from inpatient to day-case for example.

Many of these transformation opportunities have been a focus for some time but we will approach the challenge with renewed enthusiasm. A full elective care transformation charter has been developed and further detail on this, and the detail on the elective recovery plan, will be shared with the scrutiny committee in June. We have secured additional operational and transformation resource to support this programme.

Recommendation

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

Appendix1: EOE activity report 21 05 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 in 2019	4 weeks ending: 02 May 2021	as a % of same weeks in 2019	Same week in 2019	w/e 09 May 2021	as a % of same week in 2019	Same weeks in 2019	4 weeks ending: 02 May 2021	as a % of same weeks in 2019	Same week in 2019	w/e 09 May 2021	as a % of same week in 2019
RC9	Bedfordshire Hospitals NHS Foundation	East of England	Bedfordshire, Luton and Milton Keynes	1,404	1,134	81%	0	0	n/a	187	151	81%	0	0	n/a
RGT	Cambridge University Hospitals NHS Fou	East of England	Cambridgeshire and Peterborough ST	1,585	1,457	92%	1,669	1,686	101%	309	268	87%	318	276	87%
RWH	East and North Hertfordshire NHS Trust	East of England	Hertfordshire and West Essex STP	1,361	1,127	83%	1,378	1,361	99%	151	127	84%	141	149	105%
RDE	East Suffolk and North Essex NHS Found	East of England	Suffolk and North East Essex STP	1,899	1,694	89%	2,003	2,045	102%	244	217	89%	278	264	95%
RGP	James Paget University Hospitals NHS F	East of England	Norfolk and Waveney Health & Care P	667	514	77%	703	521	74%	77	76	98%	73	88	121%
RAJ	Mid and South Essex NHS Foundation Tr	East of England	Mid and South Essex STP	2,245	1,959	87%	2,494	2,266	91%	397	264	67%	381	345	90%
RD8	Milton Keynes University Hospital NHS Fo	East of England	Bedfordshire, Luton and Milton Keynes	542	577	106%	591	601	102%	72	71	97%	78	84	108%
RM1	Norfolk and Norwich University Hospitals	East of England	Norfolk and Waveney Health & Care P	2,000	1,569	78%	2,089	1,730	83%	268	165	62%	241	174	72%
RGN	North West Anglia NHS Foundation Trust	East of England	Cambridgeshire and Peterborough ST	1,166	868	74%	1,244	1,045	84%	228	74	32%	248	120	48%
RGM	Royal Papworth Hospital NHS Foundatio	East of England	Cambridgeshire and Peterborough ST	166	206	124%	141	218	154%	149	122	82%	101	115	114%
RQW	The Princess Alexandra Hospital NHS Tr	East of England	Hertfordshire and West Essex STP	467	371	80%	505	416	82%	74	78	106%	76	144	189%
RCX	The Queen Elizabeth Hospital, King's Lyn	East of England	Norfolk and Waveney Health & Care P	830	373	45%	963	473	49%	123	17	14%	123	30	24%
RWG	West Hertfordshire Hospitals NHS Trust	East of England	Hertfordshire and West Essex STP	880	618	70%	945	710	75%	125	113	91%	131	140	107%
RGR	West Suffolk NHS Foundation Trust	East of England	Suffolk and North East Essex STP	536	457	85%	599	496	83%	76	55	72%	64	69	108%

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 in 2019	4 weeks ending: 02 May 2021	as a % of same weeks in 2019	Same week in 2019	w/e 09 May 2021	as a % of same week in 2019	Same weeks in 2019	4 weeks ending: 02 May 2021	as a % of same weeks in 2019	Same week in 2019	w/e 09 May 2021	as a % of same week in 2019
RC9	Bedfordshire Hospitals NHS Foundation	East of England	Bedfordshire, Luton and Milton Keynes	3,908	3,515	90%	0	0	n/a	7,505	7,131	95%	0	0	n/a
RGT	Cambridge University Hospitals NHS Fou	East of England	Cambridgeshire and Peterborough ST	5,613	4,987	89%	6,124	5,575	91%	6,948	7,584	109%	7,776	8,386	108%
RWH	East and North Hertfordshire NHS Trust	East of England	Hertfordshire and West Essex STP	3,574	3,175	89%	3,639	3,236	89%	7,311	8,314	114%	7,485	8,318	111%
RDE	East Suffolk and North Essex NHS Found	East of England	Suffolk and North East Essex STP	4,855	4,739	98%	5,023	5,228	104%	9,341	8,046	86%	10,175	9,233	91%
RGP	James Paget University Hospitals NHS F	East of England	Norfolk and Waveney Health & Care P	1,470	1,243	85%	1,449	1,408	97%	2,704	2,701	100%	2,621	2,905	111%
RAJ	Mid and South Essex NHS Foundation Tr	East of England	Mid and South Essex STP	6,755	7,259	107%	7,263	7,403	102%	12,706	14,849	117%	13,353	15,613	117%
RD8	Milton Keynes University Hospital NHS Fo	East of England	Bedfordshire, Luton and Milton Keynes	3,548	1,722	49%	3,624	1,868	52%	2,441	2,497	102%	2,699	2,375	88%
RM1	Norfolk and Norwich University Hospitals	East of England	Norfolk and Waveney Health & Care P	4,253	3,588	84%	4,558	3,761	83%	9,108	9,696	106%	9,773	9,650	99%
RGN	North West Anglia NHS Foundation Trust	East of England	Cambridgeshire and Peterborough ST	3,741	2,634	70%	3,831	2,684	70%	5,508	5,310	96%	5,809	5,275	91%
RGM	Royal Papworth Hospital NHS Foundatio	East of England	Cambridgeshire and Peterborough ST	138	199	145%	96	216	225%	461	540	117%	339	614	181%
RQW	The Princess Alexandra Hospital NHS Tr	East of England	Hertfordshire and West Essex STP	2,089	1,862	89%	2,018	2,025	100%	3,002	3,864	129%	2,850	3,950	139%
RCX	The Queen Elizabeth Hospital, King's Lyn	East of England	Norfolk and Waveney Health & Care P	1,435	1,240	86%	1,590	1,390	87%	3,772	3,072	81%	4,133	3,629	88%
RWG	West Hertfordshire Hospitals NHS Trust	East of England	Hertfordshire and West Essex STP	3,291	2,780	84%	3,471	2,863	82%	4,629	3,988	86%	5,014	4,060	81%
RGR	West Suffolk NHS Foundation Trust	East of England	Suffolk and North East Essex STP	1,962	1,555	79%	2,215	1,724	78%	4,584	3,364	73%	4,983	3,430	69%

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	Same weeks in 2019	4 weeks ending: 02 May 2021	as a % of same weeks in 2019	Same week in 2019	w/e 09 May 2021	as a % of same week in 2019	Same weeks in 2019	4 weeks ending: 02 May 2021	as a % of same weeks in 2019	Same week in 2019	w/e 09 May 2021	as a % of same week in 2019
RC9	Bedfordshire Hospitals NHS Foundation	East of England	Bedfordshire, Luton and Milton Keynes	1,489	1,289	87%	0	0	n/a	845	651	77%	0	0	n/a
RGT	Cambridge University Hospitals NHS Fou	East of England	Cambridgeshire and Peterborough ST	915	1,345	147%	918	1,543	168%	652	628	96%	664	696	105%
RWH	East and North Hertfordshire NHS Trust	East of England	Hertfordshire and West Essex STP	1,145	963	84%	1,239	1,055	85%	592	441	75%	603	480	80%
RDE	East Suffolk and North Essex NHS Found	East of England	Suffolk and North East Essex STP	1,636	1,403	86%	1,625	1,486	91%	815	723	89%	801	731	91%
RGP	James Paget University Hospitals NHS F	East of England	Norfolk and Waveney Health & Care P	586	680	116%	580	910	157%	376	346	92%	404	441	109%
RAJ	Mid and South Essex NHS Foundation Tr	East of England	Mid and South Essex STP	2,967	2,952	99%	2,896	3,416	118%	1,247	1,240	99%	1,185	1,300	110%
RD8	Milton Keynes University Hospital NHS Fo	East of England	Bedfordshire, Luton and Milton Keynes	204	210	103%	186	236	127%	165	117	71%	165	116	70%
RM1	Norfolk and Norwich University Hospitals	East of England	Norfolk and Waveney Health & Care P	1,721	1,949	113%	1,724	2,359	137%	741	687	93%	754	803	106%
RGN	North West Anglia NHS Foundation Trust	East of England	Cambridgeshire and Peterborough ST	1,403	1,693	121%	1,411	1,904	135%	578	576	100%	575	615	107%
RGM	Royal Papworth Hospital NHS Foundatio	East of England	Cambridgeshire and Peterborough ST	86	170	197%	83	184	223%	42	75	180%	31	74	236%
RQW	The Princess Alexandra Hospital NHS Tru	East of England	Hertfordshire and West Essex STP	945	715	76%	961	796	83%	359	351	98%	336	434	129%
RCX	The Queen Elizabeth Hospital, King's Lyn	East of England	Norfolk and Waveney Health & Care P	477	492	103%	468	583	125%	222	194	87%	214	143	67%
RWG	West Hertfordshire Hospitals NHS Trust	East of England	Hertfordshire and West Essex STP	609	938	154%	593	1,006	170%	267	302	113%	258	373	145%
RGR	West Suffolk NHS Foundation Trust	East of England	Suffolk and North East Essex STP	529	595	113%	513	668	130%	289	250	87%	300	294	98%

Source: SUS, Monthly Diagnostics (DM01) and Weekly Activity Return (WAR) ***Data in this table has not been adjusted.***				Colonoscopies						Flexible-sigmoidoscopies					
				4 Week Average (Final data)			Latest week (Provisional)			4 Week Average (Final data)			Latest week (Provisional)		
Prov code	Provider Name	Region	STP	Same weeks in 2019	4 weeks ending: 02 May 2021	as a % of same weeks in 2019	Same week in 2019	w/e 09 May 2021	as a % of same week in 2019	Same weeks in 2019	4 weeks ending: 02 May 2021	as a % of same weeks in 2019	Same week in 2019	w/e 09 May 2021	as a % of same week in 2019
RC9	Bedfordshire Hospitals NHS Foundation	East of England	Bedfordshire, Luton and Milton Keynes	81	109	135%	0	0	n/a	96	41	43%	0	0	n/a
RGT	Cambridge University Hospitals NHS Fou	East of England	Cambridgeshire and Peterborough ST	144	71	50%	139	103	74%	27	14	51%	26	24	90%
RWH	East and North Hertfordshire NHS Trust	East of England	Hertfordshire and West Essex STP	74	102	139%	79	96	122%	34	22	65%	28	26	95%
RDE	East Suffolk and North Essex NHS Found	East of England	Suffolk and North East Essex STP	163	181	111%	169	218	129%	52	53	102%	50	64	128%
RGP	James Paget University Hospitals NHS F	East of England	Norfolk and Waveney Health & Care P	34	50	148%	29	75	261%	64	25	39%	61	29	47%
RAJ	Mid and South Essex NHS Foundation Tr	East of England	Mid and South Essex STP	138	233	168%	145	255	176%	73	65	89%	71	83	116%
RD8	Milton Keynes University Hospital NHS Fo	East of England	Bedfordshire, Luton and Milton Keynes	41	91	221%	40	110	275%	19	21	110%	18	26	150%
RM1	Norfolk and Norwich University Hospitals	East of England	Norfolk and Waveney Health & Care P	158	165	104%	175	206	118%	181	51	28%	176	71	40%
RGN	North West Anglia NHS Foundation Trust	East of England	Cambridgeshire and Peterborough ST	132	86	65%	116	80	69%	51	38	74%	55	44	80%
RGM	Royal Papworth Hospital NHS Foundatio	East of England	Cambridgeshire and Peterborough ST	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	6	46	784%	20	1	6%	1	7	681%	4	0	0%
RCX	The Queen Elizabeth Hospital, King's Lyn	East of England	Norfolk and Waveney Health & Care P	48	29	60%	48	54	113%	20	12	61%	14	23	164%
RWG	West Hertfordshire Hospitals NHS Trust	East of England	Hertfordshire and West Essex STP	2	100	4422%	1	125	10000%	5	48	1064%	3	59	2350%
RGR	West Suffolk NHS Foundation Trust	East of England	Suffolk and North East Essex STP	64	53	84%	60	13	21%	39	26	68%	39	1	3%

Source: SUS, Monthly Diagnostics (DM01) and Weekly Activity Return (WAR) ***Data in this table has not been adjusted.***				Gastroscopies					
				4 Week Average (Final data)			Latest week (Provisional)		
Prov code	Provider Name	Region	STP	Same weeks in 2019	4 weeks ending: 02 May 2021	as a % of same weeks in 2019	Same week in 2019	w/e 09 May 2021	as a % of same week in 2019
RC9	Bedfordshire Hospitals NHS Foundation	East of England	Bedfordshire, Luton and Milton Keynes	146	149	102%	0	0	n/a
RGT	Cambridge University Hospitals NHS Fou	East of England	Cambridgeshire and Peterborough ST	176	110	63%	175	168	96%
RWH	East and North Hertfordshire NHS Trust	East of England	Hertfordshire and West Essex STP	60	66	111%	53	49	93%
RDE	East Suffolk and North Essex NHS Found	East of England	Suffolk and North East Essex STP	130	107	82%	125	129	103%
RGP	James Paget University Hospitals NHS F	East of England	Norfolk and Waveney Health & Care P	24	63	270%	26	80	305%
RAJ	Mid and South Essex NHS Foundation Tr	East of England	Mid and South Essex STP	158	213	135%	173	194	112%
RD8	Milton Keynes University Hospital NHS Fo	East of England	Bedfordshire, Luton and Milton Keynes	54	77	141%	56	83	147%
RM1	Norfolk and Norwich University Hospitals	East of England	Norfolk and Waveney Health & Care P	199	177	89%	199	163	82%
RGN	North West Anglia NHS Foundation Trust	East of England	Cambridgeshire and Peterborough ST	121	105	87%	110	116	106%
RGM	Royal Papworth Hospital NHS Foundatio	East of England	Cambridgeshire and Peterborough ST	0	0	n/a	0	0	n/a
RQW	The Princess Alexandra Hospital NHS Tr	East of England	Hertfordshire and West Essex STP	4	31	719%	14	6	45%
RCX	The Queen Elizabeth Hospital, King's Lyn	East of England	Norfolk and Waveney Health & Care P	65	41	62%	61	68	110%
RWG	West Hertfordshire Hospitals NHS Trust	East of England	Hertfordshire and West Essex STP	7	120	1623%	4	140	3733%
RGR	West Suffolk NHS Foundation Trust	East of England	Suffolk and North East Essex STP	97	73	76%	104	19	18%

11. Report from 3i Committees: Insight, Improvement & Involvement

To APPROVE the report

For Approval

Presented by Craig Black, David Wilkes and Jeremy Over

Trust Open Board – 28 May 2021

Agenda item:	11			
Presented by:	Sue Wilkinson, Executive Chief Nurse David Wilkes, Non-executive Director Jeremy Over, Executive Director for Workforce & Communications			
Prepared by:	Richard Davies, Non-executive Director (Insight) David Wilkes, Non-executive Director (Improvement) Alan Rose, Non-executive Director (Involvement)			
Date prepared:	May 2021			
Subject:	3i Committee report: Insight, Improvement & Involvement			
Purpose:		For information	X	For approval

Executive summary:

This month the Trust commenced with the new approved framework for engagement and oversight for quality, safety and improvement. These are known as the 3i committees: Insight, Improvement, Involvement.

The reporting framework for the Board will provide greater emphasis on matters escalated by the committees, people engagement and strategy, and it is proposed that a monthly summary of the 3i committees' activities is prepared and shared with the Board.

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

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

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

Recommendation:
To approve the report and contents

Insight Committee (Dr Richard Davies - Chair)

The first meeting of the Insight committee sat on 17th May 2021.

The new Board governance structure, through the '3i's committees has been under development for some time. The first meeting of the committees have taken place since the last Board meeting and this has been an important opportunity to review and develop their focus, role, membership and interaction. It is recognised that this is an evolving process and that it is unlikely that we will get everything right first time.

A key feature of the new committee structure is the ability to be 'curious' and to spend time really understanding both what is going well within the Trust and where the focus for improvement should be.

The first meeting of the Insight committee was an opportunity to review the scope and draft aims of the committee, to think about the information that the committee will need to receive, to consider the membership, and to explore how all of this can work most effectively in practice.

Noting that this is a process in evolution, the draft aims of the committee are

- To ensure effective systems are in place to assimilate quality and safety information through specialist committees and information reporting
- To improve the understanding of the Trust's delivery of quality and safety using these sources of information to share good practice and prioritise improvements
- To work seamlessly with the Involvement and Improvement committees to support a coordinated approach to engagement oversight for quality, safety and improvement

It is envisaged that the committee's focus and reporting will be structured around three key areas

- Patient safety, effectiveness and experience
- Patient access to care and treatment
- Workforce and financial effectiveness

The committee will rely on information received from specialist sub-committees providing operational oversight for

- Patient quality and safety
- Clinical effectiveness
- Patient access
- Finance and workforce effectiveness

These specialist sub-committees will be empowered to analyse relevant data with assistance from the Trust information governance team. There has already been a considerable amount of work to enable this, with the Information governance team working with the Trust QI and Public Health teams, but further refinements will be made prior to the next meeting.

Membership of the Insight committee will ensure:

- Cross-fertilisation with other 3i committees (although there will also be links through chairs meetings and Board)
- The right people are present to provide both assurance and the seniority to enable appropriate actions.
- Clinical representation, (not just from doctors)
- Representation from community services

Further work on ensuring membership meets these criteria is underway

It was felt that the role of the Insight committee is to consider reports and ask:

- Is what we are seeing a 'blip' or a trend?'
- Is it a local or systemic issue?
- Can this be resolved through local processes and mitigations, and if so who is responsible for this and how will it be monitored?
- If this cannot be resolved locally what is the scale of the problem and how does it need to be escalated?

Improvement Committee (David Wilkes - Chair)

Context and Approach

The Improvement Committee (IC) forms part of the new 3i committee structure and effectively supersedes the Improvement Programme Board (IPB). The IPB was established as a response to the CQC visit in the autumn of 2019 following which WSFT was re-rated as Requires Improvement. The IPB has working successfully with System Partners to successfully address many of the issues raised by the CQC through focused improvement plans. The new IC seeks to further develop continuous quality improvement primarily through internal involvement and learning but will equally be responsive to any third-party inspections and resultant findings.
A first meeting of the Committee took place on 10th May 2021 which was focused on discussing how the committee should operate as well as its relationship to both other underpinning committees and the Board. It is recognised that the Committee is in a "development phase" in what is expected to be an iterative process over the coming months.

Scope and Key Areas of Focus

Much of the first meeting was taken up with a discussion around terms of reference to ensure there is clarity around committee membership, purpose, scope, ways of working, reporting framework and relationship to the other two 3i committees. A final document to this effect is expected to be signed off at the next Committee meeting. Detailed below are some of the key principles which have been agreed upon:

- The purpose of the committee is to provide centralised holistic Trust oversight, direction, enablement and governance of improvement frameworks, capabilities and delivery
- A key focus of the committee will be around supporting and enabling divisional accountability and empowering underpinning committees and forums to deliver continuous quality improvement and eliminate silo working
- Inputs into the committee will be structured around the agreed PSIRF topic or theme areas
- Specialist groups will be invited to the committee on a rotational basis to facilitate deep dives into areas where a requirement for improvement has been identified
- Ensuring that appropriate quality improvement methodologies and processes are adopted and utilised throughout the Trust
- To foster an environment of staff engagement and co-production at all levels
- To consider the establishment of a single multi-divisional Improvement Forum to allow the sharing of best practice
- Ensuring seamless working with the Insight and Involvement committees to support a coordinated approach to engagement and oversight for quality, safety and improvement
- Reporting to the Board will be focused around providing assurance and escalating any areas or issues of particular concern

IPB Decommissioning

A thorough review and analysis of the existing IPB workstreams and actions was considered at the meeting to ensure that either completed actions are fully embedded as BAU or next steps are in place for any outstanding items. Incomplete actions will be assigned to other committees as appropriate. It is suggested that a further review takes place in a few months' time, possibly under the auspices of the Scrutiny Committee, to give assurance that no actions or outstanding issues have been missed during committee transition.

Improvement Plan Reporting

The intention is to use concise focused reporting plans which clearly communicate the objectives, key drivers, BAU measures, required actions, associated data and resulting RAG status for each improvement area. A draft template was considered by the committee using the Falls Improvement Plan by way of example and it was found to be an effective tool for tracking and monitoring improvement progress. It is recognised that it may be more difficult to adopt such a template for complex areas such as maternity and a modified approach will be required.

It is the intention to develop a WSFT One Plan (effectively a list of all WSFT Projects) to provide oversight and effectively manage 3i committee information flows.

Involvement Committee (Alan Rose - Chair)

Context and Guiding Principles

As part of the new governance arrangements, with its "3i" Committees, the Involvement Committee (alongside Insight & Improvement) has had its first meeting earlier this month. This briefing summarises our agreed initial approach and includes a couple of examples of how we wish, at pace, to help empower others to take action. We realise from our own understandings and from feedback from others that, as a Trust, we can do better in terms of **involving staff, patients and stakeholders** in learning from their experience of working here, being cared for and how we work as a partner in our local health and care system. We also appreciate that the meaningfulness of this will be enhanced through the **relationships that we nurture** and the **knowledge and expertise that subject matter experts and others bring to us** as a Board sub-committee.

Our guiding principle is to be an enabling agent for change. We aim to listen to, encourage and support others to seek genuine involvement and engagement to a meaningful extent in their experiences. Although we will seek and receive relevant **data** to support our role, a **particular emphasis will be on the qualitative perceptions, feelings and experiences** of the three communities identified.

There is a strong element of **assurance** in this – as we report and escalate issues to full Board (and others, as appropriate), alongside the impact of support and enablement we wish to bring, described above. **The aim over time will be to be able to demonstrate that each of the communities described (and individuals within these) are feeling more involved in much of what the organisation is doing and that they see and feel their influence.**

Getting Going

The initial "core" membership is two NEDs (Alan Rose & Rosemary Mason), four Executives (Jeremy Over, Sue Wilkinson, Helen Beck & Paul Molyneux), with Richard Jones and James McFarlane (to each help provide a sense of synergy across the 3i). As we further develop the role and functions of the committee the membership and attendance will be defined in a way that promotes inclusion and empowerment of others (staff, patient and system partner representatives), including those who traditionally may not have felt 'heard'. In time, we expect to receive issues from both Insight and Improvement Committees and from other sources. However, we will use a wide range of approaches to listen, review survey feedback, be offered ideas from "feeder" committees and essentially gauge from these where enabling action and support could be offered and encouraged.

We envisage that to ensure reflective and useful discussion, we would normally only have approximately two main items per meeting. It was valuable to already receive two types of input from beyond the Committee at our first meeting and to immediately respond to these as examples of potential future actions:

a) A proposal from the Freedom to Speak Up Guardians (FTSUG) (James Barrett presented to us) a desire to expand their reach and effectiveness by **building a community of "Speak-Up Champion" individuals,** from around the organisation. Each would receive time and training to perform their role and sit within a wide variety of "settings" (e.g., medical teams, protected characteristic groups, community staff, etc.). It was stimulating to receive a well-worked proposal from within the organisation, backed by national guidance and learning, and we endorsed this scheme to launch. Certain enabling issues will be supported by Jeremy's team.

b) The senior workforce team (Jeremy, Claire Sorenson and Denise Pora) presented progress on the People Plan and focused on specific feedback received in recently-held workshops with staff. The main issue, which was also a multi-strand theme from the earlier "What Matters to You" engagement, is **the significant role that line managers play in supporting staff and setting the right cultures within teams** and the ways in which this can be developed at West Suffolk. It is clear that strengthening our leaders and their competencies across the organisation (we are talking hundreds of individuals) will improve vertical communication flows, improve staff motivation and morale and generally support our vision of "People First". We will hear more proposals on addressing this fundamental issue for the Trust.

Next Steps

The Committee will work on:
- Processes for receiving and gathering inputs.
- Clarifying which “feeder” Committees and sources are to be linked.
- Membership and attendance.
- Communications across 3i, to Board and with the organisation.
- Measures of effectiveness.

Potential topics for next time:

- Leadership and line manager development -- as per (b) above.
- Developing our approach to learning from patient feedback and involvement
- The ‘supporting staff in stressful times’ project, currently active.

Insight Committe Report

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

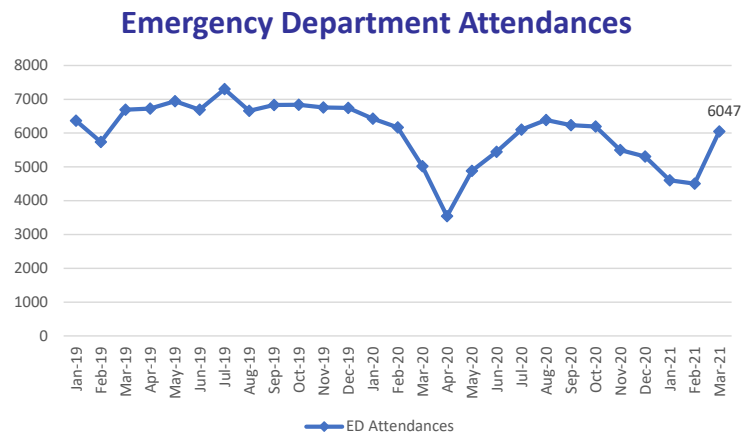
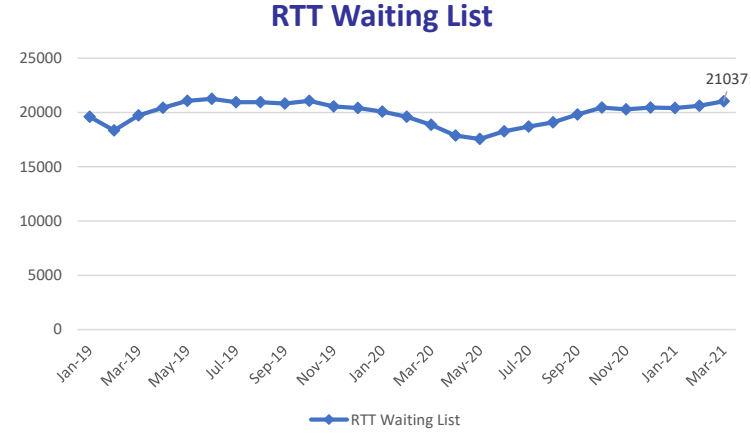
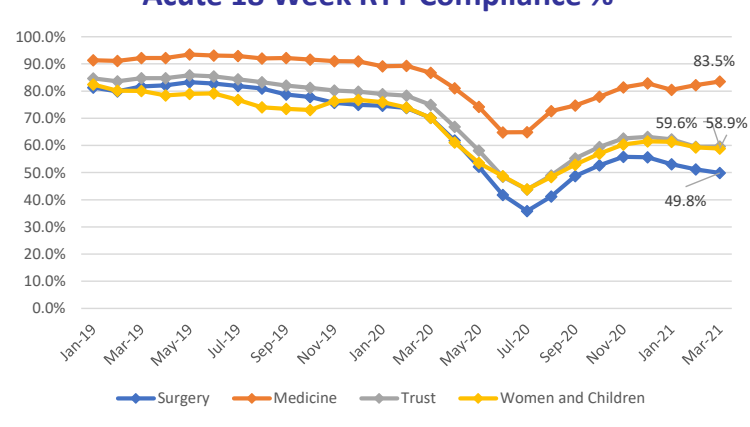
Trust Priorities [Please indicate Trust priorities relevant to the subject of the report]	**Delivery for Today**	**Invest in Quality, Staff and Clinical Leadership**	**Build a Joined-up Future**
	X		

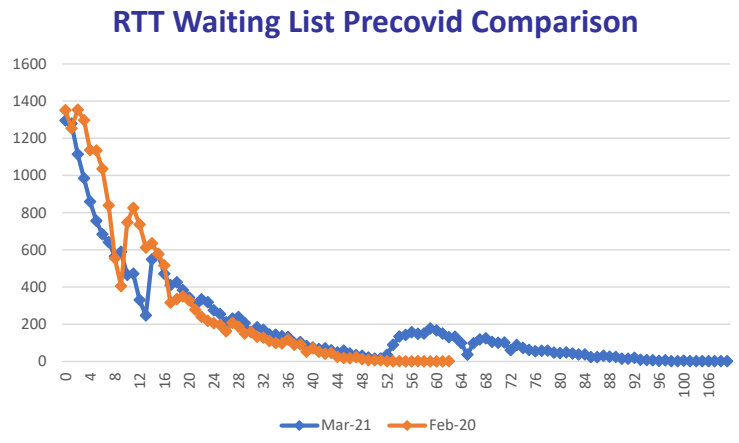
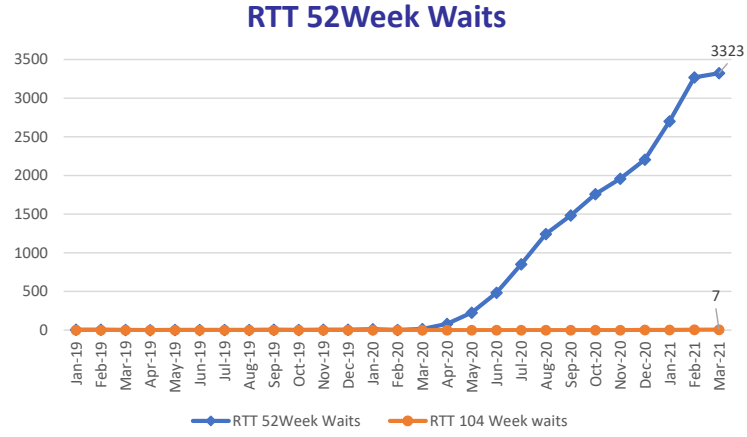
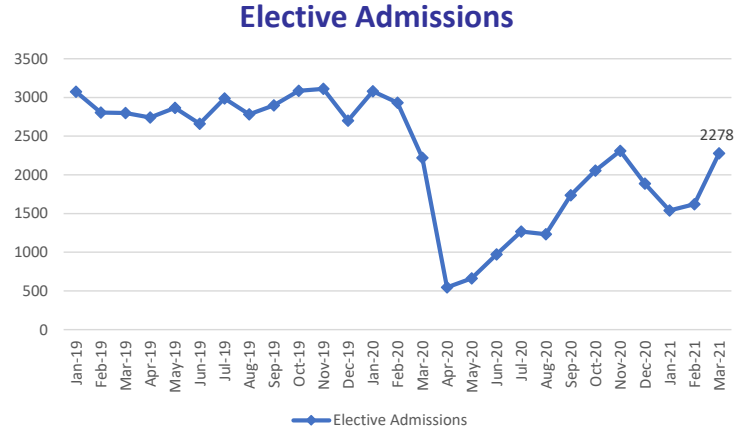
Trust Ambitions [Please indicate ambitions relevant to the subject of the report]	Deliver personal care	Deliver safe care	Deliver joined-up care	Support a healthy start	Support a healthy life	Support ageing well	Support all our staff
		X	**X**				**X**

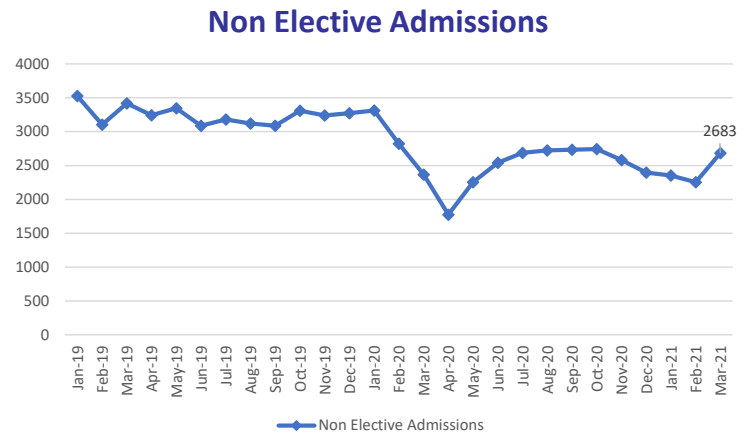
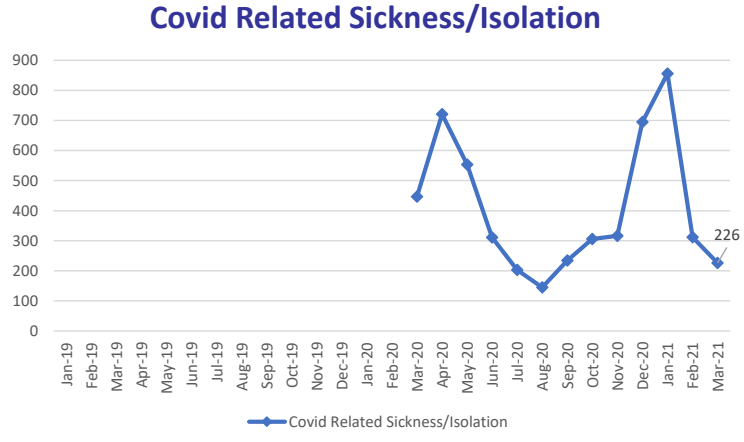
Previously Considered by:	
Risk and Assurance:	
Legislation, Regulatory, Equality, Diversity and Dignity Implications	

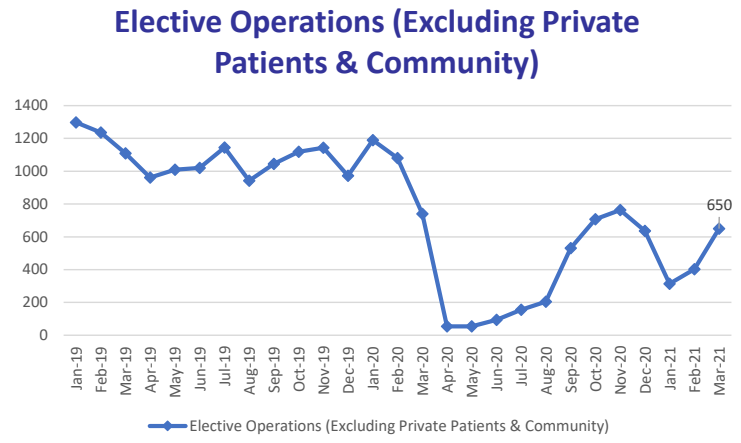
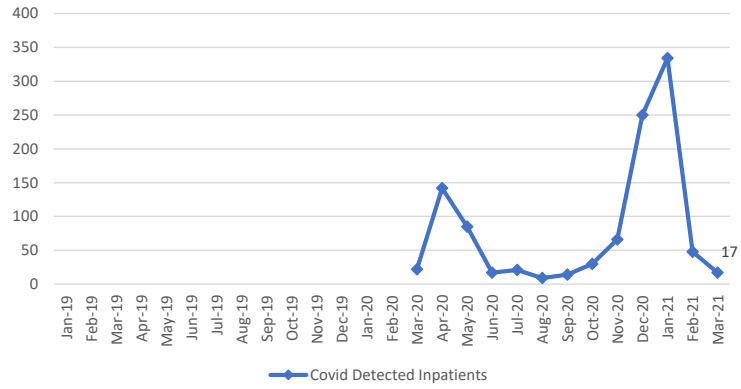
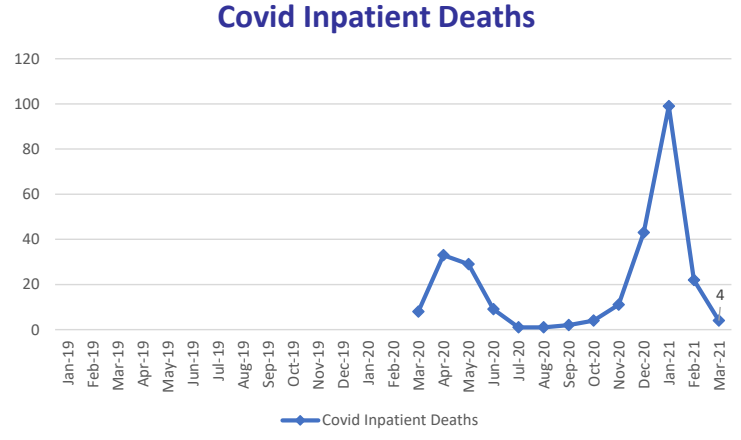
Recommendation:

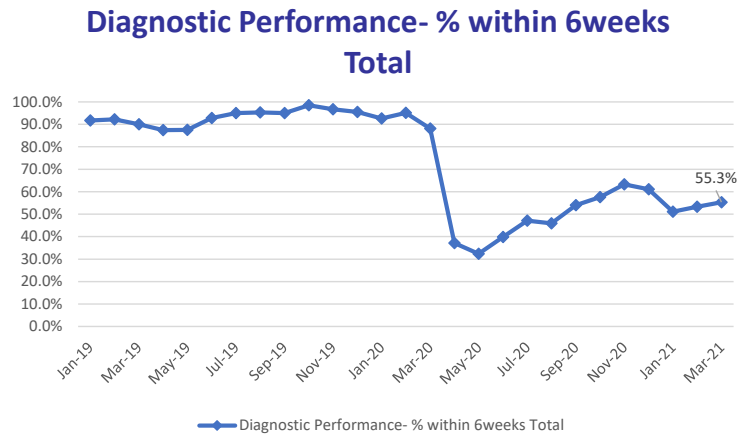
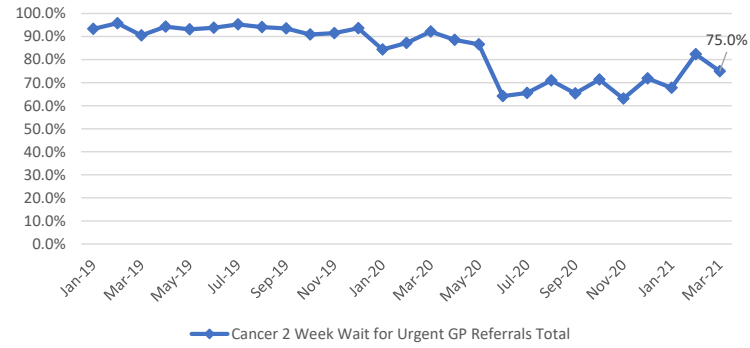
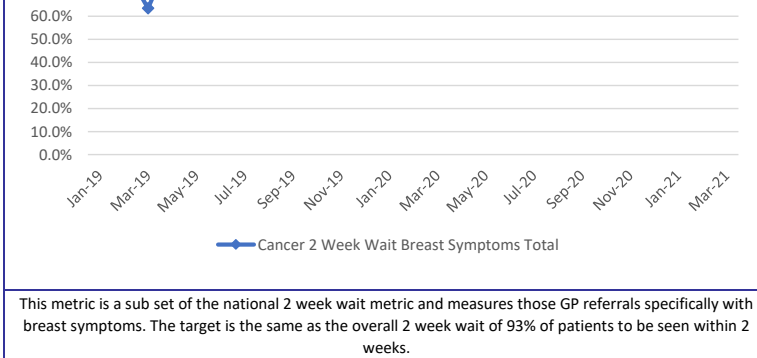
That Board note the report.

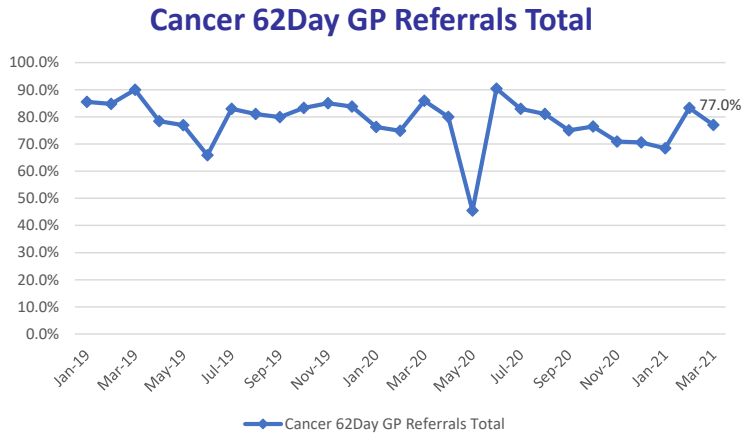
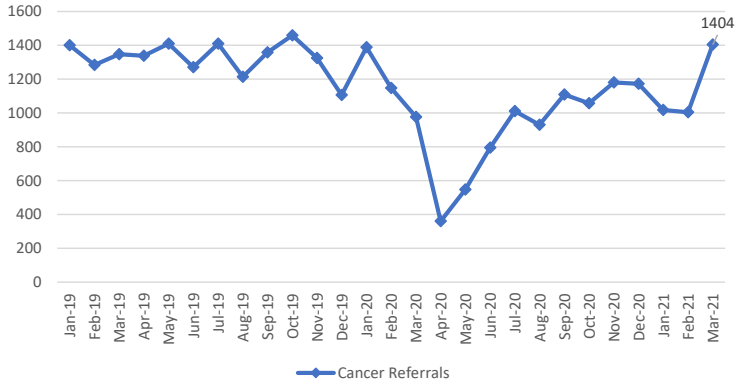
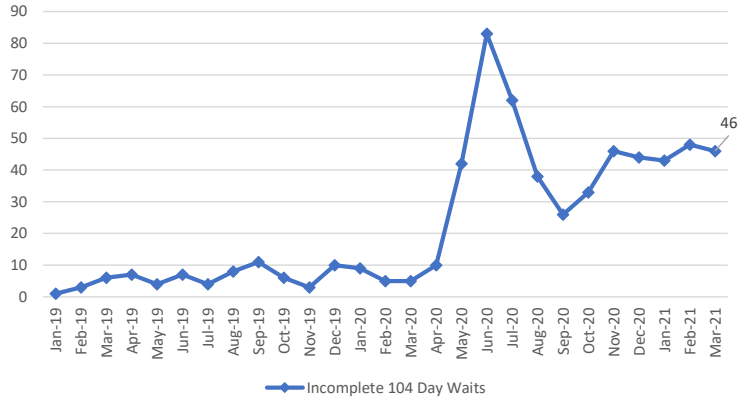
Board Report KPIs	Narratives
	There were 6047 attendances to ED in March 2021, this represents an increase of 1539 attendances compared to the previous month of February 2021.
A count of the arrivals at the Emergency Department. This metric has no national target but is key to understanding demand for non elective services.	
	Increase in overall waiting list size, which reflects the smaller numbers of patients being removed as completed from the pathway and the increase in overall trust referrals.
A count of the patients on the waiting list for treatment.	
	Medicine compliance has increased again in March and is showing good recovery. Surgery and Womens 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	

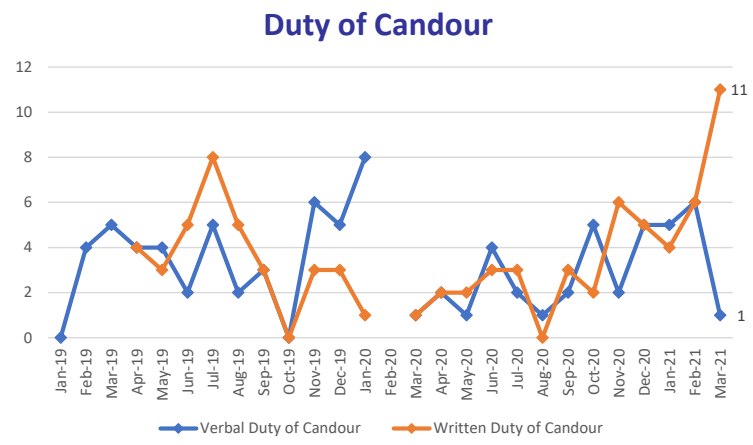
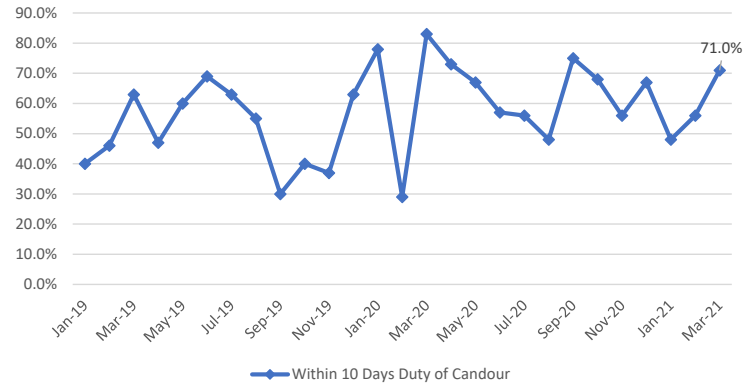
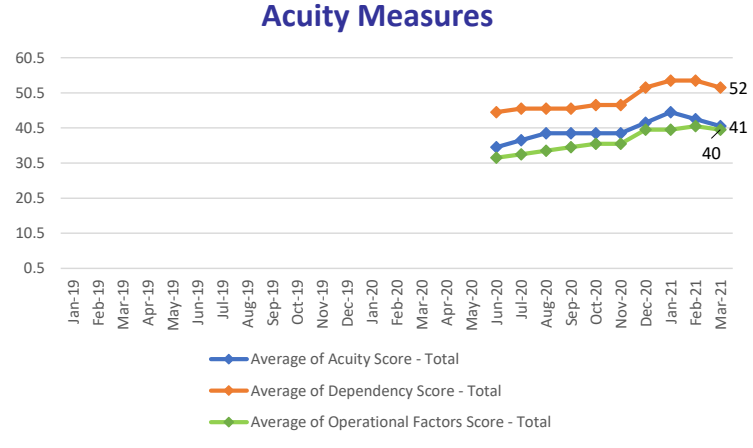
Board Report KPIs	Narratives
	As in pervious months, the tail of the waiting list is much longer than 1 year ago due to the dramatic reduction in surgical capacity, however the front end of the pathway is now closely matching that of last year, demonstrating the referrals getting back to pre pandemic levels.
A year on year comparison of the number of patients waiting for treatment.	
	Increase in 52 week waits continues due to surgical capacity as a result of the pandemic, however the increased rate has slowed in March. Expectation to see the number slightly reduce in April.
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.	
	Large increase in overall elective admissions back to the level seen in November 2020 before the second wave. This is predominantly due to the increase in Endoscopy and diagnostic procedures as well as a slight increase in day surgery capacity.
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.	

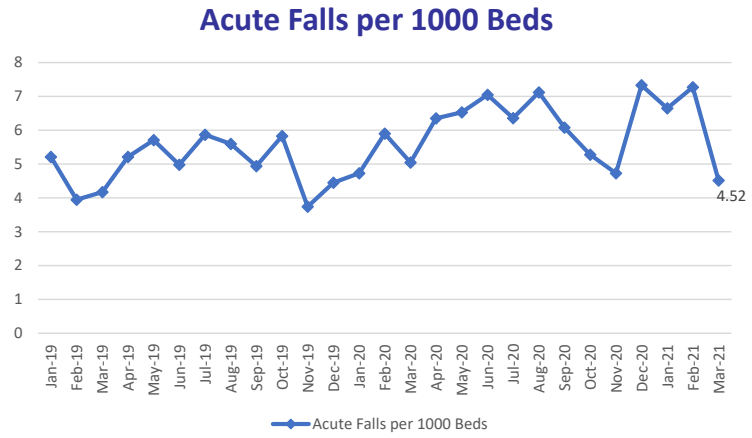
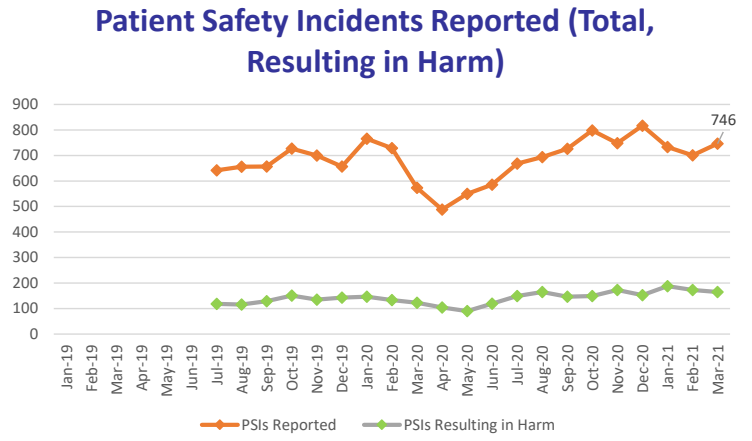
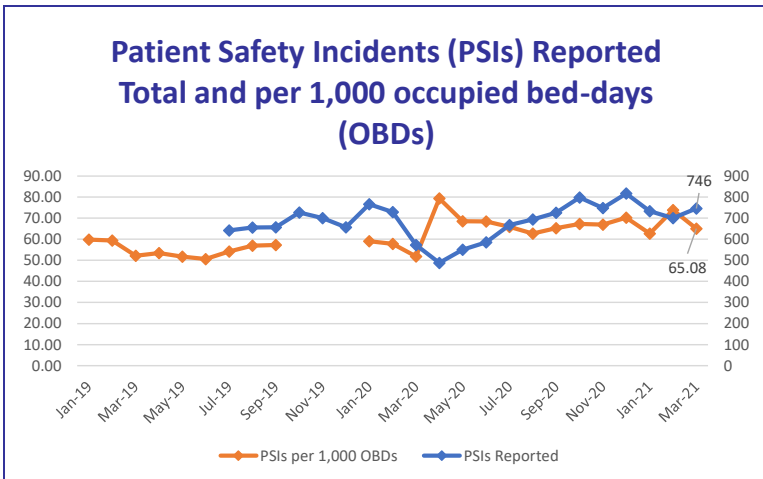
Board Report KPIs	Narratives
	There were 2683 Non elective admissions in March 21 compared to 2367 in February 21, which for the first time in many months represents an increase of 316 non elective admissions. The non-elective admissions graph is mirroring the ED attendances graph, and as the attendances have increased in March so have the admissions numbers.
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 March 2021 was 4.03% which was the same position as at the end of February 2021 (4.00%). This cumulative absence figure is likely to remain at 4% due to the absence rates that can be seen on the graph in April, May, June and July 2020.
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 March 2021 there were 226 episodes recorded which was a decrease on February 2021 which was 312 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.	

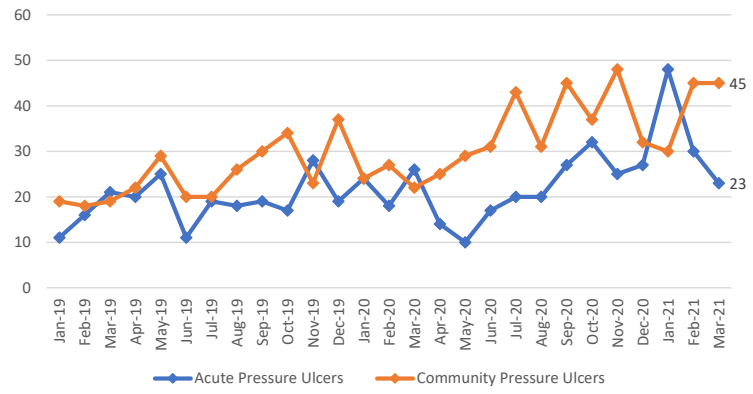
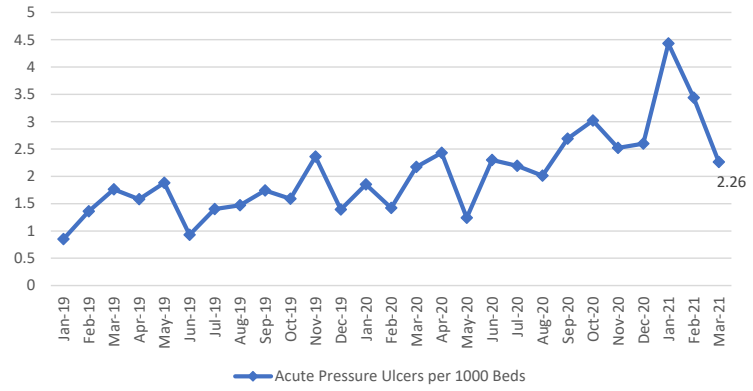
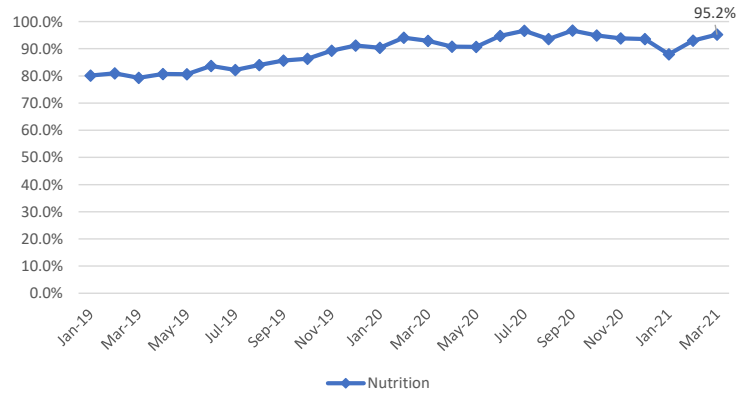
Board Report KPIs	Narratives
	Large increase in elective operations seen in March, due to an increase of patients through the day surgery unit and the ability to return to some form of clinical priority 3 and 4 patients.
This is a count of the number of operations that were carried out. This is a local measure to monitor our productivity and recovery from Covid.	
	There were 17 individual patients admitted during March, who had their first diagnosis of Covid-19. In March the highest number of Covid positive inpatients residing in the trust on any one day was 15, which was on 01/03/2021
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 4 patients who died within 28 days of a positive Covid result, in March. 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.	

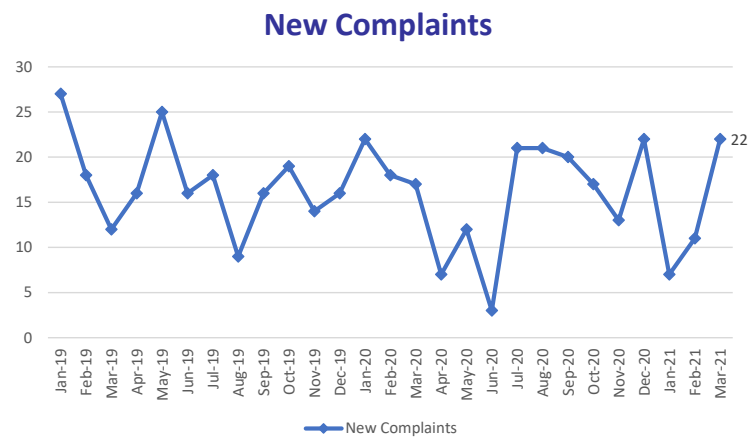
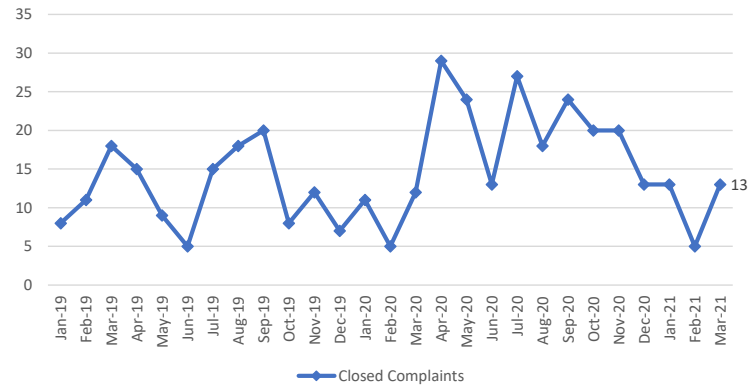
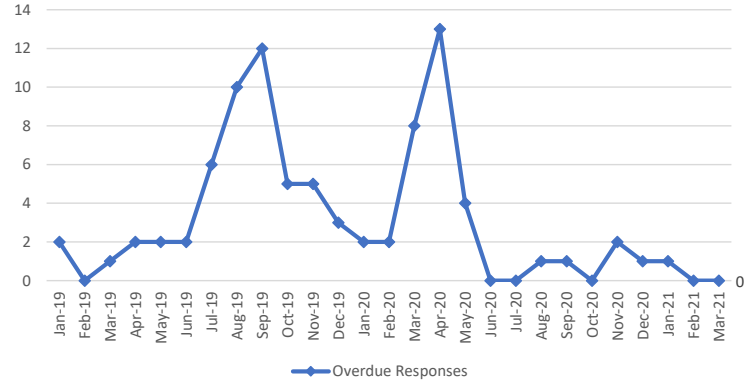
Board Report KPIs	Narratives
	The current cystoscopy performance is being investigated and while there are plans in place to address back log issues there appears to be a data error which we are working to understand. Whilst performance in CT and MRI continues to improve there remain challenges in Ultrasound and Endoscopy. There is a clear action plan for Endoscopy developed focussing on recovery of the rapid access patients in May 2021. Options for additional ultrasound capacity are being explored. CTC remains a concern with urgent patients waiting over 2 weeks. This has been hindered further by multiple closures of CT1 due to faults.
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.	
	Slight decrease but we are begin to see recovery in endoscopy 2WW. With the exception of upper and lower GI all other services met the standard. This performance is expecting to drop in April 2021 as there has been a significant increase in breast surgery referrals.
To measure compliance with the national standards for access to cancer diagnosis. This metric measures the percentage of patients who are seen within 2 weeks from referral from their GP for suspected cancer. The national standard is 93% to been seen within 2 weeks.	
	Performance dropped in March 2021 due to the large increase in referrals and the need to prioritise the not symtomatic patients.
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.	

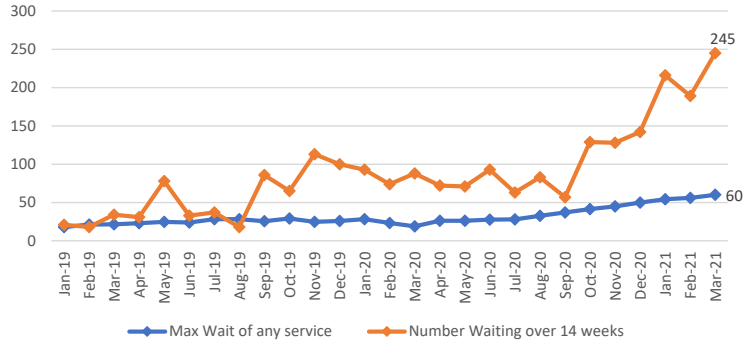
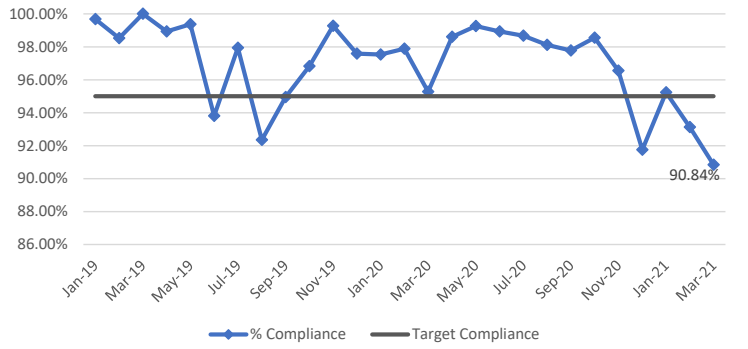
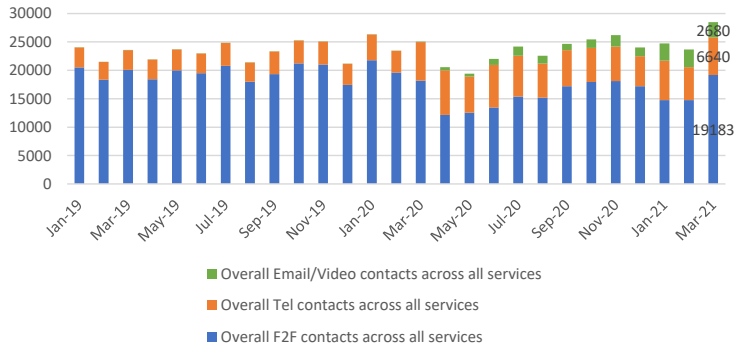
Board Report KPIs	Narratives
	Slight decrease this month. Multiple factors contributing to patients waiting, including patient choice and diagnostic delays as we continue to recover the endoscopy position.
To measure compliance with the national standards for access to cancer treatment. This metric measures 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.	
	Large increase in 2WW referrals seen in March 2021. Particular increase in Breast, Lower GI and Skin. Likely due to easing of restrictions and patients attending GP's.
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).	
	Slight reduction from last month but the numbers of patients over 104 days has been steady at around this mark for a number of months now. Continued monitoring and escalation to move patients through their pathways, it is worth noting these are not the same patients but as we are removing those over 104 days more are tipping into that bracket from the over 62 day pot. Multiple factors are causing this including patient choice.
A count of the number of patients who have waited longer that 104 days for treatment for cancer from GP referral. This is a national standard and is expected to be 0.	

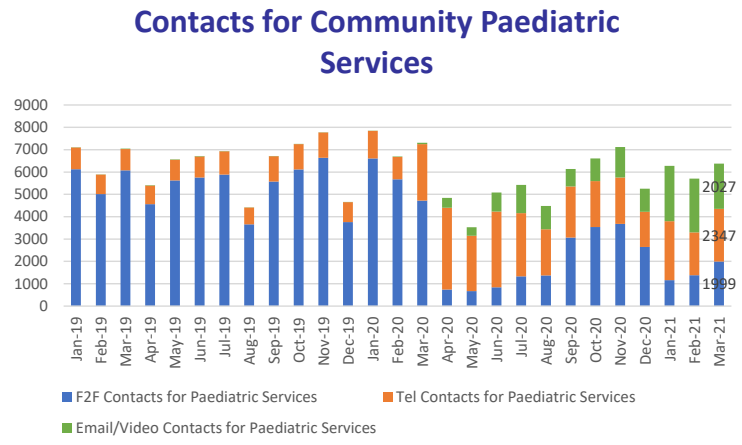
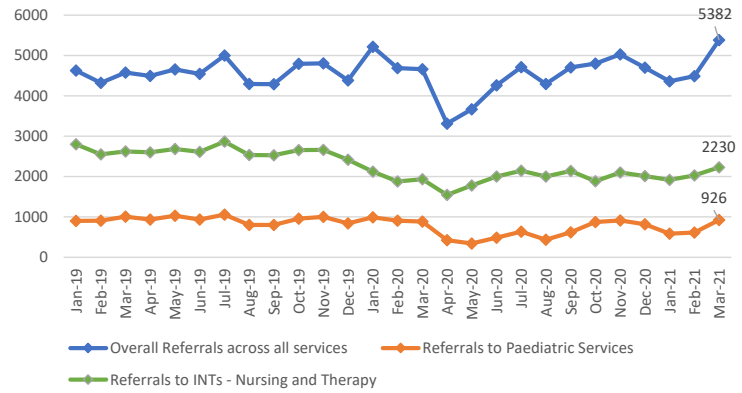
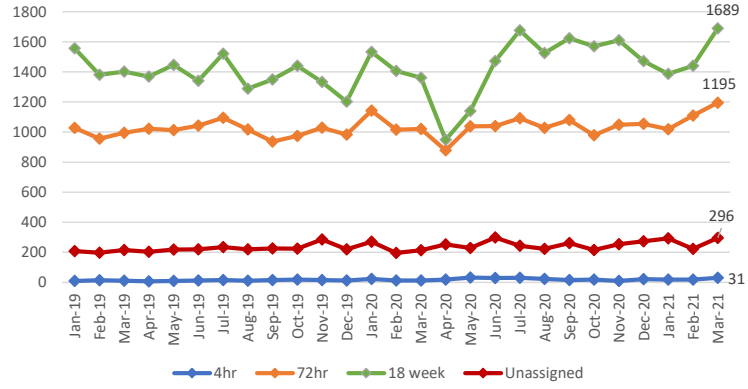
Board Report KPIs	Narratives
 This is a count of the number of verbal and written duty of candour overdue for the reporting month (and earlier) as at the date of report issue	The timeliness indicator demonstrates a wide variance in performance as might be expected when a small denominator indicator is reported as a percentage. Only one case is reported as 'verbal overdue' this month which is an improvement on recent months but there is a resultant rise in overdue written DoC. 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. On the advice of the chair of the MSC (following a meeting in late March) there is a plan to attend MSC in May and possibly seek further feedback via a survey monkey. Separately the introduction of the new weekly EIR meeting for new reported Red incidents has enabled timely discussion of the completion of verbal and written DoC for these cases.
 The percentage of cases reported in that month where verbal duty of candour was completed within the nationally required 10 working day timeframe.	
 A range of measures have been identified which are analysed to provide an overall acuity score, as displayed in this chart. This provides an overview of the acuity of admitted patients.	There has been a slight decline in the acuity and dependency metrics in March, but this mainly due to the closure of beds during this period, to facilitate urgent RAAC plank repairs. On review of the metrics, there are several areas which have experienced higher than average acuity and / or dependency which correlates with the anecdotal pressures the wards and departments have been experiencing It is notable that despite the bed base being less than it was in June 2020, all the average metrics have increased month on month, with only a slight levelling off this month.

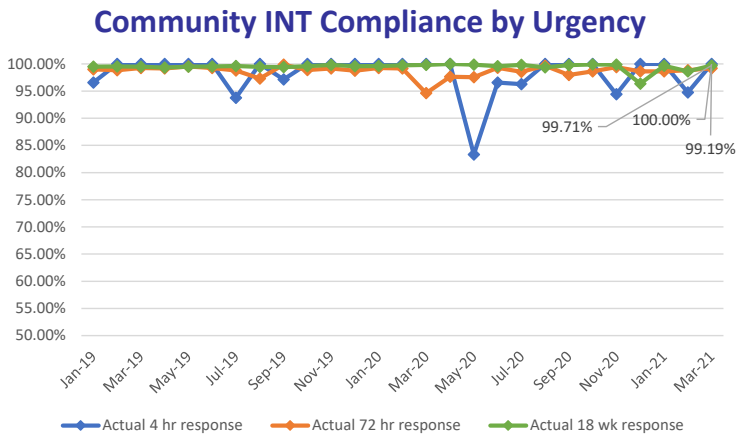
Board Report KPIs	Narratives
	The number of falls reported in March fell compared to the last three months including when expressed as falls per 1,000 bed days. This is still within normal reporting limits of the longer term reporting patterns. Within March; 30 falls resulted in no harm and this makes up the majority of the increased numbers in the month however there were also 15 with minor harm and one with moderate harm (head wound) on G4. There were some repeat fallers (n=5) three falling twice and two falling three times in the reporting month. From an improvement perspective: Falls meeting have developed a work plan with key work streams focusing on falls assessment, raising falls awareness and frequent fallers. Terms of reference and membership to this group has been reviewed, New Falls alarms with sensory mats about to be rolled out across the trust, and Planning an allocated week to raise awareness of lying/ standing Bp monitoring as this is a recurrent theme from patient fall incidents.
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 March compared to February but remained comparable to previous months. The number of incidents resulting in harm decreased compared to March despite the overall increase in total reported. 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 fell in March 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	Our pressure ulcer incidence has decreased overall during March, with an increase noted in Cat 3 PUs and a notable decrease in Unstageable PUs. Acute PU incidence reduced whilst community maintained the same reporting as February. Our Tissue Viability colleagues continue to work with all clinical teams as able and appropriate to support wound assessment and support learning where possible. Demand across the TVS is high and the team have reviewed their referral criteria in order to encourage knowledgeable and/or senior staff to review wounds prior to making referrals to maintain support for complex issues, as required. Discussions continue around the development of Data Analysis support in order to tackle themes and learning more effectively.
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	Nutrition Compliance in completing nutrition assessments within 24 hours continues to improve in March up to 95.2%, following a significant decrease at the beginning of Quarter 4. On review, the majority of areas have demonstrated consistent improvement in their compliance, with only minimal areas struggling to achieve. This has been commendable against a backdrop of increased acuity and dependency across all areas. However, there has been a decrease in compliance in Paediatrics requiring some focus from the team and Senior Nursing leads. It continues to be acknowledged that the vast majority of patients have a nutritional assessment completed and 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. Assurance also continues to be gained via the weekly Perfect Ward documentation audits. It is recognised that compliance with measuring and recording an actual weight can be inconsistent and this will be an area of focus going forward to support the ongoing improvement with assessing and monitoring nutritional needs.

Board Report KPIs	Narratives
	A much busier month in March with 22 formal complaints received. This volume is similar to the amount received pre-Covid (March 2020) and our joint highest month volume all year from April 2020. 6 complaints primary subject was listed as communication and were split between the medical and women and children's directorate. We also saw an increase in values and behaviours with staff with 3 relating to the emergency department. Some positive news is that only 1 complaint primary subject related to patient care.
New formal complaints received and accepted, this counts both West Suffolk Hospital and Community	
	A much more focussed effort on resolving some quick win complaints that had come in. Staff have been helpful with providing responses even with the increased pressure over past few months which has allowed us to complete more complaints
Formal complaints signed off by the CEO, this counts both West Suffolk Hospital and Community	
	Since April 2020 we have hit over 90% each month of complaints responded in expected timeframe with 6/11 months with 100%
Any complaints which were sent outside of the given timeframe and no extension was agreed, this counts both West Suffolk Hospital and Community	

Board Report KPIs	Narratives
Community Non Consultant Led 18week Max Wait  Services covered: Adult SLT, Heart Failure, Neurology Service, Parkinson's Nursing, Wheelchairs, Paediatric Occupational Therapy, Paediatric Physio and Paediatric Speech and Language Therapy, There are no patients waiting over 52weeks for treatment from referral, so community look at number of patients waiting over 14 weeks. Historically, 14 weeks was agreed on as an internal measure because it gives an approx. number of patients who would breach the 18 week target at the end of the next month.	As reported last month, 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. We are investigation use of a new clear mask which has been developed by CUH. 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. 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.
Community Non Consultant Led 18week Compliance  Services covered: Adult SLT, Heart Failure, Neurology Service, Parkinson's Nursing, Wheelchairs, Pead OT, Pead Physio and Pead SLT. RTT nationally is for consultant led services but the community services are required to report on compliance to 18 week Referral to Treatment locally to our CCG. Target is 95% of referrals are given a first definitive treatment within 18weeks	The aggregated % of patients treated within 18 weeks for all community services in March was 90.84% with the lowest individual service being Wheelchairs at 83.20%.
Contacts for ALL Community Services (Adults and Paediatrics)  Activity is counted as a face to face/telephone/email/video contact with a patient/carer/parent which is clinically relevant. This means activity that a clinician carries out which is writing reports, liaising with other healthcare professionals is NOT counted as activity. This is in line with acute systems where there is an assumption that clinicians will carry out related activities that result from contact with a patient.	The total activity for community services has returned to pre-COVID levels and exceeded the values although the ratio of face to face and other means of contact (telephone, video and email) have altered. The 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. March has been an exceedingly busy month.

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

Board Report KPIs	Narratives
	The Red, Amber and Green referral targets were all met in March.
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)	

12. Finance and workforce report

To ACCEPT the report

For Report

Presented by Craig Black

Board of Directors – 28 May 2021

Agenda item:	12			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	21st May 2021			
Subject:	Finance and Workforce Board Report – April 2021			
Purpose:		For information	x	For approval

Executive summary:

The reported I&E for April is breakeven.

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

We previously agreed a budget for 2021-22 to deliver a deficit of £10.5m, with a Cost Improvement Programme (CIP) of 1%. However, the funding arrangements for the first half of 21-22 are expected to facilitate a break even position and if we assume this funding continues through the second half of the year we anticipate a break even position for the full year, although it should be noted that this is contingent on these funding assumptions.

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
April 2021 (Month 1)

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

Financial Summary

I&E Position YTD	£0m	break-even
Variance against Plan YTD	£0m	on-plan
Movement in month against plan	£0m	on-plan
EBITDA position YTD	£4.7m	adverse
EBITDA margin YTD	24%	adverse
Total PSF Received	£6.2m	
Cash at bank	£18.9m	

Executive Summary

- The reported I&E for April is breakeven.

Key Risks in 2021-22

- Costs and income associated with revised activity plan
- Costs associated with increased capacity pressures relating to COVID-19, RAAC planks and winter pressures
- Funding arrangements continue in line with 2020-21
- Delivery of CIP programme

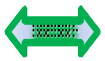
SUMMARY INCOME AND EXPENDITURE ACCOUNT - April 2021	April 2021 Budget £m	April 2021 Actual £m	April 2021 Variance F/(A) £m
NHS Contract Income	23.1	23.1	0.0
Other Income	3.1	2.9	(0.1)
Total Income	**26.2**	**26.1**	**(0.1)**
Pay Costs	16.8	17.2	(0.5)
Non-pay Costs	8.2	7.3	0.9
Operating Expenditure	**24.9**	**24.6**	**0.4**
Contingency and Reserves	0.0	0.0	0.0
EBITDA excl STF	**1.2**	**1.5**	**0.3**
Depreciation	0.8	0.7	0.0
Finance costs	0.5	0.8	(0.3)
SURPLUS/(DEFICIT)	**(0.0)**	**0.0**	**0.0**

FINANCE AND WORKFORCE REPORT – April 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	X

FINANCE AND WORKFORCE REPORT – April 2021

Income and Expenditure Summary as at April 2021

The reported I&E for April is breakeven.

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

Summary of I&E indicators

Income and Expenditure	Plan/ Target £000'	Actual/ Forecast £000'	Variance to plan (adv)/ fav £000'	Direction of travel (variance)	RAG (report on red)
In month surplus/ (deficit)	(0)	(0)	0	⟺	Green
YTD surplus/ (deficit)	(0)	0	0	⟺	Green
EBITDA (excl top-up) YTD	(6,194)	(6,193)	0	⟺	Green
EBITDA %	(31.0%)	(31.2%)	(0.2%)	⟺	Green
Clinical Income YTD	(17,959)	(17,864)	(95)	↑	Green
Non-Clinical Income YTD	(8,218)	(8,205)	(13)	↑	Green
Pay YTD	16,832	17,242	(409)	↑	Green
Non-Pay YTD	9,346	8,827	518	↑	Green
CIP Target YTD	350	296	(54)	↑	Green

2021-22 Budgets

We previously agreed a budget for 2021-22 to deliver a deficit of £10.5m, with a Cost Improvement Programme (CIP) of 1%.

However, the funding arrangements for the first half of 21-22 are expected to facilitate a break even position and if we assume this funding continues through the second half of the year we anticipate a break even position for the full year, although it should be noted that this is contingent on these funding assumptions.

The table below represents the summary plan submitted for the period 1st April to 30th September 2021

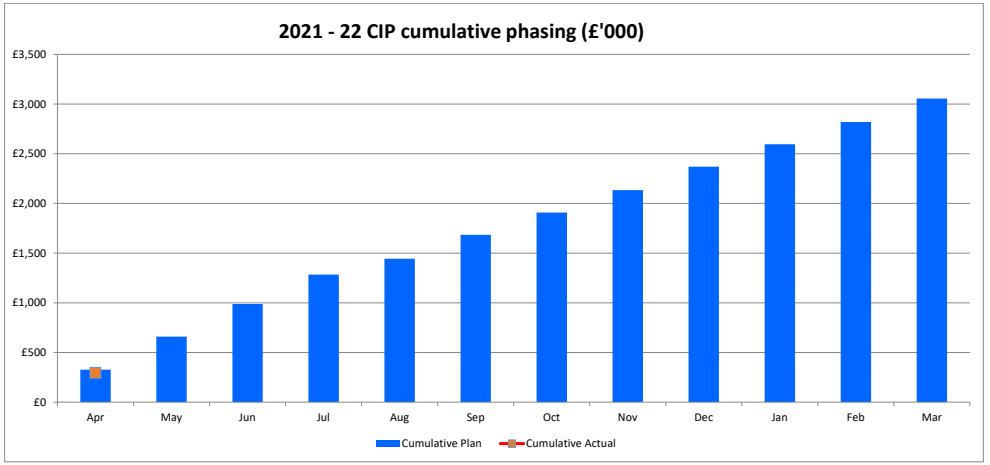
WSFT	H1 plan to 30/09/2021 £'000
Income	157,020
Expenditure	(156,938)
Total H1 provider adjusted financial position	**82**
less gains on disposal of assets	(82)
H1 adjusted financial position less gains on disposals	**0**

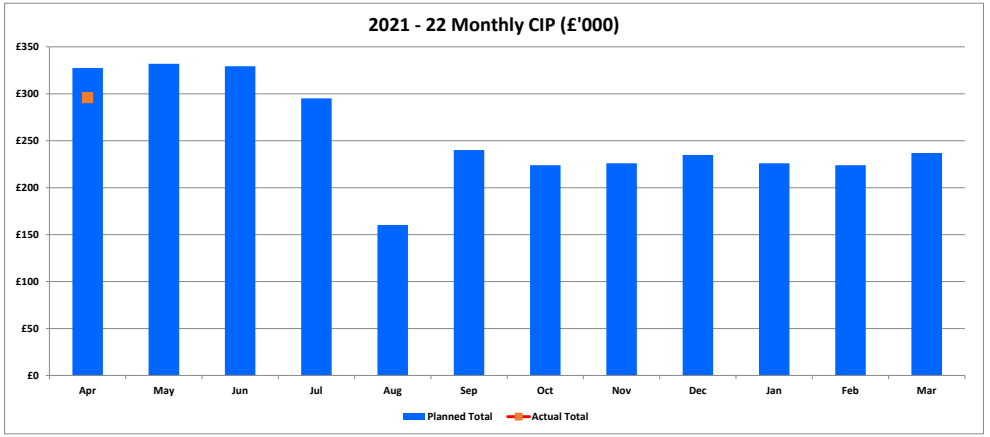
Cost Improvement Programme (CIP) 2021-22

In order to deliver the Trust's plan in 2021-22 we need to deliver a CIP of £3.1m (1.0%). In April we achieved £296k (9.7%) against a plan of £350k (11.5%). This represents a shortfall of £54k.

Recurring/Non Recurring	2021-22 Annual Plan	Plan YTD	Actual YTD
	£'000	£'000	£'000
Recurring			
Outpatients	24	4	-
Procurement	242	12	12
Additional sessions	101	20	20
Community Equipment Service	271	23	21
Drugs	51	-	-
Estates and Facilities	63	7	2
Other	256	20	8
Other Income	147	11	8
Pay controls	28	2	1
Staffing Review	36	3	3
Theatre Efficiency	20	1	1
Contract Review	319	27	10
Car Park income	75	6	-
Unidentified CIP	504		-
Recurring Total	**2,137**	**135**	**87**
Non-Recurring			
Pay controls	99	25	25
Theatre Efficiency	280	54	49
Other	540	135	135
Non-Recurring Total	**919**	**215**	**209**
Total CIP	**3,056**	**350**	**296**

Division	Divisional Target £'000	YTD Var £'000	Unidentified plan £ YTD
Medicine	709	0	0
Surgery	550	(7)	0
W&C/CSS	554	(31)	0
Community	437	(1)	0
E&F	188	(15)	0
Corporates	619	0	0
Stretch	0	0	0
Total	**3,056**	**(54)**	**0**





FINANCE AND WORKFORCE REPORT – April 2021

Trends and Analysis

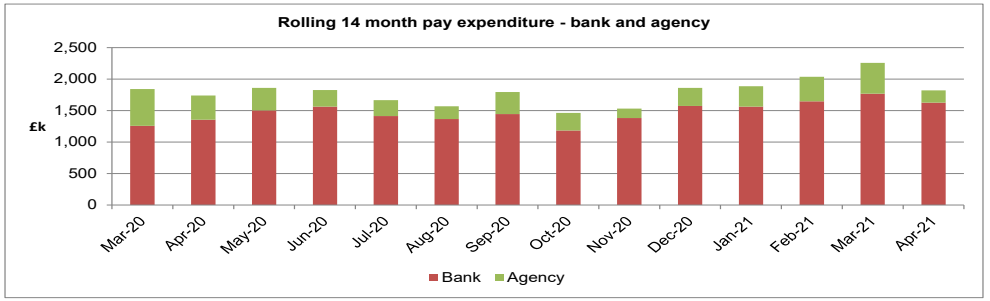
Workforce

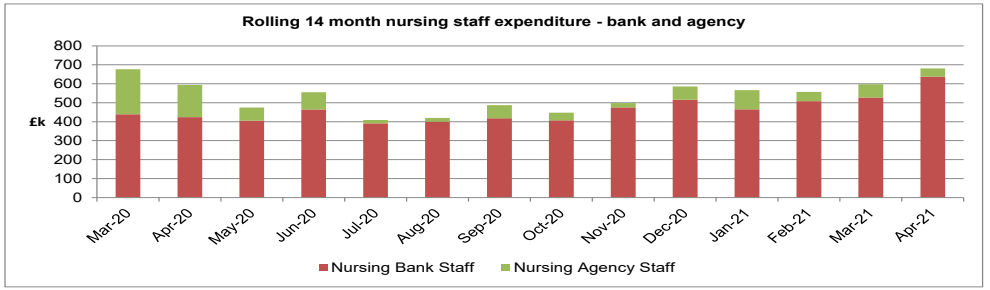
During April the Trust overspent by £0.4m on pay.

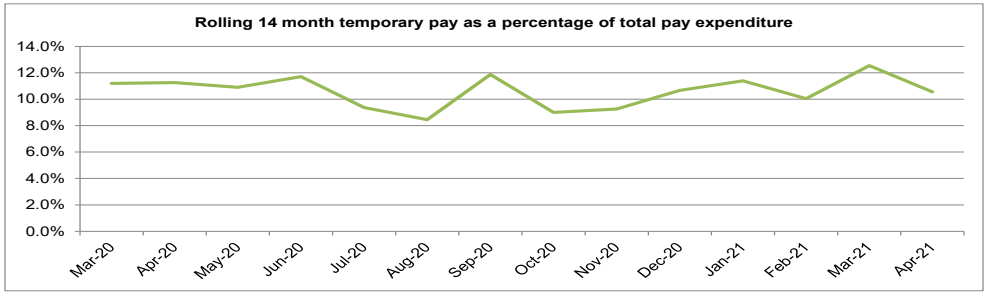
Monthly Expenditure (£)				
As at April 2021	Apr-21	Mar-21	Apr-20	YTD
	£000's	£000's	£000's	£000's
Budgeted Costs in-month	16,832	17,232	16,832	16,832
Substantive Staff	15,422	15,737	13,703	15,422
Medical Agency Staff	74	171	151	74
Medical Locum Staff	272	380	289	272
Additional Medical Sessions	182	361	264	182
Nursing Agency Staff	43	69	170	43
Nursing Bank Staff	638	528	424	638
Other Agency Staff	78	247	61	78
Other Bank Staff	301	272	199	301
Overtime	138	135	113	138
On Call	93	93	66	93
Total Temporary Expenditure	1,819	2,256	1,738	1,819
Total Expenditure on Pay	17,242	17,992	15,442	17,242
Variance (F/(A))	(409)	(760)	1,391	(409)
Temp. Staff Costs as % of Total Pay	10.6%	12.5%	11.3%	10.6%
memo: Total Agency Spend in-month	195	488	383	195

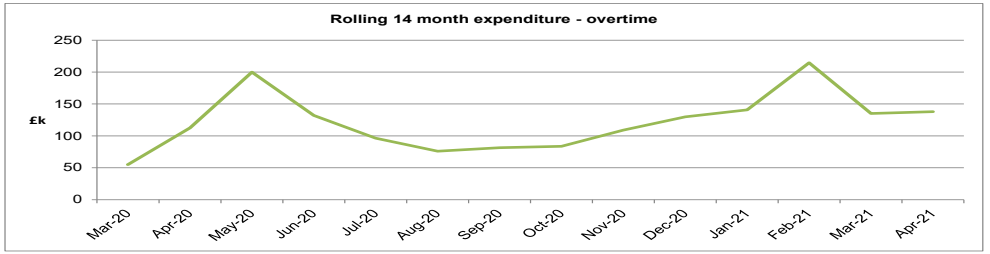
Monthly WTE				
As at April 2021	Apr-21	Mar-21	Apr-20	YTD
	£000's	£000's	£000's	£000's
Budgeted WTE in-month	4,361.0	4,489.5	4,361.0	5,562.5
Substantive Staff	4,049.3	4,041.1	3,713.2	4,049.3
Medical Agency Staff	7.2	14.7	22.0	7.2
Medical Locum Staff	27.4	29.1	26.4	27.4
Additional Medical Sessions	2.9	5.3	(0.5)	2.9
Nursing Agency Staff	20.0	14.9	24.4	20.0
Nursing Bank Staff	175.5	147.1	129.3	175.5
Other Agency Staff	16.9	41.0	13.7	16.9
Other Bank Staff	118.4	107.1	79.2	118.4
Overtime	35.2	35.1	30.0	35.2
On Call	7.3	7.0	5.6	7.3
Total Temporary WTE	410.8	401.2	330.1	410.8
Total WTE	4,460.1	4,442.3	4,043.2	4,460.1
Variance (F/(A))	(99.0)	47.2	317.8	1,102.5
Temp. Staff WTE as % of Total WTE	9.2%	9.0%	8.2%	9.2%
memo: Total Agency WTE in-month	44.1	70.5	60.1	44.1

Pay Costs









FINANCE AND WORKFORCE REPORT – April 2021

Income and Expenditure Summary by Division

	Current Month		
	Budget £k	Actual £k	Variance F/(A) £k
MEDICINE			
Total Income	(5,243)	(4,487)	(756)
Pay Costs	4,414	4,709	(295)
Non-pay Costs	1,570	1,620	(49)
Operating Expenditure	**5,984**	**6,328**	**(344)**
SURPLUS / (DEFICIT)	**(741)**	**(1,842)**	**(1,100)**
SURGERY			
Total Income	(3,822)	(2,621)	(1,200)
Pay Costs	3,475	3,508	(33)
Non-pay Costs	1,158	1,009	149
Operating Expenditure	**4,633**	**4,517**	**116**
SURPLUS / (DEFICIT)	**(812)**	**(1,896)**	**(1,084)**
WOMENS AND CHILDRENS			
Total Income	(1,374)	(1,142)	(232)
Pay Costs	1,489	1,501	(12)
Non-pay Costs	146	159	(13)
Operating Expenditure	**1,635**	**1,660**	**(26)**
SURPLUS / (DEFICIT)	**(261)**	**(518)**	**(258)**
CLINICAL SUPPORT			
Total Income	(785)	(615)	(171)
Pay Costs	2,062	2,019	44
Non-pay Costs	1,012	842	170
Operating Expenditure	**3,075**	**2,861**	**214**
SURPLUS / (DEFICIT)	**(2,289)**	**(2,246)**	**43**
COMMUNITY SERVICES			
Total Income	(3,738)	(3,710)	(28)
Pay Costs	2,654	2,705	(51)
Non-pay Costs	1,152	989	162
Operating Expenditure	**3,806**	**3,695**	**111**
SURPLUS / (DEFICIT)	**(68)**	**15**	**83**
ESTATES AND FACILITIES			
Total Income	(446)	(230)	(216)
Pay Costs	942	1,035	(93)
Non-pay Costs	652	417	235
Operating Expenditure	**1,594**	**1,451**	**142**
SURPLUS / (DEFICIT)	**(1,147)**	**(1,221)**	**(74)**
CORPORATE			
Total Income	(10,760)	(13,248)	2,488
Pay Costs	1,796	1,765	31
Non-pay Costs	2,420	2,275	145
Capital Charges and Financing Costs	1,226	1,500	(274)
Operating Expenditure	**5,443**	**4,040**	**1,402**
SURPLUS / (DEFICIT)	**5,317**	**9,208**	**3,890**
TOTAL			
Total Income	(26,169)	(26,053)	(116)
Pay Costs	16,832	17,242	(409)
Non-pay Costs	8,111	7,311	800
Capital Charges and Financing Costs	1,226	1,500	(274)
Operating Expenditure	**26,169**	**26,053**	**116**
SURPLUS / (DEFICIT)	**(0)**	**0**	**0**

Page 6

Medicine (Sarah Watson)

The division is behind plan in month by £1.1m.

Clinical income is behind plan in month by £715k. This continues to be driven by reduced Outpatient and Elective activity as a result of COVID 19. It is noted that this loss of divisional income is offset within the Corporate division due to the guarantees over the block contract.

With the pressures from COVID easing in February, activity levels have improved across Medicine and their performance against 3 metrics detailed in Table 1 below. April and May have seen a significant and sustained increase in A & E attendances, including its busiest ever day with >300 attendees. This has led to non-elective activity significantly outperforming both planned activity and the 2yr average by 9%, bringing it in line with 19/20 average activity.

Both outpatient and elective activity in month are behind on all three metrics. However, at 91% and 78% respectively, both are ahead of the national expectations for activity recovery (75% of 19/20 activity by the end of M1).

Activity Type	Vs Plan	Vs 24 Mth Avg	Vs 19/20 Avg
Non-Elective	9%	9%	0%
Outpatients	-5%	-3%	-9%
Elective	-20%	-4%	-22%

Table 1 - % differences between actual activity and planned activity, average activity over the last 24 months, and the average activity in 19/20. NB: Positive figures = actual activity outperforming, negative figures = actual activity under performing

With the effect of Clinical Income removed, the Medicine division is recording an adverse variance against budget of £385k. As well as *identified* additional costs of COVID (£31k) and the CIP deficit from 20/21 (£77k), other factors include:

- Unregistered Nursing (£73k) – this is the effect of the use of increased temporary cover within the first 3 months of 2021. With COVID pressures easing, it is not anticipated that this level of overspend will continue.
- ED Registrars (£53k) – the reduction in the use of temporary staffing to cover substantive vacancies is a continued area of focus for the division.
- Unaccrued Income (£41k) due to budget phasing - will be corrected in M2.
- Drugs (£37k).
- Cardiac centre consumables (£23k) – due to increased stock levels.

Surgery (Simon Taylor)

The division is behind plan in month by £1.1m

Clinical income is behind plan by £1.2m. The division has and continues to work to increase activity levels given the constraints from the theatre refurb and roof failsafe works. The division are maximising the use of theatres through weekend working and improving theatre utilisation. The division are also in the process of working up additional plans to mitigate for the theatre decant programme.

All Elective activity has seen a positive improvement from the previous month, 2.9% behind plan in month (March 17.5%) and day case activity has exceeded the plan. Outpatient activity is 16.3% behind plan in month (March 30.1%) and for Non-Elective activity is 8.3% behind plan in month (March 13.7%).

Pay expenditure reported an overspend of £33k in month. The overspend is driven by the additional COVID provision that was required to support our wards and Critical care which was partially offset by the underspend from vacancies across the division.

The non-pay budget is £149k underspent in month, predominantly within clinical supplies (£132k) as a result of the reduced activity levels.

Women and Children's (Michelle O'Donnell)
In April, the Division reported an adverse variance of £258k

The Division was £232k behind the clinical income plan as non-elective and outpatient activity were lower than plan. It is expected that the recovery work will increase the number of outpatient attendances in future months.

Pay reported a £12k overspend in-month as the underspend in the Paediatric Service from vacancies was offset by the additional COVID capacity on Ward F1. The capacity on Ward F1 will be retained, in accordance with national guidance, over the summer months to cover RSV and the Brazilian COVID variant.

Non-pay reported a £13k overspend in-month due to slippage on the Maternity Part Pathway Reduction cost improvement scheme.

Clinical Support (Michelle O'Donnell)
In April, the Division reported a favourable variance of £43k.

Income for Clinical Support reported £171k behind plan in-month as outpatient radiology, direct access radiology and breast screening activity were lower than plan. It is expected that recovery work will increase the volume of activity in future months.

Pay reported a £44k underspend in-month from vacancies across all services. The Pharmacy service has recently been able to appoint to vacant posts which will reduce the underspend in the coming months.

Non-pay reported a £170k underspend in-month as a non-recurring adjustment was made in relation to leases.

Community Services (Michelle Glass)
In April, the Division reported a favourable variance of £83k.

Income reported a £28k under recovery in April, where elements of the division's income plan that are allocated on a cost and volume basis, continue to be impacted by COVID. It is expected that the recovery work underway will lead to a recovery of income during the first half of the year.

Pay reported an adverse variance of £51k in month. Whilst this was incurred to support the division's response to COVID, the division has a favourable underlying pay position without COVID costs. The division utilised agency staff to cover some vacant Therapy roles, as well as to provide a peripatetic team of nurses operating across Community Health. The peripatetic resource has been required to meet both a notable increase in demand for community nursing services, as well as to mitigate the impact of reduced clinical capacity, in order to allow more time between patient home visits to don and doff PPE.

Non-pay reported a favourable variance of £162k. This was due to a one off adjustment relating to property leases, lower than budgeted activity on wheelchair equipment, dressings and medical gases. However, it is anticipated that costs will increase in line with budget from May. The position will be further impacted as a result of restoration and recovery of services, as well as managing the impact of additional demand placed on Community teams as a result of the RAAC works; with additional activity managed in the community.

Some financial pressure on the community equipment service is forecast as the service support increasing numbers of patients and maintains faster response speeds to enable timely hospital discharges, including an increase in same day and out of hours in line with last year.

Statement of Financial Position at 30 April 2021

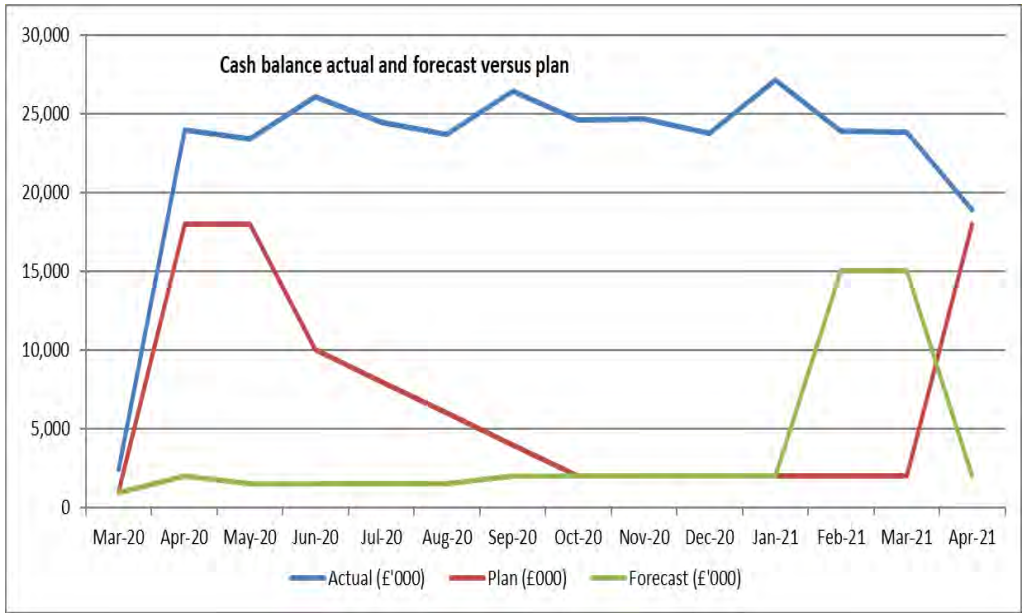
STATEMENT OF FINANCIAL POSITION	As at 1 April 2021	Plan 31 March 2022	Plan YTD 30 April 2021	Actual at 30 April 2021	Variance YTD 30 April 2021
	£000	£000	£000	£000	£000
Intangible assets	52,198	54,398	52,198	54,115	1,917
Property, plant and equipment	137,103	168,603	138,603	139,125	522
Trade and other receivables	6,341	6,341	6,341	6,341	0
Total non-current assets	**195,642**	**229,342**	**197,142**	**199,581**	**2,439**
Inventories	3,481	3,481	3,481	3,203	(278)
Trade and other receivables	19,362	19,362	19,362	20,256	894
Cash and cash equivalents	23,788	2,006	18,006	18,928	922
Total current assets	**46,631**	**24,849**	**40,849**	**42,387**	**1,538**
Trade and other payables	(52,522)	(37,779)	(47,179)	(49,700)	(2,521)
Borrowing repayable within 1 year	(6,439)	(5,500)	(5,500)	(5,350)	150
Current Provisions	(46)	(46)	(46)	46	92
Other liabilities	(1,357)	(3,357)	(3,357)	(3,896)	(539)
Total current liabilities	**(60,364)**	**(46,682)**	**(56,082)**	**(58,900)**	**(2,818)**
Total assets less current liabilities	**181,909**	**207,509**	**181,909**	**183,068**	**1,159**
Borrowings	(47,719)	(43,319)	(47,719)	(48,831)	(1,112)
Provisions	(852)	(852)	(852)	(899)	(47)
Total non-current liabilities	**(48,571)**	**(44,171)**	**(48,571)**	**(49,730)**	**(1,159)**
Total assets employed	**133,338**	**163,338**	**133,338**	**133,338**	**0**
Financed by					
Public dividend capital	158,650	188,650	158,650	158,650	0
Revaluation reserve	8,743	8,743	8,743	8,743	0
Income and expenditure reserve	(34,055)	(34,055)	(34,055)	(34,055)	0
Total taxpayers' and others' equity	**133,338**	**163,338**	**133,338**	**133,338**	**0**

There has been little movement in the balance sheet against plan and the year end position and the balances are in line with expectations for month 1.

The opening balances shown in the table above remain subject to audit.

Cash Balance Forecast for the year

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



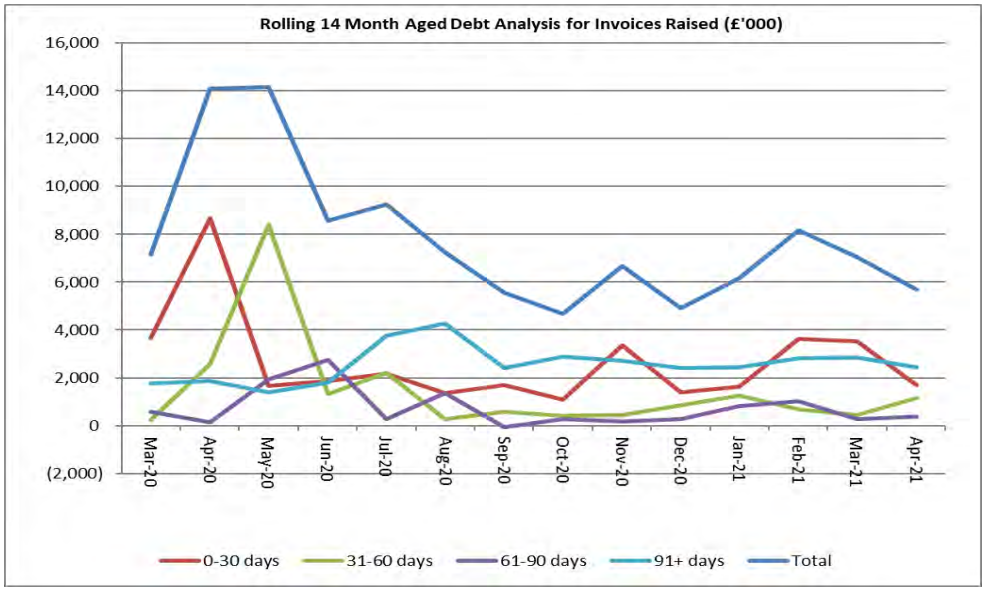
The Trust's cash balance increased significantly during the prior year and continues to be in a strong position into month 1. However the cash position will require rigorous monitoring during 2021/22 as the Trust will no longer be receiving any income in advance as it was in 2020/21.

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

FINANCE AND WORKFORCE REPORT – April 2021

Debt Management

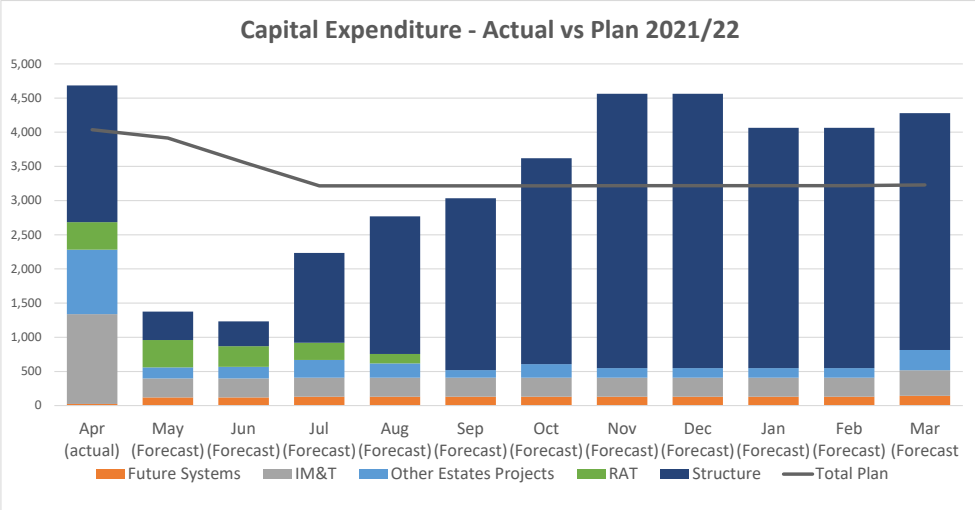
The graph below shows the level of invoiced debt based on age of debt.



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 decrease at month 1. The large majority of the debts outstanding are historic debts, although these are reducing. Over 46% of these outstanding debts relate to NHS Organisations, with 47% of these NHS debts being greater than 90 days old. We are actively trying to agree a position with the remaining corresponding NHS Organisations for these historic debtor balances and a significant amount of work has been completed in this area to help reduce these historic balances.

Capital Progress Report



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	2020-21
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Future Systems	24	120	120	130	130	130	130	130	130	130	130	143	1,447
IM&T	1,316	279	279	279	279	279	279	279	279	279	279	374	4,480
Other Estates Projects	942	162	170	260	210	110	198	141	141	141	141	296	2,912
RAT	403	400	300	250	137	0	0	0	0	0	0	0	1,490
Structure	1,999	414	364	1,314	2,014	2,514	3,014	4,014	4,014	3,514	3,514	3,466	30,155
Total / Forecast	4,684	1,375	1,233	2,233	2,770	3,033	3,621	4,564	4,564	4,064	4,064	4,279	40,484
Total Plan	4,038	3,915	3,561	3,216	3,216	3,216	3,216	3,218	3,218	3,218	3,218	3,229	40,479

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

The prime focus of the Capital Programme is work to ensure the structure of the current hospital site is safe and can continue to be used until the new hospital is built. Within this project there are a number of schemes such as RAAC planks, roof work, electrical and water infrastructure. The other main focus of the programme is the continuation of the Ecare programme.

At this early stage the projects are all being forecast to come in at around the plan figure.

Comfort Break - 10 minutes

11:00 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

13. People and organisational development (OD) highlight report

To APPROVE a report

For Approval

Presented by Jeremy Over

Board of Directors – Friday 28 May 2021

Agenda item:	13			
Presented by:	Jeremy Over, Executive Director of Workforce and Communications			
Prepared by:	Members of the Workforce & Communications directorate			
Date prepared:	18 May 2021			
Subject:	People & OD Highlight Report			
Purpose:	✓	For information		For approval

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

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

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

- Putting You First Awards
- Freedom to Speak Up – Board self-assessment
- Supporting our valued Volunteers back to the workplace
- Future of HR & OD in the NHS national programme
- Education and training centre capacity
- Supporting staff and prioritising appraisal discussions
- Consultant appointments

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

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

Previously considered by:	N/A

Putting you first

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

Putting You First – May awards

Emily Fell, Macmillan Unit
Emily started with us as a nursing assistant in 2015, completed her nursing apprenticeship and qualified as a registered nurse just over a week ago (March 2021).

Recently we had a sudden (though not completely unexpected) death on the ward. Emily provided superb support to the distraught widow who really struggled with not having seen her husband in the hours before his death.

Emily remained so calm and kind throughout and the bereaved family commented how thankful they were to know that Emily had been there for their loved one.

This is very much part of what being a nurse is, but to manage with such compassion at the very beginning of her nursing career is not to be taken for granted.

I do hope you will agree that this young staff nurse is an outstanding example of what a WSFT nurse should be.

Chloe Bonner, physiotherapist (lung function)
I would like to recommend Chloe Bonner as an excellent and superb Lung Function Department Physio.

I attended for a Lung Function test on 8 April and to be honest I was decidedly apprehensive / frightened about this appointment. I had had a LF test previously in 2012 at another hospital and knew that the mouthpiece was too large for me to cope with, and that I might end up struggling to breathe properly.

However, from Chloe's first introduction, she put my fears to rest; I explained about the mouthpiece and my anxieties and she immediately reassured me that she would change this for an alternative device - which she did straightaway - and all went well from then on. She then explained very thoroughly what each stage of the test would involve, how to respond, and what she was monitoring.

Throughout the whole appointment Chloe's voice and manner was gentle, professional, explanatory, considerate, clear and polite. I cannot speak more highly about her, and warmly commend her for a Putting You First award.

Freedom to Speak Up - Board self-assessment

The development of a culture where all staff feel confident to speak up and raise concerns at work is crucially important to us. It has a direct impact on a culture of safety with positive benefits for patient care, quality and staff experience. We know from the most recent set of staff survey results that further work is required to develop this culture at WSFT given that an increased number of staff reported that they did not feel confident to speak up.

In 2019 NHS Improvement published a self-assessment tool to enable Boards to regularly review their position and to help highlight areas for focused improvement. It is approximately 18 months since the West Suffolk Board last reviewed its position and an updated version is presented for discussion and endorsement.

Whilst it is ultimately the Board's self-assessment, and should not be delegated, the attached draft has been developed in consultation with the FTSU Guardians, the lead NED with responsibility for speaking up, and the senior workforce team to ensure we have captured their input in respect of both achievements and future opportunities for improvement.

The Board is invited to consider and comment on the draft (attached as appendix 1), and subject to any additions or amendments, endorse the self-assessment. It is proposed that this is then delegated to the Involvement Committee for oversight of delivery of the ongoing improvement actions.

Supporting our valued Volunteers back into the workplace

Forty-four volunteers have already returned to volunteering in green, non-clinical areas of the Trust including the reception desk at the front of West Suffolk Hospital, delivering patient medications, Friends shop, Radio West Suffolk and collecting wheelchairs from around the hospital site. The Voluntary Services Team are now working to reinstate the remaining 272 people who volunteer in clinical and non-clinical areas. Volunteers are returning by department starting with outpatient areas followed by wards and the schedule for returns will be agreed with department/ward manager. A significant number of our volunteers are vulnerable to COVID-19 because of their age and we think it is important that those who wish to return to volunteering have the option to do so after making an informed decision understanding their level of risk. All returning volunteers are being risk assessed using the trust individual staff risk assessment tool for COVID-19 and receive a detailed induction back to volunteering from the Voluntary Services Team.

Thirty-five volunteers supported the COVID vaccination programme in Quince House and gave a total of 1,912 hours to the programme. The Voluntary Services Team worked with EPUT and the local community to promote volunteering opportunities to support the local vaccination hubs and many of our volunteers contributed to the vaccination effort locally and continue to do so.

Once all our existing volunteers have returned we will be turning to recruitment starting with the 15 people who were in the recruitment process at the start of the pandemic and the 20 individuals who have contacted us since March 2020. The voluntary services team

will be ensuring any vacant roles are covered as well as exploring opportunities for new roles in both the community and hospital settings.

The team continues to keep in touch with all volunteers by telephone calls, letters and emails and planning is underway for our annual volunteers awards/thank you event. This year we will be holding a lunchtime Christmas party on 24 November at Moreton Hall Community Hall.

The voluntary services team were able to use the past 12 months to make significant improvements to ways of working. They are now using the Better Impact software system specifically designed for voluntary services which has provided a more streamlined and efficient administrative process for running the service. A new system for volunteers checking in using individual QR codes on an iPad has also been introduced.

Although work experience and clinical placements have not been possible during the pandemic the non-medical clinical education and voluntary services teams have run four virtual talent academies each delivering six Saturday morning sessions to students who we are not able to offer a placement on our student programme. Due to the restrictions on holding classroom group training sessions the academy is held on Microsoft Teams. The sessions are related to health care and clinical staff from the trust deliver sessions to provide information about their profession for students aspiring to a healthcare career. Fifty-five students have attended the four academies and the certificate issued to those students who complete all sessions can be used in their portfolio when applying for college or university placements.

In addition the trust will be participating in the NHS Cadet initiative set up by St John Ambulance to introduce health and care careers to disadvantaged young people. The trust will be supporting one Foundation Pathway to pilot the process and plans to support the Advanced Pathway in the future. We will also be working with local schools and colleges over the summer to develop our plans for work experience and clinical placements going forward.

The future of HR & OD in the NHS

The national 'Future of NHS HR & OD' programme is responding to the changing world of health and work in 2030 and the Long-Term Plan. Its purpose is to create a vision for the future of people services in the NHS, building on current strengths, identifying current challenges and outlining recommendations which help us achieve that vision. This is the first intentional look at how NHS people services should operate for the future and is a once in a generation opportunity to set direction for them.

The programme also seeks to identify and harness transformational HR & OD practice that has developed through the pandemic and how these important services are critical in the proposed new NHS architecture (ICSs).

The NHS of 2030 will be fundamentally different from the service we work in today, caring for an additional three million people, and a greater number of those over the age of 65. Existing ways of working, models of care and organisational boundaries will be transformed as the NHS adapts to the changing needs – and expectations – of our

population. The NHS People Profession has been tasked with shaping and leading what working in the NHS of the future needs to look like if to ensure we are successful.

The programme's first national "big conversation" took place during February and March, following which a set of draft themes and vision statements have been developed. A second large-scale engagement exercise will commence on 24 May through which anyone can provide feedback on the drafts that have been developed. Access is via: www.ournhspeopleprofession.org/

Education Centre and training capacity

The Education and Training and Non-Medical Clinical Education teams are developing plans to prepare the Education Centre for possible changes to social distancing rules on 21st June. If the two metre rule is removed or reduced (e.g. to one metre) and we are able to increase capacity in the Centre, there is significant demand both for additional spaces on existing programmes and for training that cannot currently be accommodated. The learning gained from providing significant amounts of mandatory and induction training virtually is being applied and some elements of these programmes will continue to be delivered via e-learning. However, not all training is best delivered virtually and some will revert to face-to-face as soon as possible.

Supporting staff and prioritising appraisal discussions

Further to the welcome query raised at last month's Board by our lead governor, the HR business partner team has undertaken data analysis of our appraisal records. Whilst we routinely monitor appraisal participation based on the previous 12 months, it was suggested that we look more closely at those instances where no appraisal has been recorded over a much longer period. In the first instance we have chosen a period of three years and we were able to identify 20 staff in this position (0.4% of our workforce).

6 of the 20 had 'no appraisal' recorded in error. The circumstances of the remaining cases have been reviewed and appraisals have been scheduled to take place at the earliest opportunity. We are grateful to our lead governor for prompting this piece of work.

Recent Consultant Appointments

Post:	Consultant in Dermatology
Interview:	29 April 2021
Appointee:	Dr Rabia Rashid
Start date:	6 September 2021

Current post: Consultant Dermatologist: University Hospitals Coventry & Warwickshire
August 2020 to present

Previous Position:
Feb 2018 – July 2020
Locum Consultant – University Hospitals Coventry & Warwickshire

Jeremy Over
Executive Director of Workforce & Communications
May 2021

Freedom to Speak Up review tool for NHS trusts and foundation trusts

July 2019

NHS England and NHS Improvement

How to use this tool

This is a tool for the boards of NHS trusts and foundation trusts to accompany the *Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts* (cross referred with page numbers in the tool) *and the* *Supplementary information on Freedom to Speak Up in NHS trusts and NHS foundation trusts* (cross referred with section numbers).

We expect the executive lead for Freedom to Speak Up (FTSU) to use the guidance and this tool to help the board reflect on its current position and the improvement needed to meet the expectations of NHS England and NHS Improvement and the National Guardian's Office.

We hope boards will use this tool thoughtfully and not just as a tick box exercise. We also hope that it is done collaboratively among the board and also with key staff groups – why not ask people you know have spoken up in your organisation to share their thoughts on your assessment? Or your support staff who move around the trust most but can often be overlooked?

Ideally, the board should repeat this self-reflection exercise at regular intervals and in the spirit of transparency the review and any accompanying action plan should be discussed in the public part of the board meeting. The executive lead should take updates to the board at least every six months.

It is not appropriate for the FTSU Guardian to lead this work as the focus is on the behaviour of executives and the board as a whole. But getting the FTSU Guardian's views would be a useful way of testing the board's perception of itself. The board may also want to share the review and its accompanying action plan with wider interested stakeholders like its FTSU focus group (if it has one) or its various staff network groups.

We would love to see examples of FTSU strategies, communication plans, executive engagement plans, leadership programme content, innovative publicity ideas, board papers to add them to our Improvement Hub so that others can learn from them. Please send anything you would specifically like to flag to nhsi.ftsulearning@nhs.net

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
Behave in a way that encourages workers to speak up					
Individual executive and non-executive directors can evidence that they behave in a way that encourages workers to speak up. Evidence should demonstrate that they: • understand the impact their behaviour can have on a trust's culture • know what behaviours encourage and inhibit workers from speaking up • test their beliefs about their behaviours using a wide range of feedback • reflect on the feedback and make changes as necessary • constructively and compassionately challenge each other when appropriate behaviour is not displayed	Section 1 p5	Partially (May 2021)	Nov 2021	• Board Development programme including team coaching • Executive development session (Feb 2021) with Dr Megan Reitz – speaking truth to power and the importance of 'listening up' • 360 feedback programme for executive and non-executive board colleagues undertaken during Mar-May 2021 and incorporated into appraisal	• Capture learning from NHSI-commissioned independent rapid review (when published) to inform future board and individual development
Demonstrate commitment to FTSU					
The board can evidence their commitment to creating an open and honest culture by demonstrating: • there are a named executive and non-executive leads responsible for speaking up • speaking up and other cultural issues are included in the board development programme • they welcome workers to speak about their experiences in person at board meetings	p6 Section 1 Section 2 Section 3	Partially (May 2021)	Nov 2021	• Jeremy Over, Executive Director of Workforce and Communications – executive lead • Dr Richard Davies, Non-Executive Director and Senior Independent Director – non-executive lead • Examples of staff members invited to share their experiences with Trust Board • Leadership summit 2019 for trust's senior leaders focussed on bullying and harassment, resulting in	• Implement bullying and harassment tools being launched by NHSE/I by March 2021 • Agree plan and process with FTSU guardians to review claims of detriment if they are made. Develop paragraph for the letter sent by FTSU Guardians at the close of cases to advise individuals' what to do if they experience detriment in future FTSU. • Agree process and plan for on-going evaluation of FTSU model

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
• the trust has a sustained and ongoing focus on the reduction of bullying, harassment and incivility • there is a plan to monitor possible detriment to those who have spoken up and a robust process to review claims of detriment if they are made • the trust continually invests in leadership development • the trust regularly evaluates how effective its FTSU Guardian and champion model is • the trust invests in a sustained, creative and engaging communication strategy to tell positive stories about speaking up.				'improving everyone's experience' plan monitored through PRM meeting. • Trusted Partners in place to support staff experiencing bullying and harassment • 5 o'clock club Trust Leadership and Quality Improvement Forum. Within past six months sessions have included 'Speaking truth to Power' with Dr Megan Reitz and Chris Turner focusing on 'Civility Saves Lives'. • HR policy transformation (restorative justice) and associated training, and investment in HR business partners to promote and support teams with developmental rather than punitive approaches to issues • Detriment included in process for recording and reporting concerns raised, including those raised via FTSU. • Trust has a leadership development strategy and a programme of leadership development. WSFT People Plan prioritises support for great line management, including leadership development • Evaluation and review of its FTSU Guardian and champion model carried out in Summer 2020 resulting in significant increased resource for role and appointment of two clinically qualified guardians with	• FTSU guardians developing a communication plan with Communications Team, including positive stories about speaking up • New Involvement Committee established to enhance Board oversight and listening • Proposal to establish Freedom to Speak Up Champions developed and being taken forward

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
				paid/protected time to carry out their role • Regular corporate communications about the value and appreciation of staff raising concerns	
Have a strategy to improve your FTSU culture					
The board can evidence it has a comprehensive and up-to-date strategy to improve its FTSU culture. Evidence should demonstrate: • as a minimum – the draft strategy was shared with key stakeholders • the strategy has been discussed and agreed by the board • the strategy is linked to or embedded within other relevant strategies • the board is regularly updated by the executive lead on the progress against the strategy as a whole • the executive lead oversees the regular evaluation of what the strategy has achieved using a range of qualitative and quantitative measures.	P7 Section 4	Partially (May 2021)	Nov 2021	Action taken in response to CQC recommendations (2020) and incorporated into quality improvement plan: • Improve the culture, openness and transparency throughout the organisation and reduce inconsistencies in culture and leadership. Including working relationships and engagement of consultant staff across all services. • 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	• Build on action taken resulting from 2020 CQC report and formalise a discreet WSFT strategy to bring together the current and future actions to improve the FTSU culture
Support your FTSU Guardian					
The executive team can evidence they actively support their FTSU Guardian. Evidence should demonstrate: • they have carefully evaluated whether their Guardian/champions	p7 Section 1 Section 2 Section 5	Partially (May 2021)	Nov 2021	• Review carried out in May 2020 and additional resources provided to support the role. Two Lead FTSU guardian roles created – totalling 0.8 WTE	• Discuss options for securing support to enable guardians to reflect on the emotional aspects of their role with WSFT guardians. Identify and take/facilitate action

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
have enough ringfenced time to carry out all aspects of their role effectively • the Guardian has been given time and resource to complete training and development • there is support available to enable the Guardian to reflect on the emotional aspects of their role • there are regular meetings between the Guardian and key executives as well as the non-executive lead. • individual executives have enabled the Guardian to escalate patient safety matters and to ensure that speaking up cases are progressed in a timely manner • they have enabled the Guardian to have access to anonymised patient safety and employee relations data for triangulation purposes • the Guardian is enabled to develop external relationships and attend National Guardian related events				• Two guardians appointed and both have undertaken NGO on-line training • Guardians meet and communicated regularly with the Executive Lead • FTSU Guardians are aware of WSFT staff psychology support service • Regular quarterly meetings set up with Chair, Chief Executive, SID and FTSU Guardians • Enabling Guardian to escalate patient safety matters and access anonymised patient safety data • Both FTSU guardians have established links with the NGO • Both FTSU guardians invited and actively involved in work on organisation culture – including People Plan workshops and staff survey data analysis	• Identify and agree process for guardians to meet regularly with non-executive lead
Be assured your FTSU culture is healthy and effective					
Evidence that you have a speaking up policy that reflects the minimum standards set out by NHS Improvement. Evidence should demonstrate: • that the policy is up to date and has been reviewed at least every two years	P8 Section 8 National policy	Partially (May 2021)	Nov 2021	• Policy is up-to-date. Last updated in November 2020 and due for next review by November 2022. • WSFT policy follows the NHSI/E standard integrated policy' "Freedom to speak up: raising concerns	• FTSU guardians to be involved in further development of policies in implementation of just and learning culture • Ensure processes are in place to secure feedback from workers who have spoken up

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
• reviews have been informed by feedback from workers who have spoken up, audits, quality assurance findings and gap analysis against recommendations from the National Guardian.				(whistleblowing) policy for the NHS April 2016	
Evidence that you receive assurance to demonstrate that the speaking up culture is healthy and effective. Evidence should demonstrate: • you receive a variety of assurance • assurance in relation to FTSU is appropriately triangulated with assurance in relation to patient experience/safety and worker experience. • you map and assess your assurance to ensure there are no gaps and you flex the amount of assurance you require to suit your current circumstances • you have gathered further assurance during times of change or when there has been a negative outcome of an investigation or inspection • you evaluate gaps in assurance and manage any risks identified, adding them to the trust's risk register where appropriate.	P8 Section 6	**Partially (May 2021)**	**Nov 2021**	• Assurance is provided through regular reports to the Board from FTSU guardians on concerns raised with them. • Trust Board members receive an overview of all concerns raised through all formal mechanisms through the Governance Department Quality and Learning Report. • Feedback requested from staff during COVID-19 pandemic via engagement processes "What Matters to you" and doctor's COVID survey. Feedback presented to and discussed with Trust Board members • Trust identified the need for a review following concerns about culture raised by CQC. Participation in NHSE/I rapid review. • Staff Survey data used to assess position and identify areas of organisation for enhanced support / listening through HR business partners	• Implement more frequent formal staff feedback mechanisms • Further development of the learning report to ensure a triangulated approach between patient and staff experience from a safety perspective • Active review of risk register to ensure it reflects the broader themes that are identified through staff speaking up
The board can evidence the Guardian attends board meetings, at least every six months, and presents a comprehensive report.	P8 Section 7	**Fully (May 2021)**	**Nov 2021**	• Board reports available	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
The board can evidence the FTSU Guardian role has been implemented using a fair recruitment process in accordance with the example job description (JD) and other guidance published by the National Guardian.	Section 1 NGO JD	**Fully (May 2021)**	**Nov 2021**	• Recruitment in Summer 2020 followed best recruitment practice and WSFT job description encompasses all elements of national JD.	
The board can evidence they receive gap analysis in relation to guidance and reports from the National Guardian.	Section 7	**Partially (May 2021)**	**Nov 2021**	• NGO reports informally shared with board members	• Formalise assessment of WSFT position in relation to NGO guidance and reports within People & OD highlight report at Board
Be open and transparent					
The trust can evidence how it has been open and transparent in relation to concerns raised by its workers. Evidence should demonstrate: • discussion with relevant oversight organisation • discussion within relevant peer networks • content in the trust's annual report • content on the trust's website • discussion at the public board • welcoming engagement with the National Guardian and her staff	P9	**Fully (May 2021)**	**Nov 2021**	• Internal audit commissioned in January 2020 to review FTSU. Second audit commissioned for 2021. • Detailed information provided on Trust intranet • National Guardian's office invited to review WSFT FTSU arrangements (pending outcome of NHSI/E rapid review). • FTSU and Governance Quality and Learning reports presented and discussed in open board meetings and published on website	
Individual responsibilities					
The chair, chief executive, executive lead for FTSU, Non-executive lead for FTSU, HR/OD director, medical director and director of nursing should evidence that they have	Section 1	**Partially (May 2021)**	**Nov 2021**	• 360 feedback programme for executive and non-executive board colleagues undertaken during Mar-	• Further analysis of executive 360 commissioned to provide 'team overview' and to support further team coaching

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
considered how they meet the various responsibilities associated with their role as part of their appraisal.				May 2021 and incorporated into appraisal	• NED appraisals for 2021 pending

13.1. Guardian of safe working annual report

For Approval

Presented by Francesca Crawley

Trust Board – 28 May 2021

Agenda item:	13.1			
Presented by:	Francesca Crawley, Guardian of Safe Working			
Prepared by:	Francesca Crawley, Guardian of Safe Working			
Date prepared:	May 2021			
Subject:	Safe Staffing Guardian Report – Annual Report: April 2020-March 2021			
Purpose:	x	For information		For approval

Executive summary:

The report is compiled by the Guardian of Safe Working Hours (GOSW), a role appointed as part of the new contract. The purpose of the report is to provide evidence of safe rostering and compliance with the TCS, to highlight any difficulties which have arisen, and to explain how they are being addressed.

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

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

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

Recommendation: For the board to endorse the annual report

DOCTORS AND DENTISTS IN TRAINING

This report covers the twelve month period (1st April 2020 – 31st March 2021 inclusive). During that time there have been quarterly reports from which this summary is drawn.

Introduction

This is the fifth annual report produced since the introduction of the 2016 Terms and Conditions of Service (TCS) for Doctor and Dentists in Training by NHS Employers. Full details of this contract are to be found here: http://www.nhsemployers.org/your-workforce/need-to-know/junior-doctors-2016-contract

The report is compiled by the Guardian of Safe Working Hours (GOSW), a role appointed as part of the new contract. The purpose of the report is to provide evidence of safe rostering and compliance with the TCS, to highlight any difficulties which have arisen, and to explain how they are being addressed. A system of Exception Reporting is in place, which replaced monitoring of working hours.

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

All trainees taking up appointments are on the new contract. It should be noted that a further 63 doctors are currently working in Trust grade positions are on contracts that mirror the new contract due to filling either Trust posts, or vacant training posts. They also have the ability to exception report to ensure that all issues within departments are highlighted.

Summary data

Number of doctors / dentists in training (total):	148
Number of doctors / dentists in training on 2016 TCS (total):	148(includes p/t trainees)
Amount of time available in job plan for guardian to do the role:	1 PAs / 4 hours per week
Admin support provided to the guardian (if any):	0.5WTE
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee[1]
Amount of job-planned time for Clinical Supervisors:	0, included in 1.5 SPA time[1]

Exception Reporting

A process is in place on Allocate for the Junior Doctors to fill in an exception report (ER). Doctors are expected to discuss any ER's logged with either their clinical or educational supervisor. Details of the exception report are sent to the Guardian and Clinical /Educational Supervisor.

EXCEPTION REPORTS BY DEPARTMENT (APRIL 2020 – MARCH 2021)				
Quarter **Specialty**	Quarter 1 (April – June 2020)	Quarter 2 (July – September 2020)	Quarter 3 (October – December 2020)	Quarter 4 (January – March 2021)
Surgery	2	10	11	7
Medicine	32	89	56	32
Woman & Children	0	2	0	0
Psychiatry / Off-Site	0	0	0	0
TOTAL	**34**	**101**	**67**	**39**

Exception Reporting: accuracy

It is clear that not all doctors' exception report. During the pandemic the trust has run a mainly virtual induction which includes a presentation by the GOSW encouraging ER

Patterns of Exception Reporting

Overall the numbers in medicine are much higher than in surgery.

Various reasons for exception reporting are detailed using the Allocate system and these are generally about workload or particularly sick patients.

There were significantly fewer ER during the main waves of the pandemic. This reflected better cover out of hours and consultant support on the ward. The only exception was a challenging period on the Macmillan ward (Dec 2020). This was addressed by the relevant team and the juniors felt supported throughout.

Work Schedule Reviews

There have been no formal Work Schedule Reviews reported as difficulties have been handled promptly by service managers.

Fines

Total breach fines paid by the Trust from August 2017 to date are £13,137.75 and the Guardian Fund currently stands at £7,033.14.

Vacancies by quarters:

VACANCIES BY QUARTERS – APRIL 2020 – MARCH 2021						
Department	**Grade**	**Quarter 1** Apr – June 2020*	**Quarter 2** July – Sept 2020	**Quarter 3** Oct – Dec 2020	**Quarter 4** Jan – Mar 2021	Average gaps per quarter
Emergency	ST3+		9	7	6	7.3
	FY2 / GP/ ST1-2		1	1	2	1
Anaesthetics	ST3+		1	1	1	1
Medicine	ST1-2		1	1	1	1
	ST3+		1.6	1	1	1.2
General Surgery	ST3+		0	1	1	0.6
Obs & Gynae	ST3+		0	1.3	0.8	0.7
T&O	ST3+		0	1	0	0.3
Paediatrics	ST3+		1	0.4	0.4	0.6
Total			**11.6**	**13.7**	**6.2**	**10.3**

***Figures for April – June 2020 are not available due to Trust relocation of doctors to areas affected by COVID.**

Key issues from host organisations and actions taken

The trust has supported building a new mess by ED. This is due for completion in June 2021. I have requested a tour of the site (not yet arranged). We will use the BMA 'Fight Fatigue' £30,000 towards refurbishing this area. The juniors have not had a mess for some time so this is very welcome.

The issues in surgery out of hours are ongoing, despite numerous meetings between me, the ADO, CD, College tutor and various other key players in surgery. I have mentioned this in my last three reports to the board. I am significantly concerned about this as there appears to be considerable will to try to improve the situation, but very little concrete action.

Supported Development time (SDT) has not been easy to embed in the juniors' rotas. SDT is equivalent to SPA time for consultants. It is work in progress and the BMA have confirmed that WSFT are ahead of most trusts in the region.

There has been a real issue with workspaces, particularly with social distancing. There simply is not enough space for juniors to work. This has meant that during the pandemic whole wards of juniors have had to self-isolate when one of them, working in a confined area (and having to eat/drink at some point) tested positive. There is real concern that appropriate workspace will be provided in the new hospital. This has been escalated to the lead for the new hospital. It would be ideal if someone from the JDF could be part of the relevant workstream.

Summary

This year has been dominated by the pandemic and I would like to thank the juniors for generally stepping up, not complaining, and risking their own health to continue working. I would also like to thank the trust, on behalf of the doctors, for the provision of free hot drinks and high-quality food at night.

I would also like to thank all the service managers who attend the GOSW meeting and have tried to facilitate changes such as Supported Development Time.

Finally, I would like to thank Helen Kroon as medical staffing manager who has provided considerable support (much of it out of hours) for all juniors via the WhatsApp group and personal conversations throughout this very difficult year. Many of them have commented how helpful this has been.

14. Quality and safety reports

To APPROVE the reports

Presented by Susan Wilkinson and Nick Jenkins

14.1. Maternity services quality & performance report

For Approval

Trust Open Board – 28th May 2021

Agenda item:	14.1			
Presented by:	Sue Wilkinson, Executive Chief Nurse/ Karen Newbury, Head of Midwifery			
Prepared by:	Karen Newbury – Head of Midwifery / Rebecca Gibson Head of Compliance & Effectiveness			
Date prepared:	May 2021			
Subject:	Maternity quality & safety performance report			
Purpose:	X	For information		For approval

Executive summary:

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

This report contains:

- eCare go live
- Strategy update
- Maternity improvement plan
- Safety champion feedback from walkabout/virtual session
- National Staff Satisfaction Survey Results
- Service user feedback
- External assurance and oversight
- National best practice publications and local HSIB reports
- Reporting and learning from incidents
- Maternity Clinical and Quality dashboard (Annex A) Data incomplete, please see below
- Continuity of Carer progress (see Quality dashboard Annex A) Data incomplete, please see below
- LMNS Perinatal Quality Oversight Highlight Report (Annex B)

<u>eCare go live</u>

On-going issues identified regarding data collection since going live with eCare in maternity. The majority of issue due to workflow and user input. eCare team working closely with maternity and Information teams to change workflows, focus training and undertake data corrections/cleansing. In the meantime, the information team are unable to provide the same level of reporting until all of these issues have been resolved. Business case required for digital support in maternity.

<u>Quality and Safety Framework / Strategy update</u>

The Maternity Quality and Safety Framework includes all aspects of Clinical Governance and reflects the Trust's overarching policies and processes. 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 the new Insight Committee for formal approval in June.

<u>Maternity improvement plan including Ockenden</u>

The Improvement Board receives the updated Maternity improvement plan on a monthly basis. This has been created through an amalgamation of the original CQC improvement plan with the

wider requirements of Ockenden, HSIB, external site visits and self-assessment against other national best practice (e.g. MBRRACE, Each Baby Counts, UKOSS).

Following Executive sign off and approval at LMS, the Ockenden assessment & assurance tool was submitted to NHSE earlier in 2021 and, following initial feedback, we have working through evidence collation. NOTE: A requirement for closed board minutes as one of the required sources of evidence will be considered / approved during the closed session of this month's board meeting.

Safety Champion Walkabout feedback

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

Unfortunately, due to unforeseen circumstances the Safety Champion Walkabout did not occur in April, however every chance to talk to staff was sought as opportunities arose.

Concerns raised from previous walkabouts are captured on the Safety Champion action plan until actions complete.

National Staff Satisfaction Survey Results

The National Staff Satisfaction Survey results were published in March 2021. On the back of the results, key elements of the survey were used to form a targeted questionnaire to band 5 & 6 midwives in April 2021. The results and actions taken will be shared in forthcoming papers.

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 April, the maternity service received 48 FFT returns. 100% of women would recommend the service in all areas.

External assurance and oversight

Following visits from the CCG in February and the CQC in April, the overarching Maternity improvement plan is being updated to incorporate the findings of both. The final (CCG) report and the CQC report are expected very shortly (the high-level findings and immediate actions were shared at the time of the visit).

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 12 local reports for WSFT cases and the outcome of these have been presented locally in Maternity as well as within the Board quarterly quality & learning report.

Maternity MBRRACE and HSIB action plans form part of the wider Maternity quality & safety improvement plan and will be monitored locally and via the new Improvement committee.

Reporting and learning from incidents

An external thematic review which will review all maternity's serious incidents including HSIB cases has now been agreed by NHSE to be for the last year and not the last two years. A panel have been commissioned and terms of reference have been agreed. The panel are now able to progress with the review. The timeframe for completion is yet to be confirmed by the panel.

The updated PSIRF framework required the agreement of a local patient safety incident response plan (PSIRP). This includes a Maternity section (within the main PSIRP) which sets out the reporting, investigation and external notification pathways for all incidents (not just those previously categorised as 'red' or 'an SI').

A sub-set of these are reported in the closed board 'PSIRF, complaints, claims and inquests' report on a monthly basis. This includes details of the incident, duty of candour status and whether it is reportable to the HSIB or for local investigation.

There were no incidents reported to HSIB in April however there was one case highlighted for local review; a baby admission to NNU which will be discussed in the closed board paper.

Maternity dashboard (see Annex A)

Indicators of maternity safety & quality are regularly reported and reviewed at monthly Maternity Governance meetings. A sub-set are provided for board level performance (the Performance & Governance dashboard). In March due to changing from one IT system to another (eCare) the data is incomplete for this month. Until the new system is fully embedded it is anticipated there will be a delay in data reports.

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
Grade 2 section decision to delivery time	Out of 24 grade 2 sections 6 were delayed – 5 of these by 10 mins or less. 1 case 29 mins delay. Ongoing QI project
Appraisal completion Mandatory training	This has been addressed and compliance reaches standard Escalated to line managers to support compliance
Equipment checks	Addressed with ward mangers/team leads
Supernumerary status of Labour Suite co-ordinator	Awaiting final Band 7 to join Team – started in May 2021
Documentation audits	Change IT system impacted compliance. Review underway and improvement seen.

LMNS Perinatal Quality Oversight Highlight Report

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

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 April 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. 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.

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

Annex A – Maternity Clinical and Quality Dashboard

	Green	Amber	Red	May20	Jun20	Jul20	Aug20	Sep20	Oct20	Nov20	Dec20	Jan20	Feb20	Mar20	Apr20
Total Women Delivered	>208 or <216	>216 or <208	> 224 or <200	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 <200	182	190	175	187	204	206	181	160	183	169		
Twins		No target		2	3	1	4	2	3	3	1	2	3		
Homebirths	2.5%	2% or less	Less than 1%	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	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	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%	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 7.8%	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	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%	91%	100%	n/a	100%	100%	67%		
Total Instrumental deliveries	12% - 14%	>14% - 15%	> 15%	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%	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%	1.1%	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	7	4	4	5	2	2	3	5	1	2		
Unit Closures	0		1	0	0	0	0	1	0	0	0	0	1		

Due to changing to eCare IT system on 21st March there is currently no data for March or April 2021

Appraisal completion	Standard	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	April
Midwives Hospital % in date	90%			94.0%	97%	97%	97%	100%	89%	82%	87%	80%	96%
Midwives Community & ANC % in date	90%			83.0%	90%	80%	100%	98.50%	98.50%	95%	98%	98%	99%
Support Staff Hospital % in date	90%			90.0%	90%	88%	84%	72%	76%	81%	83%	81%	90%
Support Staff Community & ANC % in date	90%			100.0%	100%	No data	93%	91.50%	91.50%	91.50%	87%	100%	89%
Medical Staff (Consultant) % in date	90%												82%
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%	95.5%	97.7%
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%	96.0%	100.0%
Midwives: % compliance with GAP training	90%		79.0%	91.0%	92.0%	98.0%	96.0%	96.0%	96.0%	96.0%	89.0%	87.0%	86.0%
Midwives: % compliance with Safeguarding Children training	90%				99.3%	No data	99.0%	94.0%	94.0%	97.0%	96.0%	98.0%	99.0%
Midwives: % compliance with Fetal Monitoring training	90%									68.6%	75.9%	78.1%	86.3%
ANC Midwives: % compliance with Fetal Monitoring training	90%									40.0%	71.4%	100.0%	100.0%
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%	94.9%	93.0%
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%	94.4%	89.5%
MCA: % compliance with Safeguarding Children training	90%				99.4%	No data	100.0%	94.0%	91.0%	97.0%	100.0%	100.0%	100.0%
Obstetric Medical Staff: compliance with PROMPT training	90%	No Data	70.0%	70.0%	73.3%	57.1%	69.6%	76.0%	79.2%	84.0%	84.6%	89.7%	90.6%
Obstetric medical staff: % compliance with GAP training	90%		88.0%	83.0%	58.0%	92.0%	87.0%	83.0%	86.0%	83.0%	79.0%	80.0%	83.0%
Obstetric Medical Staff: compliance with Safeguarding Children training	90%					No data	84.0%	50.0%	84.0%	90.0%	80.0%	85.0%	90.0%
Obstetric Medical Staff: % compliance with Fetal Monitoring training	90%									89.5%	76.2%	90.9%	82.6%
Anaesthetic compliance with PROMPT training	90%	No data	No data	No data	No data	No data	50.0%	53.9%	53.9%	60.0%	64.3%	73.3%	57.9%
Theatre staff compliance with PROMPT training	90%	No data	No data	No data	No data	No data	34.3%	47.4%	47.4%	50.0%	50.0%	74.4%	87.5%
Sonographer: % compliance with GAP training	90%		93.0%	93.0%	79.0%	86.0%	79.0%	86.0%	93.0%	93.0%	86.0%	86.0%	86.0%
Labour Suite: Adult Trolley checks	100%		86%	100%	100%	100%	100%	100%	100%	100%	100%	97%	93%
Labour Suite: Resuscitaires checks	100%		73%	86%	76%	88%	96%	98%	97%	92%	98%	99%	97%
Ward F11: Adult Trolley checks	100%			97%	100%	97%	100%	100%	100%	100%	100%	97%	97%
Ward F11: Resuscitaire checks	100%			77%	84%	93%	97%	100%	100%	100%	100%	97%	97%
MLBU: Resuscitaires checks	100%			95%	100%	93%	94%	97%	97%	96%	93%	97%	100%
Community: Emergency Bags checks	100%			89%	98%	95%	84%	82%	100%	96%	100%	94%	94%
Friday temperature checks - Labour Suite	100%			97%	100%	100%	100%	93%	97%	97%	96%	97%	97%
Friday temperature checks - Ward F11	100%			100%	100%	93%	100%	100%	97%	100%	100%	100%	90%
Friday temperature checks - MLBU	100%			97%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Friday temperature checks - ANC	100%			100%	100%	100%	100%	100%	100%	100%	100%	100%	85%
Ambient room temp - Labour Suite	100%			97.0%	100.0%	100%	100%	93%	97%	97%	96%	97%	97%
Ambient room temp - Ward F11	100%			100.0%	100.0%	97%	100%	97%	97%	100%	100%	100%	90%
Ambient room temp - MLBU	100%			97.0%	100.0%	100%	100%	100%	100%	100%	100%	100%	100%
Ambient room temp - ANC	100%			100.0%	100.0%	100%	100%	100%	100%	100%	100%	100%	85%
CD checks - Labour Suite	100%			100.0%	98.0%	100%	100%	100%	100%	100%	100%	100%	100%
CD checks - Ward F11	100%			100.0%	100.0%	97%	100%	100%	97%	100%	100%	100%	100%
CD checks - MLBU	100%			97.0%	100.0%	100%	100%	100%	100%	100%	100%	100%	100%
Supernumerary Status of LS Coordinator audit	100%			84%	74%	No data	83%	70%	91%	90%	92%	94%	93%
1-1 Care in Labour audit	100%	100.0%	100.0%	100.0%	100.0%	99.5%	100.00%	100%	100%	100%	100%		
MW: Birth Ratio	1:28	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	1	5
Compliance with MEOWS completion	100%		98.0%	99.5%	99.0%	99. 8%	99%	99.3%	99.40%	99.60%	99.50%	99.20%	97.40%
Compliance with NEWTT completion	100%	97.0%	96.0%	95.0%	99.0%	100%	100%	100%	97.50%	98%	99%	98%	95%
Carbon Monoxide monitoring - Smoking at booking recorded	95%				100.0%	100%	100%	100%	100%	97.50%	100%	100%	100%
Carbon Monoxide monitoring - Smoking at 36 weeks recorded	95%				45.0%	78%	74%	85%	97.50%	93%	90%	72.5%	80%
Compliance with DV questions - Antenatal period	100%				95.0%	100%	98%	98%	100%	98%	100%	100%	100%
Compliance with DV questions - Postnatal period	100%				97.5%	95%	90%	80%	94%	90%	98%	98%	73%
Swab Count Compliance - Birth	100%			56.0%	85.0%	87%	93%	100%	73%	85%	80%	88%	91%
Swab Count Compliance - Suturing	100%			54.0%	90.0%	87%	96%	92%	66%	78%	70%	95%	96%
Compliance with completing WHO checklist @ CS	95%		93.0%	96.0%	96.0%	90%	96%	100%	96%	96%	96%	92%	94%
Recording of Pain Score - Labour Suite	100%				99.0%	100%	100%	98%	100%	100%	100%	99%	98%
Recording of Pain Score - Triage	100%				100.0%	100%	100%	100%	100%	100%	100%	97%	82%
Recording of Pain Score - MLBU	100%				100.0%	100%	100%	100%	100%	100%	96%	100%	100%
Recording of Pain Score - Ward F11	100%				97.0%	100%	100%	98%	100%	100%	100%	97%	99%
Recording of Pain Score - MDAU	100%				100.0%	100%	100%	100%	100%	100%	100%	100%	72%
Completed Drug chart information: weight and allergies	100%					7.00%	73%	76%	60%	48%	76%	100%	100%
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%	ata per 1	ata per 1	ing data	ing data	ing data
Breast Feeding													
Total women delivered who breastfed their babies within the first 48 hrs	80%	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%	100.0%	67.0%	100.0%	100.0%
Grade 2 LSCS	80%	81%	67%	95%	78%	83%	82.3%	68%	75%	58%	81%	64.0%	75.0%
New for January 2021													
Mag Sulpate for preterm infats										First Mon	1 of 1		
Pre-term infants bith in right place										First Mon	100%		
Women Booked onto the continuity pathway	Number								415	473	542		
Women who received CoC inc delivery of care (Of all WSH women)	Number								31	36	26		
Oututstanding Datix (last day of the month)											4	2	2
Out of date guidelines									0	0	2	2	2
Number of serious incidents									1	2	2	1	1
Weekly hours of dedicated consultant cover on LS	>60	96	86	72	84	87	90	99	93	Discontir	Discontir	Discontinued	

Annex B – East of England Regional Perinatal Quality Oversight Group Highlight Report

East of England Regional Perinatal Quality Oversight Group
Highlight Report

LMNS: March 2021 | **Reporting period: March 2021 (1st -21st March)**

Overall System RAG: (Please refer to key next slide)

CQC DOMAINS

Maternity unit	Colchester (date of last inspection)						Ipswich (date of last inspection)						West Suffolk (date of last inspection)					
C-caring R-responsive E-effective W-well-led S-safe	C	R	E	W	S	Action Plan Status: To commence Progressing Completed	C	R	E	W	S	Action Plan Status: To commence Progressing Completed	C	R	E	W	S	Action Plan Status: To commence Completed

KPI (see slide 4)	Measurement / Target		Trust Rate (current reporting period)						Combined Trust
Please see exemplar v5 for full detail			Colchester		Ipswich		West Suffolk		
Caesarean Section rate	Elective	13%					10.3%		
	Emergency	17%					23.1%		
Preterm birth rate	≤26+6 weeks	≤6% annual rolling rate					0	.009 %	
	≤36+6 weeks						7.4%		
Massive Obstetric Haemorrhage	**≥1.5l**	<2.9%					2..6%		
Term admissions to NNU (all levels)		<6%					3.3%		
3rd & 4th degree tear	SVD (unassisted)	<3.5 overall rate (Unassisted 2.8%) (Assisted 6.8%)					2	2.6%	
	Instrumental (assisted)						1		
Right place of birth		95%					100%		
Smoking at time of delivery		≤6%					7.5%		
Percentage of women placed on CoC pathway		≥35% (March 21)					ND		
Percentage of women on CoC pathway :BAME / areas of deprivation)	**BAME**	≥75%	BAME	Total				ND	
	Area of deprivation		AOD						

KEY: CQC DOMAINS
Outstanding
Good
Requires Improvement
Inadequate

MW to birth ratio			Vacancy rate (MW)	LW co-ordinator supernumerary (%)
BR+ recommendation		Actual		
C				
I				
WS	1.27	ND	10.3wte	97%

Incident Reporting	LMNS confirmation of SI oversight (evidenced through governance & safety meetings) Yes ☐ No ☐

	Datix		Maternity Serious Incidents	Maternity Never Events	HSIB cases	Still Births			HIE cases (grade 2 or 3)	Neonatal deaths		Maternal Mortality	
	Unactioned	Open > 30 days				All	Term	Intrapartum		Early	Late	Direct	Indirect
C													
I													
WS	0	2	1	0	1	0	0	0	0	1	0	0	0

Assessed compliance with10 Steps-to-Safety

	Please identify unit	Col	Ips	WS
1	Perinatal review tool			
2	MSDS			
3	ATAIN			
4	Medical Workforce			
5	Midwifery Workforce			
6	SBLCB V2			
7	Patient Feedback			
8	Multi-professional training			
9	Safety Champions			
10	Early notification scheme (HSIB)			

Key	
Complete	The Trust has completed the activity with the specified timeframe – No support is required
On Track	The Trust is currently on track to deliver within specified timeframe – No support is required
At Risk	The Trust is currently at risk of not being deliver within specified timeframe – Some support is required
Will not be met	The Trust will currently not deliver within specified timeframe – Support is required

Evidence of SBLCB V2 Compliance

	Please identify unit	Colchester	Ipswich	West Suffolk
1	Reducing smoking			
2	Fetal Growth Restriction			
3	Reduced Fetal Movements			
4	Fetal monitoring during labour			
5	Reducing pre-term birth			

Assessment against Ockenden Immediate and Essential Action (IEA)

Please identify unit	Colchester	Ipswich	West Suffolk
Audit of **consultant led labour ward rounds** twice daily			
Audit of **Named Consultant** lead for complex pregnancies			
Audit of **risk assessment** at each antenatal visit			
Lead **CTG Midwife and Obstetrician** in post			
Non Exec and Exec Director identified for Perinatal Safety			
Multidisciplinary training – PrOMPT, CTG, Obstetric Emergencies (90% of Staff)			
Plan in place to meet **birth rate plus** standard (please include target date for compliance)			
Flowing accurate data to **MSDS**			
Maternity SIs shared with trust Board			

Please include narrative (brief bullet points) relating to each of the elements:

Maternity unit	Colchester	Ipswich	West Suffolk
Freedom to speak up / Whistle blowing themes			No themes identified
Themes from Datix (to include top 5 reported incidents/ frequently occurring)			PPH >1500ml (3) Communication resulting in an incorrect care pathway Late referral to the preterm prevention clinic
Themes from Maternity Serious Incidents (Sis)			Clear pathway of care of the diagnosis of gestational hypertension when blood pressure not consistently raised.
Themes arising from Perinatal Mortality Review Tool			No themes arising this month
Themes / main areas from complaints			No themes individual complaints Communication of a miscarriage to the community. Concerns around accessing perineal care care following discharge from community
Listening to women (sources, engagement / activities undertaken)			Weekly Q & A via face book for parents MVP present at the Labour Suite Forum MVP present at the guideline meeting Facebook page Patient feedback via F&FT
Evidence of co-production			Working with the Neonatal Unit to accommodate parental visiting during Covid pandemic..
Listening to staff (eg activities undertaken, surveys and actions taken as a result)			Positive impact provided by our developing PMA service by Improve wellbeing of staff Helping staff to feel valued Significant reduction in stress and burnout .
Embedding learning (changes made as a result of incidents / activities / shared learning/ national reports)			Improving MCA experience and feeling valued member of the team by meeting women in labour rather currently this is mostly following birth.

KPIs: Targets & Thresholds

Ref	KPI	Measurement / threshold data source	Ambition	Green Range	Amber Range	Red Range	Source
S1	**Caesarean section rate** (Caesarean section targets are based on England HES data for 2019/20)	% Caesarean sections: elective & emergency (NHS Maternity Statistics 19-20)	29% EL 13% EM 17%	<30% <13% <17%	NA	> 33% > 15% > 19%	Trust / MSDSv2
S2	**Preterm birth rate** (Denominator = all births over 24 weeks gestation)	% Preterm birthrate: <27 weeks & <36 weeks (National ambition / ONS data 19-20)	<6%	≤ 6% achieved in 12 months	6.1 – 7.4%	≥ 7.5 achieved in 12 months	Trust
S3	**Massive obstetric haemorrhage** (Based on NMPA data for 2017/17 for women who give birth vaginally to a singleton baby in the cephalic position between 37+0 and 42+6 weeks)	Massive obstetric Haemorrhage >1500mls (denominator = total singleton cephalic births) (NMPA)	<2.9%	≤ 2.9%	NA	≥ 3%	Trust / MSDSv2
S4	**Term admissions to NICU** ((from all sources eg Labour ward, postnatal ward / community but not transitional care babies)	% Terms admissions to NICU (national ambition)	<6%	≤ 6%	NA	≥ 6.1 %	Trust / Badgernet
S5	**3rd & 4th degree tear** (3rd/ 4th degree tears are based on NMPA data for 2017/17 for women who give birth vaginally to a singleton baby in the cephalic position between 37+0 and 42+6)	% 3rd & 4th degree tear: NMPA SVD & Instrumental 3rd & 4th degree tear (NMPA) (denominator total singleton cephalic SVD / total Instrumental births / total vaginal births)	NMPA SVD: 2.8% Instrumental: 6.8% Overall: 3.5%	≤ 3.5%	3.6 – 4.9	≥ 5%	Trust / MSDSv2
S6	**Right Place of Birth** (denominator = no of women birthing under 27, 28 with multiple or <800g)	% Right Place of Birth: <27 weeks or <28 weeks multiple & EFW <800g born in tertiary centre (national ambition)	95%	≥ 95%	80.1% – 94.9%	≤ 80%	Trust / Badgernet
S7	**Smoking at time of delivery**	% women smoking at time of delivery (Tobacco control plan 2017)	≤ 6%	≤ 6%	6.1% - 7.9 %	≥8%	Trust / MSDSv2
S8	**Percentage of women placed on Continuity of Carer pathway** denominator = all women reaching 29 weeks gestation within the month	% women placed on continuity of carer pathway at 29 weeks gestation (national ambition)	35%	25% - 35%	15.1%-24.9 %	≤ 15%	Trust / MSDSv2
S9	**Percentage of BAME women or from areas of deprivation (AOD) placed on Continuity of Carer pathway** (denominator as above)	% BAME / AOD women placed on continuity of carer pathway at 29 weeks gestation (national ambition)	75%	≥ 65%	55.1% - 64.9%	≤ 55	Trust / MSDSv2

14.2. Infection prevention and control assurance framework

For Approval

Board of Directors – 28 May 2021

Item	14.2			
Presented by:	Sue Wilkinson Exec Chief nurse			
Prepared by:	Rebecca Gibson – Compliance Manager			
Date prepared:	May 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
- Self-assessment against HSE national findings (Appendix 1)

The 'learning from outbreaks' plan which has arisen from the series of outbreak/cluster RCA has not identified any new (i.e. different) learning since the last meeting as so is not presented this time. It is recommended that the organisation undertakes a 'wash-up' review once the last few reports are completed to ensure that all learning and associated actions are comprehensive so as to enable maximum protection in the case of any 'third wave'.

Following the completion of the last few outbreak/cluster RCA reports an overview will be undertaken to look for any commonality between these findings as well as the wider NHSE BAF.

As previously reported, 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. There is a high degree of confidence in a statement of compliance with these recommendations enhanced by a local self-assessment against the full list of findings. see Appendix 1

**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: Undertake a 'wash-up' review of all Covid related investigations, including complaints and staff impact	

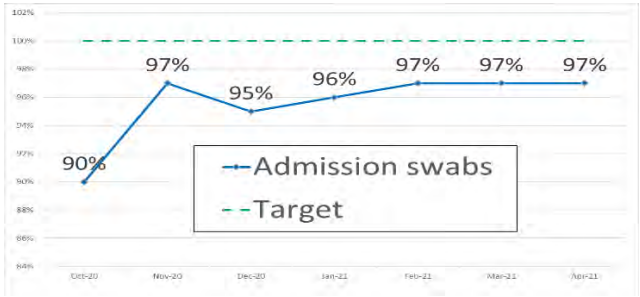
Measure	Time period reported	Data		
		Previous	Last period	This period
Nosocomial C19 (probable + definite)	Apr 21	0	0	0 →
Staff work-related C19 cases reported to RIDDOR	Apr 21	0	0	0 →
Incidents relating to C19 management	Apr 21	27	21	↓
Admissions swabs within 24 hours of DTA	Apr 21	97%	97%	97% →
C19 clusters / outbreaks	Apr 21	0	0	0 →
Staff sickness / absence due to C19	Apr 21	312	226	↓

Associated charts / tables / narrative

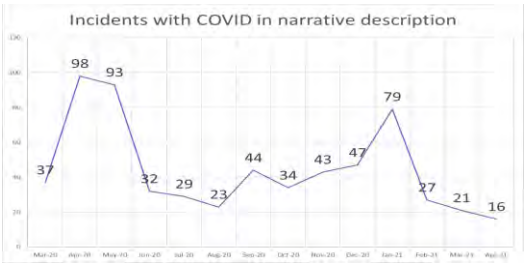
C-19 admission swabs

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

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



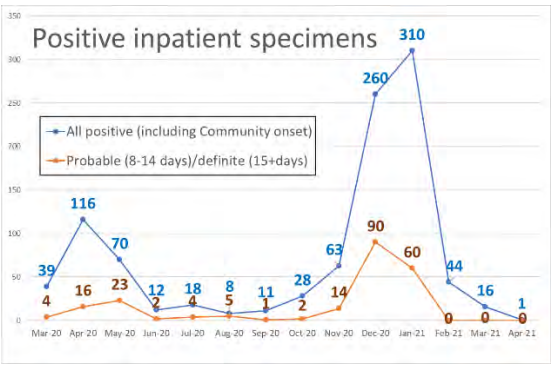
Inpatient swabs The updated NHSE IPC BAF requires oversight of the requirements for emergency admissions who test negative on admission to be retested on day 3 of admission, and again between 5-7 days post admission. It has been ascertained that eCare cannot produce an automated report to all this to be monitored. The IPC team therefore are undertaking a spot-check audit of a sample of patients with a length of stay >9 days who were Covid negative on admission (and previous 90 days) to ascertain the appropriate swabbing regime was adhered to. In order to get a wide view of compliance across the different ward types; this audit is being undertaken for wards G4, F8 and F3/F6. We anticipate the outcome of this audit and any recommendations should be included in next month's board paper.



The number of **incidents relating to C-19** recorded in April continued the reducing pattern of recent months.

14/16 April reported incidents were green and there were two amber and no reds:

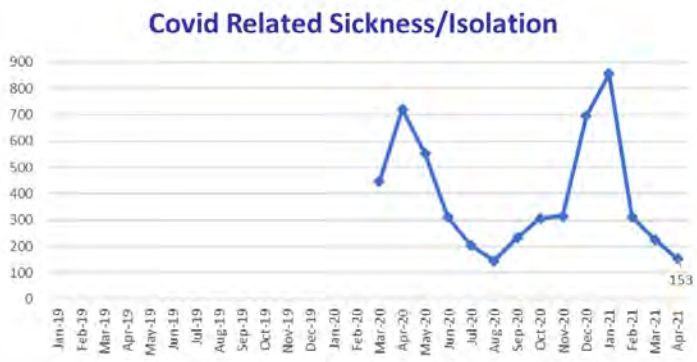
The ambers were a pressure ulcer and a community staff member who assisted in a road traffic accident.



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 April. This mirrors the decrease in community prevalence over the same period.



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 April 2021 there were 153 episodes recorded, a continued decrease from March (226 episodes). This matches the wider community picture in West Suffolk

Appendix 1 - Self-assessment against HSE national findings

Area	Improvement required	What we are doing	Improvement action	Lead	End date	Status
1. Management arrangements	Monitoring arrangements were not in place to ensure policies and procedures were read and were followed.	Workplace inspections are regularly undertaken by the H&S link staff. The link staff must complete the workplace inspection template document which covers a range of health and safety topics. All staff have to attend a Trust induction which covers the key arrangements from the H&S policy. Staff are also encouraged to read this policy. The care certificate has a H&S element which has to be completed by finding information contained in the policy.	1. Considering moving workplace inspections paper template over to perfect ward app. 2. Introduce risk based spot checks for areas of concern undertaken by the Risk Office	MD JM / MD	Dec21 Jul 21	Green
	Compliance with risk assessment control measures were not being audited resulting in the non-compliance issues contained in this report	Workplace inspections are regularly undertaken by the H&S link staff. A covid work place inspection was required at the start of the pandemic. Risk Management deep dive audits are undertaken on all departments within the Trust and were reported to the CRC now they will be reported to the insight Committee.	None required			Green
	Staff behaviour was not being challenged when non compliance was seen by managerial staff.	Staff are encouraged and do challenge anyone who is not following the arrangements which have been put in place. There are a number of routes for escalation within the Trust from reporting incidents on Datix to speaking to individual leads.	None required			Green
	Departmental managers were not aware of their responsibilities for monitoring and maintaining COVID controls.	All managers are aware of the current arrangements for covid. Regular staff briefings are emailed to all staff as well as a weekly live briefing.	1. Produce a do's and don'ts list for managers around covid arrangements 2. Quality walkabouts to recommence	MD / Tactical Execs	May21 ASAP	Green
	Poor consultation with recognised Trade Union Safety Representatives and/or employee representatives during the completion of COVID related risk assessments.	The Trade Unions have representatives on the Trusts H&S committee. They also attend a weekly workforce group.	None required			Green
	Sharing of good practice did not occur indicating lack of coordination within the system.	Best practice was shared with local Trusts on a regular basis.	None required			Green
2. Risk Assessment	Risk assessments were not carried out for all areas and did not assess all the issues required, for example ventilation requirements and maximum occupancy were often omitted.	A covid workplace inspection template was produced using guidance documents from the Government/HSE. All departments across the Trust where required to complete the template and record the findings onto the risk register. To date 168 covid workplace inspections are captured on the risk register.	None required			Green
	Risk assessments not being reviewed after; lockdowns, events, such as outbreaks, when guidance changed, or when areas were repurposed e.g. from offices to rest areas.	All risk assessments on the risk register are subjected to regular reviews. The Trusts overarching covid risk assessment is regularly updated to reflect any changes in the arrangements put in place	None required			Green
	Staff had not received training to carry out risk assessments.	Risk Register training is provided to all staff who want to use the risk register. Also, all staff who are H&S link persons have to pass the RSPH Level 2 award in health and safety which has a section regarding risk assessments. The risk office also provides risk assessment training when required. All staff have to complete the online H&S mandatory training module	None required			Green

Area	Improvement required	What we are doing	Improvement action	Lead	End date	Status
	Not all staff had access to the risk assessments, for example some hospitals used their intranet but not all staff have access to computers or were computer literate; there was a reliance on verbal cascade and colleague to colleague communication where English is not the first language.	All areas across the trust are required to have a health and safety folder which contains hard copies of the risk assessments which are captured on the risk register.	None required			Green
3. PPE	Records were not readily available to ensure the worker was provided with the correct respirator they had been fitted for. Face-fit information was not stored centrally on the person's personal file.	All staff members receive a certificate for the mask they have been fitted with, which is given or a copy given to the area manager to store. There is a central data base that can be accessed by Tactical, matrons and Ward Managers of all staff fit tested.	Investigation of RPE records being stored on individuals ESR.	LW IB	June 21	Green
	A buddy/mirror was not always available to ensure a fit check was carried out correctly.	Donning areas have mirrors	None required			Green
	Records were not readily available at the time of the inspection to demonstrate that additional training had been provided in addition to the suppliers' introductory session on using the PortaCount machine used for face-fit testing.	PortaCount is not used within the trust, we use qualitative fit testing. Fit Testers have been trained by Head of EPRR or an external trainer.	None required			Green
	Whilst pre-use checks were being carried out reusable RPE was not always being checked at suitable intervals to ensure that defective equipment was not being used.	On the issue of reusable RPE, staff are supplied with the SOP and asked to sign they have read and acknowledged the checks needed prior to every use and part changes. Each staff member issued with reusable RPE holds records of their own checks/part changes.	Reminder to be sent to all staff using reusable RPE to check regularly and report to tactical / purchasing if equipment defective.	LW	May 21	Green
	Reusable RPE was not always labelled with the individual's name and not stored in an appropriate manner e.g. seen to be stacked on top of one another in a variety of settings.	On issue of reusable RPE staff were asked to label with their name, and given storage instructions.	Reminder to be sent to all staff using reusable RPE, in regards to naming and storage of RPE.	LW	May 21	Green
	RPE was not always located close to the place of use.	RPE is located in all clinical areas of the trust. FFP3 masks are located in areas where they are used, and can be requested for other areas via purchasing. All entrances of the trust supply FR surgical masks.	None required			Green
	Alternative FFP3 respirators being used without additional face fit testing, where it had not been clearly established from the PPE supplier or manufacturer that the respirators were compatible and could be used without a further face fit test.	Information of FFP3 masks available to all staff on Trust Intranet, including compatibility of masks without further fit testing. On fitting of masks, fit testers verbally instruct and show staff members of compatible masks.	None required			Green
4. Social Distancing **4.1 Surgical masks:**	Surgical masks were being worn as a control measure in lieu of social distancing arrangements, contrary to IPC guidance that states ' Physical distancing of 2 metres is considered standard practice in all health and care settings, unless providing clinical or personal care and wearing appropriate PPE'.	The wearing of surgical masks is now mandatory across the Trust unless in a single occupancy office. The rules of 2 meters social distancing is in place as far as is reasonably practicable.	None required			Green
	Some workers assumed if they were wearing surgical masks they did not need to be socially distanced from their colleagues. For example, staff were seen walking and chatting along corridors within close proximity to each other.	The Trust has followed the Governments guidance around social distancing where reasonably practicable. Corridors have signage to remind staff, visitors and patients to keep left and to maintain social distancing. Offices and other non-clinical areas have been re arranged to ensure 2 meters social distancing is maintained where reasonably practicable. The Trust has over 3000 staff so it is difficult to police this.	None required			Green

Area	Improvement required	What we are doing	Improvement action	Lead	End date	Status
4. Social Distancing **4.2 Changing areas, locker rooms, toilets**	Maximum occupancy numbers and systems for maintaining social distancing not displayed on entry.	The Trust introduced a covid secure level 1 and 2 system. No matter if the area is level 1 or level 2 a requirement is to display a poster indicating the maximum number allowed at any one time	None required			Green
	Where maximum occupancy was identified no arrangements were in place to ensure compliance was possible. For example, no information was available to explain how to achieve the stated maximum occupancy of 10 for a changing/locker room when 120 workers were on duty.	The covid workplace inspection had a section around staggering shifts to reduce numbers in offices. The Trusts guidance is still to work from home if possible. Covid secure level 1 or level 2 posters identifying maximum numbers in office.	None required			Green
	Sinks adjacent to each other had not been taken out of use/taped over and/or no perspex screens provided to ensure separation.	This potentially is an issue	Adjacent sinks to be taped over but must continue to be flushed by Housekeeping	Estates	June 21	Green
	Floor markings were not provided to identify social distancing, for example to signpost foot traffic though a large changing facility.	Floor stickers have been provided and placed by Estates across the Trust	None required			Green
	Congestion caused by staff having to queue in the corridor and requiring colleagues to pass by in a narrow corridor space.	There have been no reports of staff having to que in corridors causing congestion	None required			Green
	Storage of personal clothing outside of lockers indicating insufficient number of lockers available.	Plastic boxes have been provided for staff if there are no lockers	Managers to be reminded that offices are to be decluttered and clothing to be placed in plastic boxes or bags if not enough lockers	Tactical	May 21	Green
	Changing facilities and lockers not close to the place of work.	Due to the age of the building it is not always possible to have changing facilities and lockers in close proximity of the ward or department.	None required			Green
4. Social Distancing **4.3 Rest areas/common rooms/doctor's mess/ pathology**	Many were multi-purpose, used for breaks, eating, locker storage and working, with Inadequate social distancing. For example, a workstation was being used whilst others were eating within 1m.	The social distancing rule of 2 meters is in place across the Trust so far as is reasonably practicable. Managers are required to ensure the arrangements are in place.	None required			Green
	Maximum occupancy numbers not being provided	The Trust introduced a covid secure level 1 and 2 system. No matter if the area is level 1 or level 2 a requirement is to display a poster indicating the maximum number allowed at any one time	None required			Green
	Where maximum occupancy numbers provided the number of seats exceeded the limit allowed. On one occasion the maximum was 5 but 14 chairs were available and were positioned close together.	In areas across the Trusts chairs have either been removed, stacked up or taped across to ensure social distancing is maintained. Notices and posters are on display	None required			Green
	Tables too small to allow 2m separation e.g. 4 workers were sat around a 1m diameter table facing each other.	Tables are set up to allow social distancing where practicable. If a table is small then only one staff would be allowed to use it.	None required			Green
	Areas repurposed for rest facilities but were too small to allow social distancing, which was compounded by lack of ventilation.	Additional areas have been provided by the Trust for staff to use. Two marquees have been provided. The Trust also has Time out and the courtyard café, calm rooms have also been put in place.	None required			Green
	Employees seen not social distancing on several occasions including eating within 1m of each other; 15 members of staff sitting in close proximity to each other, and 5 staff sitting at a table for 2.	The Trust arrangements for social distancing are in place. Staff are reminded to obey them at all times. Posters, frequent staff briefing reminders and green sheet reminders. With a large number of staff it is difficult to police to ensure arrangements are not being followed.	None required			Green

Area	Improvement required	What we are doing	Improvement action	Lead	End date	Status
	Areas were too small to accommodate the number of staff needing to use them at any one time.	Additional areas have been provided by the Trust for staff to use. Two marquees have been provided.	None required			Green
4. Social Distancing **4.4 Education Dept**	Chairs closer than 2m as they had been moved from marked position.	All chairs are spaced out to ensure social distancing. A number of chairs have also been removed. Staff are reminded not to move the chairs and presenters are reminded to ensure social distancing is maintained.	None required			Green
	Chairs arranged close together and side by side.	All chairs are spaced out to ensure social distancing. A number of chairs have also been removed.	None required			Green
4. Social Distancing **4.5 Offices, post room, medical records**	Maximum occupancy was not known or communicated.	The Trust introduced a covid secure level 1 and 2 system. No matter if the area is level 1 or level 2 a requirement is to display a poster indicating the maximum number allowed at any one time	None required			Green
	Maximum occupancy identified but the room was too small to accommodate the numbers.	The Trust introduced a covid secure level 1 and 2 system. No matter if the area is level 1 or level 2 a requirement is to display a poster indicating the maximum number allowed at any one time	None required			Green
	Occupancy exceeded at busy times due to lack of sufficient computers / workstations on a ward.	Maximum occupancy is clearly displayed on the covid secure posters. Staff are remined not to exceed these numbers.	None required			Green
	Desks and workstations were not organised to ensure social distancing. For example, excess seating and chairs were not removed, workers sat side by side or opposite facing each other when additional space was available (in one case 3 computer desks were side by side),	All workstations have been arranged to ensure social distancing also staff are encouraged to work from home to free up space. Perspex screen have been installed in some areas.	None required			Green
	Screens were not provided where reasonably practicable to do so.	Screen have been provided where the risk assessment indicated a need for it.	None required			Green
	Screens were not provided despite being required in the risk assessment. For example: failure to provide a screen to separate officer workers from employees accessing the printer.	Screen have been provided where the risk assessment indicated a need for it.	None required			Green
	Redesigning tasks not considered. For example: a drop off point for post could have been introduced, reducing the need for the worker to enter a small work area; in the reception area in a medical records library the receptionist was handing records through an open sliding window when an alternative method of transfer was possible that would avoid handing records between people.	This was considered and arrangements put in place to ensure any drop off point are easy for staff to access and maintain covid arrangements	None required			Green
4. Social Distancing **4.6 Canteens/ kitchens**	Failing to supervise controls. For example: staff repositioned tables and chairs for socialising and breaking social distancing controls.	The Time out restaurant has been set up to ensure social distancing is maintained at all times. Posters are displayed on every table reminding staff not to move the chairs.	None required			Green
	Failing to address and manage busy times with congestion and breakdown of social distancing measures.	Floor stickers are in place to ensure staff who are queuing for food are adequately social distancing. Face masks are also worn by all staff who are queuing for food.	None required			Green
	No mitigation measures in food preparation areas where sinks were provided side by side. For example: no separation screens provided; or adjacent sinks not taped over to indicate they had been taken out of use.	As we have to use both sinks that are adjacent to each other – one being a soaking sink. Our supervisors are very mindful of the situation and staffing has been adjusted accordingly.	None required			Green

Area	Improvement required	What we are doing	Improvement action	Lead	End date	Status
4. Social Distancing **4.7 Facilities, engineers, 4.8 Domestics, laundry, library**	Poor furniture layout reducing the ability to social distance.	The Trust introduced a covid secure level 1 and 2 system. No matter if the area is level 1 or level 2 a requirement is to display a poster indicating the maximum number allowed at any one time. A covid workplace inspection template was produced using guidance documents from the Government/HSE. All departments across the Trust where required to complete the template and record the findings onto the risk register. To date 168 covid workplace inspections are captured on the risk register.	None required			Green
	Reliance on surgical masks where it was reasonably practicable to provide screens at some fixed workstations. For example: 5 employees working around a conveyor belt in the laundry 'classification' area when it was reasonably practicable to stagger them and provide separation screens.	The Trusts arrangements for social distancing are in place and staff are required to follow these arrangements. Screen have been provided if the risk assessment stated a need for them.	None required			Green
	Floor markings not used to indicate direction of travel and separation distances. For example, walkways in the main library.	Floor markings have been introduced across the Trust	None required			Green
4. Social Distancing **4.9 Corridors, waiting areas, lifts**	In staff only areas a walk on the left side was policy introduced but with no marking or signage and lack of supervision it was not being adhered to.	A walk on the left arrangement was introduced at the start of the pandemic, floor stickers are in place to ensure this is followed.	None required			Green
	Signage not provided in a lift to communicate maximum occupancy.	Not all of the passenger lifts have the relevant notices	Estates to ensure correct signage is displayed in all passenger lifts across the site	Estates	May 21	Green
5. Hygiene and Cleaning	Cleaning schedules were not comprehensive, leading to areas being missed. For example, they did not always include rest rooms, porters lodge, staff toilets, changing rooms, doctor's mess, medical records and libraries. In those areas high touch points were not being cleaned in between use, for example telephones, printers, computers, photocopiers, vending machines, kettles, microwaves, equipment in engineering workshops.	Do we have comprehensive cleaning schedule's and do they adequacy consider high touch points?				Green
	Local instructions for cleaning not available at point of use.	This is captured on the covid secure poster- does the wording need to be amended to include more detail around cleaning ?	One-page SOP for cleaning workstations to be produced	Tactical	June 21	Green
	Cleaning material not available for local point of use cleaning.	Cleaning materials mainly wipes are made available for staff to use.	None required			Green
	Cleaning after use not occurring despite suitable wipes being provided.	Staff are encouraged to clean their workstations before and after use.	None required			Green
5.1 Specific to canteens	Limited information on cleaning regime for those using the facility.	Extra staff in area to heighten cleaning activities	None required			Green
	Lack of supervision and monitoring. This resulted in tables not being routinely cleaned between use by cleaning staff or those eating at the tables, despite a card system being in place to identify used tables.	We have a dedicated front of house Supervisor. Extra Staff and usual Staff reminded of their cleaning duties. Card system in place Tables regularly checked	None required			Green
	Cleaning material not always available.	Cleaning Materials and PPE available	None required			Green
	Single wipe being used for multiple tables.	Proper Cloths and Sanitiser being used	None required			Green
	Surgical masks being placed on tables.	Staff are reminded with clear signage not to place masks on the table. Signage and bins provided. Staff Comms. Has been used to inform	None required			Green

Area	Improvement required	What we are doing	Improvement action	Lead	End date	Status
6. Ventilation	Ventilation was not considered when the risk assessment was carried out.	Ventilation was included as part of the covid secure level 1 or level 2 self-assessment of areas.	None required			Green
	A room was repurposed as a rest facility but there were no windows or other means of ventilation provided.	Adequate ventilation is in place	None required			Green
	In non-clinical areas rooms were identified with no forced/mechanical ventilation and the windows were secured shut and the risk assessment did not consider whether the windows could have been unsealed to allow opening for ventilation where this was a possibility.	All first floor windows are restricted for safety reasons. All of these windows can be opened but only to 10cm.	None required			Green
	In areas where AGPs were carried out the clearance time was not available.	Yes clearance times are in place	None required			Green
	Not all opportunities to open doors and windows were being taken.	Doors and windows can be opened as far as is reasonably practicable	None required			Green

14.3. Nursing staffing report

For Approval

Trust Open Board – 28 May 2021

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

Executive summary:

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

Highlights

- Overall Trust fill rates continue to be above 90%.
- Launch of SafeCare module improving oversight of daily staffing risk assessment and mitigation
- Vacancy rates increased as expected as nursing uplifts in budget for April 2021
- Turnover rates favourable and within Trust's ambition
- Nurse sensitive indicators improved on 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 April'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 April 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 April within the data submission deadline. Table 1 shows the summary of overall fill rate percentages for these months and for comparison the previous four months.

	Day		Night	
	Registered	Care Staff	Registered	Care staff
Average fill rate for 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%
Average Fill rate for March 21	98%	87%	95%	99%
Average Fill rate for April 21	93%	96%	97%	110%

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

Highlights

- Fill rates remain favourable and above 90% in all shifts
- Highest fill rates for NAs this month reflecting the recruitment drive and additional induction in March
- Overfill of NA attributed to increase need of 1:1 care overnight
- Neonatal ward red risk for NAs. On review with unit teams there are no concerns and NA workload picked up by fluctuating capacity and RN team. No concerns flagged using local tool for acuity and dependency (BadgerNet)

Winter bank incentive impact on fill rates.

During the period between January and March 2021, at the height of the second Covid 19 wave, a bank incentive was offered to encourage staff to work additional hours on the bank to improve patient safety. The incentive would reward staff with an additional bonus of £300 if more than 75 hours was worked in this period.

The output of the scheme which ended in March 2021 was successful in achieving 32% increase in bank fill rates and a reduction in agency spend, compared with the previous 3 months. This review will be helpful in assessing the appropriateness of future incentives if significant staffing shortfalls are experienced again.

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 for nursing and support staff has increased slightly on previous month and is consistent with levels seen during the summer when community presence of Covid 19 had also reduced.

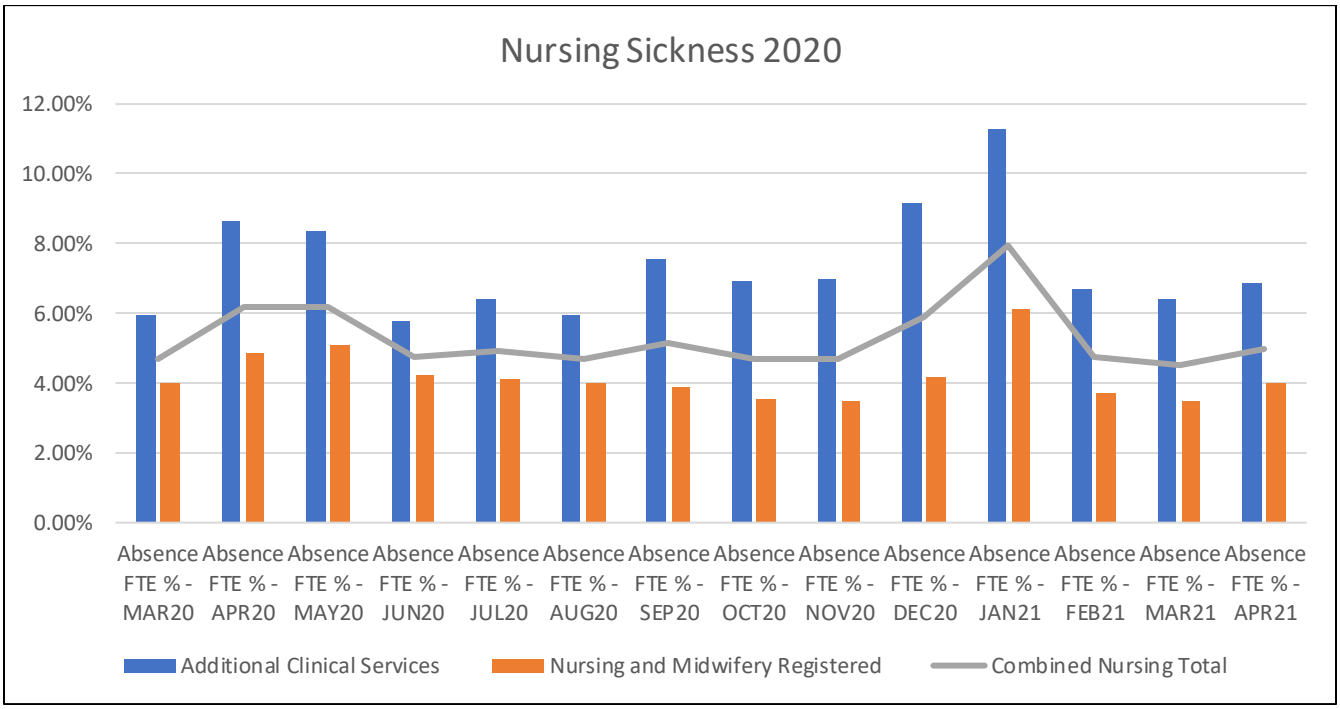


Chart 2.

	Sept	Oct	Nov	Dec	Jan 21	Feb 21	Mar 21	April 21
Unregistered staff (support workers)	7.56%	6.90%	6.98%	9.14%	11.29%	6.70%	6.39%	6.86%
Registered Nurse/Midwives	3.89%	3.57%	3.47%	4.16%	6.13%	3.71%	3.51%	3.98%
Combined Registered/Unregistered	**5.15%**	**4.72%**	**4.69%**	**5.92%**	**7.94%**	**4.74%**	**4.51%**	**4.98%**

Table 2b

Challenges to providing safe staffing have also been exacerbated by staff that are required to self-isolate, either due to exposure to Covid 19, or due to a member of their household being symptomatic. This is captured separately to sickness and is demonstrated below (chart 3). Despite overall sickness having increased marginally, self-isolation incidences have continued to reduce during April.

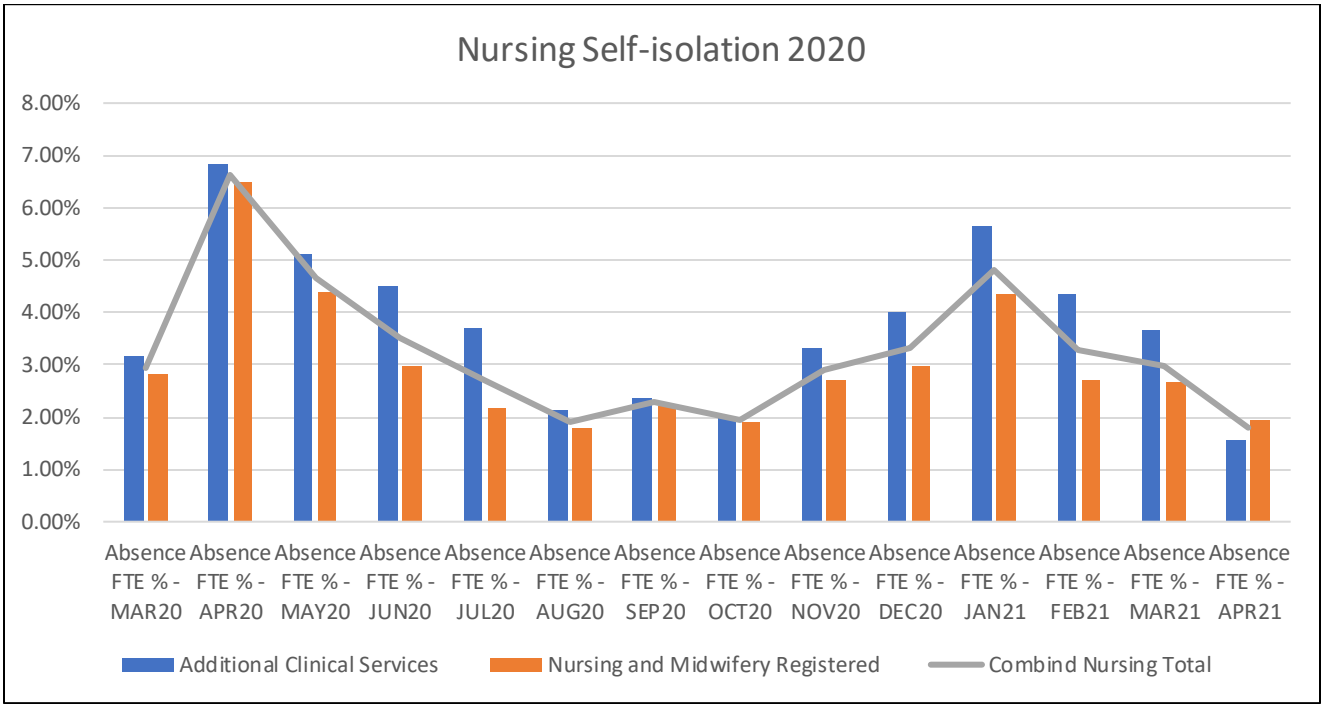


Chart 3

5. Patient Flow and Escalation

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

- F11 moved to F9 on 06/04/21
- F10 remains closed

6. Recruitment and retention

Vacancies: Registered nursing (RN):
Inpatient/ward vacancies have increased this month as expected. This is driven by an increase in budgeted establishment of 18wte, from the October nursing establishment review, and also 14wte RNs following an uplift to support the expansion of the ED footprint. When including non-ward-based areas the overall RN vacancy rate has risen from 4.4% to 7.8% this month.

	Ward Nursing	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 Actual Period 12 (March	Sum of Actuals Period 1 (April)	Sum of CURRENT MONTH VARIANCE
RN/RM Substantive	Ward	609.4	603.9	609.8	610.2	611.7	612.7	78.8
	CV19 Costs	11.4	10.3	2.0	(0.1)	1.4	1.3	(1.3)
Total: RN Substantive		**620.8**	**614.2**	**611.8**	**610.2**	**613.1**	**614**	**77.5**

Table 4

While the overall vacancy rate has increased for RNs, due to the expected uplifts, total substantive nursing staff has continued to rise consistently over the past 5 months (Chart 4a).

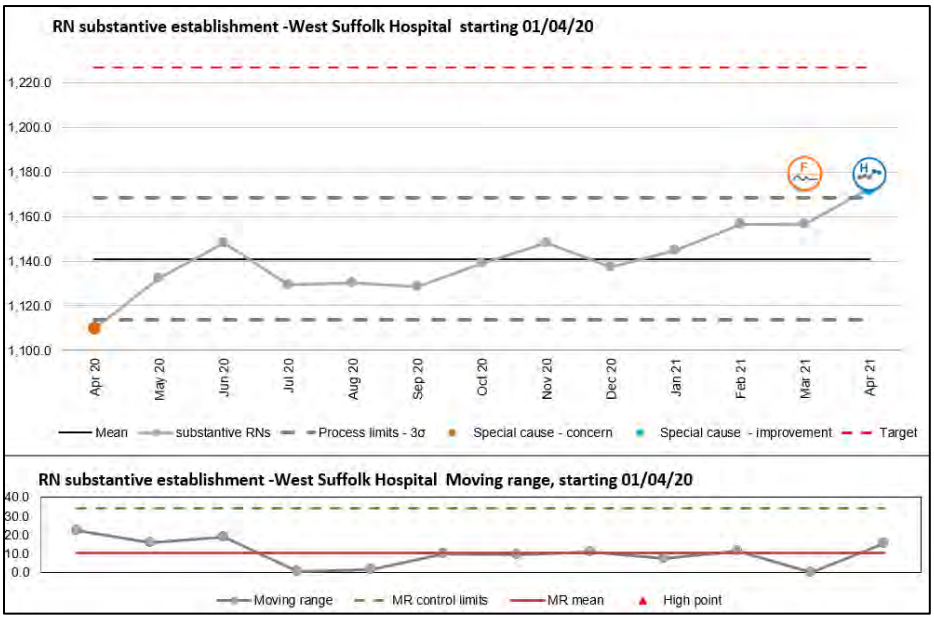


Chart 4a Data adapted from finance ledger

Vacancies NAs:

The national ambition for individual Trusts to reduce NA vacancies to 0% by end of 20/21 financial year was achieved by our organisation. This was driven by increased recruitment, additional HR support focusing on NA recruitment/onboarding and the introduction of a pastoral care role for two senior NA. However, due to the increase in establishment in ED, which has also affected NAs, the total NA vacancy rate observed in April is now 6.9% (table 6)

	Ward Nursing	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 Budget Period 12 (Mar)	Sum of Budget Period 1 (April)	Sum of CURRENT MONTH VARIANCE
Nursing Unregistered Substantive	Ward	363.4	375.1	380.6	386.2	393.8	391.3	15.6
	CV19 Costs	8.4	9.0	0.0	16.9	19.5	10.8	(10.8)
Total: NA Substantive		**371.9**	**384.0**	**380.6**	**403.0**	**413.2**	**402.1**	**4.8**

Table 5

7. New Starters and Turnover

Overseas Nurse (OSN) recruitment:

Three nurses arrived in April which is below our planned trajectory. Due to the short notice cancellation by one of the nurses and restrictions on the arrival of nurses from India, due to the escalating Covid incidences, we were unable to recover the position within this month.

New starters

	January	February	March	April
Registered Nurses	16	17	30	18
Non-Registered	11	17	28	17

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

- In April 2021 18 RNs completed induction; of these; two are community nurses, and sixteen are for the acute trust, three in midwifery.
- In April seventeen NAs completed induction; of these two NAs are in the community and fifteen for the acute Trust.

Turnover

On review of turnover figures for the last financial year, both RN and NA turnover are below the Trust's ambition of 10% which is positive.

Turn Over 01/04/2020 - 31/03/2021								
Staff Group	Average Headcount	Avg FTE	Starters Headcount	Starters FTE	Leavers Headcount	Leavers FTE	**LTR Headcount %**	**LTR FTE %**
Nursing and Midwifery Registered	1,259.00	1,081.23	95	76.73	76	61.05	**6.04%**	**5.64%**
Additional Clinical Services	570.50	482.92	151	135.64	51	43.60	**8.94%**	**9.02%**

Table 7.

Further interrogation of this data shows that leavers after 6 months of commencement in the trust is 3.45% in RNs (N=2) and 9.57% in NAs (n=9). The introduction of the pastoral NAs, that support new starters, will hopefully impact on the higher turnover seen for new NA to the organisation. The impact of this initiative will be reported in future papers

8. Quality Indicators

Falls

Total incidences of falls have reduced marginally on last month but positively, using the falls per 1000 bed day measure, there is further improvement due to increased bed occupancy. Falls per 1000 bed days is below the national average (set in 2015) of 6.63. A full list of falls and locations can be found in appendix 3.

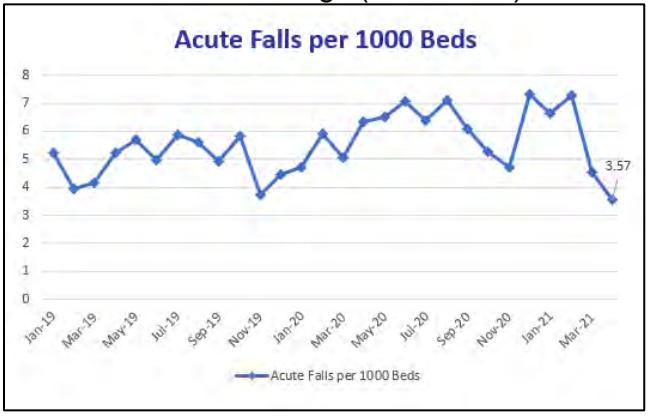


Chart 8

Pressure Ulcers

This month saw a marginal improvement in the incidences of HAPU in the acute trust and also by using the per 1000 bed days measure.

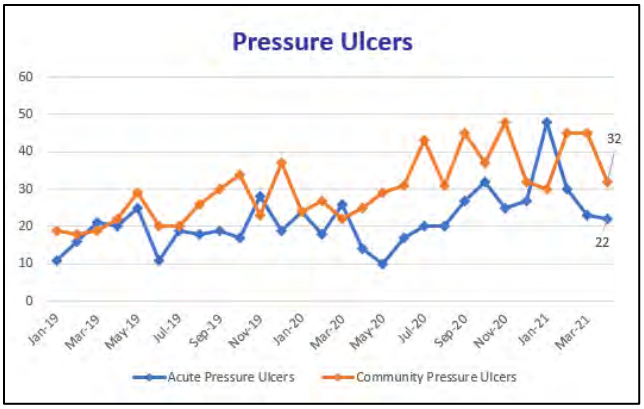


Chart 9a

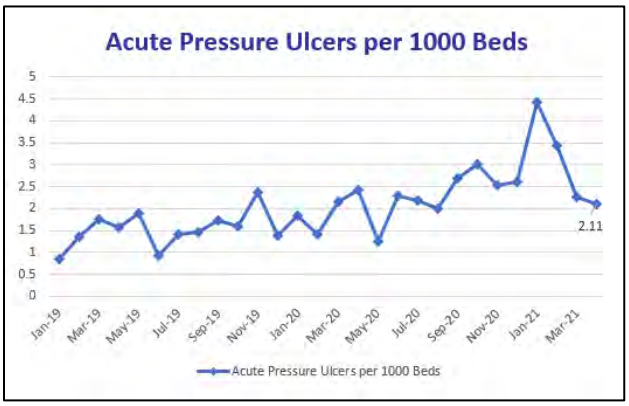


Chart 9b

9. Compliments and Complaints

Table 10. demonstrates the incidence of complaints and compliments for this period. Complaints received are lower than expectation and there is no emerging trend this month. The patient experience team will review trends quarterly to better understand themes and any wider learning.

The clinical helpline has been maintained and an average of 94 calls a day to assist relatives who are unable to attend the wards to receive updates of the care of our patients. This is a reduction on last month and likely to be indicative of visiting restrictions being relaxed.

	Compliments	Complaints
October 2020	11	17
November 2020	34	13
December 2020	44	22
January 2021	11	7
February 2021	17	11
March 2021	13	22
April 2021	26	15

Table 10

10. Adverse Staffing Incidences

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

- In April there were 8 Datixs recorded for nurse staffing that resulted in a Red Flag event (see table 11.)

Red Flag	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21
Registered nursing shortfall of more than 8 hours or >25% of planned nursing hours	4	11	11	0	3	2
>30-minute delay in providing pain relief	1	2	3	1	0	0
Delay or omission of intention rounding	8	17	17	4	9	2
<2 RNs on a shift	1	2	6	1	1	3
Vital signs not recorded as indicated on care plan	3	10	3	0	1	1
Unplanned omissions in providing patient medication	0	4	4	0	1	0
Total	17	46	44	6	15	8

Table 11.

11. 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 five red flag events in April these included

- 3x delayed induction of labours due to staffing shortages and high activity on labour suite
- 1x inability to facilitate birth on birthing unit as only midwife available was a preceptor midwife, therefore woman birthed on labour suite
- 1x delayed observations and drug round due to staffing shortages and high acuity of F11

Midwife to Birth ratio

Data temporarily unavailable due to implementation of eCare.

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 April we achieved 93% compliance. A recruitment drive for further labour suite co-ordinators has been completed and start dates have been confirmed for May 2021.

12. Establishment Review using the Safer Nursing Care Tool (SNCT) February 2021

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 inpatient biannual acuity and dependency audits have been completed in February to continue to capture seasonal variations and will be repeated again in the summer months. While it was important to track acuity and dependency in this round of the audit, it should be noted that the data has been significantly impacted by the second wave of Covid 19. Many wards experienced a reduced bed occupancy therefore the recommendations of the audit will not be valid. In addition, the investment in nurse staffing following the September 2020 review had not appeared yet within budgets therefore the impact on these changes is yet to be seen. For reference the outcome of the audit with associated narrative can be found in appendix 5.

13. SafeCare risk assessment

In April the relaunch of SafeCare was rolled out. SafeCare is a module within eRoster that enables real time risk assessment of the nursing provision of all of the inpatient areas. Using assessments similar to the Safe Nursing Care Tool (SNCT), the tool also quantifies risk based on skill mix, temporary staffing, CHPPD and vacant shifts. The resulting assessment produces a visual representation of risk highlighting areas that may not have the nursing hours needed to provide the care for their current patient group (Chart 12).

The senior nursing team can elevate or reduce risk using professional judgement (chart 12) and provide an evidenced decision-making process and audit trail of ward support.

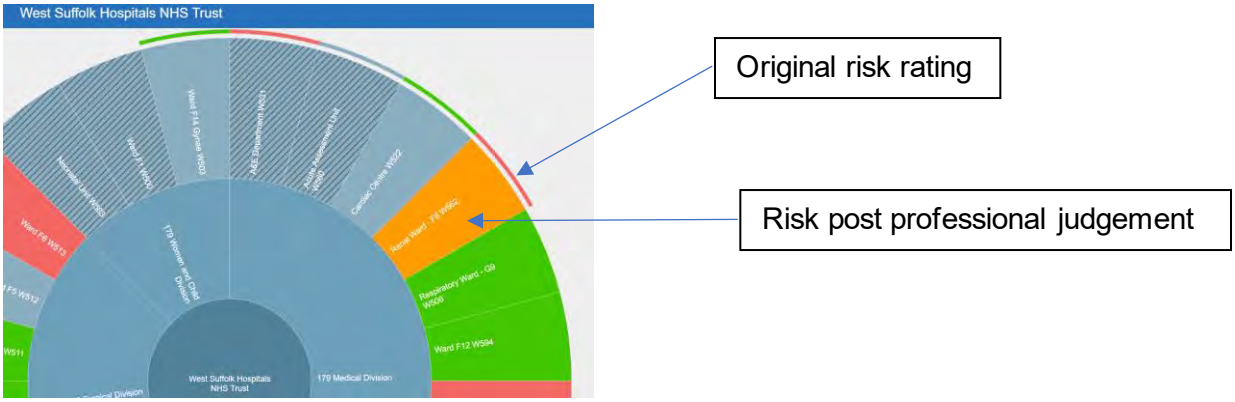


Chart 12.

The SafeCare sunburst/wheel is now embedded within the daily safety huddles to ensure that nursing provision is now consistent with the day to day needs of the ward, and support can be tailored to the areas of most need.

Future establishment reviews will also be able to use the data produced within SafeCare to monitor the provision of CHPPD and how consistently wards are able to achieve the level of nursing care hours required to provide quality patient care. Chart 13 below, is an early indication of potential reports that can be generated to inform the next establishment review.

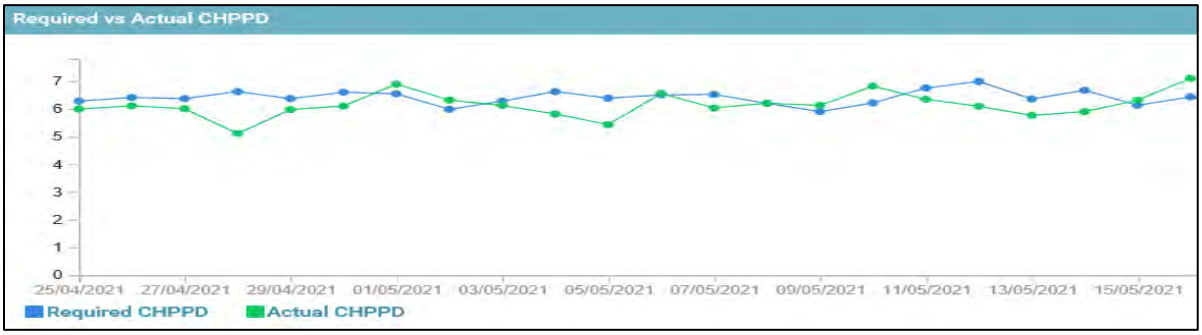


Chart 13.

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. April 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	1013	812	1460.5	1372.5	1035	954.5	1110	1076.5	80%	94%	92%	97%	452	3.9	5.4	9.3
Glastonbury Court	689.75	698.5	1037	1073.5	690	690	525	531.5	101%	104%	100%	101%	384	3.6	4.2	7.8
AAU	2070	2066	2415	2154	1725	1808.5	1380	1258	100%	89%	105%	91%	761	5.1	4.5	9.6
Cardiac Centre	2800.5	2639.75	1345.5	1345.5	1725	1711	690	673.5	94%	100%	99%	98%	632	6.9	3.2	10.1
F10	0	0	0	0	0	0	0	0	ward closed				707	0.0	0.0	0.0
G9	1368.7	1345.5333	1375	1309.5	1380	1358	1028.5	1167	98%	95%	98%	113%	752	3.6	3.3	6.9
F12	542.75	599	345	291.5	678.5	620.5	345	276	110%	84%	91%	80%	240	5.1	2.4	7.4
F7	1610	1610.25	1834	1670	1380	1301.75	1713.5	1694.5	100%	91%	94%	99%	683	4.3	4.9	9.2
F9	1610	1380.25	1836	1917.75	1035	1001	1368.5	1785	86%	104%	97%	130%	744	3.2	5.0	8.2
G1	2677.23333	2211.2	838.833333	850.75	690	692	345	345	83%	101%	100%	100%	392	7.4	3.1	10.5
G3	1610	1380.4167	1823	1931.5	1035	1035	1035	1554.5	86%	106%	100%	150%	864	2.8	4.0	6.8
G4	1610	1530.8333	1807	1910.5	1026.5	1001	1380	1511	95%	106%	98%	109%	896	2.8	3.8	6.6
G5	0	0	0	0	0	0	0	0	ward closed				760	0.0	0.0	0.0
G8	2303.5	2035	1794	1890.25	1587	1520.25	1035	1411.5	88%	105%	96%	136%	615	5.8	5.4	11.1
F8	1379.5	1347.75	2070.5	1708	1035	1017.5	1380	1409.5	98%	82%	98%	102%	723	3.3	4.3	7.6
Critical Care	2682.5	2656.8333	330	528.25	2698.5	2474.25	0	232.25	99%	160%	92%	N/A	388	13.2	2.0	15.2
F3	1679	1542	2036	1687.5	1035	1012	1357	1528.5	92%	83%	98%	113%	732	3.5	4.4	7.9
F4	754.5	710.25	391.25	357.25	655.5	540.5	517.5	460	94%	91%	82%	89%	633	2.0	1.3	3.3
F5	1717.25	1328	1372.5	1295	1035	943	920	874	77%	94%	91%	95%	698	3.3	3.1	6.4
F6	1950.5	1730	1590.5	1358.5	1265	1142	690	839.5	89%	85%	90%	122%	939	3.1	2.3	5.4
Neonatal Unit	1080	1087.8333	360	252	1068	984	360	144	101%	70%	92%	40%	116	17.9	3.4	21.3
F1	1184.5	1437.25	686	736	1035	1321	0	34.5	121%	107%	128%	100%	115	24.0	6.7	30.7
F14	744	727	216	199	720	719.5	0	48	98%	92%	100%	100%	106	13.6	2.3	16.0
Total	33,077.18	30,875.65	26,963.58	25,838.75	24,534.00	23,847.25	17,180.00	18,854.25	**93%**	**96%**	**97%**	**110%**	**13332**	**4.1**	**3.4**	**7.5**

Appendix 2. Ward by ward vacancies (April 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	35.8	(5.7)	-18.8%	AAU	28.3	27.0	1.3	5%
Accident & Emergency	77.3	65.0	12.3	15.9%	Accident & Emergency	34.5	25.4	9.0	26%
Cardiac Centre	40.7	39.9	0.8	2.0%	Cardiac Centre	15.7	16.0	(0.3)	-2%
Community - Glastonbury Court	11.7	11.8	(0.1)	-0.9%	Community - Glastonbu	12.6	11.6	1.0	8%
Critical Care Services	43.0	46.3	(3.3)	-7.6%	Critical Care Services	1.9	7.1	(5.2)	-276%
Day Surgery Wards	11.0	10.8	0.2	1.4%	Day Surgery Wards	3.9	3.9	0.0	0%
Gynae Ward (On F14)	13.1	10.2	2.9	22.0%	Gynae Ward (On F14)	2.0	1.0	1.0	50%
Neonatal Unit	20.7	20.2	0.5	2.6%	Neonatal Unit	4.3	4.6	(0.3)	-7%
Newmarket Hosp-Rosemary ward	16.6	14.8	1.7	10.4%	Newmarket Hosp-Rose	25.8	18.2	7.6	29%
Recovery Unit	21.9	20.5	1.5	6.6%	Recovery Unit	0.9	0.9	0.0	1%
Ward F1 Paediatrics	22.3	21.2	1.1	5.0%	Ward F1 Paediatrics	7.2	7.1	0.1	1%
Ward F12	11.9	8.5	3.4	28.5%	Ward F12	5.9	3.9	1.9	33%
Ward F3	22.2	20.4	1.7	7.9%	Ward F3	25.8	25.0	0.9	3%
Ward F4	13.6	13.9	(0.2)	-1.6%	Ward F4	14.6	10.3	4.4	30%
Ward F5	22.2	19.5	2.7	12.2%	Ward F5	18.1	15.0	3.1	17%
Ward F6	26.6	15.6	10.9	41.1%	Ward F6	17.4	17.7	(0.3)	-2%
Ward F7 Short Stay	24.9	21.1	3.8	15.3%	Ward F7 Short Stay	25.8	24.3	1.5	6%
Ward F9	21.8	17.5	4.3	19.6%	Ward F9	23.2	28.3	(5.2)	-22%
Ward G1 Hardwick Unit	28.6	25.6	2.9	10.3%	Ward G1 Hardwick Uni	10.5	10.7	(0.1)	-1%
Ward G3	22.1	18.7	3.4	15.3%	Ward G3	23.0	27.9	(5.0)	-22%
Ward G4	22.1	20.2	1.9	8.6%	Ward G4	22.8	23.5	(0.7)	-3%
Ward G8	32.7	28.1	4.6	14.1%	Ward G8	20.6	23.9	(3.3)	-16%
Renal Ward - F8	19.5	19.4	0.1	0.4%	Renal Ward - F8	25.8	24.9	0.9	3%
Winter Escalation 20/21 - G5	5.5	0.8	4.6	84.8%	Winter Escalation 20/2	2.9	0.0	2.9	100%
Ward F10*	0.0	0.0	0.0	NA	Ward F10*	18.0	18.8	(0.8)	-5%
Respiratory Ward - G9	23.7	21.9	1.8	7.4%	Respiratory Ward - G9	18.0	16.5	1.5	8%
Total	**605.5**	**547.7**	**57.8**	**9.5%**	**Total**	**409.3**	**393.3**	**16.0**	**4%**
Hospital Midwifery	58.6	48.1	10.5	17.9%	Hospital Midwifery	15.6	15.8	(0.2)	-1%
Continuity of Carer Midwifery	27.3	16.9	10.4	38.0%	Continuity of Carer Mid	0	0	0.0	0%
Community Midwifery	13.5	18.9	(5.4)	-39.9%	Community Midwifery	3.8	3.6	0.2	5%
Total	**99.4**	**83.9**	**15.5**	**15.6%**	**Total**	**19.4**	**19.4**	**0.0**	**0%**

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

Appendix 3:

Ward by Ward breakdown of Falls and Pressure ulcers April 2020

HAPU

	Cat 2	Unstageable	Cat 4	Total
Total	21	3	1	25
F7	5	1	0	6
Respiratory Ward	3	0	1	4
Cardiac Centre - Ward	1	1	0	2
Critical Care Unit	2	0	0	2
F3 - ward	2	0	0	2
G8 - ward	2	0	0	2
Glastonbury Court	2	0	0	2
Cardiac Centre - Diagnostics	1	0	0	1
F6 - ward	0	1	0	1
G3 -	1	0	0	1
G4 - ward	1	0	0	1
Gastroenterology Ward	1	0	0	1

Falls

	None	Negligible	Minor	Moderate	Major	Total
Total	**46**	**7**	**9**	**1**	**1**	**64**
G4 - ward	5	0	3	1	0	9
F6 - ward	6	0	1	0	0	7
F3 - ward	5	1	0	0	0	6
Gastroenterology Ward	4	1	1	0	0	6
Rosemary Ward	5	0	0	0	1	6
G8 - ward	3	1	0	0	0	4
Renal Ward	3	0	1	0	0	4
Acute Assessment unit (AAU)	3	0	1	0	0	4
G3 -	1	1	1	0	0	3
F7	2	0	1	0	0	3
F4 - ward	2	0	0	0	0	2
G1 - ward	1	1	0	0	0	2
Respiratory Ward	2	0	0	0	0	2
Cardiac Centre - Ward	1	0	0	0	0	1
Cataract Clinic	0	1	0	0	0	1
CHT Bury Rural	0	1	0	0	0	1
Community Paediatric OT	1	0	0	0	0	1
Glastonbury Court	1	0	0	0	0	1
Emergency Department	1	0	0	0	0	1

Appendix 4: Red Flag Events

Maternity Services

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

Acute Inpatient Services

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

Safer Nursing Care Tool Audit February 2021

WARD	Beds	Split WTE		WTE	Current Skills Mix (RN:NA) (%)	Current Ratio RN : Patient	PJ WTE	NHPPD (Sept 2020) WTE	SNCT (Sept 2020) WTE	SNCT (Feb 2021) WTE	Suggested Skills Mix (RN:NA) (%)	Feb SNCT Split WTE		Difference with 20/21 budgets		Difference Feb SNCT WTE	Comments
		RN	NA									RN	NA	RN	NA		
AAU	20 + 1 SR + 2 AB	22.42	23.19	45.61	52:48	Day – 1:5 Night – 1:5	49.76	30.23	40.1	44.4	70:30	31.09	13.32	8.67	-9.87	-1.20	Output consistent with previous audit consideration of possible increase in RN's in next audit as theme of higher number of Nas than required.
F1	15	14.73	7.17	21.9	74:26	Day – 1:8 Night – 1:8	23.57	8.86	15.9	11.9	70:30	8.33	3.57	-6.40	-3.60	-10.00	low bed occupancy throughout audit. Unlikely to be true reflection of need
F3	30 + 4 SR	22.15	25.84	47.99	46:54	Day – 1:8 Night – 1:11	41.9	42.54	46.4	31.8	60:40	19.08	12.72	-3.07	-13.12	-16.20	low bed occupancy throughout audit, including ward closure. Audit was extended to compensate. Unlikely to be true reflection of need
F4	30 + 3 SR	15.76	12.92	28.68	55:45	Day – 1:9 Night – 1:11	34.04	9.98	10.3	26.5	60:40	15.90	10.60	0.14	-2.32	-2.18	although bed base larger than previous audit, low occupancy as factor in these outcomes
F5	30 + 3 SR	22.16	12.93	35.09	63:37	Day – 1:8 Night – 1:11	34.04	36.07	33.7	38.7	60:40	23.19	15.46	1.03	2.53	3.56	Ward occupancy comparable to previous audit. Slightly high WTE output but consistent
F6	30 + 3 SR	23.99	14.77	38.76	62:38	Day – 1:8 Night – 1:11	34.04	39.88	39.9	43.2	70:30	30.23	12.96	6.24	-1.81	4.43	Ward occupancy consistent, patient demographic changed to include medical patient group. Therefore not consistent with future planning
F7	30 + 4 SR	22.33	28.34	50.67	44:56	Day – 1:7 Night – 1:7	52.38	22.93	24.2	19.4	60:40	11.64	7.76	-10.69	-20.58	-31.27	Continued low bed base in this audit period <50% occupancy. Not conducive to future planning. Skill mix change agreed from previous review.
F8	24 + 3 SR	23.68	18.03	41.71	57:43	Day – 1:6 Night – 1:6	39.28	32.64	33.0	27.0	60:40	16.21	10.81	-7.47	-7.22	-14.69	Low bed occupancy so difficult to plan future establishment. New ward footprint (originally G5) autumn review will be valuable
F9	30 + 3 SR	19.33	25.76	45.09	43:57	Day – 1:8 Night – 1:11	44.52	40.36	42.3	34.0	60:40	20.38	13.59	1.05	-12.17	-11.12	low bed occupancy average 82%. Skill mix change planned for April 2021
F10	23 + 3 SR	19.23	18.03	37.26	63:37	Day – 1:6 Night – 1:8	36.66	32.22	33.7	35.8	60:40	21.48	14.32	2.25	-3.71	-1.46	Consistent bed occupancy. Consistent output from SNCT.
F12	8 SR	10.23	5.85	16.08	64:36	Day – 1:4 Night – 1:4	15.71	9.58	10.2	10.4	65:35	6.74	3.63	-3.49	-2.22	-5.71	Consistent bed occupancy. Consistent output from SNCT. However small ward not reliable for SNCT
F14	4 bb + 2 bb + 2 SR	12.6	1.2	13.8	91:09	Day – 1:4 Night – 1:4	15.71	6.66	5.7	5.8	90:10	5.10	0.60	-7.50	-0.60	-7.97	Consistent bed occupancy. Consistent output from SNCT. However small ward not reliable for SNCT

WARD	Beds	Split WTE		WTE	Current Skills Mix (RN:NA) (%)	Current Ratio RN : Patient	PJ WTE	NHPPD (Sept 2020) WTE	SNCT (Sept 2020) WTE	SNCT (Feb 2021) WTE	Suggested Skills Mix (RN:NA) (%)	Feb SNCT Split WTE		Difference with 20/21 budgets		Difference Feb SNCT	Comments
		RN	NA									RN	NA	RN	NA	WTE	
G1	11 SR	17.36	5.97	23.33	72:28	Day – 1:4 Night – 1:6	20.95	13.23	13.0	17.4	70:30	12.15	5.21	-5.21	-0.76	-5.98	Increase in requirement seen on this audit, linked to opening of 12th bed. Likely to require additional staffing
G3	30 + 3 SR	19.51	25.56	45.07	43:57	Day – 1:8 Night – 1:11	44.52	45.91	35.8	27.8	60:40	16.69	11.12	-2.82	-14.44	-17.26	Significant reduction in bed occupancy and closure of bays due to Covid 19. agreed skill mix change in previous audit for April 2021
G4	30 + 2 SR	19.51	25.36	44.87	43:57	Day – 1:8 Night – 1:11	44.52	39.38	43.9	22.0	60:40	13.23	8.82	-6.28	-16.54	-22.82	2 weeks of significant reduction In bed occupancy. Output not reflective of current need. Agreed skill mix change for April 2021
G5	30 + 3 SR	19.39	25.76	45.15	43:57	Day – 1:8 Night – 1:11	44.52	43.7	50.3	25.2	60:40	15.15	10.10	-4.24	-15.66	-19.91	ward functioning as winter contingency ward at time of audit. Also consistent reduction in bed occupancy.
G8	24 + 2 SR + 4 HAS	27.5	20.61	48.11	57:43	Day – 1:5 Night – 1:8	47.14	37.32	43.0	42.1	70:30	29.45	12.62	1.95	-7.99	-6.04	Consistent bed occupancy and output. Significant uplift planned for April 2021 addressing national stroke guidance. No further change required
Cardiac Suite	15 + 4 CCU + 3 SR	30.84	12.81	43.64	72:28	Day – 1:5 Night – 1:5	39.28	29.51	33.0	30.5	70:30	21.35	9.15	-9.49	-3.66	-13.14	Consistent bed occupancy. Consistent output from SNCT.
Kings Suite	20	11.69	12.64	24.33	48:52	Day – 1:10 Night – 1:10	22.42	24.3	25.4	22.4	60:40	13.41	8.94	1.72	-3.70	-1.97	Consistent bed occupancy. Consistent output from SNCT.
Rosemary Ward	20	12.43	13.47	25.9	48:52	Day – 1:7 Night – 1:10	26.19	24.35	27.8	29.1	60:40	17.45	11.63	5.02	-1.84	3.18	some reduced bed occupancy, but recent change in patient profile may require can in skill mix or uplift.

14.4. Quality and learning report – learning from deaths, quality priorities

For Approval

Trust Open Board – 28th May 2021

Agenda item:	14.4			
Presented by:	Sue Wilkinson – Executive Chief Nurse			
Prepared by:	Rebecca Gibson – Head of Compliance & Effectiveness			
Date prepared:	May 2021			
Subject:	Quality and Learning report			
Purpose:	X	For information		For approval

Executive summary:

This report provides a summary of key learning points, trend analysis and opportunities for improvement that have arisen from in the quarter ending 31/03/21.

Key highlights in this report are as follows:

- Learning themes from investigations in the quarter
- PSIRF 'first three months'
- Mental Health
- HSIB reports
- Learning from Deaths
- Quality assurance
- Raising concerns
- Mitigated red risks
- Learning from RIDDOR incidents
- Learning from patient and public feedback

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

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

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

Recommendation:

1. Receive this report for information

1. Learning themes from investigations in the quarter

SI RCA reports submitted in Q4

There were ten SI reports submitted in Q3.

- Learning from cases reporting ward closures or clusters due to COVID are included in the separate IPC BAF report to the Board so are not repeated here.
- The Falls cases (3 in Q4) now form part of the wider safety improvement plan (under PSIRF) and so are not listed here. This will also be the case for pressure ulcers (1 in Q4).

The remaining four cases are listed here in the table below

Incident details	Learning
WSH-IR-63756 Delay in clinical investigation during pandemic	**Root Causes:** Diversion of resources in line with Government advice to combat coronavirus pandemic. **Lessons Learned**: Ensure all patients with elevated FIT (Faecal immunochemical test) scores and persisting clinical symptoms are prioritised for investigation. **Recommendations** Contact and review all remaining patients to establish if symptoms persist and confirm need for investigation and treatment. Patients with elevated FIT scores and persisting clinical symptoms require priority for investigation (completed). **Additional actions** • Additional CT Service capacity (Mobile CT provision) • Ensure all patients are provided with a written record of their consultation and plan of care which must include both a contact number for a health professional and advice to follow in the event of deterioration in their condition. • Recruitment of additional nurse
WSH-IR-67110 Patient died whilst on referral pathway for cardiothoracic surgery (reported on joint behalf of Papworth)	**Root Causes**: Case was not re-discussed at a second MDT as per WSH plan. Referral pathway involved the duplication of existing information for the agreed surgery at MDT **Lessons Learned**: Cardiac Rehabilitation Team could have provided patient with education regarding his critical LMS stenosis including a safe exercise regime prior to his discharge home **Actions** • Cardiac rehabilitation service should be involved in the care of all high-risk patients before discharge • A Consultant Cardiologist should be available to present each case at the MDT to ensure that all individual issues are discussed • Explore feasibility of developing a more streamlined referral process so referrals with the same information are transferrable to agreed surgery at RPH
WSH-IR-65904 Staffing concerns around disharmonious working in theatres	Note: It was agreed this related to service provision in the current climate and was a collection of 'near miss incidents' rather than one standalone 'major harm' incident. As such, a list of factors was more appropriate than one 'root cause' **Contributory factors / Care & service delivery problems:** • Covid created large waiting lists and decimated theatre staff wellbeing and morale. Demand outstrips ability to deliver both quantity and quality of care due to widespread pressure on waiting lists and national mandates secondary to Covid

Incident details	Learning
	• Significant service pressures and lack of national guidance on recovery approaches • Longstanding problem with recruitment of staff causing unpredictable working and short notice changes. Disrupted working patterns with increased unpredictability in work pattern Reduced staffing numbers due to difficulties with recruitment (national staffing shortages), coupled with sickness and shielding • Failure to embed '5 steps to safer surgery' and national audit findings • Estates and facility issues leading to changing working environment **Lessons Learned**: • The importance of civility and the impact good communication and consideration can have on team members and the ripple effect this can have throughout the Trust. • Need to maintain time for training, learning and clinical governance in order to reflect on themes and act to improve patient care and staff wellbeing. **Actions** A comprehensive action plan has been developed to address the key issues of demand (2 actions), staffing issues and disrupted working patterns (8 actions), civility and good communication (7 actions), other (4 actions).
WSH-IR-64084 Deteriorating patient (Cardiac arrest less than 24 hours post fall)	**Root Causes:** Change in circumstances and deterioration not considered overnight following a fall. Patient was prone to having higher NEWS than normal and had been in hospital for an extended period of time. **Lessons learnt**: 1. Medical and nursing staff should ensure that the falls care plan is put in place and followed when indicated 2. NEWS process should be followed as per policy 3. Differential diagnosis should be considered by medical staff when patients demonstrating changes to usual presentation **Actions** • Falls lead to formulate educational package (On line module and ward visual teaching aids (poster/ presentation etc.) • Evaluate current post fall protocol in identifying other injuries including review of any national guidance. • Review of the critical care outreach service resources with a view to uplifting staffing to enable two outreach nurses per shift (in and out of hours) • Consideration of an educational post within the critical care outreach service to work with staff in clinical areas **Shared learning** Ward staff to present case and learning to appropriate groups: (NMCC and Medical governance meeting) Discussion of findings and learning / actions to be added to agenda of Deteriorating Patient group

2. Patient safety incident response framework (PSIRF)

WSFT developed a local patient safety risk-based plan profiled using organisational data from patient safety incident reports, complaints, PALS, claims, inquests, mortality reviews, clinical reviews, divisional engagement and discussion at forums with patient and carer participation.

Through this review, the following events were identified for investigation through a Patient safety incident investigation (PSII) in addition to the national 'must dos':

- Failed discharges. Patient requiring unplanned readmission related to medicines management
- Inpatients receiving shared care between specialties: Incidents affecting inpatients where the care of the patient is being managed between two or more clinical specialties and where the management of the care resulted in the patient having an extended length of stay or requiring additional treatment/surgery
- Insulin and diabetes management leading to deterioration in patient's glycaemic index requiring interventional treatment at higher level of care (level 2/3)
- Incidents occurring out of hours where the assessment of the patient was delayed and timely recognition of deterioration was not escalated appropriately.
- Resource for a small number of additional PSIIs was also allocated for any significant unexpected trend in incidents that could not have been foreseen as part of the planning exercise.

The national framework also describes the use of alternative methods of review and the WSFT plan included an initial set of events for which we will use one of these methods with an expectation that this will expand over time:

- Inpatient falls resulting in a major bone fracture

  'Hot debrief' and After Action Review (AAR)as part of the National audit of Inpatient falls (NAIF)
- Pressure ulcers developed in our care

  Local patient safety audit
- Incidents reported as 'Red' that do not meet the requirements of a PSII

  Locally designed 'patient safety review' which incorporates aspects of the AAR and the Human Factors Yorkshire contributory framework

Since February the trust has developed a structured escalation and assurance meeting framework including our local partners (CCG) with

- Weekly emerging incident review (EIR) meeting – escalation and awareness forum with executive attendance to address immediate mitigations and determine pathway which the adverse event will follow. Completion of duty of candour considered as well as support for staff.
- Monthly patient safety quality assurance (PSQA) meeting - considers safety recommendations and provides quality assurance of final report including provision to family/relatives/other involved parties with executive attendance.

A forum to oversee the progress and completion of actions arising from PSIIs (and the alternative review methods) is being considered. This might also provide a forum for oversight of adherence to duty of candour statutory responsibilities but no decisions have been made yet.

The trust has also been using our PSIRF priorities to structure the priority reporting pathways to the new 3i developing board sub-committees.

3. Thematic report – Mental Health

Background: In 2011 the coalition government published its mental health strategy 'No Health Without Mental Health'. This set out the government's plans for improving the mental health and wellbeing of the population; with the ambition of delivering high-quality services. The principle of 'parity of esteem' where mental health is given equal priority to physical health was enshrined in law through the Health and Social Care Act 2012. Policy developments have included the five year forward view for mental health and NHS long term plan.

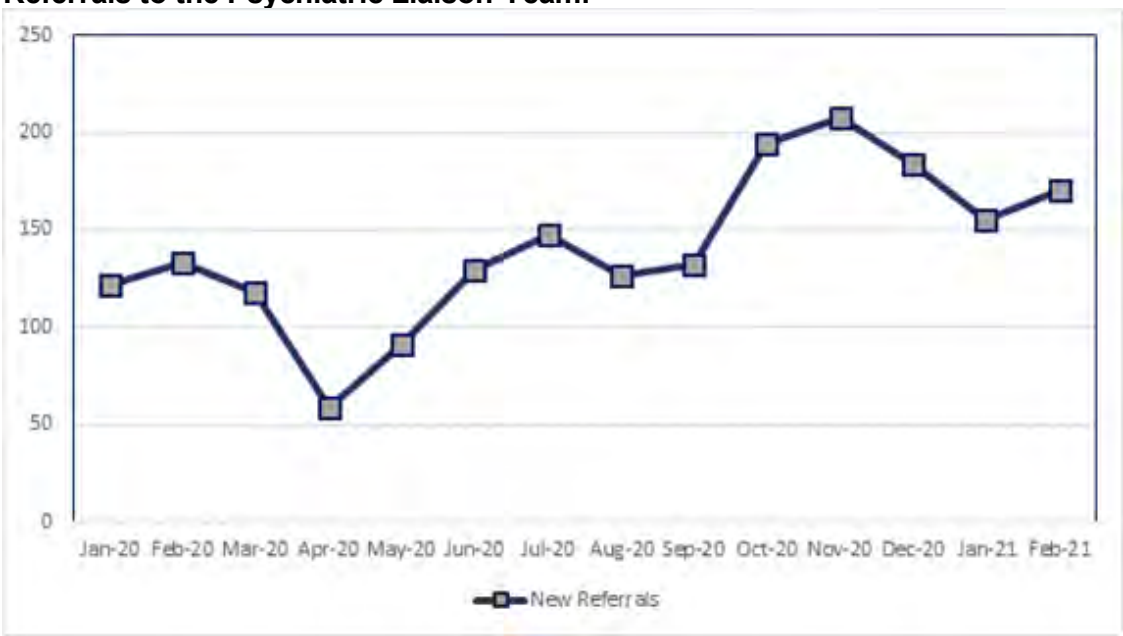
A report published by the National Confidential Enquiry into Patient Death (NCEPOD, 2017) highlighted the need to bridge the gap between mental and physical healthcare in general hospitals. The way staff responded to those patients admitted with mental health disorders for their co existing physical health problem was critically examined. Lessons from this were: the need to bridge the gap between mental and physical healthcare services. We need a workforce who are educated, trained and supported in order to make a sustainable difference. To recognise patients who have a dual pathology.

Between September 2017 and March 2019, the CQC completed an assessment of services in acute trusts; including ED, acute medical wards, maternity wards and paediatric services. They looked at how peoples' mental health needs were met and how they could be improved. They found that:

- People faced barriers in accessing help at a time of crisis
- Acute Trusts did not always see mental health care as part of the overall provision of care
- In emergency departments, patients were not always provided with a safe, therapeutic environment
- Acute Trusts need to improve staff education and governance of the Mental Health Act
- Staff feel unsupported and unprepared to meet the mental health needs of patients

In February 2021, the Trust introduced a new role into the organisation, 'Head of Mental Health' who is responsible and accountable for the implementation of robust systems and processes that ensure there is a continuing improvement in the quality and safety of the service provided to patients who have mental health need.

Referrals to the Psychiatric Liaison Team:



In March 2021 the team received 204 referrals, April 2021, 249 and up to 14th May 2021- 217. It is important to recognise that not all patients with mental health needs are referred to the psychiatric team due to mental health being on a continuum, from mental health to mental illness.

Highlights of progress to date:

Mental Health Transformational Group

- Set up in March 2021 this group meets every 8 weeks and its aim is to ensure parity of esteem of mental and physical health. Attended by divisional representatives, safeguarding, AHP's, Medics, Nurses, Safeguarding and others. The group will be accountable to the improvement group,

Mental Health Act (MHA)

- An SLA agreement between WSFT and NSFT is near completion. NSFT will provide us with MHA administration support, oversight and scrutiny.
- Patients now have their rights read, have access to advocacy and are able to appeal against their detention.
- A MHA policy will be implemented and staff training will be made available

Emergency Department (ED)

- Improvements have been made to the risk assessment
- A voluntary attender form for those patients who are escorted voluntary by the police will be introduced to ensure an agreed safe handover of care
- 136 policy is being updated to reflect when ED can be used for patients without a physical health need

Acute Admissions Unit (AAU)

- A handover form is being introduced for a safe handover of care when a patient is transferred from NSFT for assessment and treatment at WSFT. This has been introduced following learning from an incident

Paediatrics

- Since April 2021 the Psychiatric Liaison team are now assessing patients under the age of 13 and able to support this patient group

Education and training

- Needs analysis to be undertaken
- Tailor made training has been provided to Voice, RCN, RPI team and ward staff, responding to what they identify as a need.
- Mandatory training offer to be explored
- Work has been undertaken with West Suffolk Alliance on training needs
- 'We can talk' training on compassionate care for young people is being rolled out within the Trust.

4. HSIB reports

4.1 Issued in Q4 20/21 which relate to the care of a WSFT patient

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

Local ref.	Case (date)	Final report receipt	Key learning points	Safety actions identified following review of HSIB report and recommendations
WSH-IR-64286	IUD 39+ (Nov 2020)	March 2021	Trust to ensure that care is individualised to meet the needs of the vulnerable Mother in line with the National Maternity Review (2016).	Implementation of midwifery continuity of carer teams, (project lead is in post for this). The potential benefits for women who have factors which make them vulnerable during their pregnancies are understood and outcomes are being audited.
				Update MAT0004 (Maternity guideline for women at risk of social inclusion) to include guidance on all factors which may make women vulnerable in their pregnancies.
				New outpatient obstetric clinic established for women who have factors which make them vulnerable in their pregnancies – to improve continuity of carer for these service users. The referral criteria and details for inclusion in this clinic need to be in included in local guidelines so that they are accessible to everyone.

4.2 National HSIB reports issued in Q4 20/21

Whilst HSIB documents are available for specialty level review and learning, there has not previously been a formal structured process for receipt and responding to publications that are not specifically related to the care of a WSFT patient (i.e. national thematic reports) although it is anticipated that these may be reviewed locally.

A proposal for the management of these reports is being presented to the June Insight committee meeting as part of the wider improvement plan for clinical audit & effectiveness. A pilot to test the proposal is being organised with the support of the Head of Deteriorating patients and future iterations of this report will have updates on the progress of this new pathway.

For information HSIB publications (non-Maternity) issued in Q4:

Issued	Title
Jan 21	Implementation of safety improvements for the placement of NG tubes
Jan 21	Impact of delays and pressure on national glaucoma services
Jan 21	Support for staff following patient safety incidents
Mar 21	Emergency response to heart attack
Mar 21	Residual drugs in intravenous cannulae and extension lines

These publications will be reviewed through the new process and any relevant recommendations will be incorporated within our wider improvement plan.

4.3 National update

HSIB has analysed its first 22 HSIB national investigations to identify the recurring patient safety themes. Work on the 'National Learning Report' is ongoing and a final report will be published later (timeframe not yet indicated). The analysis found three broad themes of patient safety risks:

- access to care and transitions of care
- communication and decision making
- checking

From these investigations, HSIB has made 85 safety recommendations to national healthcare organisations and other relevant bodies. These fall broadly into 6 themes concerning:

- identification of safety hazards
- management of safety risks
- monitoring of safety performance
- management of improvement efforts
- training and education
- communication of safety issues

5. Learning from Deaths (LfD)

The LfD bulletins are available to all staff on the intranet

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

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

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

** SJR - Structured Judgement Review*

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

The LfD Caseload Manager started in February; this new post will enable the development of an LfD 'learning into action' project programme for 2021/22. Initial subjects highlighted for inclusion are:

- Aspiration pneumonia
- Stranded patients
- End of life care

Priorities for 2021/22 include

- Increase staff awareness of the LfD process
- Provide data for all ward areas to present at local governance forums
- Learning from deaths platform on the intranet
- Recruitment and training of medical / nursing / trainee reviewers
- Collaborative working to progress quality improvement projects (as above)

The Learning from Deaths team contributed to *dying matters week* alongside the palliative care team and chaplaincy department between 10-16 May 2021 with a "did you know that…" for social media and a poster to increase staff awareness of the LfD process.

6. Quality assurance (QA)

During COVID the previous formal Tuesday morning walkabouts ceased due to the pandemic requirement to reduce visitation to ward areas. Multi professional QA visits involving external partners provide a level of assurance to support improvement plans at divisional or subject level. To date these have taken place in:

- Maternity in Sept20 and Feb21
- Main Theatres, Day Surgery and ED in Oct20 reviewing medication security.
- Care for patients with a learning disability via a QA 'round table event' in Dec20 and a site visit in May 2021.

7. Raising concerns

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

More information is available via the FTSUG reports to Trust Board.

Staff concerns raised			
1st February 2021 to 30th April 2021			31
Route for raising concern			
Freedom to Speak Up Guardian			11
Senior Independent Director			0
Chief Executive			20
Anonymous phone line			0
Other e.g. NED other than SID			0
Concerns including element of patient safety/quality			3
Concerns including element of bullying and/or harassment			4
Detriment experienced i.e. staff experience detriment as a result of raising their concern			0
Concerns raised anonymously			1
Staff group raising concerns*		**Directorate of staff member raising concern**	
Not disclosed	3	Not disclosed	5
AHP	3	Medical	7
Medical	2	Surgical	5
Registered nursing and midwifery	15	Integrated services	2
HCA	1	Clinical support services	5
Administrative and clerical	3	Women and children	2
Maintenance and ancillary	1	Corporate	2
Manager	0	Estates and facilities	1
Senior leader	1	Bank/locum	2
Professional and technical	0		
Corporate services	1		
Other	2		

One example of a staff concern in Q4 was from staff at Newmarket Hospital. Their concerns were acknowledged and formed one of the drivers for an Exec-led risk summit.

8. Mitigated red risks

During Q4 there were seven red risk downgraded or closed:

- *Management of outbreaks and cases of infection in the Trust* (15). The risk assessment has been downgraded to amber (annually x Major). The current mitigation includes:
  - Use of standard infection prevention and control precautions
  - Trust policies and clinical guidelines on management of specific infectious conditions.
  - Trust policy and procedures for management of outbreaks of infectious conditions.
  - Trust policy and guidance on disposal of clinical waste and contaminated linen.
  - Provision of alcohol hand gel at point of care in all areas
  - Provision of personal protective equipment to reduce exposure to infectious agents.

- *The management of follow up appointments from inpatients, ward attenders and outpatients* (4054). The risk assessment has been downgraded to amber (annually x major). The current mitigation includes:
  - PTL tracking for patients on RTT pathways
  - Secretaries check the follow up when typing the patient letter
  - Local data bases managed by pa's of patients requiring follow up appointments (from 1st Apr20)
  - Full review and update of all the outpatient admin process undertaken
  - All outpatient admin SOP updated
  - Planning for mandatory training and roll out.
  - Staff training part of local induction for new starters regarding the process of follow up.
  - Oversight of follow up booking capacity and demand at weekly access meetings
  - Use of E-care message centre in some specialities to reduce risk of lost paper (slips and books).
  - Creation of follow up referral template in message centre
  - Secretarial pools set up on message centre (surgery and Medicine)
  - Use of the cymbio dashboard to identify unbooked follow ups and data quality issues
  - Regular monitoring by patient safety team of patient complaints, GP queries/issues, PALS, claims and incidents to identify any thematic issues around follow up booking

- *Compliance with National guidelines Saving Babies Lives Version 2 (SBLV2) A Care Bundle for Reducing Perinatal Mortality*. (3720). The risk assessment has been downgraded to amber (annually x major). The current mitigation includes:
  - Monitoring regularly the compliance with SBLV1. Task and finish group set up to monitor and implement changes to SBL version 2
  - process of undertaking a gap analysis of SBL v2.
  - Some elements introduced. Competency assessment for CTG interpretation. Training for staff in situational awareness and human factors introduced on PROMPT training.
  - Introduction of a buddy system 'fresh ears' for low risk women
  - Foetal monitoring lead identified

- *Unable to remove blood gas analyser results on e-care if entered into incorrect patient record* (3992). The risk assessment has been downgraded to amber (annually x major). The current mitigation includes:
  - SOP produced and disseminated to relevant staff for labelling all samples at bedside and what to do if an error is made
  - E-Care results can be over written rather than removed

- *Loss of anaesthetic data* (4534). The risk assessment has been downgraded to amber (annually x major). The current mitigation includes:
  - Purge has been reset to allow permanent recording of data collected at more frequent intervals
  - System wide review of purge functions across WSFT
  - Data purge undertaken of Trusts electronic patient records system this identified no harm to any patients.

- *Staffing difficulties due to Covid-19* (4724). The current mitigation includes:
  - Bank incentive scheme
  - Utilisation of AHP's to support nursing care
  - Pandemic staffing framework developed
  - Pandemic documentation package from Oxford reviewed
  - Lead time for agency requests have been extended to increase temporary staff

- *Lack of medical workforce to provide optimal level of care for medical patients* (4705). The current mitigation includes:
  - Covid rota implemented with daily reviews of rota to ensure coverage.
  - Move Consultants as required to cover at risk areas.
  - Consultant support from other areas within organisation.
  - Locum/Bank/agency requests for shifts.
  - Commence vaccination programme.

9. Learning from RIDDOR incidents

There were six incidents in Q4 reported to the HSE under **RIDDOR**, which is a decrease of two incidents from the previous quarter:

- Two incidents were due to a slip, trip or a fall
- One incident was from a needlestick injury
- One incident was from finger being trapped
- One incident was from physical assaults
- One incident was due to moving and handling

Learning and mitigation included:

- Additional manual handling training
- Staff in area no longer move equipment, radiographers to attend to move equipment
- Alternatives are now being costed to improve conditions and remove poor design of system for this area and prevent further potential accidents

9. Learning from patient and public feedback:

Eight complaints received in Q4 were deemed to be upheld at the time of producing this report. Actions from these are set out in the table below. The complaints team are reviewing ways of ensuring that actions are implemented. Whilst a review of the actions tab on Datix will be completed, an interim process of sending out action plans to staff with the final response to complete. Whilst action plans are being returned (in some cases with evidence) documenting that the actions and learning have been completed, the complaints team do not currently carry out spot checks. When workload allows, we will be conducting spot checks for actions (such as reminders for staff) to ensure the learning has been understood with staff across the Trust.

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

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

11:25 BUILD A JOINED-UP FUTURE

15. Future system board report

To APPROVE report

For Approval

Presented by Craig Black

Public Board Meeting – 28 May 2021

Agenda item:	15			
Presented by:	Gary Norgate – Programme Director			
Prepared by:	Gary Norgate, Programme Director			
Date prepared:	17/05/2021			
Subject:	Update on the Future System Programme			
Purpose:	X	For information		For approval

Since last month's meeting we have made progress on several fronts, the Secretary of State for Health and the Parliamentary Under-Secretary of State for Prevention, Public Health and Primary Care have visited our site, we concluded our 'digital fortnight' and we and received information on the process of how the 40 hospital projects will be scheduled and how project plans will funded.

Executive Summary

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:

1. Details of the scope of our planned environmental impact assessment (EIA) have been posted on the council's planning page. Planners have 5 weeks to consider, influence and agree the scope.
2. The project team have held two video / audio conferences with their immediate neighbours to explain the EIA and highlight the extent to which it is going to truly understand the ecology of the Hardwick Manor site and its surrounding areas.
3. Work continues on the consideration of possible typographies for the new building. These were presented to the Board and its Governors and continue to be co-produced.
4. In light of findings from last month's intrusive surveys of the existing hospital building, work on the construction of a decant ward has been accelerated. Said ward is being constructed off-site using modern methods of construction and will be re-usable (i.e. transportable) within the new infrastructure.
5. The "Digital Fortnight", during which our clinical and co-production teams refined their visions for their respective specialities in light of the latest digital innovations, has concluded with a detailed digital blueprint for each speciality. The methodology and its conclusions have been shared with NHSX.
6. The national hospitals programme (NHP) have written to the project team explaining that a schedule for the 40 hospital projects has been constructed and is in the process of being socialised with ministers and other key stakeholders. Individual projects are said to have been prioritised on the basis of; how ready they are to be built and how complementary these schemes are to the developing NHP programmatic benefits and approaches (i.e. to what extent is a particular project able to aid the development of national templates for modern methods of construction (MMC), net zero carbon, digital blueprints etc).
7. In light of this communication, the project team took the opportunity to apprise the NHP of the following; its plans for mitigating the risks associated with our planning application, its use of MMC for the development of the decant ward (stressing the challenges created by our ailing infrastructure) and the method and outcome of the digital fortnight.
8. The NHP also indicated that a process for enabling the funding of business cases would soon be available (June / July).
9. Recent sessions with the Chamber of Commerce have highlighted the need to commence work

on ensuring Suffolk is prepared to exploit the significant investment being in made in its infrastructure (Sizewell C, Felixstowe Freeport, Gateway 14 at Stowmarket and, of course, our new hospital).

10. Secretary of State for Health, Rt. Hon. Matt Hancock and Bury St Edmunds MP Jo Churchill, visited the Hardwick Lane and Hardwick Manor sites and confirmed that the new hospital would be built "this decade".
11. The next month should provide clarity on scheduling and funding. It will also see the project edge closer to completing its outline clinical designs whilst progressing discussions on the opportunities for provider collaboration and continuing to engage our public in the planning process.

Strategic Outline Case (SOC) – As discussed last month, the national New Hospital Programme (NHP) had informed the Future System team that they would not take our SOC into a formal review until they could confirm their expectations regarding the programme as a whole. Having suggested confirmation of a schedule would be available by the end of April, the latest information suggests that the process has been delayed. Informal feedback confirms that 8 projects have been proposed as 'front runners' (Hillingdon, Manchester, Whipps Cross (Barts), Epsom and St Hellier, Harlow, Leeds, Leicester and West Herts) whereas an additional 6 "smaller" projects (including Cambridge Cancer Centre) have been identified as those that can progress promptly. These choices indicate a desire to ensure the allotted £3.7bn of announced funding actually gets spent in advance of the next funding review (planned for 2024/5). If these proposals are confirmed, the Future System programme will focus on ensuring that the development of its case, including the process for securing planning permission on Hardwick Manor, is funded with a view to ensuring we are truly "oven ready" in time for the release of the next tranche of capital. In support of this strategy, the project team have been releasing a steady stream of updates to the NHP highlighting progress towards a planning application, the development of our digital blueprint, the risks associated with our existing infrastructure and the outcomes of recent ministerial visits. This activity is aimed at illustrating a firmly held belief that we represent a solid, well supported case that can be accelerated in the event of a front runner hitting delays.

Next steps: We will hopefully gain some clarity on scheduling in the next month, however, our plan of next steps remain geared to ensuring we can make a credible, fully consulted and co-produced planning application before Christmas. The plan for delivering this outcome (below) remains firmly on track:

- Phase 2 co-production of an optimised clinical model (including exploration of opportunities for vertical and horizontal integration) – underway - output due 28th July
- Production of outline schedule of accommodation (SOA) based upon the clinical design – underway, runs in parallel with the clinical design – output due 28th July
- Turning the SOA into 1:200 architectural drawings – output due 3rd November
- Completion of Environment Impact Assessment (EIA) – scope has been produced and the assessment has to run across three seasons to ensure the lifecycle of flora and forna are understood – output due 12th December
- Prepare planning submission – submission will be finalised using the outcome of the EIA and architectural drawings – 12th December to 22nd December.
- Formal submission of planning application – 22nd December.
- Outcome of planning application – 4th May 2022
- Public planning consultation will happen in two phases, the first will communicate why we are seeking permission to build on Hardwick manor and will be launched on 7th June, the second will seek comments on the outline plans for the new hospital on the site (including number of storeys, positioning, access roads, parking etc.) and will be launched in October.

Estates – Work continues on the development and execution of plans to mitigate the risks to a successful planning application. Two sessions were held with our immediate neighbours to discuss the scope of the environmental impact assessment and the key, recurring points of challenge were:

1) Why not another site (in response to which we discussed the fact that various sites across Suffolk may appear perfect and yet are often blighted by complex ownership structures, high price tags, a fundamental reluctance to sell, incumbent developers, heritage buildings, junction /

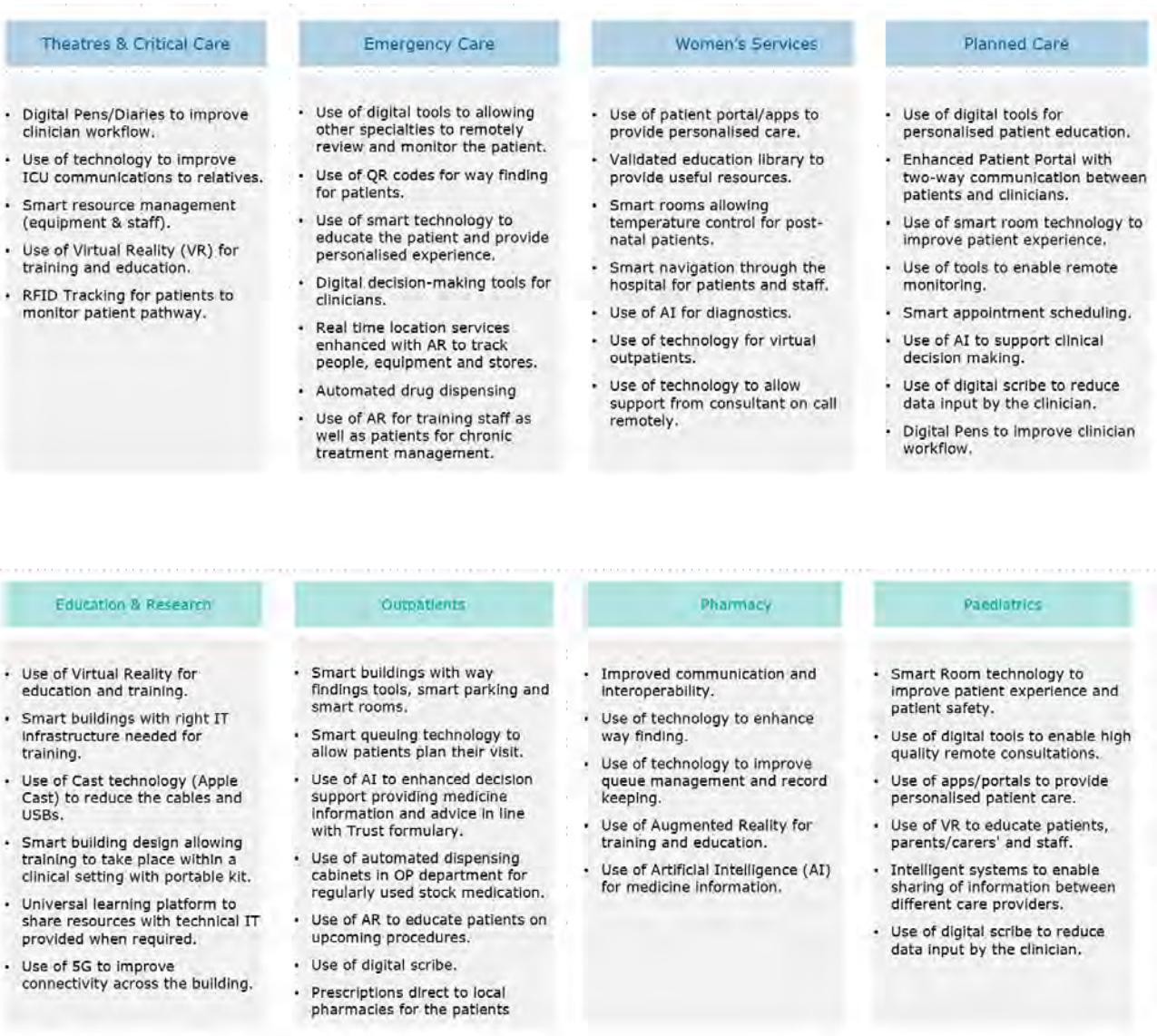
highways challenges, lack of alternatives to automobile access….)

2) Accessing the site via Horsecroft Road / Sharp Road / Gypsy Lane will be disruptive and could be dangerous (in response to which we discussed the plans for traffic assessments and the intention that site access will be via a static compound and that ongoing operational access will take place via the existing ingress and egress points on Hardwick Lane).
3) Placing a new Hospital on the Hardwick Manor site will have a significant negative impact upon an ancient, rare and valued natural habitat (in response to which we discussed the extensive investigations that are underway to truly understand the nature of the site and how, therefore, the impact of new buildings can be minimised and mitigated.
4) How will the Hospital manage site traffic before, during and after construction (in response to which we explained the various plans we have for mapping and managing traffic).

The Estates workstream continue to develop plans for exploiting modern methods of construction and minimising the carbon impact of the new build. This work, along with a view of potential typographies, was presented to the West Suffolk Board and its Board of Governors last week as part of the series of Board Development Sessions.

In terms of the efforts being undertaken to minimise the risks posed by the existing hospital's infrastructure, the photo below shows the progress being made on the construction of the decant ward that enables us to accelerate the installation of the fail-safe and bearing point extension solution required to address our infrastructure challenges. The decant ward is all built off-site using modern methods of construction and will be re-usable within our plans for the new hospital. The requested budget for the fail-safe programme covers a period of time until 2025/26 and is planned to protect the integrity of the environment until 2030. That said, if our plans for a new hospital are delayed beyond this point, the cost of post 25/26 repair could escalate significantly and there will come a point at which we would have to reconsider the validity of our preferred option against the cost of an 'in-situ' phased re-development. Such an "in situ redevelopment" would be an 8-year programme and would need to commence next year for us to have completed the project by 2030. With this in mind, we have stressed to the NHP the real need for some certainty about timing in order to minimise ineffective capital expenditure and ensure we hit the Governments stated objective to have built a new hospital in "this decade".

Clinical / Digital Workstream – At the time of the last Board, our clinical and digital teams were about to undertake a "digital fortnight" aimed at developing granular digital roadmaps for each of our clinical specialities. Said teams worked with our digital partner, ATOS, to develop a generic digital blueprint for use within our Strategic Outline Case. The next step has been to apply this blueprint to each of the clinical visions being co-produced for each specialty. To do this we employed an immersive methodology in which the first of two weeks was spent 'training' our clinical digital leadership team in the latest digital possibilities and developments. This was achieved through a number of presentations and discussions with the latest innovators including ATOS, Cerner, Google etc. Having completed this immersion, in the second week the clinical digital leads worked with each co-production team to revisit the outline vision that they had built for their respective speciality and 'overlaid' the digital possibilities. The results are summarised below and have also been presented to NHS digital / X as an exemplar example of how to truly explore the power of the 'digital possible'.



Diagnostics & Endoscopy

- Smart buildings with biometric check-in, smart way finding and smart parking.
- Enhance Patient portal to empower the patient and improve patient experience.
- Smart dispensing of TTOs.
- Use of digital pens to improve clinician workflow.
- Use of digital scribe to reduce data input.
- Use of Artificial intelligence to support clinical decision including best practice guidelines.
- Use of RFID technology for efficient resource tracking.
- Improve interoperability between different systems.

Pathology & Mortuary

- Use of technology to enable diagnostics in community settings with quality control.
- Use of medical grade integrated wearables to enable early diagnosis.
- Use of technology to allow patients to take their own samples.
- Use of digital tools to provide clinical decision support and diagnostic tests.
- Use of VR for education and training.

Community & Theatres

- Improved communication and interoperability between IT systems.
- Smart technology such as patient observer to enable remote monitoring.
- Use of technology to enhance way finding in community settings.
- Use of AR apps for equipment assessment and placement during buying.
- Use of ambient listening to record patient/consultant conversation.
- Secure dispensing and 'drop' cabinets in the community.
- Smart asset tags for equipment.

Patient empowerment

- Self-service kiosks/tablets for patients reducing the staff time.
- Digital First not digital only, alternatives available for those not digitally engaged.
- Use of QR codes on medications / devices with links directly to the relevant information in different formats.
- Smart appointment scheduling to show busy areas, slots available and delays.
- Personalised communication based on the language and activation level.
- Integrated wearables allowing patients to contribute to their record.
- A unified platform for patient education with resources in various formats.
- Use of AR to demonstrate procedures.

Clinical Intelligence

- Standardised dashboards for groups of people (surgeons/cardiologists/PAU/admissions) from core data sets
- Use of technology to support clinical decision making, diagnosis suggestion and documentation improvement.
- Increased interoperability and communication in between IT systems.
- Gamification of software and applications.
- Real-time reports accessible via various devices.
- Smarter patient evaluation/assessment based on high quality home/wearable data.
- More sophisticated, and tailored risk evaluation.

The next step is to work with ATOS on a cost benefit analysis for the recommendations and, once completed, the final visions will be used to inform our outline schedule of accommodation. WSFT is already recognised as a global digital exemplar and we see this work as a natural part of our commitment to continuous innovation. We have made the NHP aware of our work and have offered to act as a trail blazer for the national program.

During discussions of these results at the Programme Board, the team were requested to ensure technology does not detract from the fundamentals of human interaction and the role it plays in the provision of care. This point was freely accepted and assurance was duly given.

Communications and Engagement – Following a discussion at last month's Programme Board, the tricky question of deciding upon a project name for our project has continued with a test of the co-produced recommendation with the Hospital Peer Review Group, Community Engagement Group, Primary Care colleagues and members of our HOSC Task and Finish Group. This approach adds rigour to the conclusions without undermining our principles of co-production. The results, which were ratified at the programme board are as follows:

The positives of this branding were said to be; clarity, simplicity, resonance with the widest set of stakeholders, a tangible example of our commitment to the process of co-production.
The only real negative was said to be the use of the word “Hospital” which it was felt could detract from the fact that this is a system wide initiative and that “the hospital” is simply one part of it. It was agreed that our public had expressed a preference for the clarity that such a name provides, however, the actions of the project team must continue to reflect the inclusive, broad, system focus that will ensure the outcome fits with the strategic goals of all our partners.

In addition to the residents and Board / Governor sessions on the subjects of the environmental impact assessment and possible typographies, work has commenced on planning the specific engagement and consultation tasks that will underpin our pursuit of planning permission. Two periods of intensive engagement have been planned for June/July and October / November. The first will focus on engaging the wider public in our choice of Hardwick Manor as our preferred site, the benefits and the decision-making process. The second of the two periods will focus on engaging the public in the emerging typography that will eventually accompany our planning application.

The visit of the Secretary of State for Health and the Under Secretary of State for Public Health (local MP’s Matt Hancock and Jo Churchill) provided an opportunity for the Future System project to clearly illustrate the challenges of the existing infrastructure and showcase the maturity of our response and future plans. Feedback was wholly positive and subsequent public statements confirmed an expectation that a new hospital would be built “this decade”.

Finance and Economic Workstream – Following feedback on our Strategic Outline Case (SOC) from NHSI/E work has been undertaken to sharpen the narrative supporting our investment objectives, feedback has also allowed us to optimise our economic and finance cases. Nothing has fundamentally changed within our case, however, our SOC is now clearer and in great shape for whenever we are invited to formally submit!

As mentioned last month, the Future System Project has huge potential to generate a wider commercial social benefit. In progressing this potential, sessions with the local Chamber of Commerce have highlighted the risks that stem from the huge amount of inward investment being made in Suffolk (Freeport at Felixstowe, Sizewell C, Gateway 14 in Stowmarket and, of course, our new hospital). This investment could create competition for local resources and requires an integrated approach to ensure the opportunity for our wider community is not lost. To this end, the Chamber has commenced work to explore how Suffolk might prepare in order to best exploit this generational situation. The Future System project will, as a major anchor institution, play a full role in this work.

Work on the Equipment strategy for the new build has now started to move forward with the support of the Trust’s procurement and equipment specialists. This work will sit under the Finance workstream with its key outputs being an equipment strategy and spend forecast for the new hospital which will be included in the Outline Business Case. The aim of the work is to use and build upon the Trust’s current processes and forecasts and provide a basis for future capital decisions.

All in all, a month in which the significant progress has been made in the development of our clinical design and the understanding of how this can be enhanced through the application of the latest digital innovations. The work to ensure the hospital remains safe while we develop its replacement continues at pace and we continue to live our goal to make this the most co-produced hospital in the HIP programme.

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 Future System Programme Board						
Risk and assurance:							
Legislation, regulatory, equality, diversity and dignity implications	None						
Recommendation: Note the progress being made towards establishing a new health and care facility for West Suffolk.							

11:35 GOVERNANCE

16. Governance report

To APPROVE the report, including subcommittee activities

For Approval

Presented by Susan Wilkinson

Board of Directors – 28 May 2021

Agenda item:	16			
Presented by:	xx			
Prepared by:	Karen McHugh, EA to CEO Ruth Williamson, Trust Office Manager			
Date prepared:	24 May 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. **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 10 May considered:

   - New framework for engagement and oversight for quality, safety and improvement – as the new committee structure starts to establish within the organisation, a review of the three main committees and their objectives were discussed.
   - The WSFT Physician Associate policy – TEG were updated on the key developments of introducing this new policy into the organisation.
   - Future system: workplace strategy development – A detailed review of how the organisation plans to develop a workplace strategy with staff engagement, to assist with the design of office accommodation within the new health and care facility for the Trust.
   - Trust's draft operational plan 2021/22 – A review of the plans the Trust has for operational plans for the coming year, both financial and operational, and the challenges we may face.

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

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

Previously considered by:	The Board receive a monthly report of planned agenda items.
Risk and assurance:	Failure effectively manage the Board agenda or consider matters pertinent to the Board.

Legislation, regulatory, equality, diversity and dignity implications	Consideration of the planned agenda for the next meeting on a monthly basis. Annual review of the Board's reporting schedule.

Recommendation:

The board is asked to note the contents of the report

Annex A: Scheduled draft agenda items for next meeting – TBA

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
Report from 3i Committees: Insight, Improvement & Involvement	✓		Written	Matrix	RD / DW / AR
Finance & workforce performance report	✓		Written	Matrix	CB
Risk and governance report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
Integration report – Q1	✓		Written	Matrix	KV
Invest in quality, staff and clinical leadership					
Quality, safety and improvement report - Infection prevention and control assurance framework - Maternity services quality and performance report (inc. Ockenden) - Quality and learning report – learning from deaths, quality priorities - Improvement committee report - Nurse staffing report	✓		Written	Matrix	SW / NJ
People and OD highlight report	✓		Written	Matrix	JMO
Report from Involvement Committee, including exception report	✓		Written	Matrix	AR / JMO
Medical Revalidation annual report	✓		Written	Matrix	PM
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	SW
Build a joined-up future					
Digital Board report	✓		Written	Matrix	CB
Future system board report	✓	✓	Written	Matrix	CB
Strategic update, including Alliance, System Executive Group and Integrated Care System (ICS		✓	Written	Matrix	KV / SD
Governance					
Governance report, including - Agenda items for next meeting - Use of Trust's seal - TEG report - Remuneration committee report - Risk appetite statement - Scope for well led developmental review - Foundation Trust Membership Strategy - General condition 6 and Continuity of Services condition 7 certificate	✓		Written	Matrix	RJ

Scrutiny Committee report		✓	Written	Matrix	LP
Board assurance framework review		✓	Written	Matrix	RJ
Confidential staffing matters		✓	Written	Matrix – by exception	JMO
Reflections on the meetings (open and closed meetings)		✓	Verbal	Matrix	SC

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 TBC 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