Board of Directors (In Public)

Schedule	Friday 29 January 2021, 9:15 AM — 11:30 AM GMT
Venue	Via video conferencing
Description	A meeting of the Board of Directors will take place on Friday, 29 January 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 01 29 Jan.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:
   To NOTE any apologies for the meeting and request that mobile phones are set to silent
   For Reference - Presented by Sheila Childerhouse

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

NHS
West Suffolk
NHS Foundation Trust

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

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

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6. Minutes of the previous meeting
   To APPROVE the minutes of the meeting held on 4 December 2020
   For Approval - Presented by Sheila Childerhouse

   Item 6 - Open Board Minutes 2020 12 04 Dec Draft.docx

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

   Item 7 - Action sheet report.doc

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8. Staff story
   For Report - Presented by Jeremy Over

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

   Item 8 - Chief Exec Report Jan 21.docx

9:45 DELIVER FOR TODAY

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

    Item 10 - Operational Board update Jan 2021.doc

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11. Vaccination report
    To APPROVE a report
    For Approval - Presented by Nick Jenkins

    Item 11 - Vaccination Update - Board Jan 2021.doc

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

    Item 12 - IQPR Trust Board Report 29 January 2020.pdf

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

    Item 13 - Board report Cover sheet - M09.docx

    Item 13 - Finance Report- December 2020 FINAL.docx

10:20 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

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

    Item 14 - People OD highlight board report Jan 2021.doc

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

15.1. Maternity services quality & performance report including Ockenden report
For Approval

- Item 15.1 - Maternity quality and performance report Jan 2021.docx
- Item 15.1 Annex A - Ockenden response January 2021.docx
- Item 15.1 Annex D - UKOSS Covid WSH v3.docx
- Item 15.1 Annex E - Paeds staffing Report Jan -June 2020.docx
- Item 15.1 Annex F - ATAIN report on successes and challenges September 2020.pdf

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15.2. Infection prevention and control assurance framework
For Approval

- Item 15.2 - COVID IPC assurance framework Jan 2021.docx

15.3. Safe staffing guardian report
For Approval

- Item 15.3 - Safe staffing guardian report October - December 2020 coversheet.doc
- Item 15.3 - Safe staffing Guardian Quarterly Report Quarter 4.docx

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15.4. Nursing establishment review
For Approval

- Item 15.4 - WSFT Nursing review 2020.docx

15.5. Nursing staffing report
For Approval

- Item 15.5 - Staffing Review November December 2020.docx

15.6. Quality improvement programme board report
For Approval

- Item 15.6 - Improvement programme board report Jan 2021.docx
- Item 15.6 Annex A - 210111 IPB Action plans.xlsx

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16. Histopathology business case (presentation)
To receive presentation prior to decision on commercially sensitive information in closed session
For Report - Presented by Craig Black and Sarah Rollo

Item 16 - Presentation Business case for Cellular Pathology equipment replacement.pdf

Item 16 - Proposal for the acquisition of modern histopathology equipment - open board 2021.01.29 v1.doc

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17. Car parking tariff report
To APPROVE the recommendations
For Approval - Presented by Craig Black

Item 17 - Car Parking 20-21 Tariff Paper Update v1 Trust Board 29 January 2021.doc

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11:00 BUILD A JOINED-UP FUTURE

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18. Integration report
To APPROVE report
For Approval - Presented by Helen Beck and Kate Vaughton

Item 18 - Integration report _Jan 2021.doc

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

Item 19 - WSFT Future system programme overview Jan 2021.doc

Item 19 Annex A - Texas Model Case Study Report.pdf

11:20 GOVERNANCE

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

- Item 20 - Governance report.doc
- Item 20 Annex D PP(21)018 Health Safety and Welfare Policy.docx

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11:25 ITEMS FOR INFORMATION

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

RESOLUTION TO MOVE TO CLOSED SESSION

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23. 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, 29 January 2021 at 9:15**. The meeting will be held virtually via video conferencing.

Sheila Childerhouse
Chair

Agenda (in Public)

9:15 GENERAL BUSINESS		
1.	**Resolution** The Trust Board is invited to adopt the following resolution: "That representatives of the press, and other members of the public, be excluded from the meeting having regard to the guidance from the Government regarding public gatherings."	Sheila Childerhouse
2.	**Apologies for absence** To note any apologies for the meeting and request that mobile phones are set to silent.	Sheila Childerhouse
3.	**Declaration of interests for items on the agenda** To note any declarations of interest for items on the agenda	Sheila Childerhouse
4.	**Questions from the public relating to matters on the agenda** (verbal) To receive questions from members of the public of information or clarification relating only to matters on the agenda	Sheila Childerhouse
5.	**Review of agenda** To agree any alterations to the timing of the agenda.	Sheila Childerhouse
6.	**Minutes of the previous meeting (attached)** To approve the minutes of the meeting held on 4 December 2020	Sheila Childerhouse
7.	**Matters arising action sheet (attached)** To accept updates on actions not covered elsewhere on the agenda	Sheila Childerhouse
8.	**Staff story**	Jeremy Over
9.	**CEO report (attached)** To receive an introduction on current issues	Steve Dunn
9:45 DELIVER FOR TODAY		
10.	**Operational report (attached)** To approve the report	Helen Beck
11.	**Vaccination report (attached)** To approve a report	Nick Jenkins
12.	**Integrated quality and performance report (attached)** To approve a report	Sue Wilkinson / Helen Beck
13.	**Finance and workforce report (attached)** To approve report	Craig Black

10:20 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP		
14.	**People and OD highlight report (attached)** To approve report	Jeremy Over
15.	**Quality, safety and improvement report** To approve reports: 15.1 Maternity services quality and performance report, including Ockenden report 15.2 Infection prevention and control assurance framework 15.3 Safe staffing guardian report 15.4 Nursing establishment review 15.5 Nurse staffing report 15.6 Improvement programme board report	Sue Wilkinson / Nick Jenkins
16.	**Histopathology business case (presentation)** To receive presentation prior to decision on commercially sensitive information in closed session	Craig Black / Sarah Rollo, Biomedical Scientist and Deputy Manager
17.	**Car parking tariff report (attached)** To approve the recommendations	Craig Black
11:00 BUILD A JOINED-UP FUTURE		
18.	**Integration report (attached)** To approve report	Kate Vaughton / Helen Beck
19.	**Future system board report (attached)** To approve report	Craig Black
11:20 GOVERNANCE		
20.	**Governance report (attached)** To approve report, including subcommittee activities	Richard Jones
11:25 ITEMS FOR INFORMATION		
21.	**Any other business** To consider any matters which, in the opinion of the Chair, should be considered as a matter of urgency	Sheila Childerhouse
22.	**Date of next meeting** To note that the next meeting will be held on Friday, 26 February 2021 at 9:15 am in West Suffolk Hospital	Sheila Childerhouse
RESOLUTION TO MOVE TO CLOSED SESSION		
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5. Review of agenda

To AGREE any alterations to the timing of the agenda.

For Reference

Presented by Sheila Childerhouse

6. Minutes of the previous meeting

To APPROVE the minutes of the meeting held on 4 December 2020

For Approval

Presented by Sheila Childerhouse

DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 4 DECEMBER 2020 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		
Daniel Spooner	Deputy Chief Nurse		
Kate Vaughton	Director of Integration and Partnerships		

Action

GENERAL BUSINESS

20/234 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 explained that this meeting was being streamed live via YouTube to enable governors and the public to observe the meeting.

The Chair welcomed everyone to the meeting, particularly new members of the council of governors who were observing this meeting today and she looked forward to meeting them. She also welcomed back those governors who had been re-elected.

20/235 APOLOGIES FOR ABSENCE

There were no apologies for absence.

20/236 DECLARATION OF INTERESTS FOR ITEMS ON THE AGENDA

No declarations of interest were received.

20/237 QUESTIONS FROM THE PUBLIC RELATING TO MATTERS ON THE AGENDA

The Chair thanked those people who had submitted questions in advance of the meeting. She reminded everyone that questions should relate directly to items on the agenda and not to be patient specific or general.

Q What was the current bed occupancy?

A Covid had made things more complicated due to the need for greater distances between beds. This year bed occupancy was 81% versus 95% last year.

Q How many of the 20,000 plus patients on the waiting list were due to patient choice and how is the Trust addressing this? What is the average age of people on the waiting list? What is currently being done to reduce the waiting list? Can we be given the exact number of waiting list patients?

How many Midwives were recruited? How many vacancies?

A Given the complexity of these questions it was proposed that this should be included as part of the governor briefing question on performance and quality which was taking place on 18 January. More detail would be provided on patient flow, bed occupancy and responding to waiting list pressures.

- It was suggested that governors should look at the briefing from Chris Hopson (Chief Executive of NHS Providers) which talked through the challenges of managing pressures due to Covid and winter. https://nhsproviders.org/resource-library/briefings/parliamentary-briefing-current-nhs-pressures **R Jones**

ACTION: circulate link to governors.

Q Could assurance be provided that virtual consultations via video or telephone were not leading to problems with patients not getting a diagnosis or patient safety implications in the future?

A The majority of working out what was wrong with someone was in their story, therefore a lot could be done through talking to the patient. It was only proposed to make 30% of new patient appointments via video or telephone and 60% of follow-up appointments. This was new technology and doctors would learn which patients they needed to see face to face. To date the majority of doctors and patients were preferring virtual consultations as it meant that patients did not need to travel or come into the organisation.

Q Is it possible to provide any further information about the arrangements the board expect to be put into place to ensure that those vulnerable members of our community in care homes, will receive the new Pfizer-BioNTech Covid-19 vaccine as a priority, as indicated by the government? And to confirm if there is any more clarity regarding the provision of vaccines for our frontline health care staff?

A The situation was still not clear and was evolving fast. It had been announced that the priority should be for the over 80s, care home residents and staff. Unfortunately, because of the very complex storage requirements and the small quantity of vaccine that would initially be available there would be a limited supply. Colchester was the only acute hospital in the area with the facility to store products at below 80ºC. The original plan was to prioritise administration to health and social care staff but this had changed to the over 80s, but they would need to go to Colchester hospital as the vaccination couldn't travel. However, it was expected that the licensing restrictions on the vaccine would change so that distribution could take place in smaller packs which would enable primary care network sites to administer vaccines to the over 80s.

WSFT was prepared for a mass staff vaccination programme to start next week but this had now been delayed. It was hoped that other vaccines would be licensed in the near future, ie the Oxford/AstraZeneca vaccine, which did not require special storage.

20/238 REVIEW OF AGENDA

The agenda was reviewed and there were no issues.

20/239 MINUTES OF MEETING HELD ON 6 NOVEMBER 2020

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

20/240 MATTERS ARISING ACTION SHEET

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

`20/241 CHIEF EXECUTIVE'S REPORT

- The news about the vaccine was very positive however, it was not going to be an easy task to deliver the mass vaccination programme and this would involve a huge amount of work. He thanked the team for all their hard work in preparing for this.
- A lot of work had been and continued to be undertaken around preparing for winter and restoring as much activity as possible.
- Staff morale in pathology was very good but the equipment was very old and would need investment. He thanked those people who had been involved in transferring the pathology staff back to WSFT.
- This report highlighted some of the things he had experienced whilst spending time with members of the community teams. It was important to remember and appreciate that community staff mainly worked by themselves dealing with vulnerable patients; he thanked them for everything they were doing.
- The Trust continued to focus on culture, particularly Mersey Care. There were some significant lessons to learn and focus on, eg the hurt caused by investigations, and there was a need to think about how to respond to this.
- The proposal for next steps for integrated care systems and emerging legislation had recently been published which would be significant for the NHS. This was very much the direction of the travel for the alliance and there would be a need to understand what this meant both strategically and operationally.

Q The take up by staff of the flu vaccine was lower this year than last year. Given the importance of staff being vaccinated to protect patients as well as themselves, how would the Trust encourage staff to have a Covid vaccination and would this be recorded and reported to the board in the same way as the flu vaccine?

A The uptake of the flu vaccine was disappointing and the reason for this needed to be understood. The Trust continued to encourage staff to have a flu vaccination and was currently considering how it would encourage staff to have a Covid vaccine.

In the short term there would be a limited amount of Covid vaccine and only staff who had initially requested it would have it. It was hoped that these people would champion the vaccination. It was very important that senior clinical leaders demonstrated by example that they had confidence in the MHRA and the vaccine. The number of staff taking up the vaccine would be reported by staff group and work location.

Q This report gave details of the work being undertaken to prevent in-house infection. However, waiting lists were increasing and there were quite a few instances of patients not turning up for their appointments which meant that people were not getting help/treatment when they needed it. What assurance could be provided that the

communication strategy to encourage people to come into the hospital for their appointments was the correct strategy to reduce the number of 'did not attends'?

A The team was checking that the reminder system the Trust had in place was effective the it was also planning to implement a new system for this. There was a need to distil some of the residual concern about the safety of the hospital and it was trying to reinforce the message that people needed to attend their appointments.

A number of patients had contacted the hospital to say that they would not be coming in as they were worried about Covid. This was concerning as they had made a conscious decision not to attend which meant that a number people had stopped accessing cancer pathways. Other ways of providing reassurance and encouraging them to come into the hospital were being tried. The latest initiative was specialist consultant led clinics with virtual appointments for patients to look at what else could be done to help them if they did not want to come into the hospital.

This was not about mass communication, but specialist communication by addressing fears that people had directly and putting them in contact with specialists, nurse specialist and consultants; however, this was very labour intensive.

Q As the board would not be meeting until the end of January and there was a need to respond to the consultation about the proposed legislation; would this be shared with staff, including community staff, and possibly governors?

A The board's view on how to respond to the consultation was requested, ie whether this should be done individually, organisationally or as part of the ICS. Ed Garratt was very involved in this and had been invited to No 10 this week to discuss. If the board wished to respond to this it was proposed that this should be done through the scrutiny committee and reported to the board meeting on 29 January. This was very much in accordance with the Trust's direction of travel but there was a need to consider what this meant for NHS Trusts and FT status, apart from greater collaboration.

It was considered that it would be helpful for the board to discuss this but it was likely to be aligned with the responses of the alliance and ICS.

- WSFT had a real opportunity through the future system work to be a model for the future in terms of what NHSEI was looking for more broadly across the NHS.
- The board would be considering the future system work in the closed session of the meeting today. Staff, governors and the public would be informed of any decision as soon as possible. This would need to be worked through with the regional and national team first, therefore there would be a delay but the aim was to try to inform staff and the governors before the public.

DELIVER FOR TODAY

20/242 OPERATIONAL REPORT

Phase 3 recovery

- NEDs had been attending access meetings, where the focus had been on elective patients accessing the Trust's facilities and ensuring that the organisation was able to maximise the capacity available.
- Further work was required in day surgery and endoscopy and plans were in place which meant that activity levels in these areas should increase over the next couple of weeks. It was hoped to see real progress, particularly in endoscopy.

- The number of people waiting over 52 weeks continued to increase although the rate of increase had slowed.

Winter planning and Covid

- The Trust still needed to continue to follow all of the guidelines, however over the last week a slight reduction in Covid patients had been seen. There were currently 16 patients who had tested positive for Covid, one of whom was in critical care.
- Although the situation had improved since two weeks ago this continued to be monitored carefully.
- In response to the governor's question re bed occupancy, the Trust had allocated 60-70 beds for Covid patients. Even though these beds were not always full they had been designated for this purpose.
- Think NHS 111 First initiative went live on Monday. The aim was to reduce ED attendances and control the flow of those people who did need to attend.

Q There had been a variety of views about Think NHS 111 First and whether this was a heavy-handed campaign. Would WSFT be supporting this publicly and did it want to change people's behaviour?

A Yes, WSFT did want to change people's behaviour and this would be publicised across the system. People would be given an arrival time, not an appointment slot, which had caused some confusion and communication had been sent out to clarify this. If patients were clinically urgent they needed to come straight to A&E and would be triaged on arrival. WSFT's ED had an IT link with 111 so that this could be managed.

Q What was the relevance of local targets? Did this cause confusion and should the focus be on national targets?

A This could cause confusion, although the main focus was on national rather than local targets.

EU exit planning

- WSFT was as prepared as it could be for the absence of a trade agreement. An assurance template had been received yesterday for submission this morning. The Trust was able to complete this to say that it was fully compliant with all of the requests.
- ESNEFT had undertaken a table top exercise two weeks ago which has been attended by Barry Moss, Head of Emergency Preparedness, Response & Resilience, to see if there was any learning from this that would benefit WSFT, however there was very little that the Trust was not already doing.

Q Was the Trust in a position to continue to manage the potential impact of Brexit well into next year, including supply chains?

A It was not expected that anything would be any different on 1 January but by the end of January/February an interruption in supply chains my start to be seen. All the plans assumed the absence of a trade deal, ie worst case scenario.

Q Re cost recovery and cross charging patients from the EU; the organisation had not always been good at recovering debts from patients who should be paying. Was the team aware of the need to monitor this?

A Audit reports showed that the team was very effective at identifying patients who should be charged for their care. However, sometimes a debt was written off as it was economical or possible to collect.

Q Re Brexit and data protection and the safety of this, was the team aware of the need to ensure that it kept a close eye on this?

A A team of people was working on this, including a supply chain expert and the Head of Information Governance. To date the Trust had not seen any guidance on this but it was ready to react rapidly to any changes.

Community Services Update

- Jenny McCrory, team lead for Sudbury, had been invited to talk about community digital work and how this had felt on the front line and what impact this had had. The community engagement initiative would be discussed at the board workshop next week.
- To date Sudbury, Newmarket and Haverhill had been migrated across to the new IT system. Two out of the three sites had found this to be very positive and the IT team has been very supportive.
- The system already appeared to be more efficient and faster, everything was now cloud based which enabled information to be shared easily. Staff could now also access the intranet and felt part of the organisation.
- Local IT support dedicated to the community had been a great help with problems being resolved very quickly in a more hands on way. However, Haverhill had experienced a lot of problems with continual IT issues. It was not known why this was but they were the first to migrate and a number of lessons had been learned to the benefit of Sudbury and Newmarket.

Q Could the board be assured that progress was being made in addressing the issues being experienced by Haverhill?

A Yes, progress had been made and Sarah Judge, Community IT Lead, had been focussing on this. Haverhill was the first site to migrate and the first was always more challenging.

Q Was there a vision that with this system data could migrate to other colleagues more widely, ie grow into more of an IT place-based system?

A Yes, this was the case and significant progress was being with Healthcare Information Exchange (HIE) so that more colleagues across the system would be able to view patient information. However, this would be quite challenging as it needed to be done at a national level; WSFT was further ahead than a lot of the country but there was still more to be done. Despite not having the level of connectively they would like, community teams were working very well with their partners through conversations etc.

Q Was there anything that Jenny McCory and the teams required in terms of support from the board and how was morale?

A Morale was 50/50. It had been very busy both with caring for patients and the implementation of the new system which had resulted in low morale. However, they were very grateful for the additional agency staff to support the nurses; this had been very helpful both in assisting with the workload and boosting morale.

Morale in therapy staff was lower than nursing as waiting lists had increased during the first phase of Covid and there was ongoing pressure to support patient flow from the hospital, which meant that they could not see community patients. This had resulted in a couple of staff leaving which had been very disappointing, however she felt that she was being listened to and practical steps were being take to help respond to the challenges.

- The board thanked Jenny for her contribution to the meeting and also expressed its thanks to the community teams for the work that they were doing while facing the pressures of the pandemic.

20/243 INTEGRATED QUALITY AND PERFORMANCE REPORT

- Achievement of duty of candour within the require timescale had reduced this month. This was due to the processes required before the need for duty of candour could be declared.
- Falls had reduced this month which was positive and this continued to be focussed on. The new falls lead who had recently joined the Trust was a physiotherapist, which should be a great help.
- 'Stop the Pressure' day had taken place this month. There had also been a focus on harm free care with and implementing quality improvement (QI) work, which the community teams had been working very hard on.

Q As the vaccine issue would be high profile for a long time, should there be a chart showing progress on flu and Covid vaccine of staff?

A It was agreed that this would be a good idea.

ACTION: include information on staff Covid vaccines in board papers. **N Jenkins**

Q Duty of candour appeared to be an ongoing issue and was showing as red in the improvement plan. Should there be a different way of looking at this in order to resolve this?

A The way in which duty of candour was delivered was being reviewed, however this was also around quality and delivering this in a meaningful and compassionate way. The Trust was looking at training and supporting people to be able to do this. The job description for the new deputy medical director for quality was also being reviewed and one of their roles would be to support this work.

Q Given the consistent increase in pressure ulcers, was there any underlying cause?

A There were some trends in the community as a result of Covid which related to concordance and the ability of staff to go into people's homes to assess and review patients on a daily basis. The Trust had a very good tissue viability nurse who worked with the community teams and they were all very engaged. It was hoped that this would improve over time but it was a national trend and the main issue was around concordance.

20/244 FINANCE AND WORKFORCE REPORT

- The Trust continued to breakeven year to date and was continuing to forecast that it would be breakeven at year end.
- There was an under performance in CIPs, as there had been throughout the year. This was mainly due to the focus on Covid.

- Helen Beck and Craig Black had met with the project management office (PMO) and finance managers to reinforce the need for CIPs to be achieved in month 12 of this year to ensure that the organisation moved into next year recurrently in balance. Further information to illustrate progress on this would be provided at the board meeting in January.

ACTION: provide an update on progress towards achieving CIPs to next meeting and plans for 2021/22 (covered in action point 1896). **C Black**

- The cash position remained good with approximately £25m in the bank. Again, this was mainly due to the support that was being provided to the whole of the NHS this year.
- The capital programme continued to be reviewed and would be discussed further in the closed board meeting.

Q As the organisation moved out of Covid money would become very tight, what plans were in place to address this?

A The way in which the Trust was planning for next year was around ensuring that recurrent CIPs were achieved in month 12 so that it moved into next year with a baseline financial position that broadly reflected the position it was in as it went into this year. However, this would be a real challenge and it was unknown what the impact on staffing would be as a result of Covid, which would also have a financial impact.

The main issue for next year would be around volumes of activity as the Trust tried to recover the position created this year through activity not being delivered due to Covid. However, this would be very expensive and was not income that would be achieved in one financial year. The Department of Health had indicated that £3bn would be available next year in order to assist in recovering from the situation that had been created this year.

The Trust had its own challenges relating to activity due to capacity as a result of the issue around RAAC planks. There would be more uncertainly in next year's plan than there had been in previous plans, however the organisation would be starting next year in a stronger position than it had in the last ten years which should stand it in good stead.

The new legislation referred to in the Chief Executive's report signified a move towards block contracts which WSFT had been part of for a while and this reinforced how well the organisation was aligned to future strategic developments.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

20/245 PEOPLE AND ORGANISATIONAL DEVELOPMENT (OD) HIGHLIGHT REPORT

- The board received updates on the following areas:

  - The Restorative Just and Learning Culture priority in our WSFT People Plan
  - Putting You First Awards
  - International Nurse Recruitment
  - Supporting our EU colleagues
  - Staff health and wellbeing – including COVID risk assessment and flu vaccination
  - Consultant appointments

- Both nominations for a Putting You First Award highlighted examples of an exceptional level of compassion and care that had been provided by two members of staff.

- The board thanked Sarah Ryan and Victoria Farrant for their contribution to the organisation and for setting an example of the kind of care that the organisation aspired to provide.
- Over the last month a group of staff had been taking part in training provided by Mersey Care. This group would become a learning set and would be working to develop this at WSFT. The board would be updated on the progress of this.
- A lot of work was going on in the organisation to develop the right culture and it was important to join up the different initiatives, eg human factors, learning from the 5 o'clock club in relation to rudeness and civility, freedom to speak up etc. This played a part in team work and safety.

  A meeting had been arranged next week to look at bringing these together and it was important that staff felt able and safe to speak up, suggest ideas and be their best both for patients and their families and for colleagues.
- The Mersey Care training looked at the immediate response from the organisation when something went wrong. This would dictate how people felt as well as openness and learning from individuals and teams rather than seeking retribution.
- With this in mind the Trust had taken the decision to pause ongoing HR cases and support these through a just and learning culture. The team had now completed this work and approximately 75% of cases had been resolved informally or through alternative means rather than going to a formal hearing.
- Re Brexit; support had been provided to approximate 400 staff who were from EU countries.
- The international recruitment programme had been resumed for staff from the Philippines and Nigeria. This was being managed internally by the recruitment and education teams.
- The report provided details of the Trust's flu vaccination campaign; uptake to date had been disappointing at 60.1% versus 70% in 2019. The reasons for this would be looked into.
- The board noted the following appointments:
  Dr Justin Zaman, Consultant in Cardiology
  Dr Siobahn Whitley, Consultant in Radiology

Q Mersey Care training had been delivered to ten senior members of the Trust, but the just and learning culture needed to be disseminated throughout the organisation. Was there an expectation that this would be the case and not just to senior managers?

A This would be case and everyone had a duty to ensure that this was disseminated and to ensure that this became part of their work.

Q Re recruitment of nurses from Nigeria what could the Trust learn from the experience of the Filipino community or other organisations who employed Nigerian staff to ensure that appropriate support was provided?

A In advance of their arrival other Nigerian members of staff had been asked to support these individuals. Feedback on this would be requested from both new and current staff members.

Q Developing a new culture would be a long term gain which required performance management. Had WSFT looked at what and how these would be measured separately and how performance managers would approach this moving forward?

A Angus Eaton would provide further information to Jeremy Over on his experiences in managing this in other organisations.

ACTION: Consider what and how to performance manage culture change. **J Over**

20/246 QUALITY SAFETY AND IMPROVEMENT REPORT

246.1 Maternity services quality and performance report

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

- External assistance was being provided to look at clinical governance around safety and quality.
- The first draft of the maternity quality and safety framework had been produced and it was hoped that the final version would be in place by the end of this year.
- HSIB had issued a national report in November; 'Investigation into delays to intrapartum intervention once foetal compromise is suspected'. A gap analysis was currently being undertaken and further detail would be provided in a future report.
- The team continued to present to the learning from deaths group on previous maternal deaths.
- The MBBRACE-UK report re Covid had been presented to the local governance group and an action plan would be put in place.
- In addition to the clinical dashboard a maternity quality dashboard showed compliance again appraisals, training, equipment checks and audit results. The majority of checks were now in the high 90% but some still required improvement
- The Trust needed to continue to focus on postpartum haemorrhage and this was being monitored very closely.
- The midwife to birth ratio was currently amber which was a reflection on the effect that Covid was having on staff and the need to self-isolate.
- Supernumerary labour suite co-ordinator was an ongoing issue and the Trust was working on this with the NHS improvement officer. A plan was in place as to how this would be addressed and benchmarking had been undertaken against units of a similar size.
- Smoking cessation CO checks had ceased due to Covid but were due to recommence and would be re-audited in the new year.
- Swab counts and drug charts had been highlighted with staff and were improving, although still showing as red.
- The Trust was working towards 100% compliance with the CNST maternity incentive scheme.
- Annex C provided an oversight of the Trust's commitment to the saving babies lives care bundle and reducing the number of still births by 50% by 2025. There was still work to be done to achieve this but the team was confident that these actions would be completed
- The obstetrics & gynaecology monthly report provided details of the information that was shared with staff on a monthly basis in terms of governance.
- The NHS Improvement officer continued to work with the team and a meeting took place every two weeks to work through the CQC action plan.

Q Were there any particular areas of concern that needed to be focussed on and how could the board support the team in moving this forward?

A There was still a long way to go but progress continued to be made with joint working between obstetrics and midwifery and moving services forward. Continuity of carers went live this month which had been a huge step. The Trust was leading the way on this in the region and it would have a real impact on patient care and support.

Q As well as benchmarking against units of a similar size did the Trust have links with one or two units so that best practice can be shared as well as learning from each other?

A WSFT had less staff but was still expected to do exactly the same as every other Trust regardless of the number of births and staff it had. As a smaller unit this was very difficult and the NHS Improvement officer who was from a big London hospital was finding that this was a challenge. The Trust was in regular contact with three units in the region which it benchmarked against and shared learning with.

246.2 Quality and learning report, including learning from deaths

- The board delegated authority to the Scrutiny committee to approve the Trust's 2021 patient safety incident response plan in January.

Q One of the learning from deaths reviews talked about supernumerary labour suite numbers and that the Trust was not yet achieving this. As this was an issue raised by learning from deaths, what priority was being given to it?

A The Trust was focussing on the labour supernumerary suite co-ordinator. This would be answered in more detail in the maternity services quality and performance report.

Q Were there alerts in e-Care which did not work properly and were algorithms still doing what they were expected to?

A A lot work was being done on alerts to ensure that they did exactly what they were intended to. However, there was no evidence that an alert had not worked in the way it was intended but there were too may alerts which meant that some could be missed. Therefore, the efficacy of alerts was being looked at in terms of people's behaviour.

246.3 Infection prevention and control assurance framework

- The infection prevention and control team were working on developing a database that showed where the Trust was compliant, in addition to the board assurance framework. This would include compliance against Covid swabbing and incidents related to Covid management.
- Good progress was being made on meeting the ten key actions detailed in appendix A.

246.4 Improvement programme board report

- Good progress was being made with improvements and completion of actions.
- The outcome of the maternity assurance visit had now been captured and a number of actions have moved from black (complete) to blue (business as usual).
- Medicines management in main theatres and DSU and maternity up to date clinical guidelines had moved from green to black.

- The CCG clinical quality team had undertaken an assurance visit to look at medicines management and feedback had been very positive, including how welcoming and proud of their achievements the team had been.

Q What was the process for adding new items for overview of the improvement programme board?

A Each executive director had their own SRO (Senior Responsible Officer) cluster meetings and would be picking up work to be incorporated into the main action plan. Learning from individual events would be shared and any themes coming through would also be added to the improvement plan as necessary. Oversight was through the SROs.

- The improvement board was a very good process and was working well and at pace with attention to detail. There was a wide level of engagement across the Trust.

246.5 Nurse staffing report

- Nurse staffing rates were good with reduced vacancy numbers and sickness absence rates.
- A detailed paper on staffing would come to the next board meeting.

BUILD A JOINED-UP FUTURE

20/247 FUTURE SYSTEM BOARD REPORT

- A board workshop and governor briefing had taken place recently to update everyone on the process to date.
- A huge amount of work had taken place over a short period of time and this continued at pace. A further discussion would take place in the closed board meeting today.

Q Re the clinical design work which was being done at pace, was there a process for the Attain work to be fed directly into the clinical design workshops?

A Workshops on this were taking place jointly and Attain had joined a number of clinical workshops so that everyone understood what was required and what could happen quickly.

20/248 DIGITAL BOARD REPORT

- A considerable amount of work was being undertaken in relation to future systems around the digital programme and external support was being provided on this.
- A huge amount of work was also being undertaken in the community and the board particularly commended Sarah Judge for her role in this.
- It was proposed that a more detailed discussion should take place around the Trust's digital programme and the future system work.

ACTION: Consider how digital works fits within the future system programme. **C Black**

Q Had the Trust any plans to review its cyber/information security risk?

A This would be reviewed. WSFT had recently had its cyber security plus status confirmed by the Department of Health and was one of the few organisations in the country to have achieved this.

ACTION: Review cyber/information security risk. **C Black**

GOVERNANCE

20/249 GOVERNANCE REPORT

The board received this report and noted the activities of the sub-committees.

20/250 AGENDA ITEMS FOR NEXT MEETING

The board received and approved this report.

ITEMS FOR INFORMATION

20/251 ANY OTHER BUSINESS

There was no further business.

20/252 DATE OF NEXT MEETING

Friday 29 January 2021, 9.15am

RESOLUTION TO MOVE TO CLOSED SESSION

20/253 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 – 29 January 2021

Agenda item:	7			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	22 January 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

None

Closed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1875	Open	31/7/20	20/170	Outcome of nursing staff establishment review (including community) to be presented to the board when available in December	2/10/20 - confirmed that this information will be available before January **AGENDA ITEM**	SW	29/01/21	Complete
1888	Open	2/10/20	Item 27	Schedule review of COVID governance arrangements in December	**Agenda item**	RJ	29/01/21	Complete
1896	Open	6/11/20	Item 12	In preparing the CIP programme for 2021/22 provide visibility that start in a negative position based on not delivering the 2020/21 recurring CIPs	**Agenda item**	CB	29/01/21	Complete
1897	Open	6/11/20	Item 13	Develop arrangements which over time will provide assurance of progress with people plan - action timeline and deliverables (outcomes)	Action plan in development. Interim progress report in People & OD highlight report.	JMO	29/01/21	Complete
1898	Open	6/11/20	Item 13	Provide improvement plan and trajectory for corporate appraisal performance	**Update within People & OD highlight report**	JMO	29/01/21	Complete
1899	Open	6/11/20	Item 16	Undertake further engagement and review of the risk appetite statement and bring back to Board	Scheduled with BDO for audit committee on 29/1/21	RJ	29/01/21	Complete
1900	Open	6/11/20	Item 16	Action through Companies House the dissolution of The Pathology Partnership Ltd	Application made to Companies House for the dissolution of The Pathology Partnership. Notice of submission sent to Board members on 21/1/21.	RJ	29/01/21	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1906	Open	4/12/20	20/237	Circulate NHS Providers link to Governors	https://nhsproviders.org/resource-library/briefings/parliamentary-briefing-current-nhs-pressures	RJ	29/01/21	Complete
1907	Open	4/12/20	20/243	Include staff vaccination in the board reports for flu and COVID	Agenda item	NJ	29/01/21	Complete
1908	Open	4/12/20	20/245	Consider feedback on the “what and how” approach to performance management used elsewhere for the Trust's People Plan	Review experience of Angus Eaton in other organisations	JMO	29/01/21	Complete
1909	Open	4/12/20	20/248	Consider how digital work fits within the future system programme. Include cyber information security risk review in the internal audit programme	Requested that cyber security is included in draft internal audit programme for 2021/22.	CB	29/01/21	Complete

8. Staff story

For Report

Presented by Jeremy Over

9. Chief Executive’s report

To RECEIVE an introduction on current issues

For Report

Presented by Stephen Dunn

Board of Directors – 29 January 2021

Agenda item:	8			
Presented by:	Steve Dunn, Chief Executive Officer			
Prepared by:	Steve Dunn, Chief Executive Officer			
Date prepared:	22 January 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

As I write my first report of 2021 it's so important not to lose sight of how challenging this last year truly has been. To say that 2020 was extraordinary is an understatement. First of all, with Sheila Childerhouse I want to **pay a massive tribute to all of our staff** for the way they have stepped up to play their part in dealing with the Covid-19 pandemic. We know it has been hugely difficult and unsettling for all of us and particularly challenging for staff working on the front-line of this pandemic. The can-do attitude of staff and the spirit of camaraderie, both in the hospital and in the community, has been truly humbling. And although we have often had to learn as we go, we have seen the best in all of our staff.

And while there's never a good time to deal with a worldwide pandemic, Covid-19 arrived on the back of the Trust receiving a "requires improvement" rating from CQC. This was a massive disappointment for all of us and we're sorry for the shortcomings outlined in this report. Since then, we have shown real commitment to recover and improve and there has been a tremendous amount of effort feeding our improvement plan. And what is truly amazing is that we been doing that while dealing with Covid-19. I have talked previously about our commitment to create a just and learning culture at the Trust which will empower and support staff more than ever before. We've spoken to other trusts, such as Mersey Care, and we are determined to make the Trust a more inclusive and supportive place to work. We also have more staff networks such as the BAME, LGBT+ and disability networks active at the Trust, as well as new and extended wellbeing services. Without the commitment of our staff, the Trust does not work and we want to go above and beyond to make working for the West Suffolk NHS Foundation Trust a happy and fulfilling experience.

What is more, supporting our staff has never been more important. At the start of 2021 we have gone into our third lockdown and the NHS remains under pressure across the country due to the spread of Covid-19. Over the last few weeks, we have seen a significant increase in the number of Covid-19 patients to nearly four times the level that we experienced in the first peak. Like the rest of the NHS, we have also experienced a doubling of staff sickness which has put further pressure on the operational and clinical teams in the hospital and out in the community. I just want to say a big thank you for all that our staff have been doing for our community. We know how tough it's been and how flexible and professional you have been. Our very own **ward manager Rosie Cawston** recently shared her experiences of nursing during the pandemic for a feature in the East Anglian Daily Times. I've shared more of what Rosie said at the end of my report. I sincerely thank Rosie for sharing her experience. What Rosie and all our staff have done, and continue to do, is truly amazing. The People Plan report to the Board outlines in more detail the work we are undertaking to ensure we engage with our staff, support them and continue to learn and improve.

To help support staff we have been sharing some simple but important messages with our staff to ensure they consider their wellbeing. We have also been looking to improve the access to rest rooms to give them some much needed space and time. There are a number of 'calm rooms' in the acute hospital available to staff who need some space and quiet time away from their work base and we are looking at creating more. These have been designated and equipped by our My WiSH charity. Within these spaces staff, nevertheless continue to adhere to mask wearing and social distancing rules. For our community colleagues, who do not have access to these facilities, it is equally important that they do all they can to focus on their own wellbeing – including keeping nourished and hydrated and taking breaks, as difficult as that may be. We are also offering free workshops for parents to help support the emotional wellbeing of their children.

To improve our communication with staff we have also put in place weekly staff briefings on the pandemic, which I have chaired and executive team colleagues have presented at. These meetings, which have also been recorded and shared with staff, have been a massive success. Every week over 300 staff, board members and governors have joined these briefings. At these sessions we have talked about what is happening to us regionally and locally around the

pandemic, what it means for us operationally and how we are responding. We have also recently had briefings from our well-being team led by the brilliant psychologist Dr Emily Baker, and we will be hearing about some of the issues facing our community teams this week. I am also delighted that we have launched a Facebook group for our staff. We know many of our staff don't always have the time or have access to their emails, so we have set up the new group to allow staff to communicate with us via Facebook and for us to share things such as the recordings of the staff briefings, staff stories and the weekly staff newsletter, Green Sheet. What has been particularly humbling has been how, in the midst of a pandemic, literally hundreds of staff introduced themselves to colleagues and talked about the real pride they have working at the Trust, either in the hospital or in the community. So, can I say a big thank you to our communications team who have worked tirelessly behind the scenes to get things like this up and running.

And with many of us are using our laptops, PCs and **screens a lot more these days**, can I make a plea that we also need to take time out for our eyes. We all know that prolonged sitting or staring at screens can be bad for our health. Too much screen time without a break can cause eye strain and headaches. We blink less when using a screen, which can cause lack of focus and dry eyes. Eye health charity "Fight for Sight" recommends regular screen breaks and using the '20-20-20' rule – this advises looking at something approximately 20 feet away for 20 seconds, for every 20 minutes you look at a screen.

But while our eyes might be straining, there is light at the end of the tunnel. As we ramp up our **vaccination programme** for healthcare workers - thousands of our staff and local health and care providers have received the game-changing Covid-19 vaccination**.** Since kicking off our staff vaccination programme on 4 January, we have vaccinated more than 10,000 priority staff from the Trust and local NHS partner organisations. This has literally been a big shot in the arm for us all and a huge morale boost. It should also help to reduce staff sickness. I want to say thank you to everyone, including our volunteers, who have played a huge part in vaccinating staff. I have been lucky enough to spend time with the team and I have nothing but admiration for their work ethic and kindness.

Patients and staff have missed our volunteers and have been asking when they will be returning to their roles at the Trust to support our staff and patients. In October, we welcomed back our first small cohort of volunteers to the information desk, but this was put on hold when increased Covid-19 restrictions for outpatient appointments and inpatients were introduced in December. We have recently reinstated more volunteers and now have 36 covering three supporting roles for the Covid-19 vaccine programme in Quince House and they are all delighted to be back. With Covid-19 restrictions continuing to limit the areas our volunteers can return to we will be developing alternative roles for them where we can.

It would be naive to make predictions for what 2021 will bring, based on what the last 12 months has shown us, but there is a lot of hope ahead for us as a Trust. We are fortunate enough to be one of the hospitals that will be rebuilt as part of the government's Health Infrastructure Plan, meaning that this decade will see the introduction of a new health and care campus. The trust's new Future System Team is leading the programme and they are very keen to involve as many staff as possible in this process. We're very proud that the new campus will be based on a new 'co-produced' clinical model and we are looking forward to driving forward our consultation and engagement as part of that co-production process.

Previously, we had discussed how Hardwick Manor was one of a small number of options for the Trust to consider as a preferred location for the new healthcare facility. Now that the detailed evaluations of all the sites have been completed and thoroughly scrutinised, in December it was with great pleasure that we announced **Hardwick Manor as the preferred site for our future healthcare facility**. Four potential sites were investigated and rated by technical experts and representatives of our patients, staff and partners with over 3,000 pages of detailed reports produced. We considered all of the most important factors such as our ability to buy the site, the

likelihood of gaining planning permission, public transport, future growth and ecological impact. It was close, but Hardwick Manor came out on top. One of the big benefits about this proposal is the possibility of keeping some of the current site based at Hardwick Lane, including many of the most recent additions such as Quince House, the new staff accommodation as well as the Drummond Education Centre, and Eye Care Centre. This will allow us to make the best use of public funds. The Trust is also incredibly fortunate to have partner organisations on our site such as St. Nicholas Hospice, mental health provider Norfolk and Suffolk NHS Foundation Trust, and the Busy Bee's nursery that supports our staff. If we can base our new facility at the site of Hardwick Manor, this will mean that close relationships with co-located services such as these can continue. We are also keen to develop further integrated working with our health and care colleagues. More detail and updates are provided in the future system report as part of the main Board meeting agenda.

The Trust is due to renew its five-year **corporate strategy** with the previous strategy 'Our patients, our hospital, our future, together' completing in 2020. Moving forward, given our focus on, and the impact of, the coronavirus pandemic, and the recovery period we will need to navigate when we get through this current peak, we are recommending a simplified approach to our overall direction that reflects the Trust's key commitments going forward. The draft strategy is in progress and has been through an initial set of feedback, including having been presented to Governors, with further feedback ongoing. Given the current circumstances, it is difficult to determine when will be the best time to launch; we are sensitive to the heavy demands that everyone is dealing with at the moment. A potential date of late Spring will be reviewed as the strategy progresses.

2021 will also see further development and support for our community teams who have been doing an amazing job through this pandemic. I am delighted that Shelley Lee has been appointed as a second senior matron for the Trust's **community services**, working with fellow senior matron Amanda Keighley to provide clinical leadership to nursing staff across west Suffolk. I am delighted that we are continuing to strengthen and invest in community nursing. Our senior matrons are part of our commitment to ensuring we provide safe, quality healthcare to our patients, and support to our compassionate and diligent nurses. The demands on our nurses, our services, the age of our patients and the complexity of their needs are increasing all the time, and having these highly-trained and experienced clinical leaders is a great asset to our community.

Care for **patients living with neurological conditions** is also being boosted by two new specialist therapists. Physiotherapist Claudia Olhero and occupational therapist Beckie Kent are supporting the community teams with patients who have neurological conditions, offering support, training, and supervision, as well as having a small caseload themselves. Based at the Disability Resource Centre in Bury, they will be working with adults with a broad spectrum of neurological conditions, which could include Parkinson's, multiple sclerosis, stroke, motor neurone disease and Guillan-Barre syndrome. Experienced in specialist rehabilitation, the team will be providing expert advice to therapists in the community health teams. They are aiming to support existing community therapists in their ever-increasing workload, and build up networks with community nurses, the voluntary sector and our neighbouring trusts to grow existing integrated working. While virtual consultation is possible, ideally, they would be going out to see patients face to face. They will also train relatives and carers to use specialist equipment. The team will be bridging a gap between the inpatient and outpatient services at the hospital, and can work with patients within their own homes.

I am also delighted to say that prior to Christmas, the IT team completed the migration of all **adult community health teams**, including management, business support and therapy teams, into WSFT IT support. This has long been a source of community staff discontent and I am delighted that we have taken back control of community IT, with our community health teams all now having WSH email addresses. This is a staged process, so from 11 January to 5 February, we will be moving the integrated community paediatric service staff across, and they will be followed by the community informatics team and the community pain service during February.

Major improvements also lie ahead for our community services and alliance partners, thanks to major **investment in new joint hub sites**. As part of a drive to bring public services together, working in partnership and accessible at one site, a number of hubs are being developed across Suffolk. The Mildenhall Hub is expected to open this year, and among those moving into it will be our colleagues from the Mildenhall community health team. A virtual tour has been created to allow people to see the progress at the Sheldrick Way site. For our colleagues it means they will be able to see patients in clinic rooms, and signpost them to other facilities such as exercise classes or swimming. This is a very positive move for our services and patients. We have already gained benefits from being co-located with our social care colleagues, especially helping to care for patients with complex needs. This will give us immediate and prompt access to a wide range of beneficial services for the people we care for. You can access the virtual tour here. Already co-located with social care staff as part of an integrated neighbourhood team, the nurses, therapists and generic workers will be working with professionals from across the system. The Hub brings together a new school for Mildenhall College Academy; new leisure facilities including bigger swimming pools; a health centre; library, advice centre and children's centre. There will also be space for Suffolk Police and West Suffolk Council. Wow. Now that is what we mean by alliance working and integration!

In terms of other brightness amongst the winter gloom, I am also pleased to say that we have recently **completed phase 2 of the Trust's LED lighting project**. This project has seen the introduction of LED lighting to a series of hallways and wards across the West Suffolk Hospital site with the view to save on electricity bills and lower our carbon footprint. LED lighting uses less electricity than traditional forms. The LED lights installed at the Trust have been fitted with 'Smart Scan' technology which provides us with greater control of our lighting, contributing to a more comfortable environment for our patients and staff. Since the project began, we've saved a whopping £23,000 on our electricity bills and enough electricity to supply an average home for 51 years. Our CO_2 savings work out at over 13 tonnes - it would take a woodland of 82 trees 50 years to absorb this amount!

In and amongst all the pandemic pressures staff also continue to take a real pride in the quality of the services we provide. The **high quality of endoscopy services** at West Suffolk Hospital has been nationally recognised by the Royal College of Physicians. The college's Joint Advisory Group (JAG) on endoscopy awarded the service its highly sought-after professional accreditation, which focuses on standards and identifies areas for development. It is regarded as one of the most innovative and effective in the healthcare sector, and has been used as a model and source of inspiration for similar schemes both in the UK and overseas. JAG accreditation is based on evidence linked to clinical quality, patient experience, workforce and training. This is fantastic news for the very hard-working team in endoscopy as well as for our patients, who will continue to receive brilliant support from talented professionals. The accreditation from JAG goes to show how talented and caring the individuals and team are.

Congratulations are also due to the orthopaedics team, which has been reconfirmed as a **National Joint Registry (NJR) Quality Data Provider for 2019/2020**. The NJR Quality Data Provider award scheme has been developed to offer hospitals a blueprint for reaching standards relating to patient safety through National Joint Registry (NJR) compliance and to reward those who have met targets in this area. The NJR is currently the largest joint registry in the world and has brought incredibly important information to the orthopaedic world which underpins our quality improvement activities that have supported the achievement of some of the best orthopaedic outcomes data in the country. The data has also been used for very valuable publications in top level peer reviewed orthopaedic journals.

There was also a happy new year surprise for members of the WSFT catering team, when they were presented with the **Hospital Catering Award** they won at the recent Health Business Awards. As there could only be a virtual ceremony, the award was sent to the Trust to be handed over by Director of Resources, Craig Black at Quince House. Health Business magazine's editorial

team put the Trust forward for an award in recognition of its catering team “going above and beyond this year to provide arrangements for overnight staff”, as well as the introduction of an ‘afternoon tea’ service as a special culinary treat for inpatients. I am delighted for our splendid catering team, who have rightly been recognised for the excellent work they do for our staff, patients and visitors. In these most challenging of times, their excellent service is a vital part of the care we provide. Congratulations to the whole team on this richly deserved award.

Lastly, I should mention that we have agreed with West Suffolk CCG that will we reduce our **outpatient phlebotomy** opening times to enable phlebotomy staff to offer further support to the inpatient phlebotomy team at West Suffolk Hospital. The phlebotomy department at Bury will be open 7.15am – 4pm with effect from Monday, 11 January, until further notice. All Saturday appointments will be cancelled with effect from Saturday, 30 January 2021 until further notice, (though existing booked appointments on Saturdays 9, 16 and 23 January will be honoured). These changes will be kept under review should the Government advice change.

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

Being a nurse in a pandemic

Hello, my name is Rosie and I've been a ward manager at the Trust since December 2019. My ward has been a Covid-19 ward throughout both waves of the pandemic.

It continues to be a challenging time for us; the numbers of Covid-19 admissions and how dramatically they have risen in recent weeks is frightening. Like a lot of people I know within the NHS, I often struggle to sleep before a shift, something I have not struggled with before. I now have anxiety about what the day ahead holds.

The way we work has changed
Like many NHS Trusts, staffing is difficult at the moment, with many of us having to isolate or having tested for Covid-19. This does put pressure on a hospital; our staff have had to be flexible in moving around to support other areas.

The way we work has changed and we have to prioritise our workload differently. As a nurse, you have to administer medications morning, lunchtime, evening and bedtime. With Covid-19 measures, such as applying and removing PPE between each patient and washing your hands, you try to administer medications efficiently. You don't have time unfortunately to stop and chat to patients for long; they don't have visitors to keep them company so we are the only people they see.

Being a ward manager
As a ward manager, I have an open-door policy and I'm always at the end of phone, should my colleagues want to talk about anything. At the staffing huddle at the start of a shift, it is my opportunity to check in with staff and see how they are doing. Like most wards, we have a really positive team spirit – to pitch in and help one another. Staff often come in on their days off and are doing additional shifts because they want to support their colleagues.

In my experience, at West Suffolk Hospital we really do support one another. Ward managers will often pop in on each other. What is clear is that we are all in this together and everyone feels similar emotions, frustrations and feelings. We often have the chief nurses, heads of nursing and chief executive visiting the wards, wanting to know how we are doing and what they can do to help. This goes a long way to know we are on everyone's radar.

We also have a psychological wellbeing team service. They have visited the ward regularly to see how staff are. A lot of the staff have struggled mentally so it's good that we have the opportunity to debrief and chat about what's going on.

Our hospital charity, My Wish, has done a phenomenal amount of work to help make staff feel valued and make our day better. In the last wave, we received money to make a staff room for the ward and that has really boosted morale.

'A hoax'
It's frustrating when people say Covid-19 is a hoax or 'blown out of proportion'. I go on social media and see things where people are carrying on like normal. I think if people worked just five minutes on any NHS ward at the moment, they would change their mind.

Staff have been working in this environment for nearly a year and I think everyone is exhausted. I have met people who are sceptical of Covid-19 - it is very much real and I have witnessed first-hand the implications it has, not just on staff at the hospital, but on patients and their family too.

The future
I am hopeful about the vaccines that are being rolled out. Initially it did feel that we were no further forward than we were in March. However, I need to remember that we have climbed this mountain and we are nearly at the top. The vaccines will make a difference, we need to hang onto this. I've had the vaccine and I know a lot of my colleagues are signed up and eager to have theirs.

Everyone at the Trust is trying their best. It is really challenging. It feels so much worse than the previous wave in March. Staff are tired and exhausted. Yet they are coming into work every day with a smile under their masks and working in really difficult situations.

I hope the public remain patient with us, and remember we are continuing to adapt to an ever-changing situation.

9:45 DELIVER FOR TODAY

10. Operational report

To APPROVE the report

For Approval

Presented by Helen Beck

Trust Board – 29th January 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 Lesley Standring, Head of Operational improvement			
Date prepared:	18 January 2021			
Subject:	Operational Update			
Purpose:	x	For information		For approval

Executive summary:

This paper provides an update on the key operational areas of work during the month. This includes; an update on current operational pressures and the most recent forecast data, community services and 7 day services.

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

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

Previously considered by:	Future planning meeting. Winter planning meeting Brexit Planning Group
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

In the last month the Trust has seen an unprecedented rise in COVID demand which reflects the pressures being felt across the country.

Facing rising COVID cases and significant staffing and capacity shortages we took the decision to pause all non-urgent elective and diagnostic work in mid-December. As it stands we are undertaking P1 (priority procedures to be performed in less than 72 hours) and P2 (priority procedures to be performed in less than 1 month) operations in line with NHS E/I direction and Federation of Surgical Specialty Associations guidance.

This decision supports our front-line teams and we have seen many staff redeployed to alternative clinical areas.

Learning from our wave one experience we are trying to maintain some high priority diagnostics within endoscopy, MRI and CT scanning. We continue to treat our cancer patients in a timely way once diagnosed but are still working through the previous backlogs of patients still awaiting a diagnosis. The ICS has just been given permission to trigger surge capacity with the independent sector which once again gives us access to 100% of the BMI staffed capacity, however it should be noted that this is only a small unit and their staffed capacity is a maximum of 2 theatres per day.

As with the first wave of Covid ED attendances and non Covid admissions have fallen significantly during December and January, which has been a significant factor in the Trusts ability to manage its capacity during this unprecedented surge. In line with national guidance we have implemented Lateral Flow Tests on all patients expected to be admitted via ED as an initial screen. These are done in conjunction with SAMBA tests which give a result in 90 minutes but this is often backlogged due to the limited number of machines available to us. We are anticipating delivery of an additional 5 SAMBA machines which will ease this pressure.
The new ED RAT area is due to open w/c 8th February and is eagerly awaited by the team as it will significantly improve our ability to keep patients isolated until their Covid status is known.

At our peak we had 185 Covid positive inpatients. That has reduced somewhat over the last 10 days and at the time of writing we have 138 positive inpatients. The reduction is a combination of a slowing admission rate and increased availability of designated settings which has facilitated patient discharge. A designated setting is a nursing or residential home which can take medically optimised patients who are isolating due to having testing positive for Covid or having been in contact with other Covid positive patients.

Critical care admissions continue to be high, however. At the time of writing there are 15 patients being care for by the critical care team (maximum capacity is 20). We have provided mutual aid to the wider critical care network and are expecting to see increased admissions to critical care for some time.

Our planning assumptions considered a peak of 250 positive inpatients which, thankfully, we have not yet seen. The most recent data provided by the Cambridge Judge Business School (19 January 2021) shows West Suffolk with a declining forecast with potential reduction of inpatients by 50% by 1 February, however these forecasts tend to have a wide degree of uncertainty and we believe are potentially being influenced by our recent increase in discharges to the newly identified designated settings.

It is worth noting that the trusts forecast is in stark contrast to Colchester and Ipswich, both show continued growth which would exceed total SNEE capacity by 11 March. It is likely that this is due to the impact of new designated settings for Covid positive and Covid contact discharges, which have caused a rapid reduction in cases reported within the trust and are skewing the data.

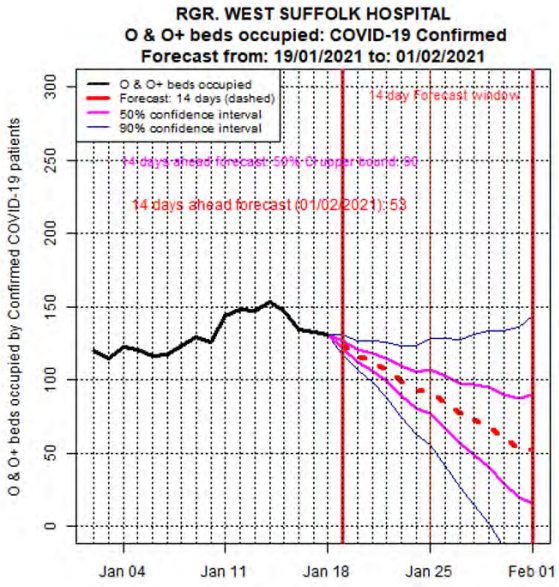


Table 1: Cambridge Judge Business School WSFT forecast, 19 January 2021.

The table below has been produced by our Trust public health team and aims to only offer short term (5 day) projections to support operational planning.

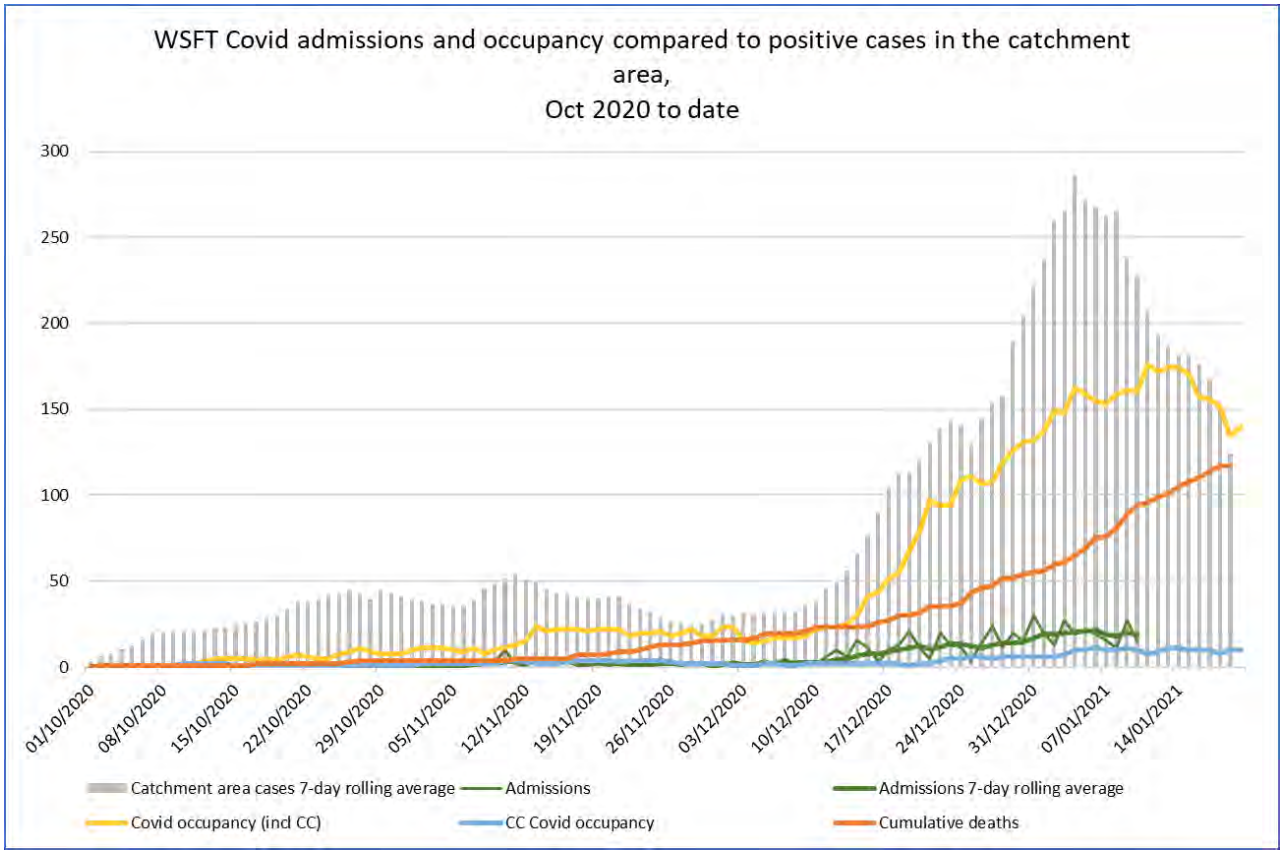


Table 2: WSFT PH projections 20.01.21

Community position

Community beds
Community teams have been working incredibly hard to support the pandemic effort over the past month. We currently have over 128 beds commissioned within the community to support patient discharge. This includes designated settings at Newmarket (converted in month) and Silverbirch (nursing home) in Ipswich.

We continue to work collaboratively with system partners but have been hampered by the number and frequency of outbreaks in the community which reduce the number of available beds. That said there are now pathways in place for positive, contact and reablement patients who are medically optimised, good processes to manage patients regardless of setting and weekly MDT's to ensure patient safety and 'flow' through the beds.

COVID Virtual Ward

We plan to have a COVID virtual ward in place by 1 February. This model will support step down management for positive patients who are clinically suitable to be managed in a virtual ward. The ward will sit with the CPOD team and will see patients cared for in their home environment whilst remaining under the care of WSFT. The use of pulse oximeters to enable patients in the virtual ward to monitor and record vital signs, such as oxygen saturation levels, will support this initiative.

Enhanced Integrate Neighbourhood Team (INT)

Progress with the enhanced INT is being made and Newmarket is now live. Under this new model up to 5 patients will be supported at home in each of the 6 localities. The remaining localities go live over the next 2 weeks.

Post Covid Rehab

This is not a new service, but formed of services that were already available and address symptom management of COVID.

Whilst COVID has presented a variety of different symptoms they do align with pre-existing community services which can be accessed via existing referral routes.

- AHPS: Conditioning programme
- Suffolk Wellbeing service: Anxiety management
- Medical: Speciality dependent on need
- WSFT respiratory physio: Breathlessness management and dysfunctional breathing
- WSFT FIT group: 6 week exercise programme with support from full MDT
- WSFT SALT: Persistent swallow problems
- Abbeycroft: Falls programme, strengthening programme and 'breathe better for health'
- Community OT: Cognitive assessment and treatment, fatigue management

Community therapy teams are signposting patients and staff to the following website which is a valuable source of information www.yourcovidrecovery.nhs.uk . A patient information leaflet about these services is currently in draft.

Long Covid

If symptoms persist for longer than 12 weeks and have not been managed through one of the above pathways then the GP can refer the patient into SNELCAS (Suffolk and North Essex Long Covid Advisory Service)

Patients are reviewed by the clinical oversight team with a 1:1 call (functional assessment tool) who will refer to appropriate service/s. The team keep track of all the patients with long COVID under them and re do regular assessments

Community Structure

Review of the community structure remains at an informal stage but good progress is being made with the consultation documentation with support of HR teams at the trust and in social care. A formal timeline is being developed along with revised JD's.

We plan to ask Rethink to return to provide their feedback to staff in due course.

7 day services

The NHS England 7-day service programme was paused in early 2020. It is unclear whether the programme will be resurrected and if so in what form. We continue to monitor time to first consultant assessment informally with the most recent data comparable to the most recent national audit results (80% of patients seen by a consultant within 14 hours of admission).

Recommendation

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

11. Vaccination report

To APPROVE a report

For Approval

Presented by Nick Jenkins

Trust Board – January 2021

Agenda item:	11			
Presented by:	Nick Jenkins			
Prepared by:	Jo Rayner			
Date prepared:	24 January 2021			
Subject:	The Vaccination Programme at West Suffolk Foundation Trust			
Purpose:	x	For information		For approval

Executive summary:

In November 2020 a multi-disciplinary project team was formed to deliver a hospital hub vaccination programme. Since opening on 4th January 2021, more than 12,000 vaccinations have been delivered to WSFT staff and healthcare workers from partner organisations and community healthcare teams. The vaccination programme has been successful in delivering quickly but also professionally and this has been recognised by a steady stream of compliments from a range of sources.

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

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

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

Recommendation:

Trust Board to note the update on the vaccination programme.

The Vaccination Programme at West Suffolk Foundation Trust (WSFT)

Background

In November 2020 a multi-disciplinary project team was established to develop a vaccination programme for WSFT. On 4th January 2021 the vaccination programme began upon delivery of the first batch of vaccine. Taking delivery of the Pfizer vaccine without an ultra low freezer requires the vaccine to be used within 5 days. Each box delivered holds 195 vials which initial guidance stated contained 5 doses in a vial, equating to 975 vaccines per delivery. This guidance quickly changed to enable 6 doses per vial extending this to 1170 vaccines per delivery.

The Model

Various locations across the Trust were evaluated to be the vaccine hub and the second floor of Quince house was implemented. All of the executive offices were decanted over the Christmas period and set up as vaccination rooms providing 6 vaccinations rooms alongside other offices and meeting rooms for recovery areas and consumable storage. The core model consists of 5 vaccinators with the sixth vaccination room being held as a contingency should any queues develop to ensure the wait time is kept to a minimum.

A bespoke booking system was developed by our IT Department, which has an automatic feed (via a robot) into the national recording system. This has enabled the booking system to be managed in line with local processes and bespoke sessions to be built as required, for example a dedicated session to manage staff with allergies to allow them to be vaccinated.

The interest from people wanting to offer their time to support the programme has been overwhelming and a core rota of vaccinators was filled with a combination of our own staff taking extra shifts outside of their usual duties and staff from partner organisations offering their time to support the programme. The remaining vaccinator volunteers have been contacted and invited to start the process to join the rota part of which is to complete further online training to become a vaccinator.

The welcome and check in process for the vaccinations has been managed with a combination of the Trust volunteers and staff members providing support both alongside their usual duties as well as volunteering extra time outside of working patterns.

The Data

The model was initially set up to deliver 10-minute appointments in 5 vaccination rooms over 11.5hrs which allowed at 345 vaccinations per day which ensured vaccine would be used within the 5-day shelf life to reduce the risk of any wastage. Whilst this model delivered a managed start to the process it was very quickly recognised that the team were able to increase the appointment slots. This was increased gradually over the first few days and soon reached capacity at 621 vaccines per day. This enables for one delivery box to be used within 2 days.

On Monday 25th January, the vaccination programme was 3 weeks old and achieved 12,000 vaccinations.

Impact

To date just under 80% of WSFT staff have been vaccinated with second doses scheduled in the 12-week window as per national guidance. Approximately 8,000 people from partner agencies have been able to access the vaccine at Quince House including community healthcare workers such as care home staff, community pharmacists and private dentists to name a few.

The feedback the team has received has been overwhelmingly positive and compliments continue to be received. The themes include well deserved recognition for the vaccinators, volunteers and those working onsite to ensure the process is smooth. Many compliments have been received about the ease of booking and the swift and professional service. One of the compliments even said the service and process at WSFT had been the best they had experienced among all of the areas they worked in from across the country.

Next Steps

The project team have been scoping additional sites which could be opened to support the effort across West Suffolk using the successful hospital hub model that has been deployed in Quince House. The team are also working with system partners to provide a coordinated response to the wider vaccination programme.

12. Integrated quality and performance report

To APPROVE a report

For Approval

Presented by Helen Beck and Susan Wilkinson

Trust Board Report

Agenda Item:	12			
Presented By:	Helen Beck & Sue Wilkinson			
Prepared By:	Information Team			
Date Prepared:	Dec-20			
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.

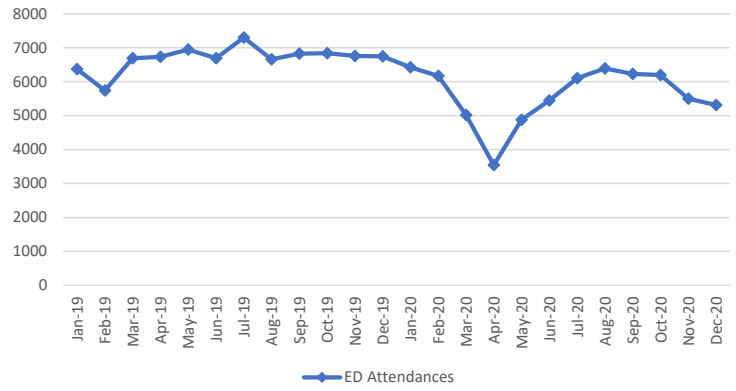
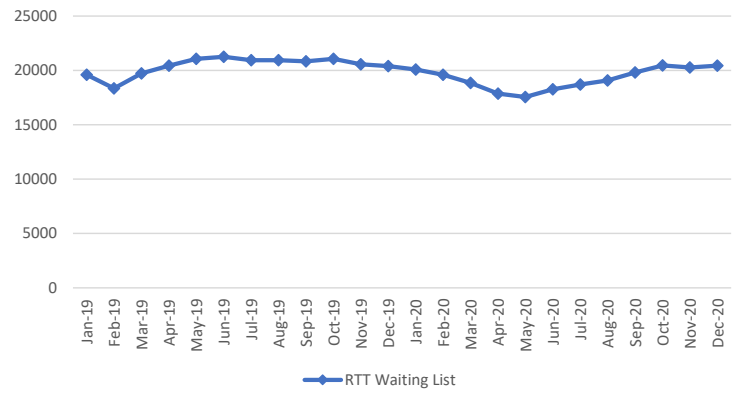
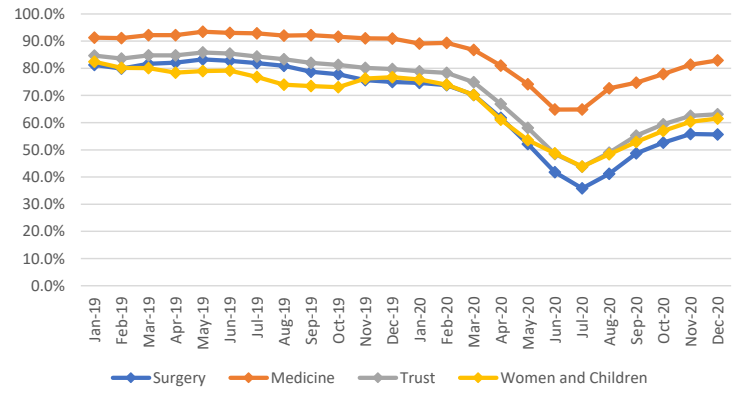
Trust Priorities [Please indicate Trust priorities relevant to the subject of the report]	**Delivery for Today**	**Invest in Quality, Staff and Clinical Leadership**	**Build a Joined-up Future**
	X		

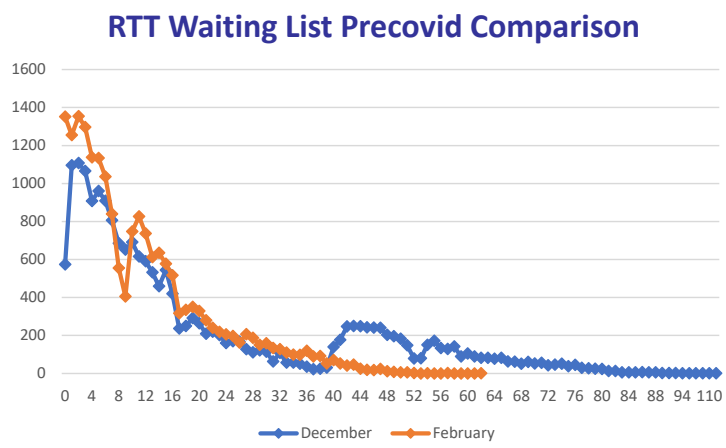
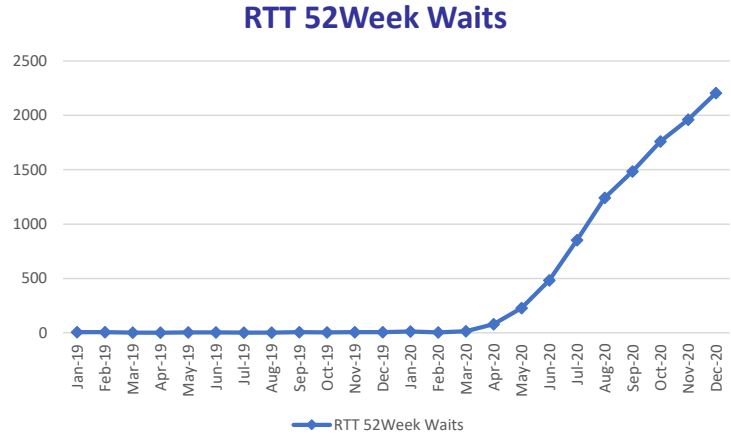
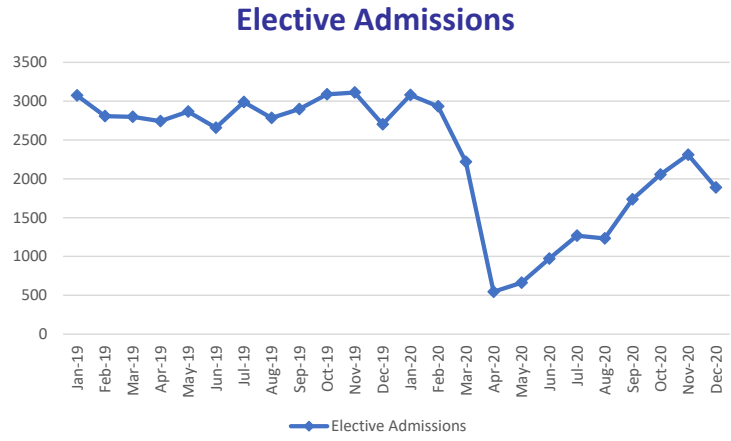
Trust Ambitions [Please indicate ambitions relevant to the subject of the report]	Deliver personal care	Deliver safe care	Deliver joined-up care	Support a healthy start	Support a healthy life	Support ageing well	Support all our staff
		X	**X**				**X**

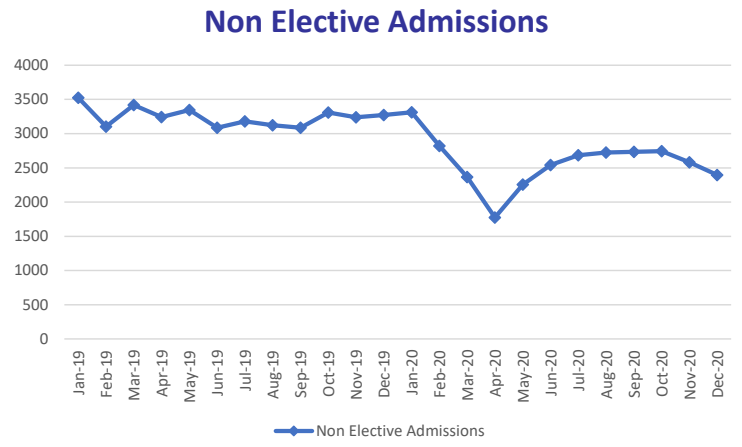
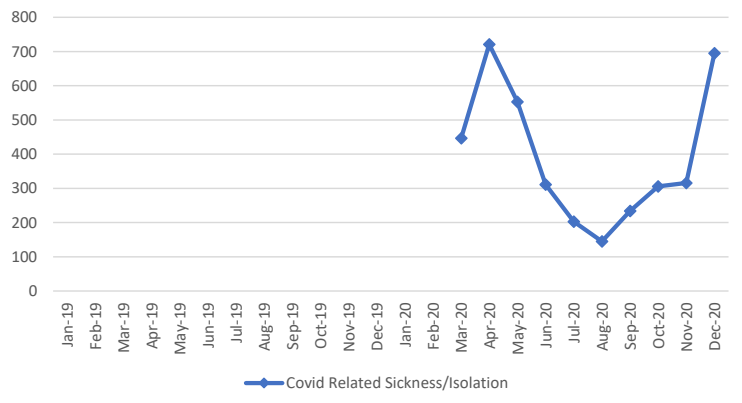
Previously Considered by:	
Risk and Assurance:	
Legislation, Regulatory, Equality, Diversity and Dignity Implications	

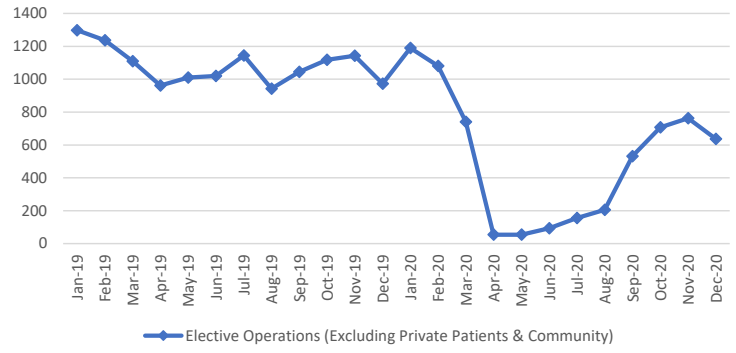
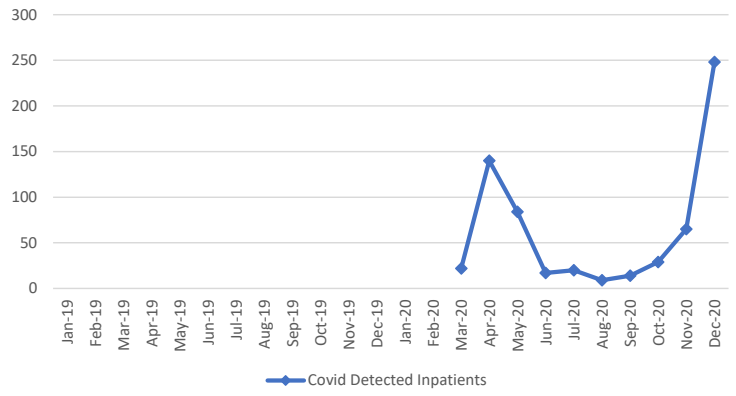
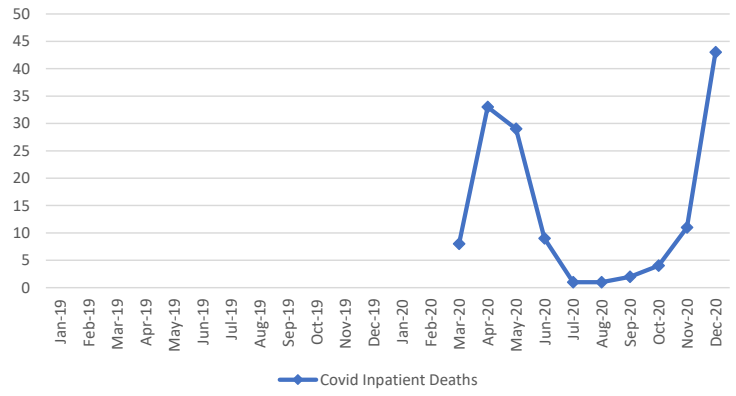
Recommendation:

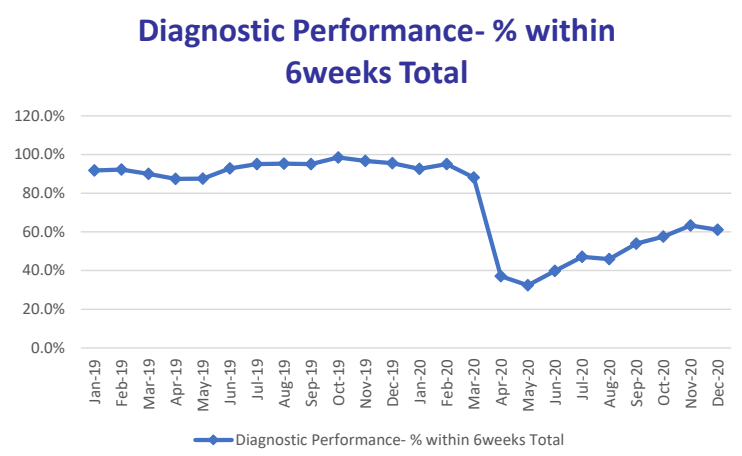
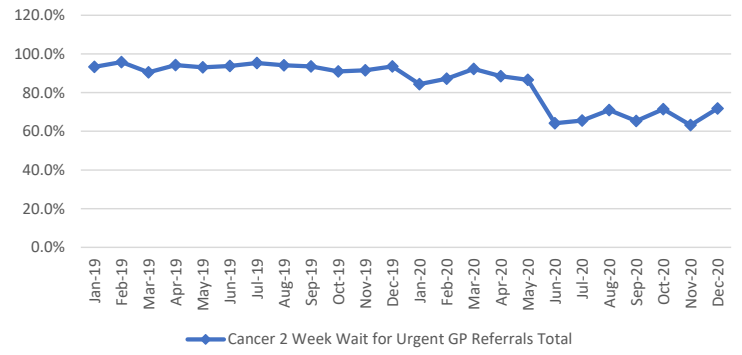
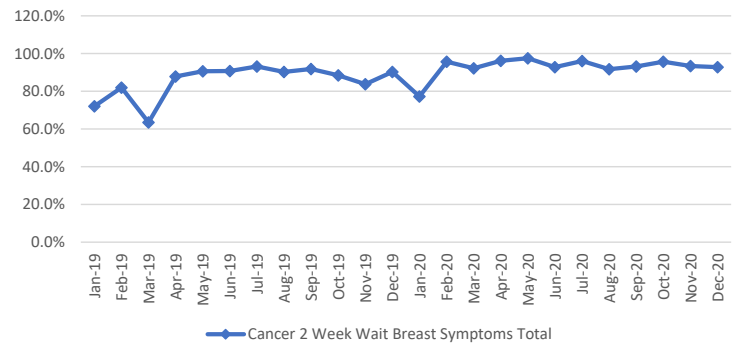
That Board note the report.

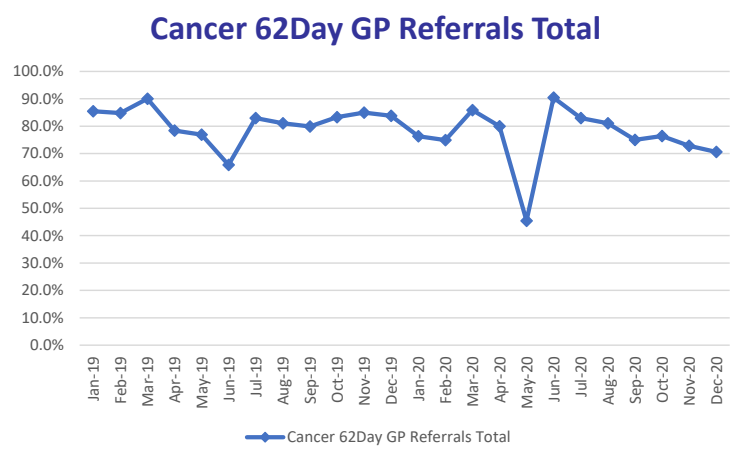
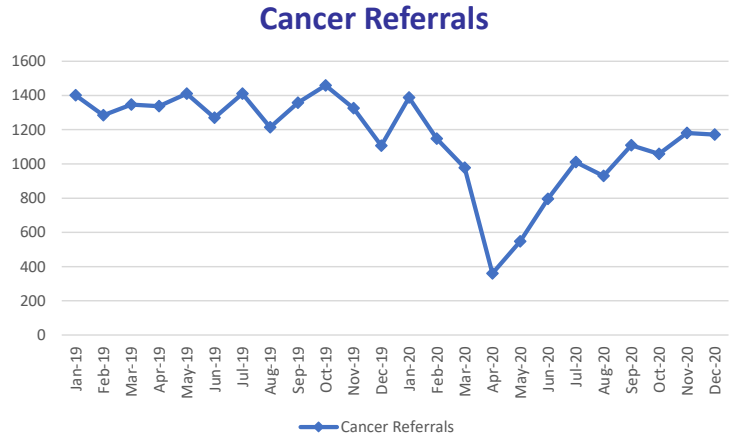
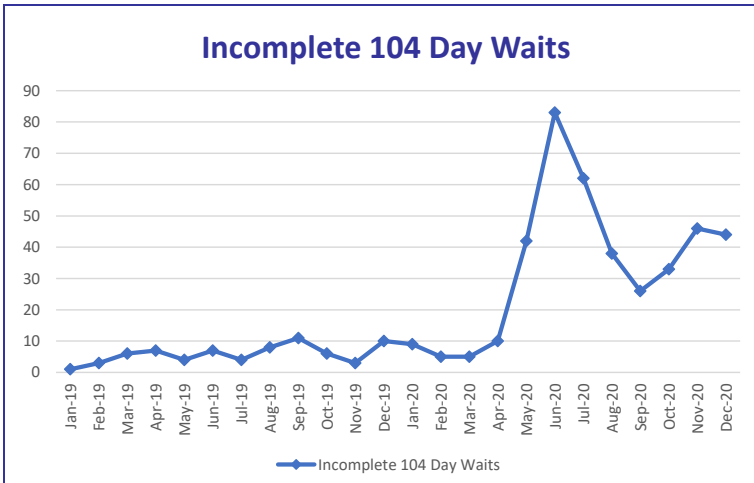
Board Report KPIs	Narratives
Emergency Department Attendances 	There were 6746 attendances to ED in December 19 compared with 5309 in December 20 (a decrease of 1437 patients) This reduction continues to coincide with the second wave of Covid - resulting in patients less inclined to attend the hospital and social distancing/wearing of masks reducing the transmission of other viruses
A count of the arrivals at the Emergency Department. This metric has no national target but is key to understanding demand for non elective services.	
RTT Waiting List 	Slight increase in the overall waiting list size from November to December. A number of patients were cancelled towards the end of December due to Covid restrictions which will have had an impact on this. As at the end of December referrals had mostly returned to normal levels so we would not be expecting to see the same dip in the overall RTT number that we had in April/May last year.
A count of the patients on the waiting list for treatment.	
Acute 18 Week RTT Compliance % 	Improvement in the medical division continued in December with their performance at the highest level since March 2020. W&C and Surgery continued at a fairly static level, as patients were being treated in clinical priority. However there is an expectation that these performance % will drop again for those services reliant on face to face interactions, diagnostics and theatres.
% of patients on incomplete RTT pathways	

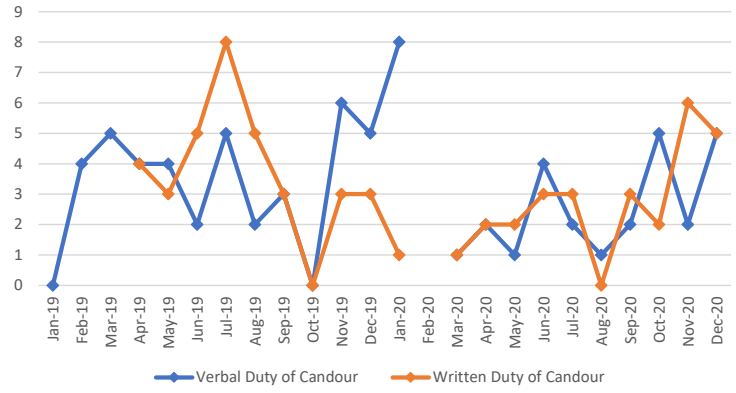
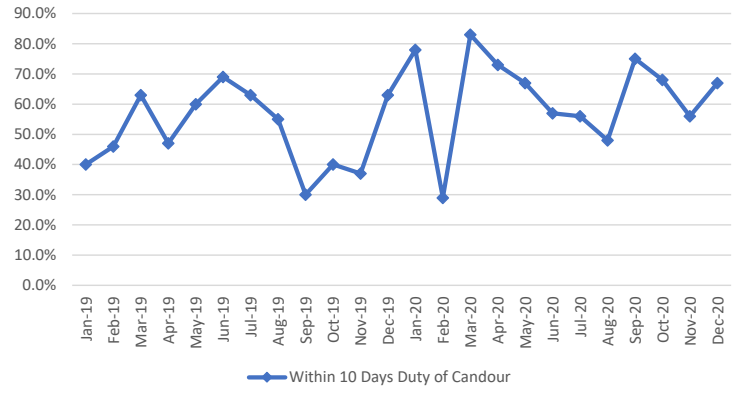
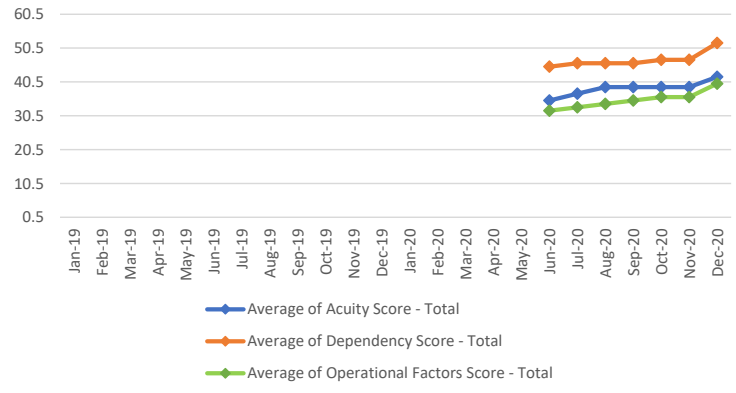
Board Report KPIs	Narratives
	As we have seen in previous months the waiting list 'tail' is significantly longer due to the restrictions in surgery as a direct impact of Covid-19 and the need to treat patients with the highest clinical priority. The waiting list shape has changed and we can see the dip at around the 40 week mark which was when referrals dropped off during the first wave of the pandemic.
A year on year comparison of the number of patients waiting for treatment.	
	Continued increase in amount of patients over 52 weeks, we are currently at 2206 over 52 weeks. This is expected to continue to grow whilst we are not in a position to operate on routine surgical patients.
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.	
	Whilst there is a normal trend for activity to be reduced in December, this year it was even more impacted than normal due to the need to cancel some activity towards the end of the year.
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.	

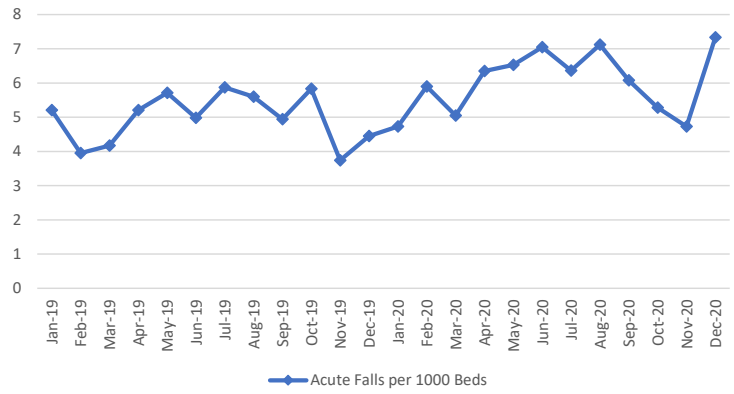
Board Report KPIs	Narratives
	There were 2396 Non-elective admissions in December 20 compared to 3272 in December 19 which represents a decrease of 876 non-elective admissions in December 20. Again, this coincides with the second wave of Covid and in part to improved pathways and admission prevention services.
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.	
	Absences as at the end of December 2020 remained at 3.9%, as it was at the end of November 2020. It is likely this will increase in January 2021 due to significantly higher absence in the Trust throughout the months of December 2020 and January 2021.
A measure of staff sickness across the Trust. This includes community staff. This is a local metric to monitor the capacity of our workforce.	
	This chart illustrates the number of sickness episodes related to COVID-19. In December 2020 there were 695 episodes recorded which is a significant increase on November 2020 which was 316 episodes.
A count of our staff who have been off sick with a Covid related symptoms or to isolate. This is a local metric to monitor the impact of Covid on our workforce.	

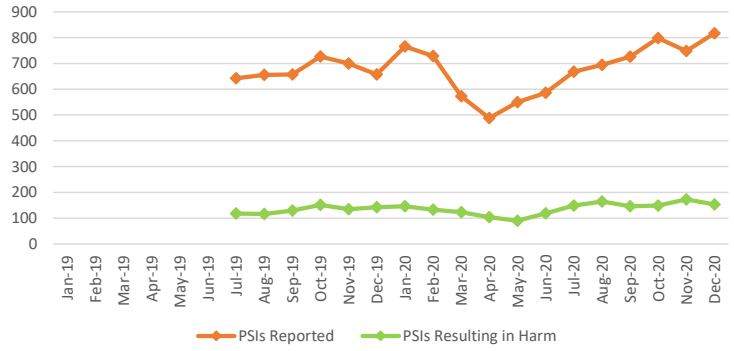
Board Report KPIs	Narratives
Elective Operations (Excluding Private Patients & Community)  This is a count of the number of operations that were carried out. This is a local measure to monitor our productivity and recovery from Covid.	In normal circumstances the amount of patients operated on in December drops down by at least 100 as an impact of bank holidays and Christmas breaks. This year it was further impacted by the need to cancel some Orthopaedic surgery in December 2020.
Covid Detected Inpatients  This is a count of the number of patients admitted to the hospital who tested positive for Covid. This is a local measure to understand the local impact of Covid. This number is reported daily as part of national daily reporting requirements.	Inpatients with covid and deaths follows national picture.
Covid Inpatient Deaths  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.	Inpatients with covid and deaths follows national picture.

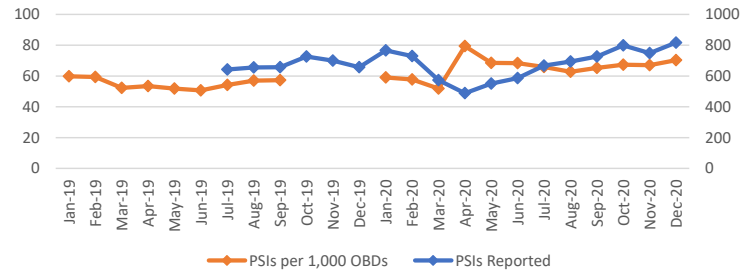
Board Report KPIs	Narratives
	The picture for Diagnostics showed the staged recovery process gradually taking shape as we returned from just emergency work during the first wave to undertaking emergency, urgent and routine as part of the recovery plan. For wave 2 we are only undertaking imaging on urgent and cancer patients. Due to staffing, capacity has also had to be reduced in some parts of the service, and the next picture will show a drop-in activity across the whole service, while waiting times for routine and surveillance patients continue to grow.
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 increase in performance for 2WW standard from November to December. Most services met and over achieved the 93% standard, with the exception of Urology (90.2%), Skin (91%), and Upper & Lower GI - both at under 30% compliance. This is due to the straight to endoscopy elements within these pathways, however we are seeing some improvement in these areas and backlogs are reducing.
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 at 92.8%. Large amount of referrals for Breast Symptomatic in December 2020 with over 300 patients being seen across breast services, this is more than we have on a normal month.
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.	

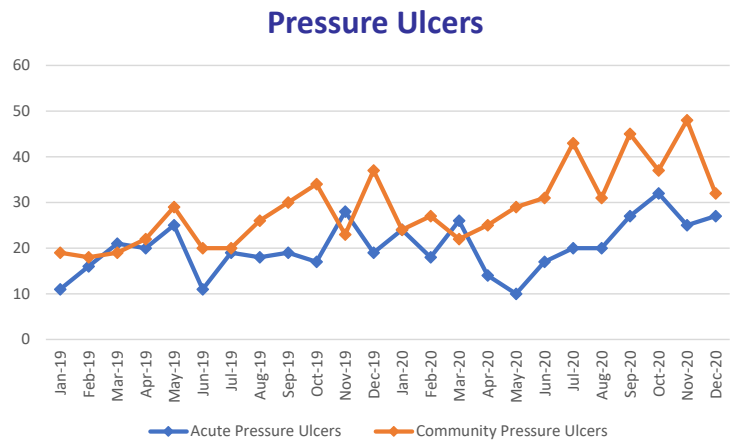
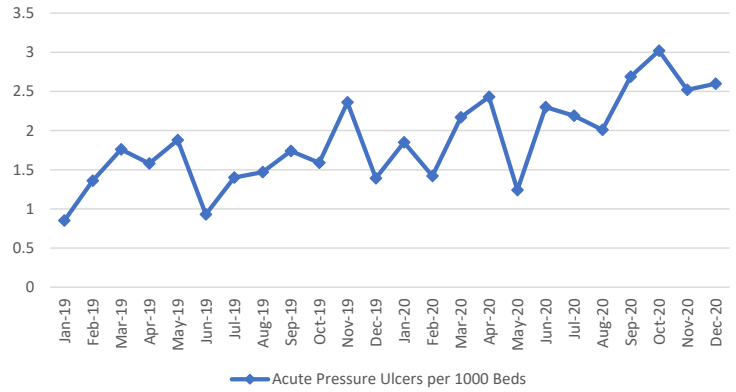
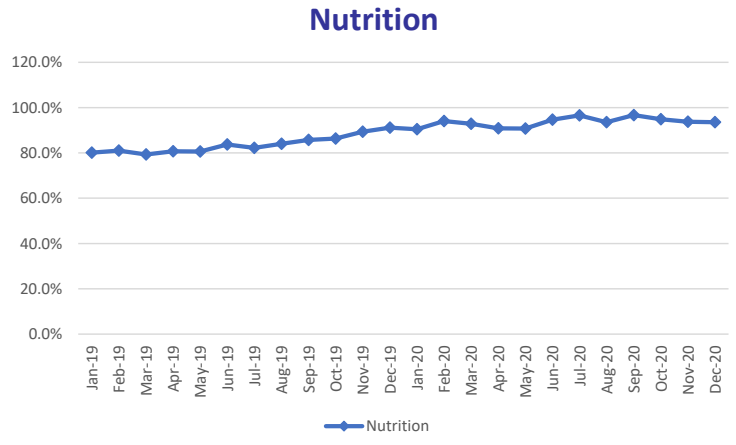
Board Report KPIs	Narratives
	Expected reduction in 62 day performance as we continue to work through the diagnostic backlogs within the cancer pathway, once patients are diagnosed we are treating them quickly but many are over 62 days by this point. 15.5 breaches currently recorded of with 8.5 are within upper or lower GI and impacted by the endoscopy challenges.
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.	
	Historically we see referrals drop off in December but this was not the case this year and in some tumour sites we saw unprecedented levels of referrals, though not yet back at 'normal' levels for others. Work is on-going with primary care to encourage appropriate and accurate referrals.
A count of the number of patients referred to the hospital with suspected cancer, requiring investigation. This metric shows the activity by month for cancer services, which informs the national metric which measures the number of these patients that were seen within 2 weeks (further in the performance pack).	
	Overall patients over 104 has reduced, but this continues to remain high for the Trust. Most of this is a direct impact of covid-19 and the diagnostic delays.
A count of the number of patients who have waited longer that 104 days for treatment for cancer from GP referral. This is a national standard and is expected to be 0.	

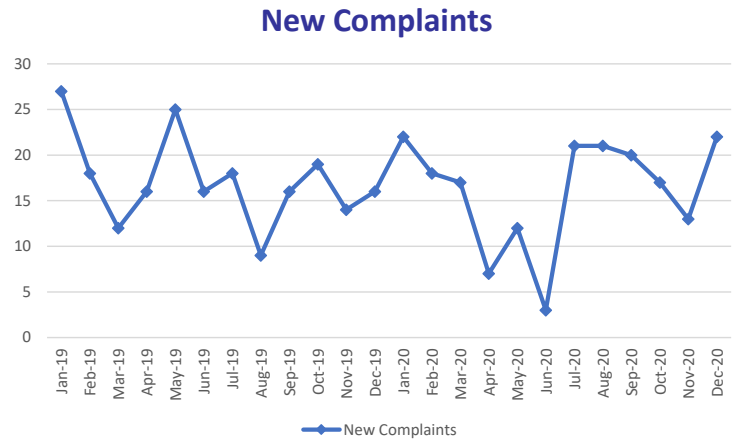
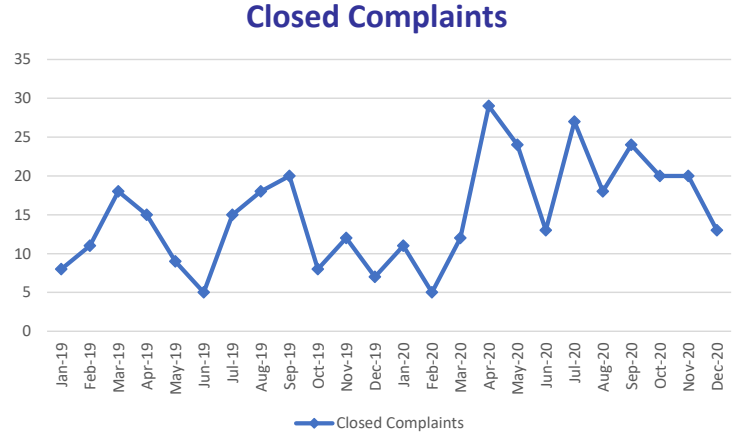
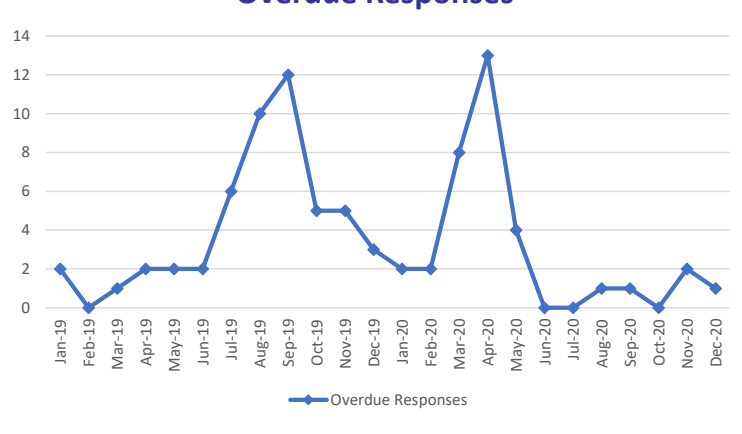
Board Report KPIs	Narratives
Duty of Candour  This is a count of the number of verbal and written duty of candour overdue for the reporting month (and earlier) as at the date of report issue	The timeliness indicator demonstrates a wide variance in performance as might be expected when a small denominator indicator is reported as a percentage. The overall range shows that the target of 100% is unlikely to be met with current controls in place however the divisional quality & safety managers do work with the Duty of Candour leads to ensure timely completion including support with narrative if required. If a Duty of Candour conversation relates to a serious incident this is also picked up through the Day 2 / Day 5 meetings. Certain types of incidents (mainly pressure ulcers and falls) have a greater likelihood of achieving a verbal Duty of Candour within the ten working day window and therefore months which have a higher proportion of that incident type often show a higher percentage performance. One of the wider aspects of the new PSIRF project will be a more targeted review of Duty of Candour to see why some incident types can be harder to achieve a timely Duty of Candour conversation and what support can be put into place to enable this. The trust is due to start its new PSIRF reporting framework from February 2021 and so this Duty of Candour project will be planned for March/April.
Within 10 Days Duty of Candour  The percentage of cases reported in that month where verbal duty of candour was completed within the nationally required 10 working day timeframe.	
Acuity Measures  A range of measures have been identified which are analysed to provide an overall acuity score, as displayed in this chart. This provides an overview of the acuity of admitted patients.	There has been a sharp rise in the acuity, dependency and operational measures in December which is reflective of the pressure the Organisation has been under. An increase in acuity and dependency has been noted in multiple wards, but predominantly those converted to Covid areas. It is also important to note that the increase is due to an additional ward being opened in December to support the winter pressures. This ward has been opened without any additional nursing resource being recruited and is being managed with the redeployment of staff from other areas.

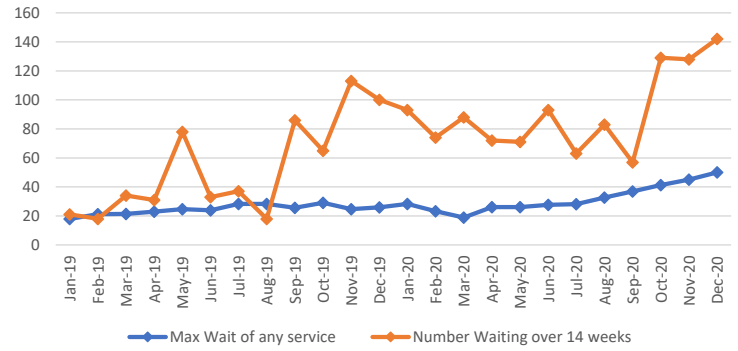
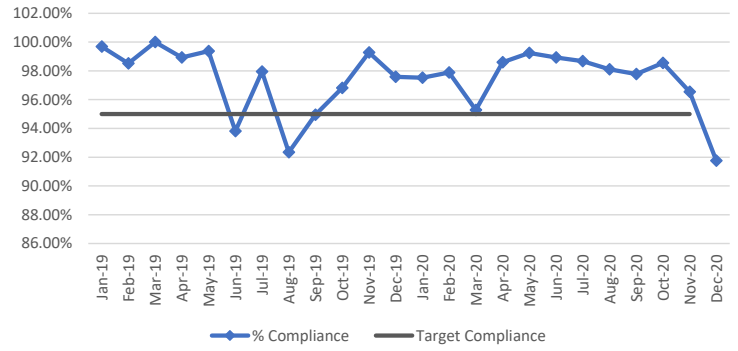
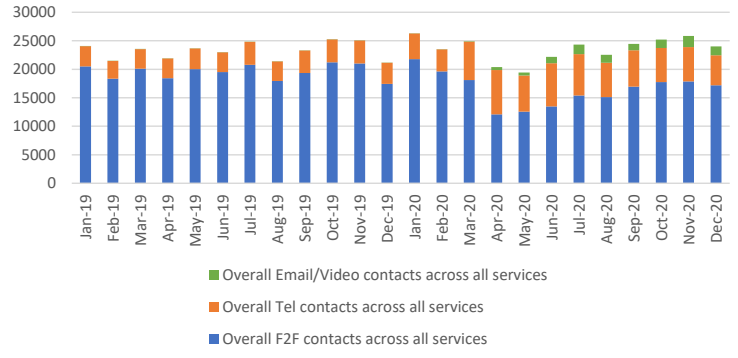
Board Report KPIs	Narratives
Acute Falls per 1000 Beds  	The number of falls reported in December rose considerably and this is also demonstrated in the falls per 1,000 bed days. Whilst high compared to recent months, this is still within normal reporting limits of the longer-term reporting patterns. It should be recognised that the impact of Covid -19 including high staff sickness and staff isolating has impacted on the staffing levels on the wards and the availability of specials which may partly explain the increase falls. Staff do of course as always remain vigilant to ensure the safety of patients at risk of falling. Within December; 62 falls resulted in no harm and this makes up the majority of the increased numbers in the month however there were also ten with minor harm, two with moderate harm and two with major harm. There were some repeat fallers (n=9) but no patient fell more than twice in the reporting month. Where patients are at high risk of falls, care plans are being initiated, specials requested and staff deployed to the areas to assist. Following the falls champion day in November held, the falls champions will be sharing the information and education with their areas. The falls lead also commenced employment in late 2020 and the trust has signed up to participate in the national falls audit which is being trialled with the PSIRF early adopters of which WSFT is a participant. Where patients are at high risk of falls, care plans are being initiated, specials requested and staff deployed to the areas to assist. Following the falls champion day in November held, the falls champions will be sharing the information and education with their areas. The falls lead also commenced employment in late 2020 and the trust has signed up to participate in the national falls audit which is being trialled with the PSIRF early adopters of which WSFT is a participant.
A measure of the number of falls in the acute hospital measured per 1000 bed days. Community falls are excluded from this metric.	

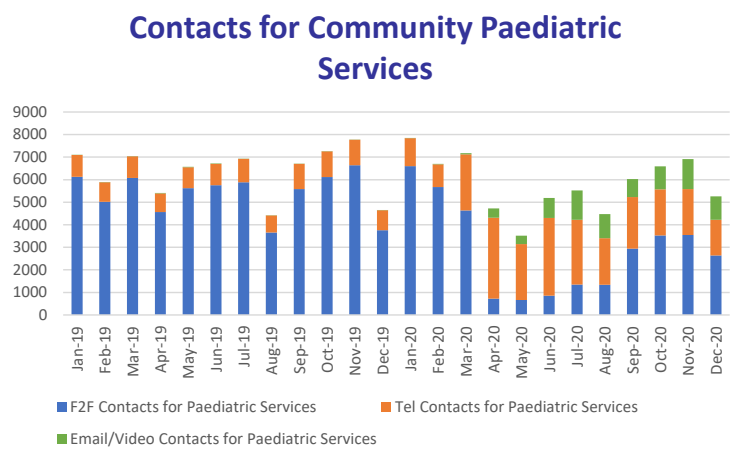
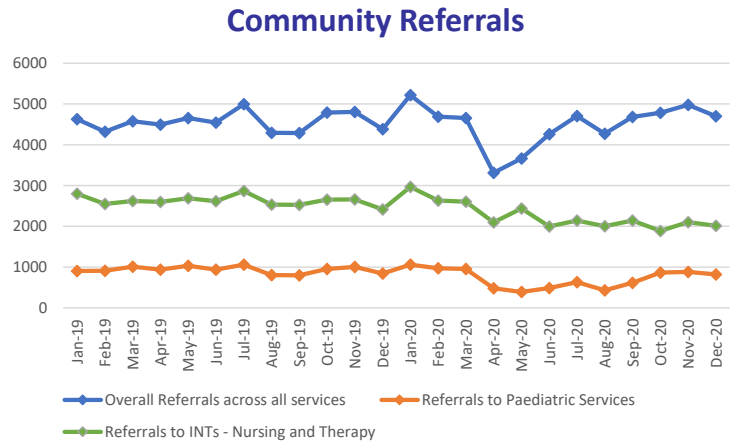
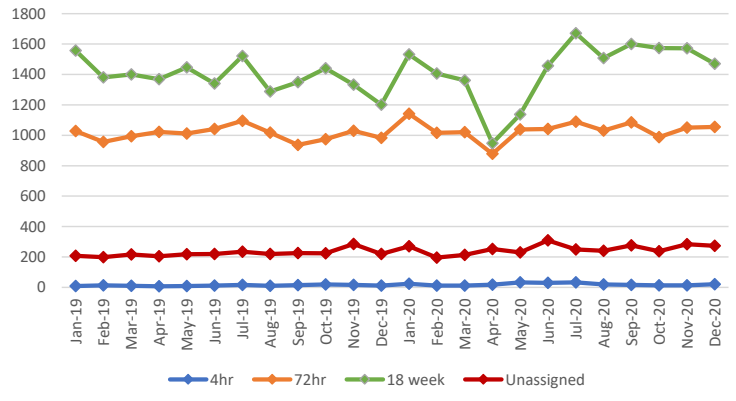
Patient Safety Incidents Reported (Total, Resulting in Harm  	The number of patient safety incidents reported in December rose however the number of those resulting in harm decreased following a rise in November. The rise in harm incidents in November was still within normal reporting limits and a drill-down into incident categories showed that the increase in the numbers of pressure ulcers (PUs) was the main contributor to increased harm. The rise in (total reported) incidents in December was as a consequence of increased numbers of PUs present on admission and falls. 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	

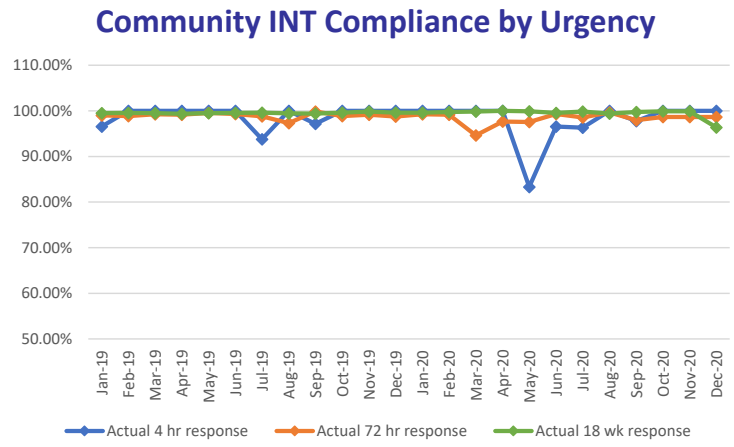
Patient Safety Incidents (PSIs) Reported Total and per 1,000 occupied bed-days (OBDs)  	The incidents reported per 1,000 bed days rose slightly in December but remains within the normal limits of the recent 12 months.
The number of patient safety incidents reported as a percentage of occupied bed days to measure reporting rates	

Board Report KPIs	Narratives
 A count of the number of recorded new pressure ulcers across the Trust. This metric will include those recorded in the acute hospital and community settings	The number of new PUs reported by the Community teams fell in December compared to recent months however trust wide there was a considerable rise in the number of PUs reported as present on admission (either to hospital or to the care of the Community teams). Concerns around this increase were discussed on a national call hosted by NHSE/I on 12th January as similarities have been noted by tissue viability teams across the country, particularly amongst community patients. A focus continues on the TVS reviewing all unstageable PUs to ensure that correct grading and treatment plans are in place, work is also commencing with CCG colleagues to support the harmonisation of wound care formularies to ensure that the same products are made available for patients across all settings in a bid to reduce MASD (moisture associated skin damage) incidence.
 A measure of the number of pressure ulcers in the acute hospital measured per 1000 bed days. Community inpatient pressure ulcers are excluded from this metric.	
 % of patients with a Malnutrition Universal Screening Tool (Adults)/Paediatric Yorkhill Malnutrition Score (Children) assessment completed within 24 hours of admission	In December, 94% of patients had a nutrition risk assessment completed within 24 hours of admission. Although this is the fourth month to show a small decline, it is very low numbers (~3% in the quarter) and not significant when viewed on a chart. Overall, the compliance has been above 90% through the past 12 months, a consistent and embedded improvement. There is continued focus on the quality of these assessments, promoting patient weights being recorded and actioning and implementing nutrition care plans. A protected mealtime audit was completed in November, with positive results, following the change of meal delivery times. This audit will be repeated quarterly to gain assurance that the principles of protected mealtimes are being upheld.

Board Report KPIs	Narratives
	An increase in formal complaints overall for December and the highest received this year and since the pandemic has started. An increase of complaints for the emergency department (2 > 5). 3 out of 5 related to delay or failure to diagnose or delay in treatment. A continued trend we are continuing to see is around patient care and that care needs were not adequately met with 7/22 complaints falling under this sub category. Furthermore, issues arising again around communication with relatives, assumingly due to the visiting restrictions.
New formal complaints received and accepted, this counts both West Suffolk Hospital and Community	
	A reduced amount of complaints closed within December due to three main reasons. An increase in formal complaints caused additional administration work. Fewer working days and annual leave across the team and seen across the trust. Keeping in touch team needed more attention due to low staffing levels and increased demand and therefore additional time was spent ensuring this service resumed full capacity.
Formal complaints signed off by the CEO, this counts both West Suffolk Hospital and Community	
	1 complaint was resolved out of timescale. This was due to a delay in the trust office and We have apologised to the complainant for the slight delay which was overdue by a matter of days. We have however resolved all outstanding backlog complaints that were overdue and have ensured complainants have been kept up to date with any delays and or extensions.
Any complaints which were sent outside of the given timeframe and no extension was agreed, this counts both West Suffolk Hospital and Community	

Board Report KPIs	Narratives
Community Non Consultant Led 18week Max Wait  Services covered: Adult SLT, Heart Failure, Neurology Service, Parkinson's Nursing, Wheelchairs, Paediatric Occupational Therapy, Paediatric Physio and Paediatric Speech and Language Therapy, There are no patients waiting over 52weeks for treatment from referral, so community look at number of patients waiting over 14 weeks. Historically, 14 weeks was agreed on as an internal measure because it gives an approx. number of patients who would breach the 18 week target at the end of the next month.	2 services have patients waiting over 18 weeks at the end of December: Paed SLT and Wheelchairs. The maximum wait for each of these services are 50 weeks (increased from 46) and 28 weeks (decreased from 35) respectively. Paed SLT and Wheelchair services were both exceeding the wait times prior to COVID, these 2 services have papers and support from the CCG both in understanding demand and increasing resources.
Community Non Consultant Led 18week Compliance  Services covered: Adult SLT, Heart Failure, Neurology Service, Parkinson's Nursing, Wheelchairs, Pead OT, Pead Physio and Pead SLT. RTT nationally is for consultant led services but the community services are required to report on compliance to 18 week Referral to Treatment locally to our CCG. Target is 95% of referrals are given a first definitive treatment within 18weeks	The aggregated % of patients treated within 18 weeks for all community services in December was 91.8% with the lowest individual service being Paed SLT at 76.5%.
Contacts for ALL Community Services (Adults and Paediatrics)  Activity is counted as a face to face/telephone/email/video contact with a patient/carer/parent which is clinically relevant. This means activity that a clinician carries out which is writing reports, liaising with other healthcare professionals is NOT counted as activity. This is in line with acute systems where there is an assumption that clinicians will carry out related activities that result from contact with a patient.	The total activity for community services has returned to pre-COVID levels although the ratio of face to face and other means of contact (telephone, video and email) has altered. The INTs activity is still based in face to face but some other services have moved to telephone contacts successfully. Overall activity is lower in December than the previous 3 months but this is in line with historical seasonal variance (See December 2019).

Board Report KPIs	Narratives
	The Paediatric services have moved a high proportion of their activity to telephone and email/video contacts but they are still unable to carry out any group work due to social distancing requirements. There are also shortages in clinic availability in certain locations. The wearing of masks and social distancing means Speech and Language therapy is particularly hard to do. The services are reviewing all possible options. Overall activity is lower in December than the previous 3 months but this is in line with historical seasonal variance (see December 2019).
Activity is counted as a face to face/telephone/email/video contact with a patient/carer/parent which is clinically relevant. This means activity that a clinician carries out which is writing reports, liaising with other healthcare professionals is NOT counted as activity. This is in line with acute systems where there is an assumption that clinicians will carry out related activities that result from contact with a patient.	
	Referrals to the majority of the community services have returned to pre-COVID numbers.
There should be one reason per referral, i.e. if a patient is referred in to the INTs for 2 requirements either simultaneously or over time, eg leg ulcer dressing and phlebotomy, then there are 2 referrals.	
	Referrals to the INT services have returned to pre-COVID numbers, in particular the Green referrals have increased and stabilised above pre-Covid numbers.
Referrals into the Integrated Neighbourhood Teams have urgencies of Red (within 4 hours), Amber within 72hrs) and Green (within 18 weeks). These contractual urgencies are locally agreed pan Suffolk with the CCG and there is a 98% response target for Red, Amber and Green response times have a 95% threshold (These are local contractual targets)	

Board Report KPIs	Narratives
 Referrals into the Integrated Neighbourhood Teams have urgencies of Red (within 4 hours), Amber within 72hrs) and Green (within 18 weeks). These contractual urgencies are locally agreed pan Suffolk with the CCG and there is a 98% response target for Red, Amber and Green response times have a 95% threshold (These are local contractual targets)	All response thresholds were met in December.

13. Finance and workforce report

To ACCEPT the report

For Report

Presented by Craig Black

Board of Directors – 29 January 2021

Agenda item:	13			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	22nd January 2021			
Subject:	Finance and Workforce Board Report – December 2020			
Purpose:		For information	x	For approval

Executive summary:
The reported I&E for December is a favourable variance of £88k. We expect funding to match any COVID related pressures and therefore forecast that we will break even at the year end. This will include receiving all FRF and MRET funding associated with meeting the Financial Improvement Trajectory (FIT).

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

We are developing the budget for 2021-22 with a plan to break even. However, due to COVID there is still some uncertainty around funding and the budget may be updated as this becomes clear.

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

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

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

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

Recommendation:
The Board is asked to review this report.

FINANCE AND WORKFORCE REPORT
December 2020 (Month 9)

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	£0.1m	favourable
EBITDA position YTD	£28m	adverse
EBITDA margin YTD	15%	adverse
Total PSF Received	£37.2m	
Cash at bank	£23.7m	

Executive Summary

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

Key Risks in 2020-21

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

SUMMARY INCOME AND EXPENDITURE ACCOUNT - December 2020	December 2020			Year to date			Year end forecast		
	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)
	£m	£m	£m	£m	£m	£m	£m	£m	£m
NHS Contract Income	17.6	17.8	0.2	166.5	161.6	(5.0)	220.4	216.0	(4.4)
Other Income	2.5	2.1	(0.5)	26.6	25.0	(1.6)	35.4	31.3	(4.2)
Total Income	**20.1**	**19.9**	**(0.2)**	**193.2**	**186.6**	**(6.6)**	**255.8**	**247.3**	**(8.5)**
Pay Costs	16.6	17.4	(0.8)	144.2	149.8	(5.6)	199.6	202.7	(3.1)
Non-pay Costs	6.4	5.2	1.2	71.9	64.9	7.0	87.3	80.8	6.5
Operating Expenditure	**22.9**	**22.6**	**0.3**	**216.1**	**214.6**	**1.4**	**286.9**	**283.5**	**3.4**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA excl STF	**(2.8)**	**(2.7)**	**0.1**	**(22.9)**	**(28.0)**	**(5.2)**	**(31.1)**	**(36.2)**	**(5.1)**
Depreciation	0.7	0.6	0.1	6.0	5.3	0.8	8.1	7.0	1.0
Finance costs	0.3	0.4	(0.1)	2.9	3.9	(1.0)	3.9	5.2	(1.3)
SURPLUS/(DEFICIT)	**(3.8)**	**(3.7)**	**0.1**	**(31.9)**	**(37.2)**	**(5.4)**	**(43.1)**	**(48.5)**	**(5.4)**
Provider Sustainability Funding (PSF)									
PSF / FRF/ MRET/ Top Up	3.8	3.8	(0.0)	31.9	37.2	5.4	43.1	48.5	5.4
SURPLUS/(DEFICIT) incl PSF	**(0.0)**	**0.1**	**0.1**	**0.0**	**(0.0)**	**(0.0)**	**(0.0)**	**0.0**	**0.0**

FINANCE AND WORKFORCE REPORT – December 2020

Contents:

Key:

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

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

FINANCE AND WORKFORCE REPORT – December 2020

Income and Expenditure Summary as at December 2020

The reported I&E for December is a surplus of £87k (YTD break even position). Due to COVID-19 we are receiving top up payments that includes MRET and FRF. This ensures we break even YTD. The 'top up' element is £22.6m YTD.

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

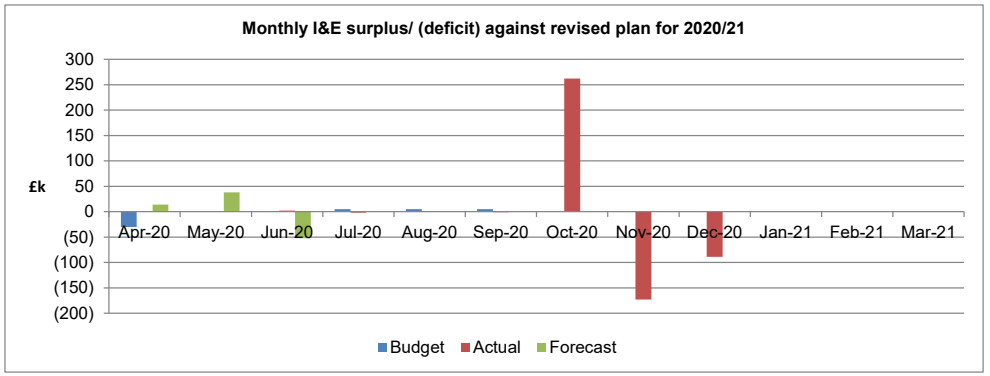
2021-22 Budgets

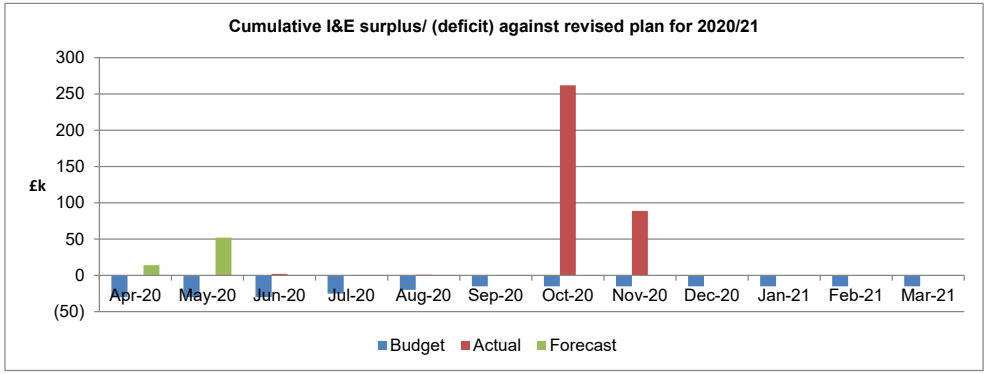
We are developing the budget for 2021-22 with a plan to break even. However, due to COVID there is still some uncertainty around funding and the budget may be updated as this becomes clear.

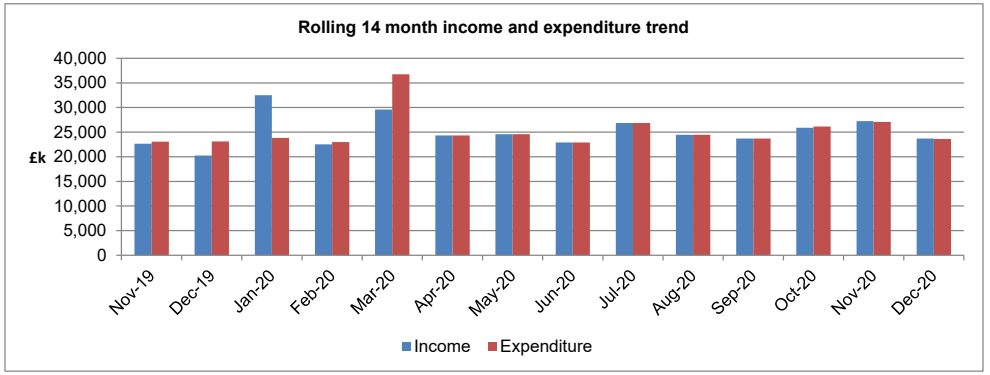
We anticipate setting a CIP of 1%. In addition to this were there to be any recurrent shortfall in the 20-21 CIP this would add to the requirement in 21-22.

Summary of I&E indicators

Income and Expenditure	Plan/ Target £000'	Actual/ Forecast £000'	Variance to plan (adv)/ fav £000'	Direction of travel (variance)	RAG (report on red)
In month surplus/ (deficit)	(5)	89	94	↑	Green
YTD surplus/ (deficit)	0	(0)	(0)	↑	Green
Forecast surplus/ (deficit)	(0)	0	(0)	↔	Green
EBITDA (excl top-up) YTD	(3,844)	(3,750)	95	↑	Green
EBITDA %	(19.1%)	(18.9%)	0.3%	↑	Green
Clinical Income YTD	(175,575)	(169,914)	(5,661)	↓	Red
Non-Clinical Income YTD	(49,464)	(53,890)	4,425	↓	Green
Pay YTD	144,207	149,758	(5,551)	↑	Red
Non-Pay YTD	80,830	74,037	6,793	↑	Green
CIP Target YTD	6,608	3,456	(3,152)	↑	Red







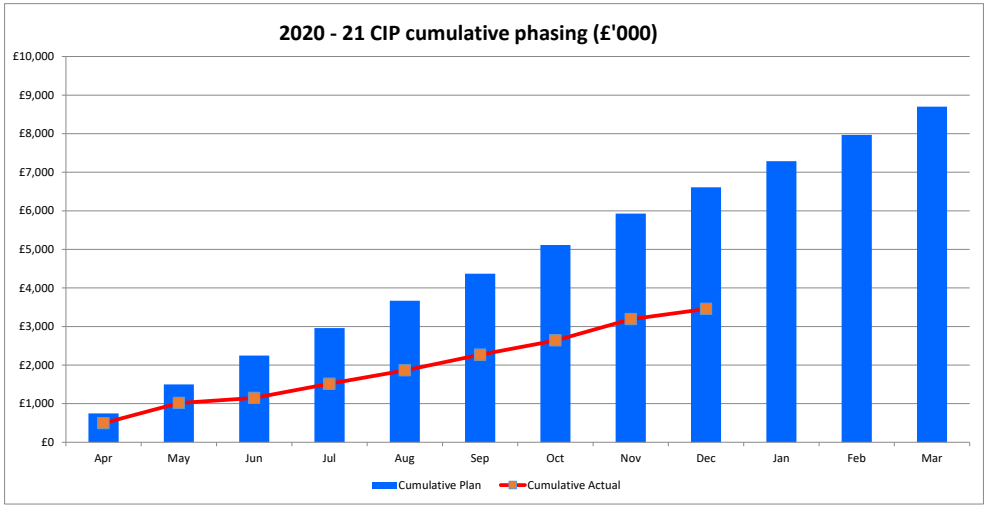
Cost Improvement Programme (CIP) 2020-21

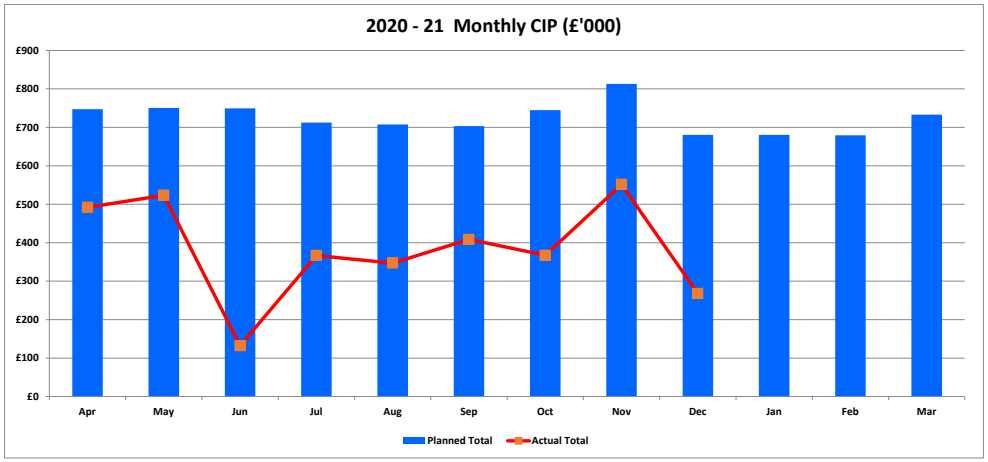
In order to deliver the Trust's control target in 2020-21 we need to deliver a CIP of £8.7m (3.4%). The plan for the year to December is £6.6m (75.9% of the annual plan) and we achieved £3.5m (39.7%). This represents a shortfall of £3,152k.

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

Recurring/Non Recurring	2020-21 Annual Plan	Plan YTD	Actual YTD
	£'000	£'000	£'000
Recurring			
Outpatients	254	168	41
Procurement	492	369	387
Activity growth	200	150	150
Additional sessions	363	273	40
Community Equipment Service	510	383	259
Drugs	367	275	264
Estates and Facilities	187	153	86
Other	949	758	818
Other Income	493	369	131
Pay controls	327	232	146
Service Review	16	16	16
Staffing Review	819	587	515
Theatre Efficiency	302	227	-
Contract Review	50	38	-
Workforce	-	-	-
Consultant staffing	-	-	-
Agency	-	-	-
Unidentified CIP	975	720	-
Recurring Total	**6,304**	**4,717**	**2,852**
Non-Recurring			
Pay controls	580	467	485
Other	1,810	1,418	113
Estates and Facilities	6	6	6
Non-Recurring Total	**2,396**	**1,891**	**604**
Total CIP	**8,700**	**6,608**	**3,456**

Division	Divisional Target £'000	YTD Var £'000	Unidentified plan £ YTD	Unidentified plan £ year
Medicine	2,555	(1,607)	191	255
Surgery	2,029	(608)	152	203
W&C/CSS	1,847	(242)	0	0
Community	1,422	(362)	94	125
E&F	516	(286)	140	202
Corporates	331	(47)	143	191
Stretch	0	0	0	0
Total	**8,700**	**(3,152)**	**720**	**975**

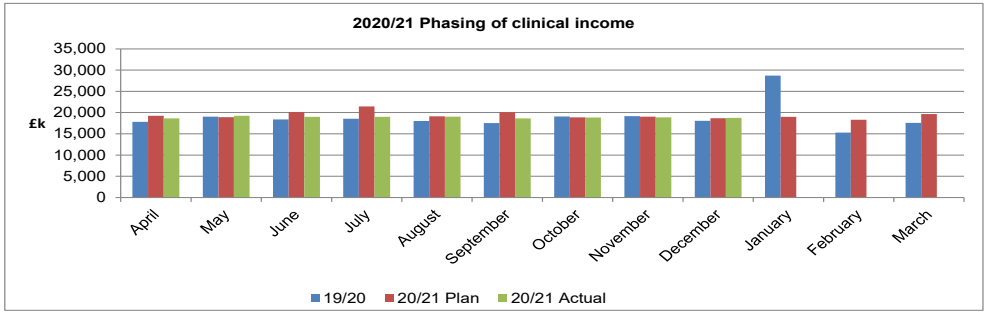




FINANCE AND WORKFORCE REPORT – December 2020

Income Analysis

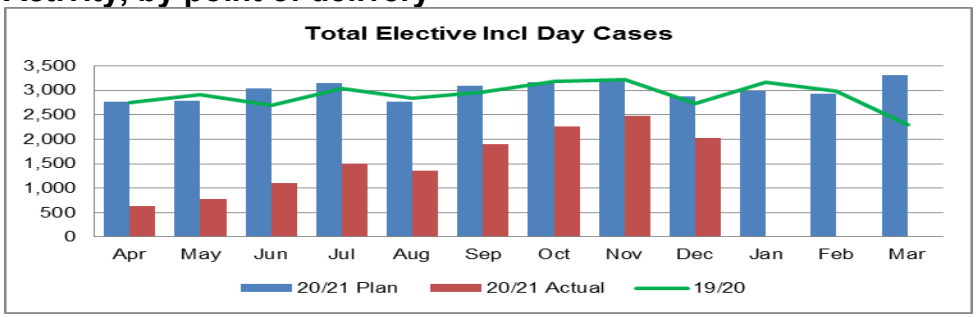
The chart below demonstrates the phasing of all clinical income plan for 2020-21, including Community Services. This phasing is in line with phasing of activity.

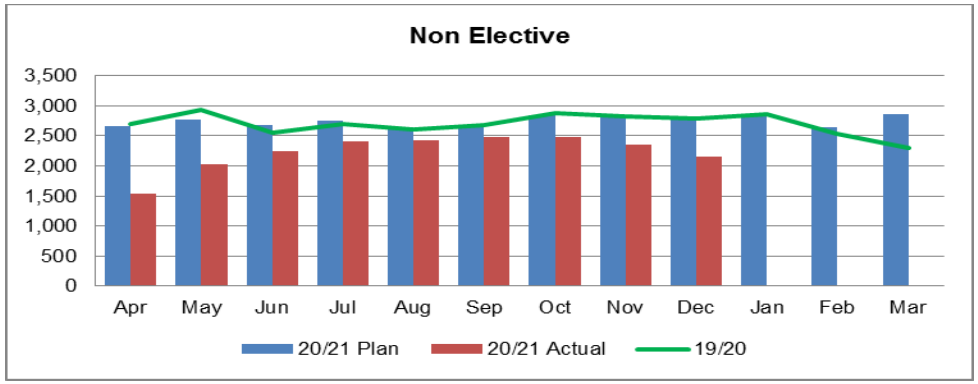


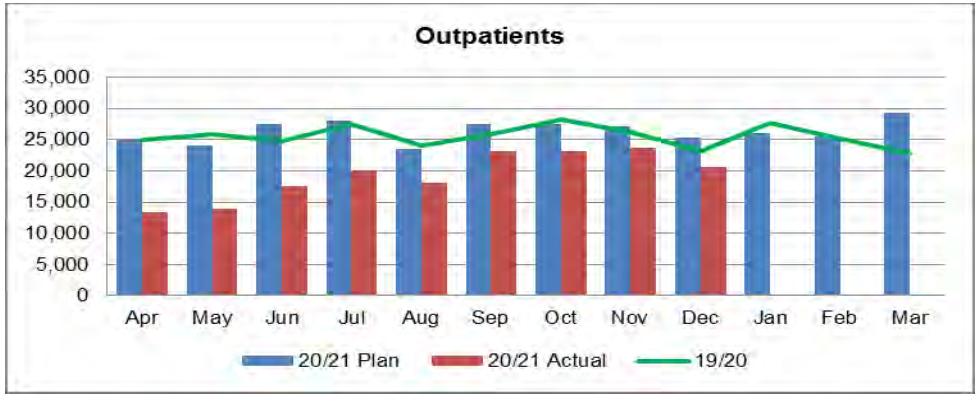
The income position was slightly ahead of plan for December. The income was based on the national agreed block payments as set out by NHS England, these were put in place to give Providers assured income during the coronavirus period.

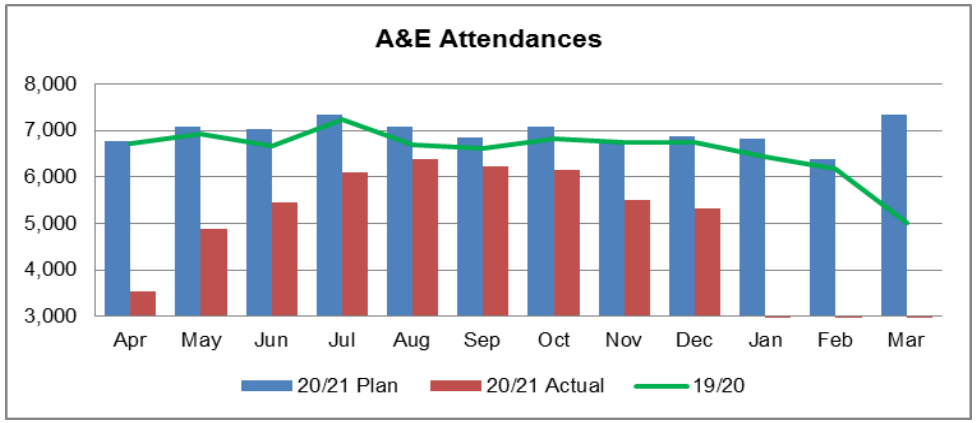
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	1,007	829	(178)	9,203	7,638	(1,565)
Other Services	2,003	4,016	2,013	25,529	46,265	20,736
CQUIN	180	161	(19)	1,624	1,306	(319)
Elective	2,730	2,112	(618)	25,888	12,959	(12,930)
Non Elective	6,710	6,512	(198)	58,595	58,104	(491)
Emergency Threshold Adjustment	(354)	(354)	0	(3,076)	(3,076)	0
Outpatients	3,078	2,318	(760)	28,627	18,229	(10,397)
Community	2,988	2,988	0	26,892	26,892	0
Total	**18,340**	**18,580**	**240**	**173,282**	**168,316**	**(4,966)**

Activity, by point of delivery









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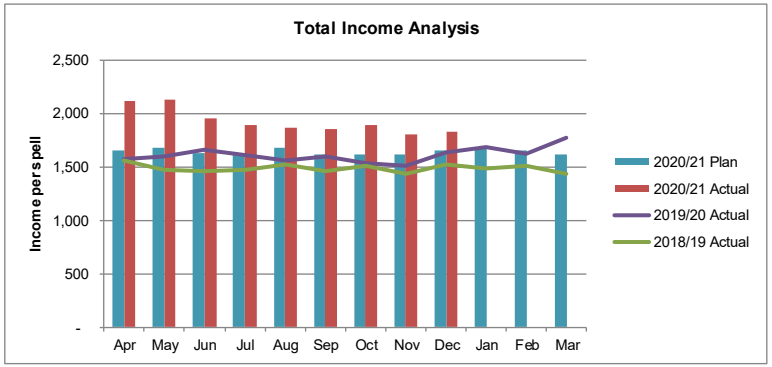
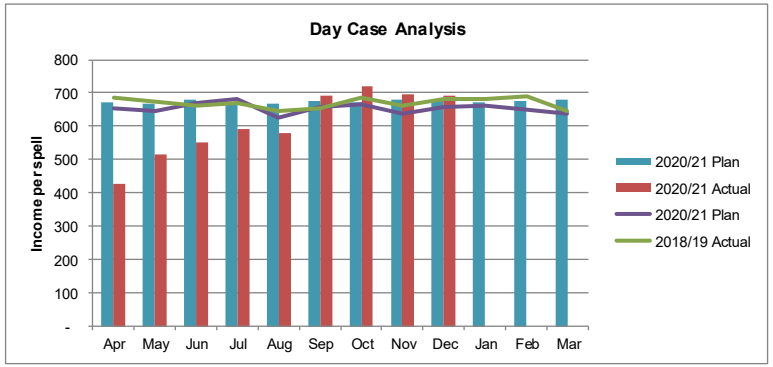
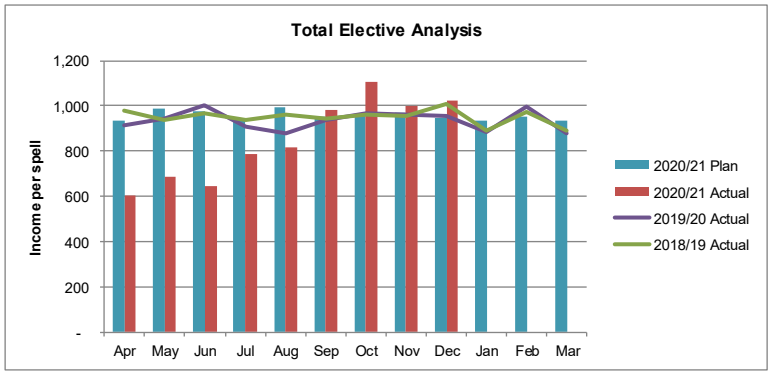
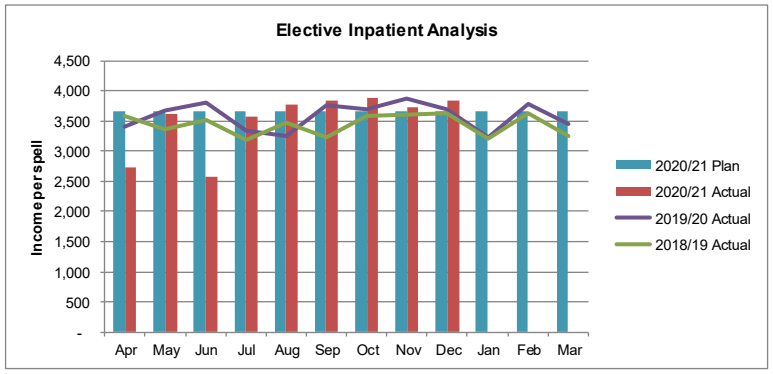
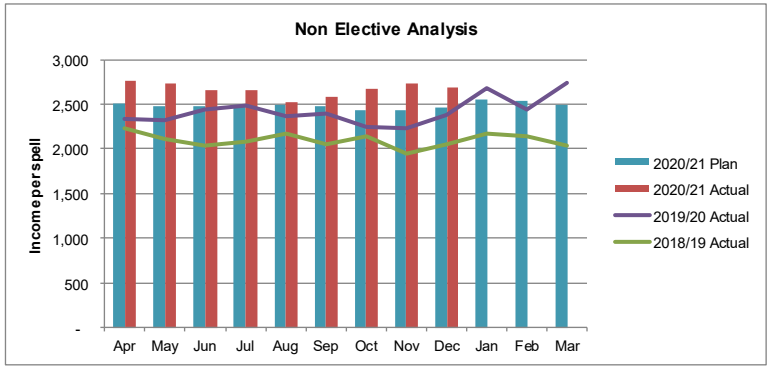
Trends and Analysis

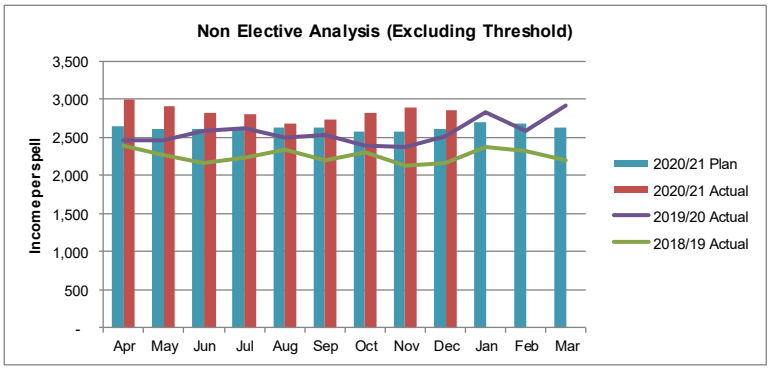










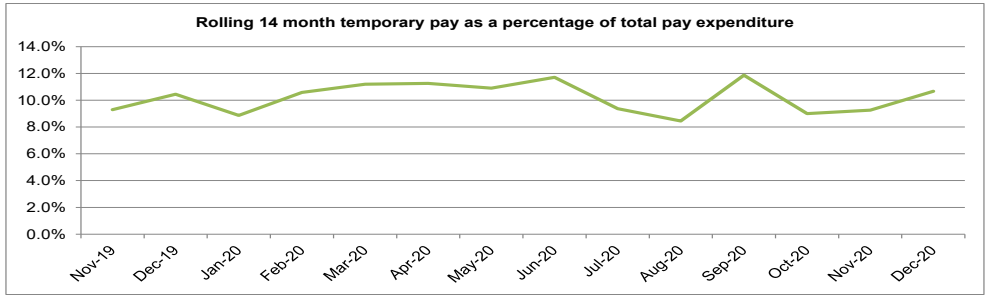


FINANCE AND WORKFORCE REPORT – December 2020

Workforce

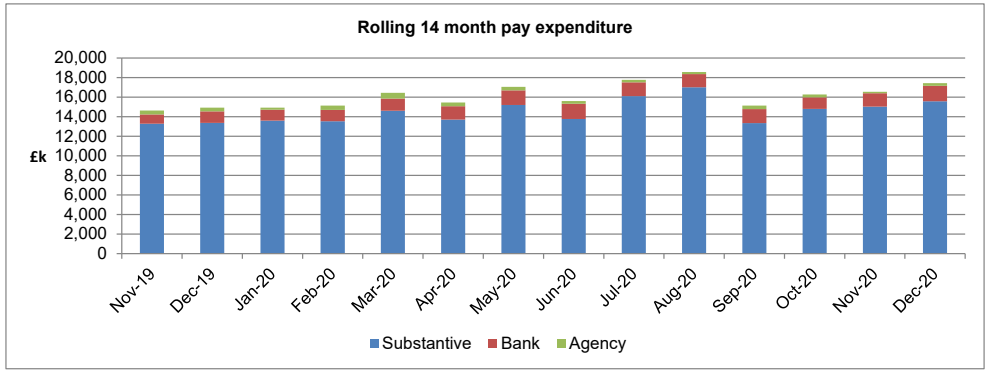
Monthly Expenditure (£)				
As at December 2020	Dec-20	Nov-20	Dec-19	YTD
	£000's	£000's	£000's	£000's
Budgeted Costs in-month	16,577	16,172	14,483	144,207
Substantive Staff	15,565	15,014	13,352	134,457
Medical Agency Staff	153	82	171	1,489
Medical Locum Staff	351	306	354	2,800
Additional Medical Sessions	251	179	142	2,402
Nursing Agency Staff	70	23	122	569
Nursing Bank Staff	516	475	400	3,902
Other Agency Staff	62	46	73	466
Other Bank Staff	239	217	161	1,899
Overtime	130	109	56	1,021
On Call	87	94	79	752
Total Temporary Expenditure	1,859	1,531	1,557	15,301
Total Expenditure on Pay	17,424	16,545	14,910	149,758
Variance (F/(A))	(847)	(373)	(427)	(5,551)
Temp. Staff Costs as % of Total Pay	10.7%	9.3%	10.4%	10.2%
memo: Total Agency Spend in-month	285	151	366	2,525

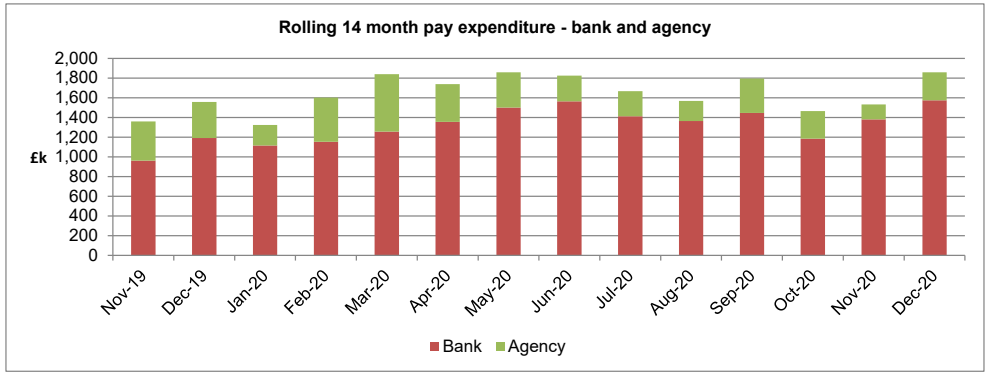
Monthly WTE				
As at December 2020	Dec-20	Nov-20	Dec-19	YTD
	£000's	£000's	£000's	£000's
Budgeted WTE in-month	4,190.7	4,191.7	3,898.4	38,125.4
Substantive Staff	3,922.8	3,887.8	3,626.5	34,164.9
Medical Agency Staff	10.6	10.8	11.1	136.7
Medical Locum Staff	26.5	29.0	30.3	245.4
Additional Medical Sessions	7.5	3.2	5.9	45.7
Nursing Agency Staff	16.4	3.6	16.2	117.7
Nursing Bank Staff	153.1	139.1	120.2	1,167.9
Other Agency Staff	15.1	8.7	11.4	91.5
Other Bank Staff	89.5	86.6	64.7	752.2
Overtime	30.3	27.2	13.9	268.5
On Call	5.2	6.4	6.8	57.5
Total Temporary WTE	354.2	314.7	280.5	2,883.2
Total WTE	4,277.0	4,202.5	3,907.0	37,048.1
Variance (F/(A))	(86.3)	(10.9)	(8.5)	1,077.3
Temp. Staff WTE as % of Total WTE	8.3%	7.5%	7.2%	7.8%
memo: Total Agency WTE in-month	42.1	23.1	38.7	346.0

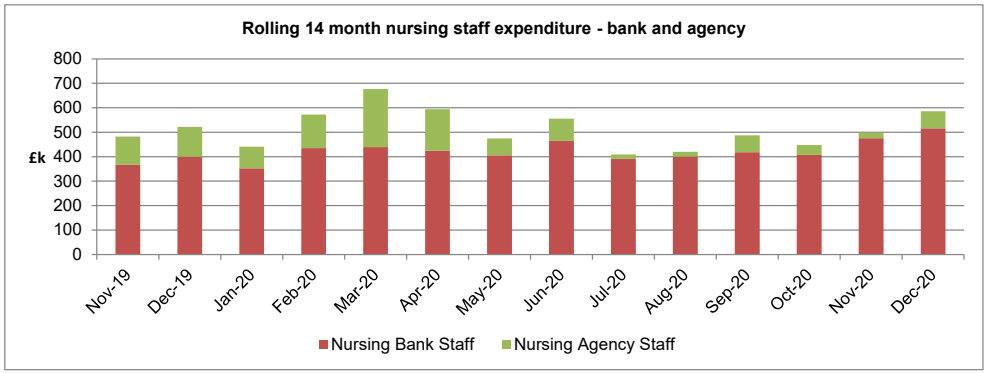


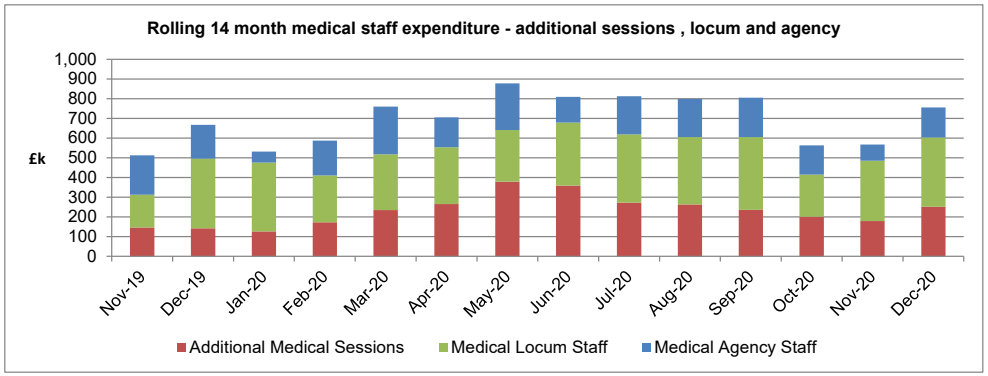
Pay Trends and Analysis

During December the Trust overspent by £847k on pay (£5.6m overspent YTD). This includes all COVID related pay costs.

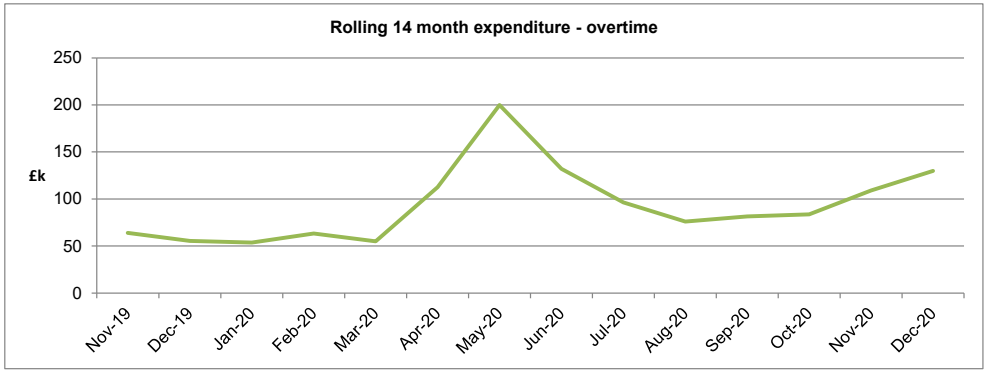








Expenditure on Additional Sessions was £251k in December (£179k November)



FINANCE AND WORKFORCE REPORT – December 2020

Income and Expenditure Summary by Division

	Current Month			Year to date		
	Budget £k	Actual £k	Variance F/(A) £k	Budget £k	Actual £k	Variance F/(A) £k
MEDICINE						
NHS Contract Income	(7,237)	(6,463)	(774)	(64,625)	(53,675)	(10,950)
Other Income	170	158	12	(2,278)	(2,254)	(24)
Total Income	**(7,067)**	**(6,305)**	**(762)**	**(66,903)**	**(55,930)**	**(10,974)**
Pay Costs	4,420	5,008	(588)	38,378	43,308	(4,930)
Non-pay Costs	1,680	1,797	(117)	14,222	14,561	(339)
Operating Expenditure	**6,100**	**6,805**	**(705)**	**52,600**	**57,869**	**(5,269)**
SURPLUS / (DEFICIT)	**966**	**(501)**	**(1,467)**	**14,303**	**(1,940)**	**(16,242)**
SURGERY						
NHS Contract Income	(5,142)	(4,736)	(406)	(47,145)	(31,453)	(15,692)
Other Income	(196)	(174)	(22)	(1,861)	(1,439)	(423)
Total Income	**(5,338)**	**(4,910)**	**(428)**	**(49,006)**	**(32,891)**	**(16,115)**
Pay Costs	3,576	3,712	(136)	30,672	32,679	(2,007)
Non-pay Costs	1,046	1,081	(36)	9,992	8,166	1,826
Operating Expenditure	**4,622**	**4,794**	**(172)**	**40,664**	**40,845**	**(181)**
SURPLUS / (DEFICIT)	**716**	**116**	**(600)**	**8,342**	**(7,954)**	**(16,297)**
WOMENS AND CHILDRENS						
NHS Contract Income	(1,870)	(1,747)	(123)	(16,985)	(14,695)	(2,289)
Other Income	(167)	(96)	(71)	(794)	(578)	(216)
Total Income	**(2,037)**	**(1,843)**	**(194)**	**(17,779)**	**(15,273)**	**(2,505)**
Pay Costs	1,514	1,455	60	12,928	12,964	(36)
Non-pay Costs	171	248	(77)	1,542	1,681	(139)
Operating Expenditure	**1,686**	**1,703**	**(18)**	**14,470**	**14,645**	**(175)**
SURPLUS / (DEFICIT)	**351**	**140**	**(211)**	**3,308**	**628**	**(2,680)**
CLINICAL SUPPORT						
NHS Contract Income	(568)	(509)	(59)	(5,201)	(3,698)	(1,503)
Other Income	(157)	(135)	(22)	(2,207)	(2,087)	(120)
Total Income	**(725)**	**(644)**	**(82)**	**(7,408)**	**(5,786)**	**(1,623)**
Pay Costs	2,073	2,119	(47)	15,569	15,203	366
Non-pay Costs	1,033	1,379	(346)	9,782	10,892	(1,110)
Operating Expenditure	**3,106**	**3,499**	**(393)**	**25,351**	**26,095**	**(744)**
SURPLUS / (DEFICIT)	**(2,380)**	**(2,855)**	**(475)**	**(17,943)**	**(20,310)**	**(2,367)**
COMMUNITY SERVICES						
NHS Contract Income	(2,476)	(2,400)	(76)	(22,282)	(22,411)	130
Other Income	(1,029)	(1,051)	23	(9,326)	(9,269)	(57)
Total Income	**(3,505)**	**(3,452)**	**(53)**	**(31,608)**	**(31,680)**	**72**
Pay Costs	2,570	2,677	(107)	22,849	23,533	(684)
Non-pay Costs	1,042	793	250	8,839	11,106	(2,266)
Operating Expenditure	**3,612**	**3,470**	**142**	**31,689**	**34,638**	**(2,950)**
SURPLUS / (DEFICIT)	**(107)**	**(18)**	**89**	**(81)**	**(2,958)**	**(2,877)**
ESTATES AND FACILITIES						
Other Income	(434)	(241)	(193)	(3,905)	(1,828)	(2,077)
Total Income	**(434)**	**(241)**	**(193)**	**(3,905)**	**(1,828)**	**(2,077)**
Pay Costs	902	950	(48)	8,112	8,477	(365)
Non-pay Costs	626	672	(46)	5,637	5,897	(260)
Operating Expenditure	**1,528**	**1,623**	**(95)**	**13,749**	**14,374**	**(625)**
SURPLUS / (DEFICIT)	**(1,094)**	**(1,382)**	**(288)**	**(9,844)**	**(12,546)**	**(2,702)**
CORPORATE						
NHS Contract Income	(298)	(315)	17	1,648	(20,017)	21,666
Other Income	(4,525)	(6,002)	1,477	(49,997)	(60,266)	10,270
Total Income	**(4,824)**	**(6,318)**	**1,494**	**(48,349)**	**(80,284)**	**31,935**
Pay Costs	1,521	1,502	19	15,698	13,594	2,105
Non-pay Costs	767	(783)	1,550	21,802	12,536	9,266
Capital Charges and Financing Costs	993	1,010	(18)	8,934	9,074	(140)
Operating Expenditure	**3,282**	**719**	**2,562**	**46,435**	**26,129**	**20,305**
SURPLUS / (DEFICIT)	**1,542**	**5,598**	**4,056**	**1,914**	**54,154**	**52,241**
TOTAL						
NHS Contract Income	(17,591)	(16,169)	(1,421)	(154,589)	(145,951)	(8,638)
Other Income	(6,339)	(7,542)	1,203	(70,369)	(77,721)	7,352
Total Income	**(23,930)**	**(23,712)**	**(218)**	**(224,958)**	**(223,672)**	**(1,286)**
Pay Costs	16,577	17,424	(847)	144,207	149,758	(5,551)
Non-pay Costs	6,366	5,189	1,177	71,817	64,839	6,978
Capital Charges and Financing Costs	993	1,010	(18)	8,934	9,074	(140)
Operating Expenditure	**23,935**	**23,623**	**312**	**224,958**	**223,671**	**1,287**
SURPLUS / (DEFICIT)	**(5)**	**89**	**94**	**0**	**(0)**	**(0)**

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Medicine (Sarah Watson)

The division is behind plan by £1,467k in month (£16.2m YTD).

Clinical income is behind plan in month by £774k and £10.9m YTD. This continues to be driven by the reduced activity against plan across the Trust as a result of COVID 19 and is witnessed in medicine across all types of activity (elective, non-elective & outpatient). It is noted that this loss of divisional income is offset within the Corporate division due to the guarantees over the block contract.

The significant change in operating models necessary to cope with wave 1 of the COVID-19 Pandemic brought with it a significant and immediate reduction in activity levels across Medicine in March 2020. From April to November 2020, we have been recording that this reduction between anticipated and actual activity has been narrowing. However, as a result of the Trusts decision in December to pause non-urgent procedures and face to face outpatient appointments in response to Wave 2, the gap between anticipated and actual activity for both Elective and Outpatient activity is now increasing. Elective activity is now 34% behind plan (November 24%) and Outpatient activity is 14% behind plan (November 9%). We anticipate that this gap will continue to increase in January 2021.

Non-Elective Activity had already been reducing as a result of the 2nd national lockdown in November 2020. This was further exacerbated by the impact of Wave 2 in December with the shortfall between planned and actual activity increasing to 17% (November 13%). We anticipate this gap to increase again in January.

With the effect of Clinical Income removed, Medicine division is recording an adverse variance against budget of £693k in month and £5.3m YTD. Continuous drivers of this variance are *identified* additional costs of COVID (£167k) and unmet CIP schemes (£189k). Additionally, in month we have seen an increase in temporary consultant spend (£67k) as a result of the onset of wave 2.

The division has recorded £9.3m of expenditure towards COVID YTD, £3.5m is a result of additional costs, whilst £4.1m is using existing resources (e.g. medical wards) solely towards COVID. The remaining £1.7m is recognising the CIP schemes that are unable to be met due to COVID.

Surgery (Simon Taylor)

The division is behind plan by £600k in month (£16.3m year to date).

COVID has had a major effect on Surgery's activity. The Division is £428k behind the income plan in month (£16.1m YTD).

Pay was overspent by £126k in month (£2.0m YTD), due to temporary staffing to support COVID pressures.

Non-pay has overspent by £36k in month and is underspent by £1.8m YTD due to activity related savings on consumables.

Surgery missed its CIP plan in month and has not identified a full plan due to COVID planning. COVID has also impacted on some the delivery of some CIP schemes that will not be achievable, until normal service is possible. Surgery is working up a process to see which CIP's can be revived later this year.

Women and Children's (Michelle O'Donnell)
In December, the Division reported an adverse variance of £211k (£2,680k YTD).

COVID continues to depress activity with low levels of elective activity in Gynaecology and low levels of non-elective activity in Paediatrics. Also, in-month neonatal and maternity activity was lower. Consequently, income is behind plan by £194k in-month (£2.5m YTD).

Pay reported a £60k underspend in-month and an overspend of £36k YTD. In-month, the maternity service continued to have vacancies which created an underspend. The YTD overspend has been caused by additional COVID nursing support in F1 and the COVID related double running of antenatal clinics. The Division has a favourable underlying pay variance without these COVID costs.

Non-pay reported a £77k overspend in-month (£139k YTD). Non-pay costs were high in-month as the Maternity service purchased funded equipment as a result of a Local Maternity System initiative.

Clinical Support (Michelle O'Donnell)
In December, the Division reported an adverse variance of £475k (£2,367k YTD).

Income for Clinical Support reported £82k behind plan in-month (£1.6m YTD). In-month, activity from outpatient radiology, direct access radiology and breast screening dipped as the second wave of COVID took effect. Overall activity has increased from the start of the year as the department has overcome many of the COVID related capacity constraints.

Pay reported a £47k overspend in-month and an underspend of £366k YTD. In-month, COVID support initiatives in Radiology and Pathology caused the overspend. It has been difficult to fill vacancies in Radiology, Outpatients and Pharmacy and so a consistent underspend against the budget has resulted.

Non-pay reported a £346k overspend in-month (£1.1m YTD). However, £324k of the in-month overspend relates to COVID (£918k YTD). The main cause of the underlying overspend relates to the unbudgeted non-recurrent costs of bringing the Pathology service back in house.

Community Services (Michelle Glass)
The division reports favourable variance of £89k in month (adverse £2.9m YTD).

Income reported a £53k under recovery in month (£72k over recovery YTD), following an adjustment relating to prior month figures.

There was an in-month over spend on pay of £107k (£684k YTD). The overspend was incurred to support the division's response to COVID and the division has a favourable underlying pay spend without COVID costs. The division is utilising agency staff to cover some vacant roles in Integrated Therapy services as well as to provide a peripatetic team of nurses operating across the Community Health Teams and additional staffing to support winter beds in the community. This resource will continue to be required through winter to ensure capacity is in place to meet increasing demand for community services.

Non-pay reported a favourable variance of £250k in December (£2.3m adverse variance YTD). The YTD position primarily reflects delays in the delivery of some CIP schemes due to the impact of COVID, additional costs incurred to support the Division's COVID response and an overspend on Community Equipment. Additional community equipment costs have been incurred to provide the equipment needed to enable timely hospital discharges, including an increase in same day and out of hours deliveries and to support more than a doubling of discharges through Pathway 1 this year. Additional community equipment costs were also incurred to support end of life patients to remain at home in line with the revised end of life patient strategy and to provide community equipment for additional external bed capacity secured.

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

FINANCE AND WORKFORCE REPORT – December 2020

Statement of Financial Position at 31 December 2020

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2020	Plan 31 March 2021	Plan YTD 31 December 2020	Actual at 31 December 2020	Variance YTD 31 December 2020
	£000	£000	£000	£000	£000
Intangible assets	40,972	48,986	45,743	44,236	(1,507)
Property, plant and equipment	110,593	142,614	129,957	123,880	(6,077)
Trade and other receivables	5,707	6,366	6,366	5,707	(659)
Total non-current assets	**157,272**	**197,966**	**182,066**	**173,823**	**(8,243)**
Inventories	2,872	3,000	3,000	3,369	369
Trade and other receivables	32,342	18,000	18,000	20,699	2,699
Cash and cash equivalents	2,441	2,005	20,005	23,745	3,740
Total current assets	**37,655**	**23,005**	**41,005**	**47,813**	**6,808**
Trade and other payables	(33,692)	(30,838)	(30,302)	(37,357)	(7,055)
Borrowing repayable within 1 year	(58,529)	(3,200)	(3,200)	(4,669)	(1,469)
Current Provisions	(67)	(70)	(70)	(57)	13
Other liabilities	(1,933)	(2,000)	(22,000)	(24,869)	(2,869)
Total current liabilities	**(94,221)**	**(36,108)**	**(55,572)**	**(66,952)**	**(11,380)**
Total assets less current liabilities	**100,706**	**184,863**	**167,499**	**154,684**	**(12,815)**
Borrowings	(52,538)	(51,358)	(52,672)	(51,529)	1,143
Provisions	(744)	(750)	(750)	(744)	6
Total non-current liabilities	**(53,282)**	**(52,108)**	**(53,422)**	**(52,273)**	**1,149**
Total assets employed	**47,424**	**132,755**	**114,077**	**102,411**	**(11,666)**
Financed by					
Public dividend capital	74,065	164,063	143,057	129,054	(14,003)
Revaluation reserve	6,942	6,900	6,900	6,942	42
Income and expenditure reserve	(33,583)	(38,208)	(35,880)	(33,585)	2,295
Total taxpayers' and others' equity	**47,424**	**132,755**	**114,077**	**102,411**	**(11,666)**

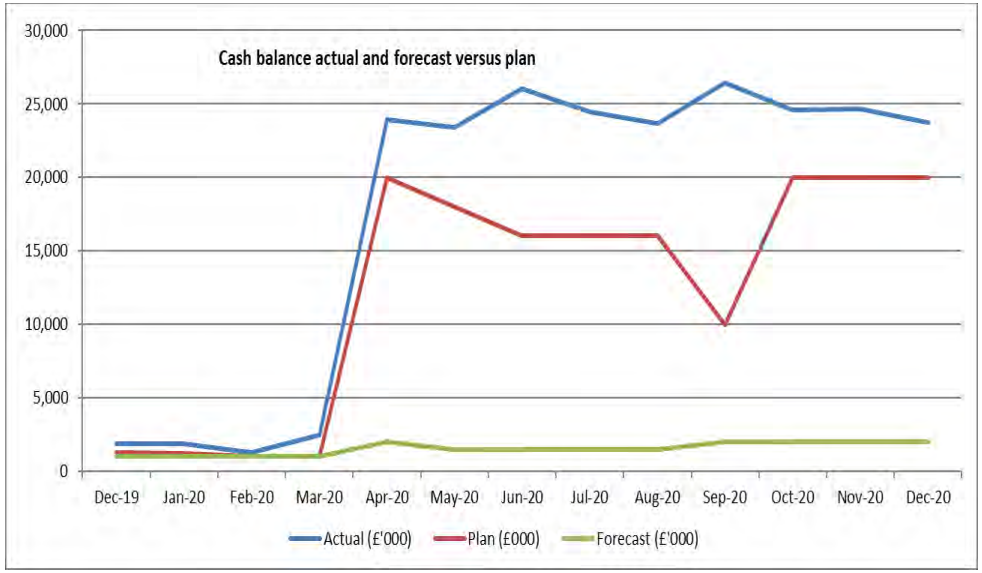
There have been no significant movements in the Balance Sheet since the previous month. Capital is showing as being slightly below plan and work is currently being undertaken to review the capital forecasts to ensure that the capital programme remains on track for the year.

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

We did not draw down the public dividend capital (PDC) owed to us in December and this is being drawn down in January and February. This is due to the fact that we have a healthy cash position and therefore did not draw down in advance of need.

Cash Balance Forecast for the year

The graph illustrates the cash trajectory since December 2019. The Trust is required to keep a minimum balance of £1m.



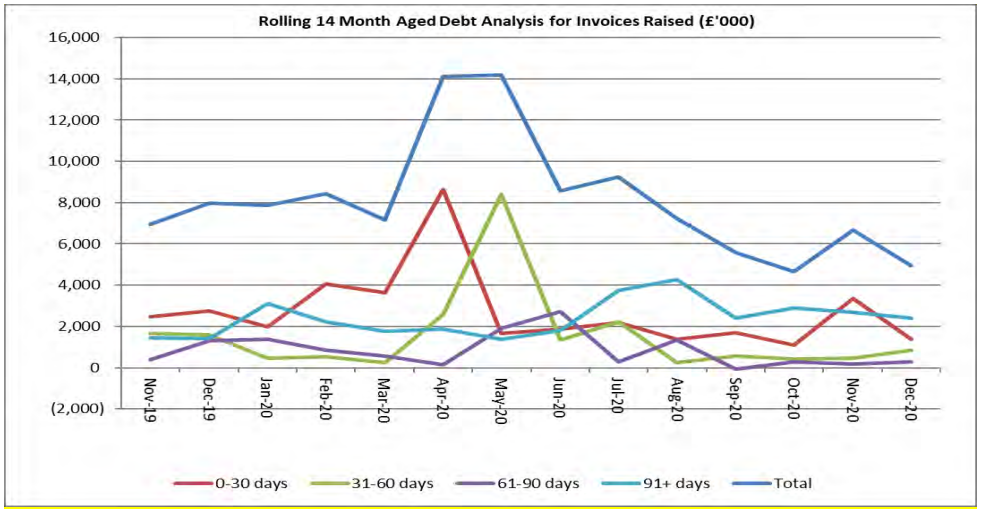
The cash balance has increased significantly and this is due to the current cash regime within the NHS. Contract payments have been paid in advance to ensure that there are adequate cash balances across the NHS and to ensure that payments to suppliers can be made quickly to keep the supply chain in full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

The cash position continues to be rigorously monitored on a daily basis during the current pandemic. Cash flow forecasts are required to be submitted to NHS England every fortnight to ensure that adequate cash reserves are being held within the NHS. Based on current forecasts, the Trust will not require any revenue support during 2020/21. Capital support will be required to support the Capital Programme and this will be received as public dividend capital.

FINANCE AND WORKFORCE REPORT – December 2020

Debt Management

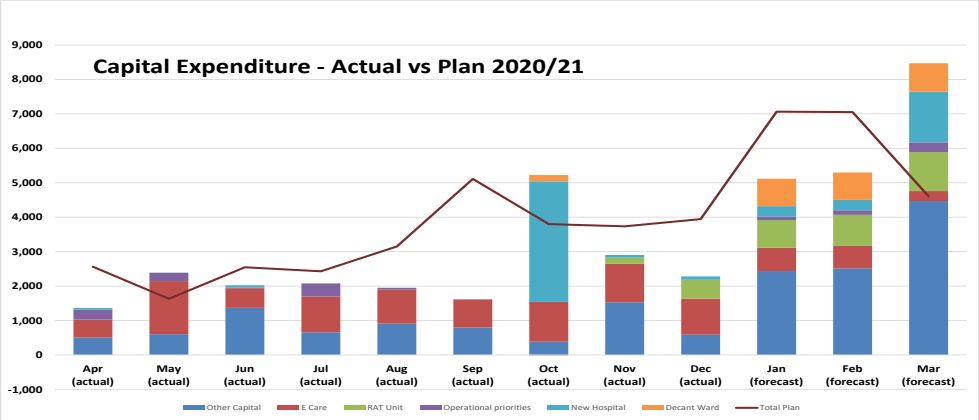
The graph below shows the level of invoiced debt based on age of debt.



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 as at the end of month 9. The large majority of the debts outstanding are historic debts. Over 73% of these outstanding debts relate to NHS Organisations, with 48% of these NHS debts being greater than 90 days old. We are actively trying to agree a position with the remaining corresponding NHS Organisations for these historic debtor balances.

Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Actual £'000	Aug Actual £'000	Sep Actual £'000	Oct Actual £'000	Nov Actual £'000	Dec Actual £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	Total 2020-21 £'000
E Care	520	1,541	568	1,037	988	813	1,156	1,118	1,048	681	653	289	10,412
RAT Unit	0	0	0	0	0	4	1	177	550	800	900	1,133	3,565
Operational priorities	289	243	24	382	52	11	-12	-1	2	100	135	281	1,506
Decant ward	0	0	0	0	0	0	181	0	0	794	794	825	2,594
New Hospital	51	2	62	3	0	0	3,501	78	90	302	302	1,471	5,862
Other Schemes	507	605	1,369	658	911	797	385	1,529	589	2,438	2,515	4,470	16,773
Total / Forecast	**1,367**	**2,391**	**2,023**	**2,080**	**1,951**	**1,625**	**5,212**	**2,901**	**2,279**	**5,115**	**5,299**	**8,469**	**40,712**
Total Plan	**2,562**	**1,632**	**2,546**	**2,430**	**3,151**	**5,113**	**3,799**	**3,734**	**3,945**	**7,063**	**7,053**	**4,608**	**47,636**

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

The Coronavirus pandemic has had a significant impact on the capital programme both in terms of the items on the capital programme and the timing. The ED scheme is now being deferred indefinitely and the decant ward has been delayed; these are the main reasons for the reduction in the forecast capital expenditure figure. However, expenditure on the new hospital has been forecast the figures include the purchase of Hardwick Manor. The prime focus of the programme has been to support the Coronavirus response with significant expenditure on medical equipment, building works and IT including greater provision of home working. The figures shown are as submitted to NHSI these have remained unchanged since the previous month. The forecast is currently in line with the plan. Meeting the forecast will be challenging. Ecare figures reflect the latest forecast position.

10:20 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

14. People and organisational development (OD) highlight report

To APPROVE a report

For Approval

Presented by Jeremy Over

Board of Directors – Friday 29 January 2021

Agenda item:	14			
Presented by:	Jeremy Over, Executive Director of Workforce and Communications			
Prepared by:	Members of the Workforce & Communications directorate			
Date prepared:	21 January 2021			
Subject:	People & OD Highlight Report			
Purpose:	✓	For information		For approval

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

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

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

- Putting You First Awards
- Our WSFT People Plan
- Staff Psychology Support Service
- Appraisal and Mandatory Training
- Freedom to Speak Up – data submission to national office
- Exploring new recruitment opportunities and supporting our local community
- Consultant appointments

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

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

Putting you first

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

Putting You First – January awards

Cybèle de Jong

I have only recently joined the trust a few weeks ago and I have shadowed Cybèle (Nursing Assistant, Ward G5/F8) a number of times, every time she made me feel at ease and welcomed me with a smile which makes things so much better especially when I haven't done this sort of job before and was very nervous.

I recognised she went above and beyond for a patient - one time she went out of her way and asked patient if he wanted a newspaper as he said he was missing reading about the news so she went to the shop to get him one out of her own money which made the patient very happy.

She is just a lovely lady and an amazing carer and I feel like she deserves to be recognised for how caring she is.

Sarah Rollo

My nomination is Sarah Rollo. She is the deputy manager in the Histopathology laboratory.

I think she lives and breathes the trust values and does this very much behind the scenes. This has been a stretch for her as she is covering for the long term sickness for the laboratory manager but she has risen to the challenges that we have found ourselves in within pathology recently.

She has guided the Histopathology team through the dissolution of the pathology network and has been instrumental in forming the vision for the future. She goes above and beyond to look after, develop and nurture the team around her and has turned around the efficiency of the diagnostic service with a proactive approach to managing the workload which ensures our patients get their results in a timely fashion.

I would like to take the opportunity to recognise and thank Sarah for all of her hard work.

Jaspreet Sidana

Jas is one of the ITU consultants and the link consultant between ITU and the paediatric team. She is always incredibly supportive and helpful.

She has facilitated the setup of a combined paediatric and ITU simulation teaching programme and also supported the implementation and development of paediatric new services like the new PICC line service.

She has taken part in the paediatric critical care network as representative of our ITU team. It is a real privilege to have such an experienced and lovely colleague.

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

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

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

The impact of the pandemic has meant that a detailed action tracker remains in development, as we have focused our time and attention on delivery of improvements and interventions that are needed *now*, as a priority. A number of these are included in the summary discussion below:

WMTY1: Promote the value of great line management:
The ongoing pandemic is continuing to highlight the positive impact good line management can have on staff and the value that it brings is clear. While the winter period will continue to place massive pressure on our teams, work continues on reviewing current training and development for line mangers.

Through discussion with the Covid workforce group and the leads of our cultural work, we are developing a shift brief / debrief checklist for managers, to support great leadership, teamwork and staff well-being. This is founded on the human factors approach, with particular recognition of the importance of maintaining well-being during times of pressure and stress. We plan to launch this next week.

WMTY2: Creating an empowering culture
The ongoing work to provide an empowering culture is the golden thread throughout the West Suffolk People Plan.

In order to support this work a '*supporting staff in stressful times'* survey was conducted. The purpose of this project was not whether to improve the support provided to staff in these situations, rather how best to do it. It asked for staff experiences during a range of events from patient complaints, attendance at coroners court to participation in HR processes.

There were over 200 responses to this survey. The data gives insight into the experiences of staff and has already been used to support HM Senior Coroner, Nigel Parsley, talking about inquests and coroner's court at the 5 o'clock club on 21st January, which had strong attendance and participation from our staff.

The qualitative data shows that going to a coroners court not only impacts on the emotional wellbeing but also on the time of a clinician, which in turn has a detrimental impact on patient care: "I had to then cancel clinical days to attend legal debriefs - when no-one asked me anything at all about the case or the statement I had written."

Key words that came up were:

This helped us develop our appreciation of the impact on individuals when they are in these situations and what worked well and what would have benefitted staff. It also highlighted two themes: the need for a clear offer of support offered at the start of the incident, and the importance of civility amongst colleagues.

WMTY3: Build relationships and Belonging at WSFT
The impacts of working during Covid-19 continue to influence this priority. The equality, diversity & inclusion action plan is on-going and training and we will be using the result of the 2020 Staff Survey to further develop key strategies.

Further discussions have taken place with Dr Sinha, BAME Staff Network Chair to support his role, provide capacity and promote the role of the network, the next meeting of which is planned for February. This work is ongoing and the Board will be updated verbally.

We will also be monitoring take-up of the Covid vaccine by ethnicity, to provide assurance around equal access for all our staff.

WMTY4: Appreciating All Staff
One key deliverable has been prioritising staff safety in relation to COVID/ Winter 20/21, which is ongoing including staff Covid vaccinations. The other key deliverable has been strengthening support for our staff's physical and mental wellbeing, which was a dedicated part of the staff briefing on 19th January 2021. A separate detailed update is provided later in this paper.

We know that it is improving the day-to-day experience at work that is often the most impactful – hence our continued commitment to support such as free hot drinks, car parking, and hot food at night. The impact of social distancing has constrained capacity within our staff rest areas and this has been an issue for a number of our teams. We will

be establishing new temporary staff rest areas in two of our courtyards to increase the space available.

WMTY5: The Future and Recovery
The future and recovery has been shaped by the current pandemic. The working landscape has been irrevocably changed and continuing work is being undertaken to ensure that policies and guidance are updated to reflect that.

The key to a successful recovery will be underpinned by the people plan and the work that is ongoing. It is also the wider SNEE system that will be able to support the WSFT people plan.

Over recent weeks we have established two new and additional communication forums with and for our staff. The first of these is a weekly 'MS Teams Live' forum for staff to hear directly about the current situation with the opportunity for Q&A with the exec directors. This has proven popular with up to 300 staff attending in any one session. The sessions are recorded and made available for playback, with key themes summarised in the next day's staff briefing e-mail. The second is a Facebook group for all staff. This has proven popular with over 1,200 joining in the first month. The most noticeable benefit has been the ability for staff to share their 'story' and experience of working at WSFT with colleagues, breaking down the barriers between teams and departments.

Our People Plan commits to the ongoing use of the WMTY-style discussion groups for staff. Given the particular impact on staff working in ITU and Theatres at the current time, our WMTY facilitators are undertaking some sessions for staff in these teams to provide a safe place for reflection, discussion and organisational learning – in order that we may further support these teams as much as we can with what they need.

Recruitment and education planning has, similarly, been focused on the support that is provided at this moment in time. Recruitment to key roles continues, to ensure there is no backlog in recruitment activity. We have also developed and implemented an incentive scheme for our registered nurse, midwife and AHP bank workers, to support safe staffing levels.

Staff Psychology Support Service – update

The staff support psychology service was launched on 30th March 2020 and was staffed by 2.2 WTE psychology staff redeployed from current duties. The service was set up and is led by Dr Emily Baker, Consultant Clinical Psychologist. Emily advised at the outset that following the initial 'core phase' of the pandemic and the need for intensive psychological support for staff, evidence indicated that a significant number of staff would experience PTSD like symptoms in the weeks and months following the end of the immediate crisis. As a result the Executive Team approved a proposal in May 2020 for a team of psychologists and therapists to provide this on-going support for a period of at least two years. The team is now almost at full strength and will comprise seven clinical psychologists/therapists/practitioners (5 WTE).

The team identified that there were fewer referrals from some groups of staff and MyWish has provided funding for one of the posts. This will enable the team to further develop the service to meet the needs of and support BAME staff who may face particular issues during the pandemic and around accessing and using mental health services. The service

is led clinically by Emily and managed by the Workforce Team as part of the overall wellbeing offer for Trust staff. A service monitoring and evaluation framework is being put in place and will be brought to the Board later in 2021. Informal and anecdotal feedback is excellent; the team are in the process of also gathering further formal qualitative and quantitative data to evaluate the scope and efficacy of the service.

The service is available for all trust staff and has been well-used since it was set up. Over 425 members of staff have used the service and 125 group sessions have been run. Staff can contact the team from 8am to 5pm Monday to Friday. Outside these hours staff have access to the NSFT first response team and support from MIND.

The team offer face-to-face, telephone and virtual support. Some staff attend for a one-off appointment whilst others have a series of appointments for counselling or psychological therapy. The support includes psychological first aid, advice and guidance and signposting and safety plans. Reflective practice sessions and check-ins are also available for teams. The team also offer ward-based and 'outreach' approaches to team support for both acute and community provisions.

Appraisal and mandatory training

As our teams have come under ever increasing pressure during this wave of the pandemic, it has become more challenging for them to prioritise activities such as these. That is not to say they are not important – we know the supportive role that appraisal conversations play in staff two-way feedback and their personal development, and the importance of mandatory training in providing assurance in crucial knowledge and skills – but releasing time for these things has become more difficult.

The Trust **appraisal** compliance target is set at 90%; the December 2020 compliance figure is 78.9% an increase of 4.8% since the previous report to the Board in September 2020 (74.1%). Implementation of the action plan to support increased compliance continues although a number of actions remain paused due to the pandemic. As wider plans for recovery are considered over the coming weeks and months, we will consider and agree the improvement trajectory for appraisal.

Training was paused at the end of March and face-to-face refresher **mandatory training** restarted in July, but was paused one more on 6th January until at least 15th February. Face-to-face clinical inductions, including mandatory training, have continued throughout the pandemic and been delivered within the constraints of social distancing. This means that an overall compliance rate of 86% in January 2021 and a reduction of only two subjects from 90%+ compliance (13 in January 2020 and 11 in January 2021) represents a significant achievement on the part of the Trust clinical and non-clinical education teams and mandatory training subject experts/trainers. The mandatory training recovery plan continues to be implemented and updated to work towards achievement of compliance of at least 90% in all subjects (95% in information governance).

I would like to record my thanks, on behalf of the Board, to our education teams led by Denise Pora and Diane Last, and to our mandatory training subject matter experts, for the way they have all responded to the constraints of the pandemic and moved swiftly to remodel training programmes and continue to support teams across the organisation with maintaining crucial knowledge and skills. Without their commitment, often unsung and

'behind the scenes', we would not have shored-up the mandatory training compliance to the level that has been achieved thus far.

Freedom to Speak Up – Q3 submission to National Guardian's Office

The next full report from our WSFT Freedom to Speak Up Guardians to the Board is due next month. In the meantime, the following is the data submission from our Guardians to the National Speak Up Guardian's Office:

Number of cases brought to FTSUGs / Champions per quarter - 17

Numbers of cases brought by professional level
Worker - 11
Manager - 3
Senior leader - 0
Not disclosed - 3

Numbers of cases brought by professional group
Allied Health Professionals - 1
Medical and Dental - 2
Ambulance (operational) - 0
Public Health - 0
Commissioning - 0
Registered Nurses and Midwives - 2
Nursing Assistants or Healthcare Assistants - 2
Social Care - 0
Administration, Clerical & Maintenance/Ancillary - 7
Corporate Services - 0
Not Known - 3
Other - 0

Of which there is an element of
Number of cases raised anonymously - 3
Number of cases with an element of patient safety/quality - 5
Number of cases with an element of bullying or harassment - 8
Number of cases where people indicate that they are suffering detriment as a result of speaking up – 0

Response to the feedback question,
'Given your experience, would you speak up again?
Total number of responses - 9
The number of these that responded 'Yes' - 4
The number of these that responded 'No' - 0
The number of these that responded 'Maybe' - 1
The number of these that responded 'I don't know' - 4

Common themes from feedback

- Staffing levels
- Bullying
- Poor relationship / insensitivity / not being listened to by line manager;
- Concerns about COVID – PPE

- Reallocation of role; working from home

Summary of learning points

- Need to raise profile of FTSU Guardians
- Importance of speaking up and listening to resolve concerns
- Importance of clear communication to alleviate uncertainty and prevent this leading to concerns, particularly during times of stress

Exploring new recruitment opportunities and supporting our local community

Following the announcement of the closure of Debenhams, the HR team proactively arranged a recruitment day at the store. The recruitment team collated and organised information for the day, and two HR recruitment assistants attended - Marie Bennett and Sarah Snowden. Two members of the Pathology team also attended to talk about their experience and what job roles Pathology could offer.

The day was very well received by Debenhams staff, including 45 attendees enquiring about roles at WSFT. Marie mentioned it was ideal to highlight to staff that they had a lot of transferrable skills the Trust could benefit from. Much of the feedback was they had not considered a career in healthcare, they had only considered retail; which opened a different perspective to their thinking during this difficult time. They were also very thankful that an external organisation was interested in trying to help.

Individuals were asked to record that they worked at Debenhams in their application so the recruitment team could track successful recruitment rates; depending on this the recruitment team may consider arranging another recruitment day.

To date the response has been very positive:

- Housekeeper - two applications – one successful at interview
- Ward Clerk – shortlisted
- Phlebotomy – four applications
- Receptionist (Day Surgery) – four applications
- Some may apply for Bank posts (in particular haematology)

There are some Debenhams applications in process, and also nine band 2 posts and one band 3 post that are currently being advertised, which may attract applications from Debenhams staff.

The day was very enjoyable with such a positive feel about it, and was well received by our staff as well as the Debenhams team, in difficult times.

Recent Consultant Appointments

Post:	Consultant in Neurology
Interview:	8 December 2020
Appointee:	Dr Smriti Agarwal
Start date:	8 December 2020
Current post:	Fixed-term consultant in Neurology

	West Suffolk NHS Foundation Trust: February 2020 - present Previous Position: *May – October 2020:* Locum Consultant: Cambridge University Hospitals
Post: Interview: Appointee: Start date:	Consultant in Obstetrics & Gynaecology – maternal medicine 4 January 2021 Dr Vincent Boama 4 January 2021
Current post:	Fixed-term Consultant in Obstetrics & Gynaecology West Suffolk NHS Foundation Trust: May 2019 - present Previous Position: *September 2014 – December 2018* Attending Physician: Sidra Medicine and Al Wakra Hospital, Doha, Qatar
Post: Interview: Appointee: Start date:	Consultant in Obstetrics & Gynaecology – early pregnancy 4 January 2021 Dr Gemma Brierley 4 January 2021
Current post:	Fixed-term consultant in Obstetrics & Gynaecology West Suffolk NHS Foundation Trust: December 2019 - present Previous Position: *August 2017 – December 2019:* ST7 in Obstetrics & Gynaecology: Oxford University Hospitals
Post: Interview: Appointee: Start date:	Consultant in Emergency Medicine 8 January 2021 Dr Pratheep Paranjothi 1 March 2021
Current post:	Locum Consultant West Suffolk NHS Foundation Trust and Norfolk and Norwich University Hospitals: June 2020 - present Previous Position: *August 2019 – June 2020* ST6 Emergency Medicine: West Suffolk NHS Foundation Trust

Jeremy Over
Executive Director of Workforce & Communications
January 2021

15. Quality, safety and improvement reports

To APPROVE the reports

Presented by Susan Wilkinson and Nick Jenkins

15.1. Maternity services quality & performance report including Ockenden report

For Approval

Trust Open Board – 29th January 2021

Agenda item:	15.1			
Presented by:	Sue Wilkinson, Executive Chief Nurse/ Karen Newbury, Head of Midwifery			
Prepared by:	Karen Newbury – Head of Midwifery/Rebecca Gibson Compliance Manager			
Date prepared:	January 2021			
Subject:	Maternity quality & safety performance report			
Purpose:	X	For information		For approval

Executive summary:

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

This report contains:

- Strategy update
- Ockenden self-assessment and assurance report (Annex A)
- External assurance and oversight of CQC improvement plan
- National best practice publications and local HSIB reports
- Learning from incidents / learning from deaths
- Maternity Clinical and Quality dashboard **(**Annex B**)**
- Continuity of Carer progress (see Quality dashboard Annex B)
- Maternity Safety Highlight Report incorporating CNST Maternity incentive scheme **(**Annex C**)**
- UKOSS Covid report (Annex D – CNST requirement)
- Paediatric Staffing report (Annex E – CNST requirement)
- ATAIN Programme report (Annex F – CNST requirement)

Strategy update

A draft Maternity Quality and Safety Framework has been developed which will replace the Maternity Risk Management Strategy. It includes all aspects of Clinical Governance and it reflects the Trust's overarching policies and processes. The draft has been circulated to key Maternity staff for comment as well as being shared more widely with the wider Trust Safety and Quality teams.

As part of this piece of work all groups and forums involved in Quality and Safety are reviewing their Terms of Reference to ensure that these are clear on the purpose, level of decision making, core membership and escalation of concerns.

Initially it was anticipated that the framework might be in place by 31st December 2020 but it is still in its final development stage whilst the service focussed on the response to the Ockenden report.

The framework also overlaps with the trust-wide work on the patient safety incident response framework (PSIRF) and a Maternity specific section of the incident plan (the PSIRP) has been agreed as a working draft and this part of the framework has also had CCG review as part of the wider PSIRP development. See Annex B for the most recent draft of the 'Maternity incidents, adverse outcomes and externally reportable events investigation pathways'

Ockenden

The review by Donna Ockenden of maternity care at The Shrewsbury and Telford Hospital NHS Trust identified a number of important themes which the report states must be shared across all

maternity services as a matter of urgency including '*Local Actions for Learning'* and early recommendations stated as '*Immediate and Essential Actions'*.

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

NHSE have published an assurance assessment tool which draws together elements including:

- All 7 IEAs of the Ockenden report,
- NICE guidance relating to maternity,
- compliance against the CNST safety actions, and
- a current workforce gap analysis

Originally due for submission by the 15th January 2021; an extension was granted to take into account service pressures due to COVID. The assurance assessment tool will therefore be reported through our LMS and shared with the regional teams by the 15th February 2021.

A local review is currently underway to ensure that all Maternity NICE guidance issued have a completed baseline assessment and that local clinical guidelines / practice reflect NICE requirements.

NHSE ask that organisations review the report at their public board, and use the assurance assessment tool to support these discussions. Annex A sets out a summary of the WSFT completed tool including areas of non/partial compliance or development need. This has been overseen by Beverly Gordon (Project midwife supporting WSFT) supported by the Maternity quality & safety team. The summary report is enclosed in an appendix.

External assurance and oversight of CQC improvement plan

NHSI Improvement Officer Mai Buckley (Group Director of Midwifery) is providing external specialist support and oversight to enable Maternity to address the concerns/actions raised by the CQC. A meeting took place in January 2021 with key leads to review outstanding elements of the CQC action plan and the related clinical quality review in September 2020.

A number of 'red' actions have been delayed including two from the original CQC action plan relating to PROMPT training and the baby abduction policy. Additional concerns raised were as follows:

- Safety huddles and morning obstetric MDT ward rounds not embedded in practice.
- Funding identified for temporary ward clerk but bank shifts unfilled due to sickness/shielding
- Job plans not been completed
- RAG Triage tools not been implemented
- Midwifery led birth centre criteria pathway not been completed.

Mai notes that the Risk management strategy (Maternity Quality and Safety Framework) has been drafted and circulated widely for comment but its implementation has been delayed. The impact of delays in the wider trust wide governance structure review is acknowledged as having potentially impact upon this in terms of ensuring alignment as well as the unavoidable impact of COVID-19.

Leadership developments including appointment of a new CD for the division and individual dedicated consultant obstetric leads for governance, guidelines, and labour ward / fetal monitoring. It is acknowledged that these roles need to be embedded to ensure there is medical engagement and oversight to enable the CQC and wider Maternity improvement to progress at pace.

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, MBRRACE-UK have issued the following national reports (these can be found at https://www.npeu.ox.ac.uk/mbrrace-uk/reports)

- Perinatal Confidential Enquiry: Stillbirths and Neonatal Deaths in Twin Pregnancies (published 14th Jan 21)

- Saving Lives, Improving Mothers' Care 2020: Lessons to inform maternity care from the UK and Ireland Confidential Enquiries in Maternal Death and Morbidity 2016-18 (published 14th Jan 21)
- Perinatal Mortality Surveillance Report for births in 2018 (published 10th Dec 20)

HSIB have now issued five maternity national learning reports:

- Summary of themes arising from the HSIB maternity programme.
- Severe brain injury, early neonatal death and intrapartum stillbirth associated with group B streptococcus infection.
- Neonatal collapse alongside skin-to-skin contact.
- Maternal death national learning report.
- Delays to intrapartum intervention once fetal compromise is suspected

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 eight 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.

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

Learning from incidents / learning from deaths (LfD)

Meetings of the LfD group in 2020 received presentation from the Obstetric lead Miss Kate Croissant of the three maternal deaths reported in the last decade including assurances relating to the action plans from the two earlier deaths (the most recent 2018 death was reported via HSIB and has an associated improvement plan reported elsewhere). The group was reassured to receive evidence of action completion at the time and (given the passage of time, especially for the first case) that these actions were still current and/or further improvements had been made through clinical advancements.

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

Maternity dashboard (see Annex B)

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 December there were eight indicators categorised as Red and three as Amber on our clinical dashboard (NB: RAG rating currently still based on National Maternity Perinatal Audit 2016/2017 data. There is an ambition to update all indicators to reflect more recent standards such as 'Saving Babies lives' care bundle v2 and that of the other units within our LMNS and this is in development as part of a regional project to develop a standard dashboard for all maternity units in the region.

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

Indicators	Narrative
Total Women Delivered Total Number of Babies born at WSH Midwifery Led Birthing Unit (MLBU)	Variable month by month. With increased number of induction of labours this is affecting the number of women eligible to birth in the birthing unit

Indicators	Narrative
Births	
Total number of Instrumental Deliveries	This is an isolated variance from previous months.
Inductions of Labour (ex pre-labour & twins)	With the full implementation of SBLCBv2 and an increase of gestational diabetes this is to be expected. This was exceptionally high in November, but within normal parameters in December
Postpartum Haemorrhage >=1500mls	QI project has taken place since July. To monitor closely.
Supernumerary Labour Suite Co-ordinator	NHSI – Improvement Officer supporting workforce plans to resolve this issue.
Appraisal completion	Part of wider Trustwide improvement plans
Mandatory training	
Emergency equipment checks Smoking cessation / CO checks Domestic violence checks	Identified non-compliance is discussed at an individual level with clinicians including escalation to line manager any continued non-compliance. In addition an 'all Consultants' feedback session was provided in November
Swab count Drug chart completion	Compliance was low for December – new staff and CoC midwives. Further support regarding documentation to commence.
MLBU 'fresh ears' (documentation)	Quality assurance midwife lead working with the Birthing unit lead midwife on strategies to improve performance

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 December 2020 report are represented in our quality dashboard (see Annex B)

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). See Annex C Maternity Safety Highlight Report for current performance against the 10 indicators.

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

Other Maternity indicators including those incorporated elsewhere in board reporting schedule

- Maternity serious incidents in November / December - 2

These are reported in the closed board 'serious incidents, complaints, claims and inquests' report on a monthly basis. This includes details of the incident, duty of candour status and whether it is reportable to the HSIB or for local investigation. Sadly, there were 2 SIs reported in Maternity in November / December:

- WSH-IR-64286 STEIS 2020/22037 IUD
- WSH-IR-65391 STEIS2020/24158 Intrapartum stillbirth

As per protocol both cases were reported to HSIB, MMBRACE and a local rapid review took place to identify if there were any learning points / issues for immediate action. The Perinatal Mortality Review Tool was also completed. See separate '*Serious incidents, complaints, claims and inquests'* Closed Board report for details

- Saving Babies Lives Care Bundle version 2 (SBLCBv2) Report

Last reported to the Board in November, the next quarterly update will be provided in February.

UKOSS Covid report – Local information (Annex D- CNST requirement)

UKOSS (UK Obstetric Surveillance System) report on the characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2, between March and April 2020. Local information was compared to the national picture and showed lower numbers in our region and in this timeframe all women were asymptomatic. To note there was a local increase in mental health concerns and domestic abuse disclosures.

Paediatric Medical Staffing for Neonatal Report (Annex E – CNST requirement)

This report is to provide assurance that the Neonatal medical staff support provided to the Maternity Unit meets the standards expected to provide safe effective care. Following review of the rotas from January – June 2020 the BAPM (British Association of Perinatal Medicine) standards were met and compliance achieved.

ATAIN Programme Report (Annex F – CNST requirement)

ATAIN (Avoiding Term Admissions into Neonatal Units) programme was introduced in October 2018, using tools developed by NHS improvement to focus on four particular areas; Respiratory conditions, Hypoglycaemia, Jaundice and Asphyxia. The report shows through targeted training and the introduction of a visual check and temperature recordings in addition to the newborn early warning trigger and track (NEWTT), term admissions to the NNU have decreased and this has enabled unnecessary separation of mothers and babies.

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 – Ockenden response report

See separate report attached

Annex B – Maternity Clinical and Quality Dashboard

NHS West Suffolk NHS Foundation Trust

	Green	Amber	Red	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Total Women Delivered	>208 or <216	>216 or <208	> 224 or <200	178	180	187	174	183	202	203	178	159
Total Number of Babies born at WSH	>208 or <216	>216 or <208	> 224 or <200	179	182	190	175	187	204	206	181	160
Twins		No target		1	2	3	1	4	2	3	3	1
Homebirths	2.5%	2% or less	Less than 1%	5 2.8%	7 3.9%	5 2.7%	3 1.7%	2 1.1%	6 3%	7 3.4%	4 2.2%	3 1.9%
Midwifery Led Birthing Unit (MLBU) Births	≥20%	19- 15%	14% or less	3 1.7%	12 6.7%	26 13.9%	22 12.6%	20 10.9%	27 13.4%	26 12.8%	17 9.6%	17 10.7%
Labour Suite Births	77.5%	69% - 74%	68% or less	170 95.5%	161 89.5%	154 82.4%	149 85.6%	161 88%	169 83.7%	170 83.8%	157 88.2%	139 87.4%
Total Caesarean Sections	<26.%		> 22.6%	34 19.1%	36 20%	56 29.9%	46 26.4%	43 23.5%	48 23.8%	47 23.2%	39 21.9%	33 20.8%
Total Elective Caesarean Sections	11%	>11% -13%	13% or more	14 7.9%	14 7.8%	23 12.3%	14 8%	20 10.9%	20 9.9%	18 8.9%	11 6.2%	10 6.3%
Total Emergency Caesarean Sections	14.3%	14.4%-14.9%	15% or more	20 11.2%	22 12.2%	33 17.6%	32 18.4%	23 12.6%	28 13.9%	29 14.3%	28 15.7%	23 14.5%
Total Instrumental deliveries	12% - 14%	>14% - 15%	> 15%	9.6%	10.6%	7.0%	8.6%	11.5%	14.9%	14.3%	10.1%	14.5%
Inductions of Labour (ex pre labour & twins)	<31%	>31% -32.9%	>33%	39.9%	35%	32.6%	36.2%	39.3%	38.1%	38.9%	52.8%	36.2%
Grade 1 Caesarean Section (Decision to Delivery Time met)	100%	96 - 99%	95% or less	100%	100%	100%	100%	100%	91%	100%	N/A	100%
Grade 2 Caesarean Section (Decision to delivery time met)	80%	76 - 79%	75% or less	57%	81%	67%	95.4%	78%	83%	82.3%	68%	75%
Postpartum Haemorrhage 1500 mls or more	<3.5%	3.5% - 3.8%	> 3.8%	1.7%	1.1%	8%	4.0%	2.7%	2.5%	3.9%	2.8%	2.5%
Shoulder Dystocia	2	3-4	5 or more	3	7	4	4	5	2	2	3	5
Total women delivered who breastfed babies with first 48 hours	>80%	75-80%	<75%	76.7%	72.8%	78.4%	71.4%	79.2%	82.2%	81.8%	73.1%	71.8%
1 to 1 Care in labour	100%	96-99%	95% or less	97.4%	100%	100%	100%	100%	99.5%	100%	100%	100%
Supernumerary Labour suite co-ordinator	100%			100%	100%	No data	84%	74%	Insuff data	83%	70%	91%
Midwife to birth ratio	1:30		1:32 or more	1:26	1:26	1:27	1:30	1:27	1.31	1:31	1:27	1:25
Completion of WHO checklists	>95%	80-94%	<80%	No data	No data	93%	96%	96%	90%	96%	100%	96%
Unit Closures	0		1	0	0	0	0	0	1	0	0	0

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

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

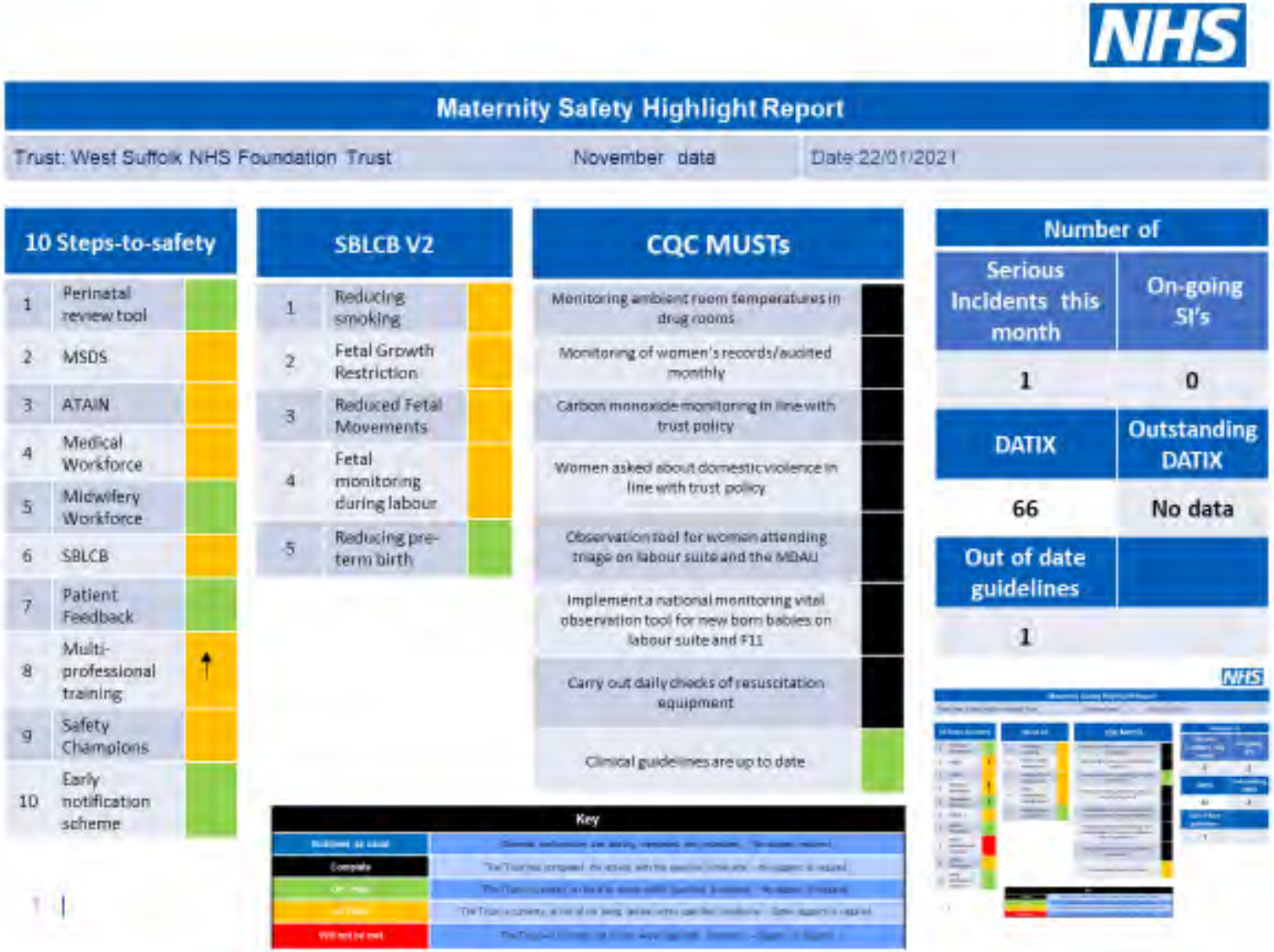
MONTHLY QUALITY & SAFETY AUDITS:

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

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

Women who received 70% of care	Number									31
	%									1.30%
Weekly hours of dedicated consultant cover on LS	>60		96	86	72	84	87	90	99	

Annex B – Maternity Safety Highlight Report for November & December 2020 data



NHS

Maternity Safety Highlight Report

Trust: West Suffolk NHS Foundation Trust | November data | Date:22/01/2021

10 Steps-to-safety

1	Perinatal review tool
2	MSDS
3	ATAIN
4	Medical Workforce
5	Midwifery Workforce
6	SBLCB
7	Patient Feedback
8	Multi-professional training
9	Safety Champions
10	Early notification scheme

SBLCB V2

1	Reducing smoking
2	Fetal Growth Restriction
3	Reduced Fetal Movements
4	Fetal monitoring during labour
5	Reducing pre-term birth

CQC MUSTs

Monitoring ambient room temperatures in drug rooms
Monitoring of women's records/audited monthly
Carbon monoxide monitoring in line with trust policy
Women asked about domestic violence in line with trust policy
Observation tool for women attending triage on labour suite and the MDAU
Implement a national monitoring vital observation tool for new born babies on labour suite and F11
Carry out daily checks of resuscitation equipment
Clinical guidelines are up to date

Number of

Serious Incidents this month	On-going SI's
1	0
DATIX	**Outstanding DATIX**
66	No data
Out of date guidelines	
1	

Key

Maternity Safety Highlight Report

Trust: West Suffolk NHS Foundation Trust	December data	Date:22/01/2021

10 Steps-to-safety

1	Perinatal review tool	
2	MSDS	
3	ATAIN	
4	Medical Workforce	
5	Midwifery Workforce	
6	SBLCB	
7	Patient Feedback	
8	Multi-professional training	↑
9	Safety Champions	
10	Early notification scheme	

SBLCB V2

1	Reducing smoking	
2	Fetal Growth Restriction	
3	Reduced Fetal Movements	
4	Fetal monitoring during labour	
5	Reducing pre-term birth	

CQC MUSTs

Monitoring ambient room temperatures in drug rooms	
Monitoring of women's records/audited monthly	
Carbon monoxide monitoring in line with trust policy	
Women asked about domestic violence in line with trust policy	
Observation tool for women attending triage on labour suite and the MDAU	
Implement a national monitoring vital observation tool for new born babies on labour suite and F11	
Carry out daily checks of resuscitation equipment	
Clinical guidelines are up to date	

Key	
Action as need	
Complete	
Will not be met	

Number of

Serious Incidents this month	On-going SI's
1	1

DATIX	Outstanding DATIX
66	No data

Out of date guidelines	
0	

Annex D UKOSS Covid report

See separate report attached

Annex E Paediatric Staffing report

See separate report attached

Annex F ATAIN Programme

See separate report attached

West Suffolk NHS
NHS Foundation Trust

Response to the Ockenden Report – January 2021

Report Title	Assessment and Assurance of 7 Immediate and Essential Actions Required in Response to the Ockenden Report
Report for	Information and approval
Report from	Maternity Services
Report Author	Karen Newbury – Head of Midwifery Beverley Gordon – Project Midwife

1. Report Title: Assessment and Assurance of 7 Immediate and Essential Actions Required in Response to the Ockenden Report

2. Purpose of the Report

To provide information on the current assurances and actions required to ensure maternity services in the Trust are safe.

3. Background

On the 10th December 2020, a report was published and made public which outlined the 'emerging findings and recommendations from the independent review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust'. This report included the overview of 250 Clinical Reviews and as a result of the thematic review, 7 key areas of safety in maternity services were identified. Each Maternity Unit in the UK have been asked to review all their systems, processes and pathways to ensure that the lessons learned from this and other national reports, safety recommendations and initiatives have been implemented in order to assure women, their families and organisations that the risk of similar failures are reduced locally.

An initial response was sent to NHSE by the Chief Executive 21/12/20 outlining the immediate main assurances the Trust could provide. The next steps were to provide evidence of assurance or progress towards the 7 immediate and essential actions by 15/1/21 (now changed to 15/2/21). Included in this and following on from these immediate actions and assurances was the need to demonstrate the overall assurances from the maternity services within the Trust that all of the key recommendations from this report and from other safety assessments such as CQC and CNST were being actively addressed and updated processes and organisational learning was evident.
This report demonstrates the current assessment and assurances for the 7 immediate and essential actions and provides an overview of all the recommendations and the assurance available and actions required to promote safety within the Trust's Maternity Services.

4. Summary of Assessment and Assurance on 7 Immediate and Essential Actions

There are 7 main areas of immediate concerns with 12 sub-sections in these 7 aspects of safety. The details of the assessment and these 7 actions is included in Appendix 1. The NHS tool for the Maternity Assessment and Assurance of all of the required recommendations as well as the immediate and essential actions from the report is also available with versions that include the full evidence bases for the assessment within the Trust.

The resulting assessment is summarised as follows:

1: Enhanced Safety
Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.
The Trust is partially compliant as the LMNS and Regional processes need to be developed and implemented so that there is shared learning across the organisation and within the local and regional networks. The Perinatal Clinical Quality Surveillance Model will need to be implemented within these networks as well as locally. As these processes are relatively new, this has not been raised as a risk at this time.

2: Listening to Women and Families
Maternity services must ensure that women and their families are listened to with their voices heard.
The Trust is currently fully compliant with the immediate and essential actions.

3: Staff Training and Working Together
Staff who work together must train together
The Trust is partially compliant as the twice daily consultant led ward rounds are only on the normal working week Monday to Friday and once daily at weekends and on public holidays. This is being addressed and the risk has been assessed and recorded on the risk register.

4: Managing Complex Pregnancy
There must be robust pathways in place for managing women with complex pregnancies.
Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.
The Trust is partially compliant as the women do not have a single named consultant and their care is managed by an MDT approach. This has been raised as a risk but the risks to mothers and babies is considered to be low as women are referred to tertiary centres when required but the processes need to be formalised. Links with Maternal Medicine Centres will be formalised when these are established.

5: Risk Assessment Throughout Pregnancy
Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.
The Trust is partially compliant as it has not been custom and practice to document a formal risk assessment at each contact although the practitioner will act on the findings of each assessment and investigation undertaken. This has not been raised as a risk currently as the process for continual risk assessment is being embedded and will be monitored over the coming months.

6: Monitoring Fetal Wellbeing
All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.
The Trust is currently compliant with this as there are now 2 leads for fetal monitoring in place.

7: Informed Consent
All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.
The Trust is currently partially compliant as pathways are not published on the Trust website. This has been raised as a risk as this requires input from a number of corporate teams to undertake this project effectively. The risk to safety is low as information leaflets and booklets are available on the Website and guidelines are shared with women if requested to do so alongside individualised discussion with women about risks and benefits of chosen patterns of care.

5. Next steps
The full recommendations are being assessed in order to be able to demonstrate assurance of a safe service and quality of care for women and their families over the coming months.

Appendix 1 Assessment and Assurance on 7 Immediate and Essential Actions

Action number and detail	Immediate and Essential Action required	WSH compliance	Actions Required	Comments
1: Enhanced Safety Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.	1a Perinatal Clinical Quality Surveillance Model	**GREEN**	Implement the model locally, regionally and Nationally. Received 29/12/20.	Commitment to implement demonstrated.
	1b SI's shared with Boards/LMS/HSIB	**GREEN**	Process for embedding shared learning with LMNS is starting in January 2021. Process for obtaining external clinical review of incidents, PMRT and SI's to be agreed at LMNS/Regional level to ensure there is equity and standardisation in the Trusts. LMNS meetings commenced 13/1/21. Assurances of learning within the organisation to continue through audits and spot checks.	Quality and Safety Reports submitted to the Board monthly outlining Sis and lessons learned from incidents etc. Quarterly Board report written by Corporate Governance team to demonstrate organisational learning. Regional and LMNS wide meetings to discuss implementation of the model from January.
2: Listening to Women and Families Maternity services must ensure that women and	2a Robust Service Feedback Mechanisms	**GREEN**	Guideline group being set up which will include MVP member wherever possible.	MVP actively involved in review of quality and safety within maternity services.

their families are listened to with their voices heard.	2b Executive/Non-Executive Directors in place	**GREEN**		Maternity Safety Champions in place and actively involved in Safety initiatives.
3: Staff Training and Working Together Staff who work together must train together	3a Consultant Led ward rounds twice daily	**AMBER**	Risk raised as currently there is a once daily consultant led ward round at weekends and on public holidays. To commence trial of 2x daily ward rounds from 23/1/21. Job planning required to introduce additional rounds	To audit compliance with weekend and public holiday ward rounds once established. Handover of care guidelines to be updated. Once completed, will be completed and Green.
	3b MDT training scheduled	**GREEN**		Trajectory to have 100% in all relevant staff groups by April. Training currently virtual and may be restricted by Covid plans in place.
	3c CNST funding ringfenced for maternity	**GREEN**		Assurance that any money will be ringfenced.
4: Managing Complex Pregnancy There must be robust pathways in place for managing women with complex pregnancies Through the development of links with the tertiary level Maternal Medicine Centre there must be	4a Named consultant lead/audit	**AMBER**	Risk register entry raised, consultant not named on the records of women. Guidelines for internal and external referrals to be clarified.	Currently groups of consultants manage complex care and review women at appointments. There is a MDT discussion resulting in an agreed management plan. Diabetes specialist team in place. Monthly regional MDT occurs to discuss complex cases.

agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.				TORs for MDT meetings to be approved.
	4b Development of Maternal Medicine Centres	**AMBER**	Regional Maternal Medicine Centres to be agreed and pathways set up. Trust will then utilise these processes.	
5: Risk Assessment Throughout Pregnancy Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.	5a Risk assessment recorded at every contact	**AMBER**	Change to practice implemented. Assurance of embedding of changed practice to be audited in future months.	Documented risk assessment at each contact has not been the routine practice as the national guidance has not been clear on this requirement. Now this has been raised, staff informed of the need for this and this will now be monitored through audit.
6: Monitoring Fetal Wellbeing All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician	6a Second lead identified	**GREEN**	Terms of reference for CTG training sessions being reviewed and approved.	Consultant lead for fetal monitoring in place from January. Lead Midwife already in place.

both with demonstrated expertise to focus on and champion best practice in fetal monitoring.				
7: Informed Consent All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.	7a Pathways of care clearly described, on website	**AMBER**	Risk raised as currently unable to publish guidelines etc on the Trust Website. Minimal risk as patients can request guidelines from the Trust. Increase the number of information leaflets/booklets in other commonly used languages.	Key information leaflets available on the Website mainly in English.

Maternity Governance – Quality & Safety

Report Title	Report on Covid 19 effects on women in the local area – UKOSS
Report for	Approval and Information
Report from	Maternity Services
Report Author	Beverley Gordon, Project Midwife

Report Title

Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK: national population-based cohort study. BMJ 2020; Published 08 June 2020

Purpose of the Report

To provide local information on the maternity response to Covid-19 and the effect on women and their families.

Background

The Maternity Incentive Scheme year 3 has been relaunched after a pause during the Covid 19 first wave. The standards and requirements have been updated and now include aspects of care relating to Covid 19 which the Trust needs to consider and share learning for the future.

Safety action 9: Can you demonstrate that the Trust safety champions (obstetrician, midwife and neonatologist) are meeting bi-monthly with Board level champions to escalate locally identified issues?

d) Together with their frontline safety champions, the Board safety champion and MatNeoSIP Patient Safety Networks has reviewed local outcomes in relation to:

I. Maternal and neonatal morbidity and mortality rates including a focus on women who delayed or did not access healthcare in the light of Covid-19, drawing on resources and guidance to understand and address factors which led to these outcomes.
II. The UKOSS report on Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK.
III. The MBRRACE-UK SARS-Covid-19 https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK_Maternal_Report_2020_v10_FINAL.pdf
IV. The letter regarding targeted perinatal support for Black, Asian and Minority Ethnic groups

And considered the recommendations and requirements of II, III and IV on I.

This report relates to part ii above and is an overview of the UKOSS report and the local impact on women and maternity services and is based on the following publication:

BMJ2020;369:m2107 ***Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK: national population based cohort study.***

Marian Knight,[1] Kathryn Bunch,[1] Nicola Vousden,[2] Edward Morris,[3] Nigel Simpson,[4] Chris Gale,[5] Patrick O'Brien,[6] Maria Quigley,[1] Peter Brocklehurst,[7] Jennifer J Kurinczuk,[1] On behalf of the UK Obstetric Surveillance System SARS-CoV-2 Infection in Pregnancy Collaborative Group

Summary of findings

Abstract

Objectives

To describe a national cohort of pregnant women admitted to hospital with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection in the UK, identify factors associated with infection, and describe outcomes, including transmission of infection, for mothers and infants.

Design

Prospective national population based cohort study using the UK Obstetric Surveillance System (UKOSS).

Setting

All 194 obstetric units in the UK.

Participants

427 pregnant women admitted to hospital with confirmed SARS-CoV-2 infection between 1 March 2020 and 14 April 2020.

Main outcome measures

Incidence of maternal hospital admission and infant infection. Rates of maternal death, level 3 critical care unit admission, fetal loss, caesarean birth, preterm birth, stillbirth, early neonatal death, and neonatal unit admission.

Results

The estimated incidence of admission to hospital with confirmed SARS-CoV-2 infection in pregnancy was 4.9 (95% confidence interval 4.5 to 5.4) per 1000 maternities.

233 (56%) pregnant women admitted to hospital with SARS-CoV-2 infection in pregnancy were from black or other ethnic minority groups, 281 (69%) were overweight or obese, 175 (41%) were aged 35 or over, and 145 (34%) had pre-existing comorbidities.

266 (62%) women gave birth or had a pregnancy loss; 196 (73%) gave birth at term. Forty one (10%) women admitted to hospital needed respiratory support, and five (1%) women died. Twelve (5%) of 265 infants tested positive for SARS-CoV-2 RNA, six of them within the first 12 hours after birth.

Conclusions

Most pregnant women admitted to hospital with SARS-CoV-2 infection were in the late second or third trimester, supporting guidance for continued social distancing measures in

later pregnancy. Most had good outcomes, and transmission of SARS-CoV-2 to infants was uncommon. The high proportion of women from black or minority ethnic groups admitted with infection needs urgent investigation and explanation.

A full description of the study and results can be found in Appendix 1.

Background to Study

In response to the SARS-CoV-2 pandemic declared in March 2020, a national prospective observational study using the UK Obstetric Surveillance System (UKOSS) was carried out. UKOSS is a research platform that collects national population-based information about specific severe complications of pregnancy from all 194 hospitals in the UK with a consultant led maternity unit. This research study aimed to describe, on a population basis, characteristics and outcomes of pregnant women admitted to hospital with SARS-CoV-2 in the UK, in order to inform on-going guidance and management. The maternity service had nominated reporting clinicians to notify UKOSS of all pregnant women with confirmed SARS-CoV-2 infection admitted to the service using a live reporting link specific to each individual reporter. The clinicians were also required to complete the database generated by the maternity service, specific to cases reported via UKOSS and all women tested for SARS-CoV-2 whether negative or positive. The nominated clinicians were also sent a reporting email at the end of the month to ensure that all cases had been reported / to confirm zero cases. After notification, clinicians were asked to complete an electronic data collection form containing details of each woman's characteristics, management, and outcomes. Reporters who had not returned data were contacted by email at weeks one, two, and three after notification.

At the time covered by the study, women were tested only if they had symptoms of SARS-CoV-2 infection. UKOSS defined neonatal infection as detection of viral RNA on polymerase chain reaction testing of blood or a nasopharyngeal swab or aspirate.

The study found that 233 pregnant women admitted to hospital with SARS-CoV-2 infection in pregnancy were from black or other ethnic minority groups, 281 were overweight or obese, 175 were aged 35 or over, and 145 had pre-existing comorbidities. 266 women gave birth or had a pregnancy loss; 196 gave birth at term. 41 women admitted to hospital needed respiratory support, and 5 women died. 12 of 265 infants tested positive for SARS-CoV-2 RNA, 6 of them within the first 12 hours after birth.

Local Information – Maternal

Processes were put in place at the start of the crisis to manage the changing situation within the Trust and reduce transmission and harm to patients and staff. These are summarised in appendix 1. Guidelines and SOPs were put in place for staff and patients – see Appendix 1. To compare the effects of Covid-19, the period of time from 1/3/20-31/10/20 was chosen to look at in detail with a comparison to 1/3/19-31/10/19 so that seasonal variations could be accounted for.

The characteristics of the women with positive Covid tests to date are included in the following table 1 and outcomes in table 2.
Women who were admitted for Covid-19 infection reasons were reported to UKOSS as requested.

Table 1 Characteristics of pregnant women with confirmed SARS -CoV-2 infection for whom data were available, WSH, 1 March to date

CHARACTERISTICS	No (%)* of women = 6
Age, years:	
<20	1 (16.6%)
20-34	5 (83.3%)
≥35	0
Body mass index:	
Normal	2 (33.3%)
Overweight	1 (16.6%)
Obese	3 (50%)
Missing data	0
Woman and/or partner in paid work	4 (66.6%)
Missing data	1 (16.6%)
Black or other minority ethnic group (all)	2 (33.3%) – other white / European.
Asian	0
Black	0
Chinese/other	0
Mixed	0
Missing data	0
Current smoking	1 (16.6%)
Ex smokers	2 (33.3%)
Missing data	0
Pre-existing medical problems	
Asthma	2 (33.3%) one mild
Hypertension	0
Cardiac disease	1? undiagnosed
Diabetes	0
Multiparous	1 (16.6%)
Missing data	1
Multiple pregnancy	0
Gestational diabetes	0
Gestation at symptom onset, weeks:	
<22	1
22-27	0
28-31	0
32-36	2 (33.3%)
≥37	3 (50%)
*Percentages of those with complete data.	

Table 2 Hospital outcomes and diagnoses among women with confirmed SARS -CoV-2 infection in pregnancy

Maternal outcomes	**No (%) of women (n= 6)**
Needed critical care	0
Needed extracorporeal membrane oxygenation	0
SARS-CoV-2 pneumonia on imaging	0
Final outcome:	
Died	0
Discharged well	6 (100%)
Still in hospital	0

Summary of Maternal details and Covid-19

1487 mothers were delivered in the period 1/3/20 to 31/10/20. This represents a decrease of 71 (4.5%) on the same period 2019. The number of positive swabs was 6 which represents **0.4%** of mothers.
7 women had Covid swabs taken as they were symptomatic and the swabs were negative.

Mental Health

1558 mothers were delivered in the period 1/3/19-31/10/19.
1487 mothers were delivered in the same period 1/3/20 to 31/10/20.

In this period of time in **2019, 206 (13.25%)** women reported having had a previous or have a current mental health concern.
In the same period of time in **2020, 330 (22%)** of women reported having had a previous or have a current mental health concern. This represents a significant increase and the service is needing to adapt by increasing resources available to women to prevent a significant escalation in symptoms and illness.

Safeguarding Referrals

The midwives have had more opportunity to ask the Domestic Abuse (DA) questions during lockdown as the partners have not been coming to routine appointments except the scan appointments during this period of time.
The specialist safeguarding team have still seen the women for routine appointments, all except the booking appointment which has been managed over the phone. The policy is if there is safeguarding concerns the midwives will inform the lead midwife after the 16/40 appointment and a referral will be sent to MASH then.

1/3/19-1/10/19: **71** (4.5% of women) referrals from midwifery to MASH. **6** (8.5% of referrals) were around DA.

1/3/20-1/10/20: 63 (4.25%) of women) referrals to MASH. **12** (19% of referrals) were because of DA. 3 reported controlling behaviour from partner, 3 had a previous history of DA with the current partner but no new disclosure, 1 was the female attacking the male, 2 reported stalking from ex partners, 3 had reported DA and had left their partners.

This information indicates that whilst the percentage of women being referred in pregnancy is consistent, the number of women who reported or had a history of domestic violence/abuse has increased during Covid-19.

Local Information – Neonatal – March 1st to 31st October 2020

No positive swabs amongst neonates during this period of time. When known before birth, babies of mothers who were positive were given prophylactic antibiotics.

Table 3 Term admissions and babies admitted to transitional care – comparison to previous year

Number of Babies born 1/3/20-31/10/20	Term Admissions % of babies born 1/3/20-31/10/20	Admissions to TC % of babies born 1/3/20 – 31/10/20	Number of Babies born 1/3/19-31/10/19	Term Admissions % of babies born 1/3/19-31/10/19	Admissions to TC % of babies born 1/3/19 – 31/10/19
1506 ↓(5.25%)	60 (3.98%) ↓	219 (14.5%)↑	1590	68 (4.27%)	119* (7.48%)

** This data has been collected manually from admission registers and does not include readmissions from home to TC so may not be accurate*.

The number of babies born is reduced by 84 for the same period of the year as last year. The percentage of term admissions has reduced slightly in the Covid period compared with the same period as last year. This is more likely due to the increase in babies being admitted to transitional care. The methodology for recording admissions to TC has changed in the last 6 months so that data will be able to be extracted more easily in the future but it appears, even though the numbers may not be accurate, that there has been an increase in the number of babies admitted to TC and NNU overall mainly related to admission to TC as admissions to NNU have decreased. Not all of the babies admitted to transitional care were term.

Most of the transitional care provided is for babies who are admitted from the maternity areas and have their care provided in the bay on the postnatal ward.

During Covid-19 visiting restrictions, a small number of women requested to have their baby's care on the NNU instead of the maternity ward so that their partners could have more contact with their baby.

Babies who are readmitted with treatable jaundice, weight loss and feeding problems are admitted to a single room on the NNU. Occasionally due to capacity issues on the NNU, some babies are admitted to the paediatric inpatient ward instead so do not have the full benefit of the transitional care model.

Table 4 Serious Incidents, morbidity, stillbirths and neonatal losses

Morbidity & Mortality	Number and % 1/3/20-31/10/20	Number and % 1/3/19-31/10/19	Covid related 2020
Stillbirth	1(0.06%)	4 (0.25%)	Contributory factor but not root cause
Neonatal Death	1(0.06%)	0	Contributory factor but not root cause
Therapeutic Cooling	1(0.07%)	1 (0.06%)	Contributory factor but not root cause

The number of stillborn babies born in the Covid period has reduced compared with the same period from last year. There are no reported direct links to Covid in any of the perinatal mortality or morbidity cases that have been reviewed. However, in one report from HSIB, it is noted that there are reports of the staff having to take additional time to don PPE before carrying out their work including neonatal resuscitation but this was not deemed to have directly affected the outcome in this case.

Guidelines and Policies

A number of specific policies, SOPs and guidelines were put in place to manage the Covid risk whilst continuing to manage a safe service. This guidance included managing the service in a different way. The changes to services are outlined in Appendix 1.

The links for the guidelines that were put in place are as follows:

http://staff.wsha.local/Intranet/MaternityGuidelines/docs/MAT-SOPO9-Self-monitoring-of-BPApril2020.pdf

http://staff.wsha.local/Intranet/MaternityGuidelines/docs/MAT-SOP14COVID-19ANC.pdf

http://staff.wsha.local/Intranet/MaternityGuidelines/docs/MAT-SOP15ManagementofCovid19inclinicorhomesetting.pdf

A letter explaining the increased risk of women in the BAME group has been given to relevant women.

More work is being carried out on specific additional information and advice required for women from the BAME background and for women with other co-morbidities associated with higher risk of complications of Covid.

This work is linked to the new and existing recommendations from MBRRACE which can be found in a separate document.

Conclusions

The number of women with a positive Covid-19 diagnosis that have occurred locally is low in comparison with the national scene, representing just 0.4% of all the women giving birth for this period. 5 out of 6 women were asymptomatic and were found to be positive on routine screening. They all remained well throughout their maternity care. One woman was diagnosed when a swab was taken because of anosmia and family and household members being symptomatic and subsequently being Covid positive. However, she also remained well. No babies were affected. The number of baby losses has decreased in this period of time although

the numbers remain low and this may be due to the continued implementation of Saving Babies Lives version 2 and identifying 'at risk' pregnancies at booking. The number of babies needing therapeutic cooling is the same.

Having guidance and support in place for staff, women and babies and increasing the communication around prevention of cross-infection procedures has helped to reduce the risk of significant harm and transmission. Routine screening is very helpful in detecting asymptomatic women.

The number of women experiencing or reporting mental health concerns has increased compared with the same period last year. The percentage of women being referred to MASH with a report of DA or history of DA has increased as well. There have been more opportunities for women to be seen on their own so that the questions can be asked directly.

A further report will be written for the period starting 1st November 2020 to capture the significant increase in the number of Covid-19 positive women during the current wave.

Action Plan

Recommendations / Findings	Action plan	Action lead	Timeframe for action completion
1. Ensure that a record is kept for antenatal/postnatal admissions that have symptoms in the third trimester of pregnancy or peri-partum. The most common symptoms reported by women were fever, cough, and breathlessness – ensure all symptoms reported by women during pregnancy or peri-partum are recorded.	Covid database to be maintained locally giving details of characteristics and outcomes from women with and without symptoms. Continue reporting relevant cases to UKOSS as required.	Karen Bassingthwaighte Rebecca Lemesre for UKOSS reportable cases.	On-going requirement – summarise each month as part of Board report
2. As the majority of women admitted with Covid-19 were found to of black and minority ethnic groups, ensure ethnicity information is recorded. Women of BAME background should be advised that they may be at higher risk of complications of Covid-19; we advise they seek advice without delay if they are concerned about their health (RCOG Coronavirus and pregnancy guideline 2020).	Ensure ethnicity is recorded on Maternity Information system and women receive appropriate information and advice in their own language about additional risks this represents and who to contact for support and additional care if needed. Record of ethnicity to be kept on the Covid database. Develop and implement specific guideline for BAME women and leaflets or translations of information leaflets in own language.	All staff Karen Bassingthwaighte Rebecca Lemesre Karen Green/Kate Croissant	On-going requirement On-going requirement In place by 31/12/20
3. Maternal age, pre-existing co-morbidities, pregnancy outcomes and details/outcomes of babies should be recorded.	Ensure risk assessment completed giving details of co-morbidities	Karen Bassingthwaighte	On-going requirement

Recommendations / Findings	Action plan	Action lead	Timeframe for action completion
	Letters to women at greater risk due to comorbidities – needs to be developed	Karen Green/ Karen Bassingthwaighte	In place by 31/12/20
4. Follow-up of women who have symptoms and/or have a positive swab result	Follow-up process in place so that there is a designated person following up women who stay at home or after discharge. Pan-Covid study: Global Registry of women who are suspected or confirmed to have corona virus infection in pregnancy. The aim is to register all these women in the global register, to find if the infection is associated with **Miscarriages / FGR and stillbirth / pre-term birth / vertical transmission to neonates.**	TBC Rebecca Lemesre (UKOSS) and Barkha Sinha	In place by 31/12/20 On-going requirement

Appendix 1 Changes to antenatal processes for Covid period

Change due to COVID	Impact on service/ care	Impact on women	Impact on partners	Impact on staff	Amendments made
Bookings in community virtually phone /'Visionable'	New way of working & time to access the cameras & headphones was delayed	Not face to face but no negative feedback received	Maybe more difficult if over the phone	New way of working but was quicker but some difficulties completing records to begin with New IT skills	This has continued as has been successful & no plans to change currently **Working well**
Bloods BP & urine taken at 12/40 scan not booking appt	This had a massive impact on antenatal clinic as it meant they were seeing all the women having scans & completing their obs Screening bloods were delayed	Longer time in ANC	Not able to attend	Deferred tasks to another appt – changed after few weeks to the Community MW coming to ANC to do this as women also had lots of questions	This was reviewed after a couple of months & now the community have drop in clinics where BP, urine & bloods are taken before the scan appt **Working well**
OOA women who were care of WSH had no face to face contact so BP & urine were not at their 20/40 scan	Increase on the ANC midwives &	women were getting a poorer service	Not able to attend	Increased ANC workload	This has not been resolved – these are not large amounts of women
No antenatal appointments were stopped in our Trust but we had a plan (see SOP) as per RCOG guidance if necessary					

GTT were continued but facilitated as specific clinic created in the community	This was able to continue but we had to move our phlebotomist to the community am / ANC pm	Improved access such as parking but ? where waited for 2 hrs between the test	None	MCA was amazing in changing her way of working & the huge increase on workload	This is still in place but more women are being seen locally in their areas by the MSW
Antenatal clinics were moved to Newmarket Hospital within 1 -2 weeks for the follow up appts/ scans	This has impacted on ANC, Scan & medical staff having to work at another site & travel Increased cost as notes are transported form WSH to Newmarket twice a day by Taxi The clinical area (has a decommissioned Xray machine) poor office space a share staff room/ IT access is very poor & unsatisfactory	Women have had to travel from across West Suffolk to Newmarket Poor quality clinic room Improved & free car parking	Unable to attend originally but are now called in to attend scans only	Increased travel, poor working conditions Large very busy clinics MCA has changed her days of working to support this	This still continues & have secured a better office space for 2 days Looking at a plan to return to WSH & meeting to be arranged for MDT approach
Where possible Consultants phoned women to discuss plans of care if Face to Face not required	Capacity of rooms for the Drs to be able to call women Plan for virtual appts	No Face to face but not required to attend a clinic when no exam required	None	Different way of working for Drs – some found it challenging	This has been a challenge to complete these in a timely manner in recent weeks I am not sure how many are virtual I suspect most are phone

Antenatal clinic layout had to be changed to aid social distancing	This has reduced the women able to attend & no partners Shared with gynae so try to avoid combined clinics	Partner unable to accompany for appt but can come in for scan only now	Partner unable to accompany for appt but can come in for scan only now	Increased work load of cleaning between clinics & the increased workload for the receptionists	Continues currently but look at reviewing
With immediate effect partners were stopped attending any appointments at WSH or Community		Increased anxiety for some women, what if there is problem / bad news If there is an individual need that it is in the woman's best interest to attend a separate can be facilitated	Partners felt upset & angry that they could not attend	Increased stress & challenging conversations for staff	Partners are now able to attend for scans
Community Midwife clinics were impacted by the building's rules & regulations & whether women could enter without checks from the staff in that building		The process was more difficult for women in some areas – waiting in cars	Partners unable to attend	Increased workload & challenges with dealing with other organisations processes	This has improved now
Women attending Newmarket & community having to wait in their cars to be called to come into the building		The inconvenience for women	Partners unable to attend	Increased workload for staff having to phone them to come in	This has now stopped at Newmarket as the waiting area has been adapted to allow women in socially distanced but still in some areas
Women phoned in the morning prior to attending antenatal		Phone call	None	Massive impact on admin staff	This has now been reviewed & the scan staff are asking

clinic to check they had no symptoms					when they call the woman to come up
Carbon monoxide monitoring was stopped nationally	This meant we were not meeting the requirements for SBLCB2 but continued to ask all women at booking & 36/40 if they smoked women & refer to OLS & ask all smokers at each appt	Less visible encouragement to stop	Partners who attended are offered a CO reading which could increase the chance of them stopping	Changing their way discussing & monitoring smokers	This has been reinstated nationally this week so I am looking at this with the smoking cessation midwife to reintroduce safely
Commenced self - monitoring of BP for women (see SOP)	Increased processes & training for women & originally purchasing BP machines as the national programme to provide them was delayed	Asking the women to be responsible for their own care & reporting to health professionals	None	Increased task to train & ensure the woman understands the use, process, readings & who & when to contact	This has continued & I am not aware of any issues raised
All parent education classes were stopped immediately	No parent education for women & looking at provision of a new virtual class This has been unsuccessful until recently – video clips on Face Book	Lack of information for women about labour & postnatal care Women are directed to an independent provider for the LMS – Suffolk Babies	Lack of information	The staff felt uncomfortable about virtual classes & despite several attempt were not proactive in supporting this	More recently videos have been produced for feeding We have met with IT support to move this forward With C of C this will be more proactive & is commencing
Contacting women who were in the	Due to our low BAME community	Increased info	None	Staff to ensure they s=discuss the	This needs review re current process,

BAME group & sending out letters to them all & continued advise to these women	searching for the women Creating a letter which had to be sent to all the women highlighted			COVID risks for these women at booking & appts if later & giving letter	women to be included in addition & email process at booking
Plans for if women were COVID positive or symptomatic & had an antenatal appt/ scan (see SOP)	Increased processes & time of appts & visits	Delay of appts / visits Anxiety	Potential	Increased workload as appts rearranged, longer calls with women as anxious Increased staff anxiety	Continues
Guidance for midwives & MSW to reduce contamination when performing postnatal home visits These were a minimum of 3 visits as per RCOG but additional for high risk women (see SOP)	Increased time for appts & visits due to PPE	Staff wearing PPE & requesting to visit is a different way such as partner not in the room etc if he was symptomatic	partner not in the room etc if he was symptomatic	Increased stress & anxiety Longer visits & clinic appts	This has not really changed although staff are more confident now due to PPE & use to this way of working

Appendix 2 Results of National UKOSS reporting

Results

We received responses from all 194 hospitals with obstetric units in the UK. From 1 March to 14 April 2020, 630 women admitted to hospital with confirmed SARS-CoV-2 infection in pregnancy were notified in the UK, among an estimated 86 293 maternities. Data were returned for 579 (92%) women; 15 were duplicate cases, 35 were reported in error, 87 had the diagnosis made as outpatients and were not admitted overnight, nine had no positive polymerase chain reaction test and no evidence of pneumonitis on imaging, and six had no evidence of infection during pregnancy, leaving 427 pregnant women admitted to hospital with confirmed SARS-CoV-2 across the UK. This represents an estimated incidence of hospital admission of 4.9 (95% confidence interval 4.5 to 5.4) pregnant women per 1000 maternities.

Women had symptoms at a median of 34 (interquartile range 29-38) completed weeks' gestation, with most women admitted to hospital having symptoms in the third trimester of pregnancy or peripartum (342/424; 81%). The most common symptoms reported by women were fever, cough, and breathlessness. Table 5 below shows the characteristics of the women. In the sensitivity analysis excluding women from London, the West Midlands, and the north west of England, 75 (46%) of 162 women admitted were from black and minority ethnic groups.

Table 5 Characteristics of pregnant women with confirmed SARS -CoV-2 infection for whom data were available, UK, 1 March to 14 April 2020

CHARACTERISTICS	No (%)* of women (n=427)
Age, years:	
<20	4 (1)
20-34	248 (58)
≥35	175 (41)
Body mass index:	
Normal	126 (31)
Overweight	141 (35)
Obese	140 (34)
Missing data	20
Woman and/or partner in paid work	343 (80)
Black or other minority ethnic group (all)	233 (56)
Asian	103 (25)
Black	90 (22)
Chinese/other	30 (7)
Mixed	10 (2)
Missing data	10
Current smoking	20 (5)
Missing data	8
Pre-existing medical problems	145 (34)
Asthma	31 (7)
Hypertension	12 (3)
Cardiac disease	6 (1)
Diabetes	13 (3)
Multiparous	263 (62)
Missing data	4
Multiple pregnancy	8 (2)
Gestational diabetes	50 (12)
Gestation at symptom onset, weeks:	
<22	22 (5)
22-27	60 (14)
28-31	64 (15)
32-36	106 (25)
≥37	142 (33)
Peripartum	30 (7)
Missing data	3
*Percentages of those with complete data.	

The incidence of admission with confirmed SARS-CoV-2 infection in pregnancy seemed to vary according to women's ethnic group, age, and body mass index. Two hundred and sixty six (62%) women admitted to hospital gave birth or had a pregnancy loss; the remaining 161 (38%) women had ongoing pregnancies at the time of this analysis. Forty one (10%) women needed level 3 critical care; four of these women received extracorporeal membrane oxygenation (table 6).

Table 6 Hospital outcomes and diagnoses among women with confirmed SARS -CoV-2 infection in pregnancy

Maternal outcomes	No (%) of women (n=427)
Needed critical care	41 (10)
Needed extracorporeal membrane oxygenation	4 (1)
SARS-CoV-2 pneumonia on imaging	104 (24)
Final outcome:	
Died	5 (1)
Discharged well	397 (93)
Still in hospital	25 (6)

Of the women who received critical care, 33 (80%) had been delivered, 27 (66%) of them owing to worsening respiratory condition; eight (20%) were still pregnant. All eight (100%) of the women who were still pregnant after their critical care admission had been discharged. Nineteen (58%) of the 33 postnatal women had been discharged at the time of this analysis; three women admitted to critical care had died, and 11 (33%) were still inpatients, of whom seven (64%) remained in critical care.

Overall, five women who were admitted with confirmed SARSCoV- 2 died, a case fatality of 1.2% (95% confidence interval 0.4% to 2.7%) and a SARS-CoV-2 associated maternal mortality rate of 5.8 (1.9 to 13.5) per 100 000 maternities. Three women died as a direct result of complications of covid-19 and two from other causes.

In total, 25 (6%) women, 7 (28%) antenatal and 18 (72%) postnatal, were still inpatients at the time of this analysis. Nine (2%) women were treated with an antiviral agent. Eight of them were given oseltamivir, one of whom also received lopinavir/ritonavir. One woman was given remdesivir. All women managed with antivirals were discharged home.

Sixty four (15%) women were given corticosteroids for fetal lung maturation, of whom 47 (73%) had given birth. Thirteen (20%) of these 64 women remained as inpatients, 12 (92%) of whom had given birth.

Four women (0.9% of those admitted; 4.6 (1.3 to 11.2) per 100 000 maternities) had a miscarriage, at a range of 10 to 19 weeks' gestation. Of the 262 women who had given birth, 196 (75%) gave birth at term (table 4). Sixty six women gave birth preterm; 53 (80%) had iatrogenic preterm births, 32 (48%) due to maternal covid-19, nine (14%) due to fetal compromise, and 12 (18%) due to other obstetric conditions.
Fifty nine per cent of women (n=156) had a caesarean delivery, but most of the caesarean births occurred for indications other than maternal compromise due to SARS-CoV-2 infection. Forty two women (27% of those who had a caesarean birth) had a caesarean birth for reasons of maternal compromise, 37 (24%) due to concerns about fetal compromise, 30 (19%) due to failure to progress in labour or failed induction of labour, 25 (16%) for other obstetric reasons, 16 (10%) because of previous caesarean birth, and 6 (4%) at maternal request.

Twenty nine (19%) women had general anaesthesia for their caesarean birth; 18 (62%) of these women were intubated because of maternal respiratory compromise, and 11 (38%) were intubated to allow for urgent delivery.

Five babies died; three were stillborn and two died in the neonatal period. Three deaths were unrelated to SARS-CoV-2 infection and were due to obstetric conditions unrelated to SARS-CoV-2 infection and/or pre-existing fetal conditions; for two stillbirths, whether SARS-CoV-2 contributed to the death was unclear.

Sixty seven (25%) of 265 liveborn infants were admitted to a neonatal unit, 50 (75%) of whom were preterm, including 23 (34%) who were less than 32 weeks' gestation (table 5). One infant was diagnosed as having neonatal encephalopathy (grade 1) after a spontaneous vaginal birth at term.

Twelve (5%) infants of women admitted to hospital with infection tested positive for SARS-CoV-2 RNA, six of them within the first 12 hours after birth. Two of the six infants with early onset SARS-CoV-2 infection were from unassisted vaginal births; four were born by caesarean, three of which were pre-labour.

No viral analyses were performed on umbilical cord blood, placenta, or vaginal secretions. The six infants who developed later infection were born by pre-labour caesarean (n=4) and vaginal birth (n=2). Only one of the infants with an early positive test for SARS-CoV-2 RNA was admitted to a neonatal unit, compared with five infants with a later positive test.

Report on Paediatric Medical Staffing for the Neonatal Unit - January to June 2020

Report Title	**Paediatric Medical Staffing in the Neonatal Unit January to June 2020**
Report for	Information and Approval of Actions
Report from	Women's & Children's Services
Report Author	Beverley Gordon, Project Midwife, WSH Reviewed by Head of Midwifery

Report Title

Paediatric Medical Staffing in the Neonatal Unit January to June 2020

1. Purpose of the Report

To provide assurance that the Neonatal medical staff support provided to the Maternity Unit meets the standards expected to provide safe effective care.

2. Background

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

3. Standard to be achieved:

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

This report relates to the neonatal medical workforce specifically.

Standard expected for the Neonatal medical workforce

• The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If this is not met, an action plan to address deficiencies is in place and agreed at board level.

The period of time that has been analysed is the six month period between Wednesday 1 January 2020 and Tuesday 30 June 2020 as this was the requirement for the safety action.

Neonatal medical workforce

The Trust is required to formally record in Trust Board minutes whether it meets the recommendations of the neonatal medical workforce training action. If the

requirements are not met, an action plan should be developed to meet the recommendations and should be signed off by the trust Board.

Neonatal Workforce standards and action

Do you meet the BAPM national standards of junior medical staffing depending on unit designation?

If no, please submit a Trust board approved action plan to the Neonatal ODN. There should also be an indication whether the standards not being met is due to insufficient funded posts or no trainee or/suitable applicant for the post (rota gap). There should also be a record of the rota tier affected by the gaps.

BAPM "Optimal Arrangements for Neonatal Intensive Care Units in the UK including guidance on their Medical Staffing" 2014 or "Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: A Framework for Practice" 2018

SCU Special Care Unit

Tier 1

A resident tier 1 practitioner dedicated to the neonatal service in day-time hours on weekdays and a continuously immediately available resident tier 1practitioner to the unit 24/7. This person could be shared with a co-located Paediatric Unit out of hours.

Tier 2

A resident tier 2 to support the tier 1 in SCUs admitting babies requiring respiratory support or of very low admission weight <1.5kg. This Tier 2 would be expected to provide cover for co-located paediatric services but be immediately available to the neonatal unit.

4. Summary of Findings and Compliance

The rotas have been reviewed for the period of time covered by this report – January to June 2020. These confirm that the Trust meets the BAPM standards of junior medical cover for a Special Care Unit during this period of time. Where short term cover has been required, the escalation plan has been followed and the workload has been allocated accordingly or alternative arrangements made to provide services.

If a junior staff member was not available for rostered shift, other staff would be requested to cover this and the consultant on call would ensure that the cover was suitable for the service that needed to be covered.

4. Compliance with Standards				
Clinical Workforce Group	**Standard to be met**	**WSH compliance**	**Progress Report**	**Evidence Source**
Neonatal medical workforce	**Do you meet the BAPM national standards of junior medical staffing depending on unit designation?** If no, please submit a Trust board approved action plan to the Neonatal ODN. There should also be an indication whether the standards not being met is due to insufficient funded posts or no trainee or/suitable applicant for the post (rota gap). There should also be a record of the rota tier affected by the gaps. BAPM "Optimal Arrangements for Neonatal Intensive Care Units in the UK including guidance on their Medical Staffing" 2014 or "Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: A Framework for Practice" 2018 **SCU Special Care Unit Tier 1** A resident tier 1 practitioner dedicated to the neonatal	**Yes**	Awaiting this report to be approved at Paed and WHG Governance, submission to Divisional Board and the Trust Board	**Neonatal medical workforce** Neonatal medical workforce Six month period between Wednesday 1 January 2020 and Tuesday 30 June 2020 Evidence received to say rota covered with correct tiers as per guidance. Rotas received as evidence. We meet the requirements for neonatal medical staffing as a Special Care Unit, as described in BAPM "Optimal Arrangements for Neonatal Intensive Care Units in the UK including guidance on their Medical Staffing" 2014 or "Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: A Framework for Practice" 2018. Our tier 1 staffing : Mon-Fri 0900 – 1700 Dedicated paediatric trainee doctor on Neonatal Unit (mix of Paediatric ST1, F2 and GPVTS doctors) At all other times Tier 1 doctor on-call , covering both Paediatric Ward and

	service in day-time hours on weekdays and a continuously immediately available resident tier 1 practitioner to the unit 24/7. This person could be shared with a co-located Paediatric Unit out of hours. **Tier 2** A resident tier 2 to support the tier 1 in SCUs admitting babies requiring respiratory support or of very low admission weight <1.5kg. This Tier 2 would be expected to provide cover for co-located paediatric services but be immediately available to the neonatal unit.			neonatal Unit (but always available in case of emergency) Tier 2 : Mon-Fri 0900 – 1700 There is usually a middle grade doctor (Paediatric registrar or equivalent) covering NNU exclusively. There are occasional gaps in the rota when the registrar is covering both general paediatric ward and NNU. Middle grade cover is always available in an emergency. Tier 3 : Mon-Fri 0900 – 1700 Currently there is a Paediatric Consultant performing a neonatal ward round on Monday, Wednesday and Friday mornings. At other times cover is provided by the Consultant who is Paediatrician Of The Week (POW) between 0900-1700 Monday to Friday, and by the Consultant Paediatrician On-Call at all other times. Consultant is always available for any emergency (but may be on-call from home overnight or at times over the weekend).

5. Conclusions

The Trust meets the expected standards for medical staffing of the Neonatal Unit according to BAPM levels of care and the rota are covered appropriately.
There is a need to ensure that there is adequate mitigations put in place if additional staff are required to fill vacancies and/or planned and unplanned leave.

6. Recommendations

Monitor the junior medical staffing cover every 6 months and provide updates.
Provide evidence of the escalation plan in use to cover short and long term shortages.
Next report will be due January 2021.

7. Action Plan

Action plan lead	Name: Dr Ian Evans	Title: Neonatal Lead	Contact:

Recommendation	Actions required	Action by date	Person responsible	Comments/action status
Monitor the junior medical staffing cover every 6 months and provide updates on compliance	6 monthly report to provide continual assurance of staffing levels	31/1/21	Neonatal Lead Medical Secretary providing rota support	Next review July- December rotas, report in January 2020.
Ensure Escalation Plan is in place for short and long term cover when required.	Review escalation plan for neonatal medical staff to ensure there is an agreed process in place for short- and long-term cover of vacancies and planned and unplanned leave.	31/12/20	Neonatal Lead Operational lead	

Appendix 1 Documents reviewed as part of evidence

British Association of Perinatal Medicine (BAPM) Optimal Arrangements for Neonatal Intensive Care Units in the UK including guidance on their Medical Staffing A Framework for Practice June 2014

https://www.bapm.org/resources/31-optimal-arrangements-for-neonatal-intensive-care-units-in-the-uk-2014

Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: A Framework for Practice November 2018

https://www.bapm.org/resources/2-optimal-arrangements-for-local-neonatal-units-and-special-care-units-in-the-uk-2018

SOPS

Lists of Senior and Junior staff

Escalation plan

Rotas – Consultant and juniors Jan- June

NHS
West Suffolk
NHS Foundation Trust

ATAIN Programme

Avoiding Term Admissions to the Neonatal Unit

REPORT ON PROGRESS OF THE IMPLEMENTATION OF ATAIN SINCE COMMENCEMENT

SEPTEMBER 2020

Sarah Paxman - Clinical Risk Midwife
Beverley Gordon – Project Midwife
Jane Lovedale – Clinical Risk Manager
Dr Ian Evans - Neonatal Safety Champion
Karen Ranson - Ward Manager NNU

Background to project

Trends and admission rates

Between 2011 and 2014, the number of term (at or over 37 weeks gestation) live births in England declined by 3.6%, but the number of admissions of term babies to neonatal units increased to 24% with a further increase of 6% in 2015.

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

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

Review structure

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

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

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

Local reviews

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

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

The review meetings commenced September 2018.

Process for review

The neonatal and midwifery team review the maternal and neonatal records prior to the ATAIN meeting using the approved NHS improvement tools. Cases identified which require

in depth obstetric review are discussed with a consultant obstetrician to determine if different care in labour may have reduced the risk for the baby.

Implementation

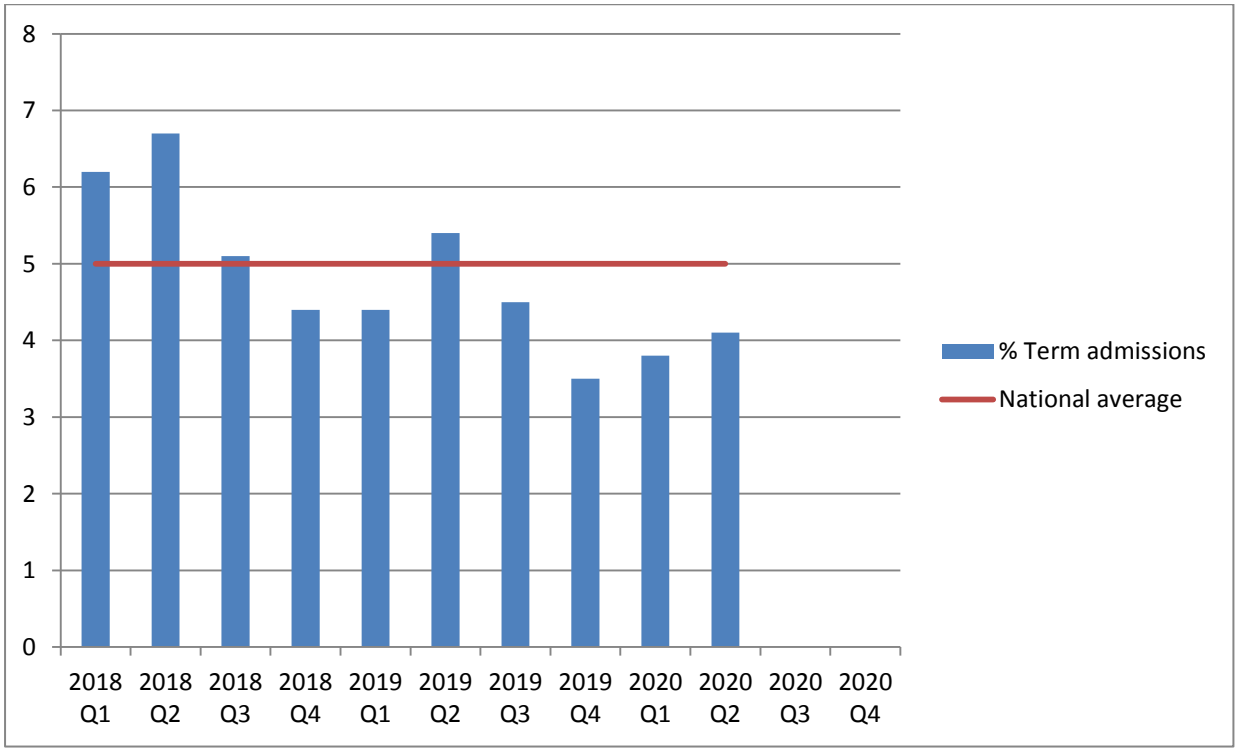
Details of the implementation of the improvement programme were disseminated to the relevant staff groups at meetings and through newsletters and posters. Regular updates about learning and progress are shared via the maternity publication Risky Business, and the Neonatal Unit communication systems ('Wise Words').

Neonatal transitional care (TC) was implemented in October 2018, and audit is currently undertaken by the neonatal unit team.

Findings

Since the improvement programme began in September 2018, term admission rates have varied month on month, but there has been an overall trend of reduction in the numbers.

Overall term admission rates



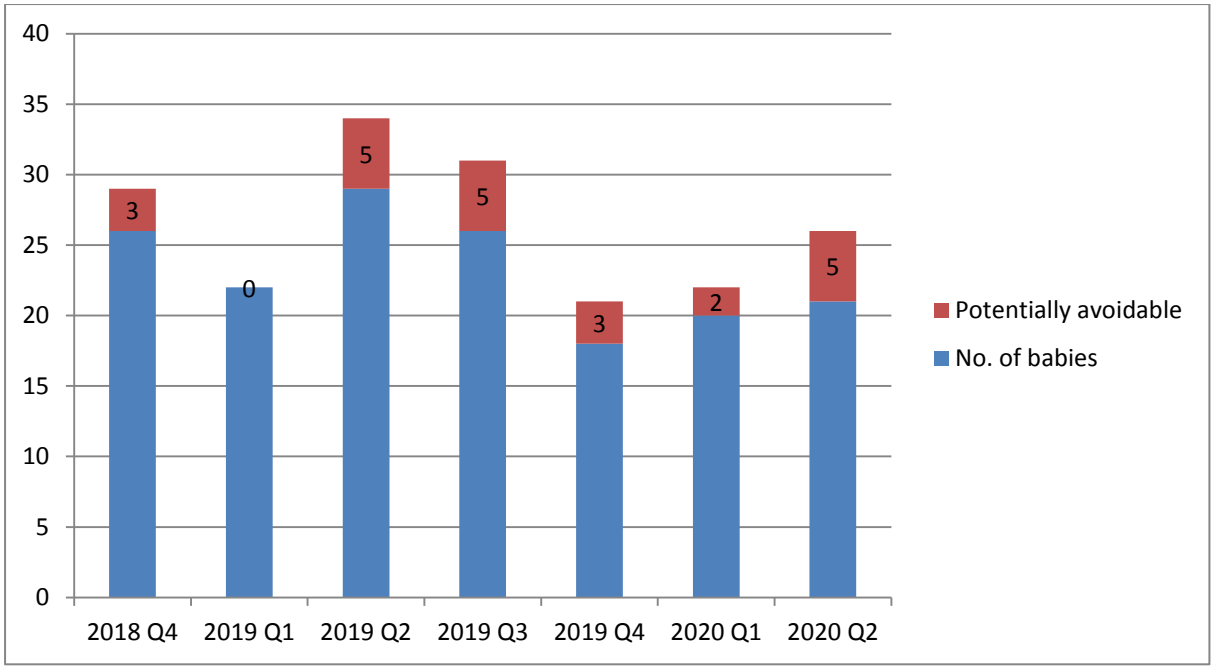
Monthly meetings review all term babies who were admitted to NNU, and consider if there were any factors which could have meant that the admission could potentially have been avoided. A lot of incidental learning is also identified through this process. In particular, this includes areas where data collection and documentation can be improved.

The discussion is focused on the 4 key clinical areas which make up the majority of admissions to neonatal units:

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

There are several other reasons why babies are admitted. Most commonly; known or suspected congenial abnormality, or significant social issues which mean that the baby cannot be independently cared for by the mother on the postnatal ward. These cases are included and discussed, but not to the same depth as the 4 key areas that form part of the ATAIN programme.

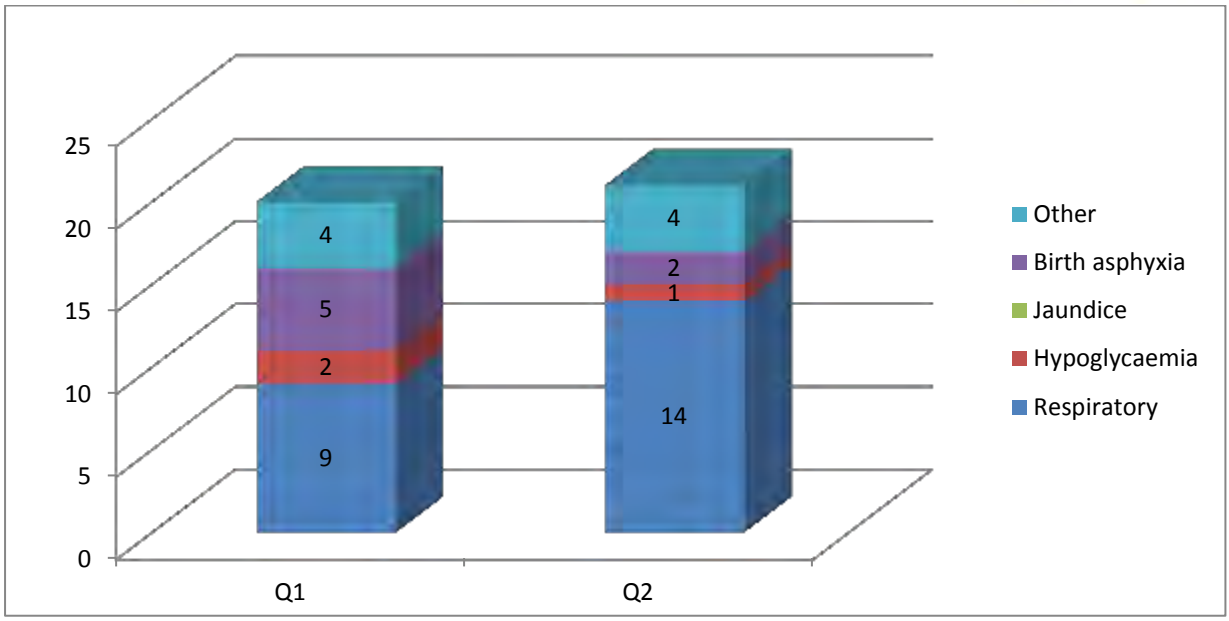
Potentially avoidable term admissions – whole project



Progress against the 4 aspects of reducing term admissions

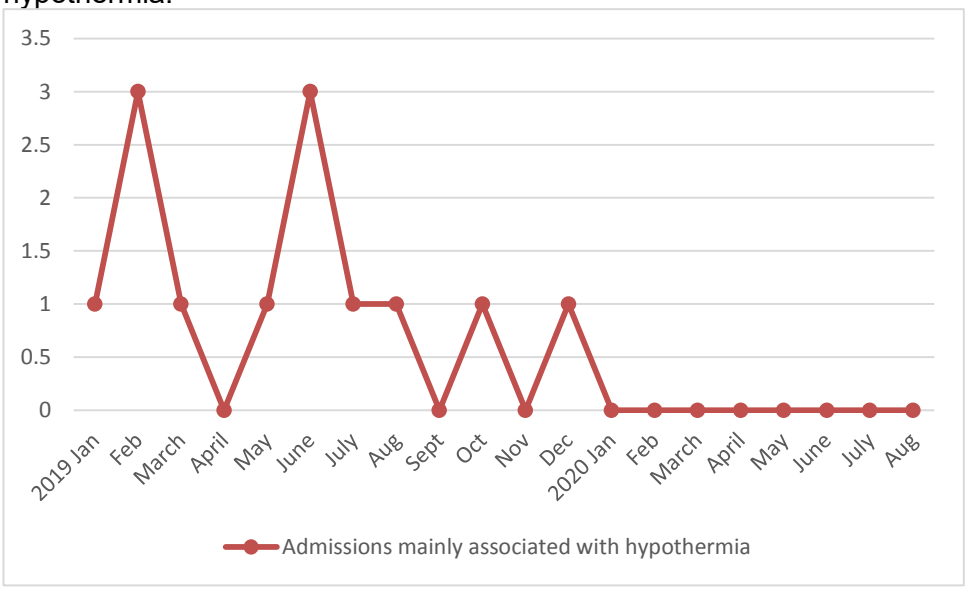
Data collection during quarter one and quarter two in 2020 demonstrates that respiratory symptoms are the primary reason for the admission of term babies into the Neonatal Unit, followed by birth asphyxia and hypoglycaemia.

Although many babies develop jaundice and are treated for it on the NNU, this is not usually the principle reason for admission.

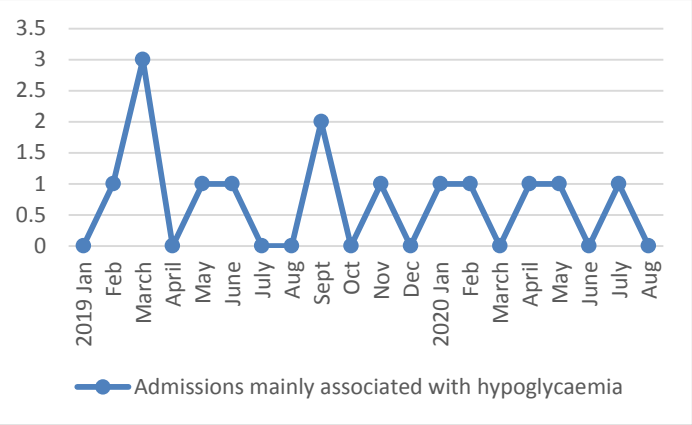


Brief summary of the learning identified in relation to the 4 key areas, and the steps that have been taken so far to make improvements:

Respiratory conditions	
Early 2019	Themes were beginning to arise which indicated that risk factors for hypoglycaemia and hypothermia were not always being appropriately acknowledged.
	It was recognised that there was a pattern of babies having low admission temperatures when they were admitted to the neonatal unit, even when there was evidence that they had previously had a normal temperature. This raised the question about whether appropriate steps were being taken to maintain normal temperatures in the maternity department. A potential reluctance by midwives to use warming cots was discussed during meetings. Nurses sometimes noted that the cots had been set incorrectly, or that the baby was dressed inappropriately. Warming cot guidance was laminated and attached to warming cots.
June 2019	Task and finish group initiated to act on the learning identified and make positive changes to the service. Reminders to midwives about the mechanisms of thermoregulation and the potential impact of becoming cold. Work was commenced to explore the options for an improved observation chart (NEWTT) Relevant guidelines scheduled for updating and improvement The NNU Manager and the Clinical Risk Midwife attended a regional event to discuss the ATAIN programme and the progress of different units so far.
September 2019	Progress was being made on the implementation of a newborn risk pathway which incorporated a formal newborn risk assessment, allocation to an appropriate schedule of observations / blood glucose monitoring, and early assessment using a modified RAPP tool (a visual check and temperature recording at 1 hour and 2 hours of age to check the positioning and well-being of the baby). The chart also included a NEWTT observation chart (newborn early warning trigger and track).

October 2019	Other learning themes began to be recognised: • Early feeding • 'Dusky episodes' during the first few hours of life and a possible link with skin-to-skin contact.
December 2019	The Newborn Risk Pathway was launched as part of a PDSA project (plan do study act). Small changes were made in response to feedback and audit findings after two weeks. A crucial part of the new newborn early warning trigger and track charts, was that the parameters of the 'normal' temperature range were adjusted because the experience of reviewing babies temperature recording on the postnatal ward had demonstrated that midwives had a tendency not to take action if the temperature just fit within the 'normal' parameters. By making this 'trigger; action, it helped to highlight that action was needed to warm the baby and prevent further deterioration
December 2019	Targeted training on hypothermia and hypoglycaemia added to midwives mandatory training programme. This will be delivered by the Practice development Nurse for NNU.
February 2020	The guideline for the prevention, detection and management of hypothermia was updated and improved. This chart demonstrates the improvement seen to the number of babies admitted to the NNU with respiratory problems associated with hypothermia. 
May 2020	Sepsis guidance updated and improved. This may help to improve identification and treatment of maternal sepsis during labour, thereby reducing the risk for babies.

Hypoglycaemia	
2019	Many of the learning and improvements detailed in the Respiratory category also apply to learning specifically about Hypoglycaemia. (See table above) In particular, identification of risk factors for hypoglycaemia, keeping babies warm and early feeding within the first hour are essential. Many of the themes were identified during case reviews in early 2019 related to these issues.

February 2019	Management of diabetes guideline during pregnancy guideline updated
February 2020	Hypoglycaemia guideline updated in line with BAPM guidance. This included significant changes to the definition and management of hypoglycaemia. Key changes to practice in line with BAPM guidance Implementation of glucose gel Patient Information Leaflet – protecting your baby against low blood glucose  There appears to be some small reduction in admissions mainly associated with hypoglycaemia. However, it has been reported that a thorough audit is required to properly assess the impact of the significant changes made to clinical practices since the implementation of the new hypoglycaemia guideline in February 2020

Jaundice	
2018-2020	No themes have been identified as a result of the programme so far. Jaundice is managed and treated on the NNU if necessary on admission. Babies who are otherwise well, but require treatment with phototherapy do not meet the criteria for admission. Phototherapy treatment is able to be administered on the postnatal ward or in TC without the need to separate mother and baby.

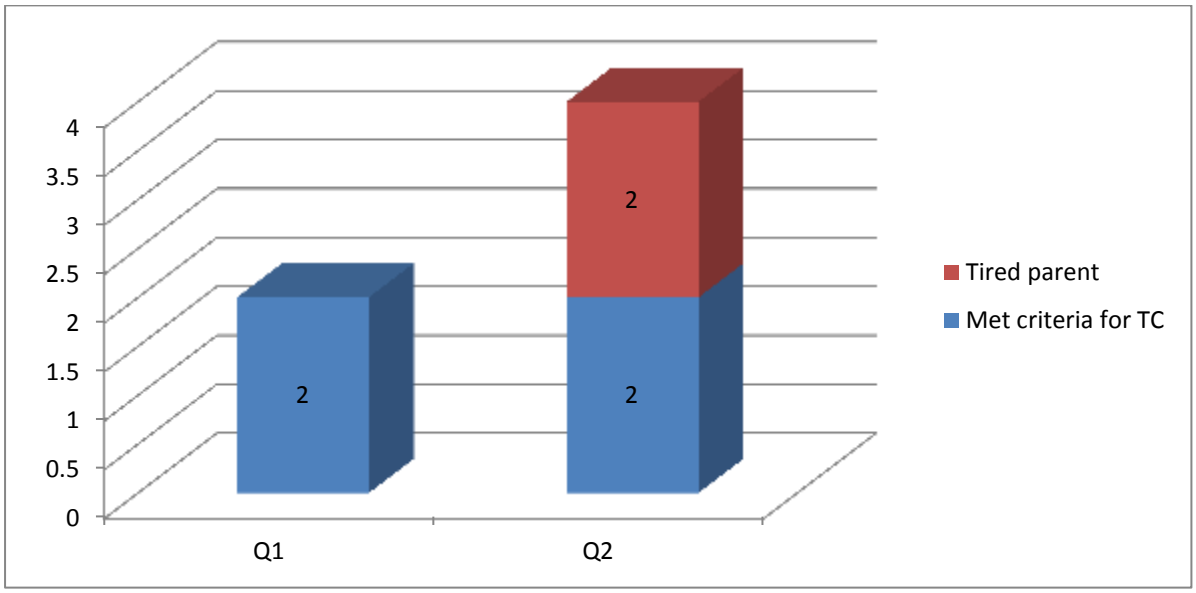
Asphyxia (perinatal hypoxia – ischaemia)	
2019	Cases where babies were born in poor condition, with low cord gas measurements / low apgar scores are investigated through the incident reporting system. Therefore the learning from those cases is not usually disseminated as a result of the ATAIN programme, but is reported and actioned separately.
April 2020	Learning identified through ATAIN meetings: sometimes the paediatric SHO attends a birth, when more senior attendance is indicated (presence of meconium and category 1 emergency CS) This was communicated to all via Risky Business, and by direct email to all paediatricians.
July 2020	Learning identified through ATAIN meetings: oxygen is not always administered promptly by midwives to babies who have O2 sats <95% after the first hour. Action tended to focus on escalation to the paediatrician. The Paediatric Safety Champion liaised with the Practice Development Midwife to communicate this learning to the midwifery team.

Other learning issues identified through ATAIN:

- Practice of offering to keep babies on NNU so that tired mums can sleep.
- Issues regarding recommendation of formula for babies without clinical indications. Escalation to paediatric governance re. poor compliance with infant feeding e-learning package.

These have been addressed within the rolling action plan and progress will be monitored. If the same issues reoccur, then further action will be required.

Avoidable admissions 2020, quarter 1 and 2



Continuation of ATAIN programme

Monthly ATAIN meetings using agreed audit tools are ongoing. The tools and reports were adapted in June 2020, to make them easier to understand at a glance.

Monthly reports are shared with the Paediatric Service Manager, the Paediatric Safety Champion, the Clinical Risk Manager and other members of the maternity quality and safety team.

Quarterly reports will be produced from September 2020 (quarter 3), and these will be shared with the ward teams, the Women's Health Governance group and the Board level Safety Champion.

Conclusions

The ATAIN project is now business as usual for the Maternity and Neonatal Units and the processes for review and sharing learning are embedded. There are shared goals to reduce avoidable admissions to the neonatal unit and avoid unnecessary separation. The

introduction of transitional care has also enabled the number of admissions to stay lower than the national average.

There is a continued need to ensure that antenatal, intrapartum and early neonatal care is of the highest standard and to ensure that all admissions are appropriate and are for the minimum amount of time to keep the babies healthy and well.

15.2. Infection prevention and control assurance framework

For Approval

Board of Directors – 29th January 2021

Item Number	15.2			
Presented by:	Sue Wilkinson Exec Chief nurse			
Prepared by:	Rebecca Gibson – Compliance Manager			
Date prepared:	January 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*.

Due to the current pressures upon the trust and lockdown regulations this report does not include an update on additional 'fresh eyes' assurance measures against national requirements through walkabouts or observational audits although regular IPC audit is maintained.

The dashboard continues to develop and this month includes new measures related to staff testing and sickness absence / isolation. The report also includes the first version of the integrated 'learning from outbreaks' plan.

The Patient safety & quality team are supporting the Infection prevention & control team to maintain reporting oversight recognising dual factors of reduced staffing and increased caseload. This includes maintenance of an affected patient list and populating demographic data in the HCAI RCA notification forms that will be sent to the CCG (with clinical input to complete the clinical part of the form including harm review). The patient safety & quality team are also coordinating the ongoing duty of candour notifications.

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

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

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

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

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

Putting you first

Development of a dashboard to gather robust assurance

Key indicators should enable the organisation to measure compliance against NHSE guidance

Dashboard indicator	Measure (or narrative where measure not yet identified)
Admissions swabs	Time between decision to admit (DTA) and swab (Standard = 100% within 24 hours)
Admission day swabs	Swab undertaken on day of admission (all patients who are not already confirmed +ve)
Nosocomial (hospital onset) transmission	Defined by the days from admission to first positive specimen sample date
Incidents relating to C19 management	Number of incidents where C-19 is mentioned in incident description.
C19 Outbreaks	Reported in the month.
Antimicrobial audit compliance	Data reported from Q2 onwards. Reports are sent to IPCC, AMG and are shared with the Lead Pharmacists so any actions are discussed and actioned accordingly
Staff work-related C19 cases reported to RIDDOR	The reporting requirements changed in May 2020 to be more specific thus March/April data is not comparable and is not reported https://www.hse.gov.uk/coronavirus/riddor/index.htm
Patient swabs	On admission, Day 3, Day 7, Discharge to care home
Staff lateral flow tests	Available to all staff on a voluntary basis
Possible additional indicators for future reporting months	
Equipment training	IPC audits
Donning & doffing training	Contact tracing
Cleaning audits compliance	Staff risk assessments % completion
Patient moves	Staff moves between clinical areas
Contacts with wellbeing services	

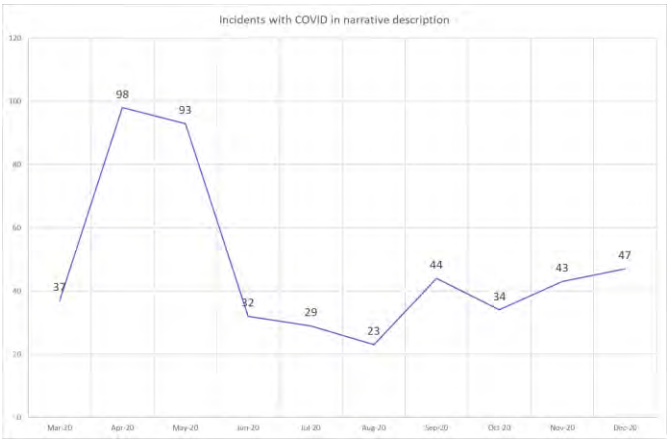
Dashboard

Measure	Time period reported	Data	
		Last period	This period
Compliance to Antimicrobial stewardship (AMS) standards	Q2	91.7%	ND
AMS ProTectis compliance	Q2	85.8%	ND
Nosocomial C19 (probable + definite)	Dec 20	2	91 ↑
Staff work-related C19 cases reported to RIDDOR	Nov - Dec	0	0
Incidents relating to C19 management	Dec 20	43	47 ↑
Admissions swabs within 24 hours of DTA	Dec 20	97%	Data issue
C19 clusters / outbreaks	Dec 20	3	6 ↑
Staff sickness / absence due to C19	Dec 20	316	695 ↑
Staff uptake of lateral flow test	To date	New	3205

Associated charts / tables / narrative

C-19 admission swabs

Using the previous reporting method it appeared to show a drop in admission swabs taken in December however this coincided with the introduction of the Samba machines in mid-Dec and thus the data is no longer accurate. The Information team are reviewing how to obtain data on swabs for the required admission, Day 3, Day 7 (and ongoing) but in the meantime reassurance can be taken from the fact that patients in ED require a Samba result to enable their admission to hospital.



The number of **incidents relating to C-19** recorded in December was consistent with previous months. The Apr/May spike has been previously explained as a consequence of health & safety RIDDOR reporting (pre-changes) and cross infection / isolation breaches.

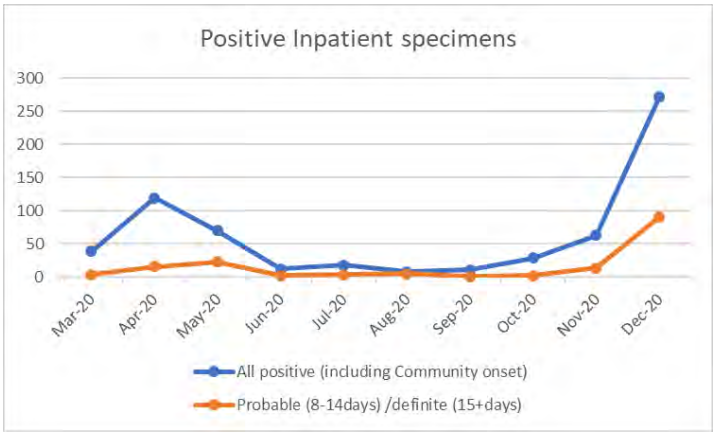
Looking at January to date (as at the 18th) it is expected to rise in next month's report as a consequence of the increased admissions and nosocomial cases.

45/47 December reported incidents were green and there were 2 amber:

- G4 outbreak
- Paediatric surgery cross infection breach

Nosocomial (Hospital-Onset) C19 definition based on first positive specimen (swab date) X days after admission:

Probable (8-14 days)	Definite (15 + days)



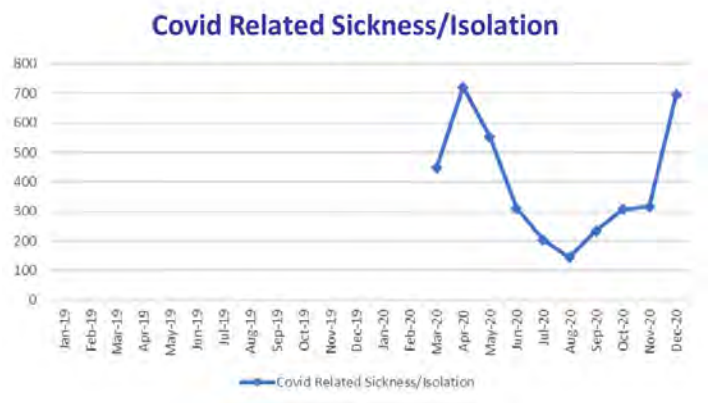
Month	Probable	Definite
Mar-20	1	3
Apr-20	9	7
May-20	15	8
Jun-20	1	1
Jul-20	4	0
Aug-20	5	0
Sep-20	1	0
Oct-20	1	1
Nov-20	4	10
Dec-20	50	41

There were 91 identified probably/definite cases in December including those reported within the outbreak/clusters on G4, F10, G3, F7, G8 and Kings Suite.

This is a considerable increase compared to previous months and is representative of the increases in community prevalence.

Staff uptake of lateral flow test

Whilst data quality issues mean that we cannot yet report staff positive as a percentage of staff taking the lateral flow test we can report that to date 3,205 staff have taken up the offer of a lateral flow testing kit and are submitting results



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. A considerable rise was noted in December compared to November.

Annex 1 – Action and learning from COVID outbreaks / ward clusters

To date the organisation has reported 12 outbreaks requiring ward closure, ward infection clusters or staff infection clusters*.

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

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

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

The first two outbreaks took place in the first wave and included one on G9 before it was re-fitted which gave rise to a range of actions very specific to that event. As these actions were fully addressed in the refurbishment (and this has been formally confirmed via a review of the action plan with the Tactical team) they are not included below.

Subsequent cases are more thematic and actions have been developed as part of the wider trust response to COVID. The number of reported clusters have risen alongside the increases in community cases and COVID positive admissions as might be expected.

The trust has put into place all possible requirements for prevention of onwards transmission as set out in national guidance including the NHSE Board assurance framework reported to Board in previous months iterations of this report. The areas of partial compliance around side-room availability and ventilation are recorded within the Trust risk register and acknowledged by our regional colleagues.

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

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

- Data information systems
- Onsite COVID-19 testing capacity
- Test and Trace system
- Use of PPE
- Staff exposure to aerosol generating procedures (AGPs)
- Staff movement between wards
- Trust-wide learning
- Staff wellbeing
- Movement of patients throughout the hospital
- Unknown source of transmission

Additional themes emerged in the cases (reports still in development) later in 2020.

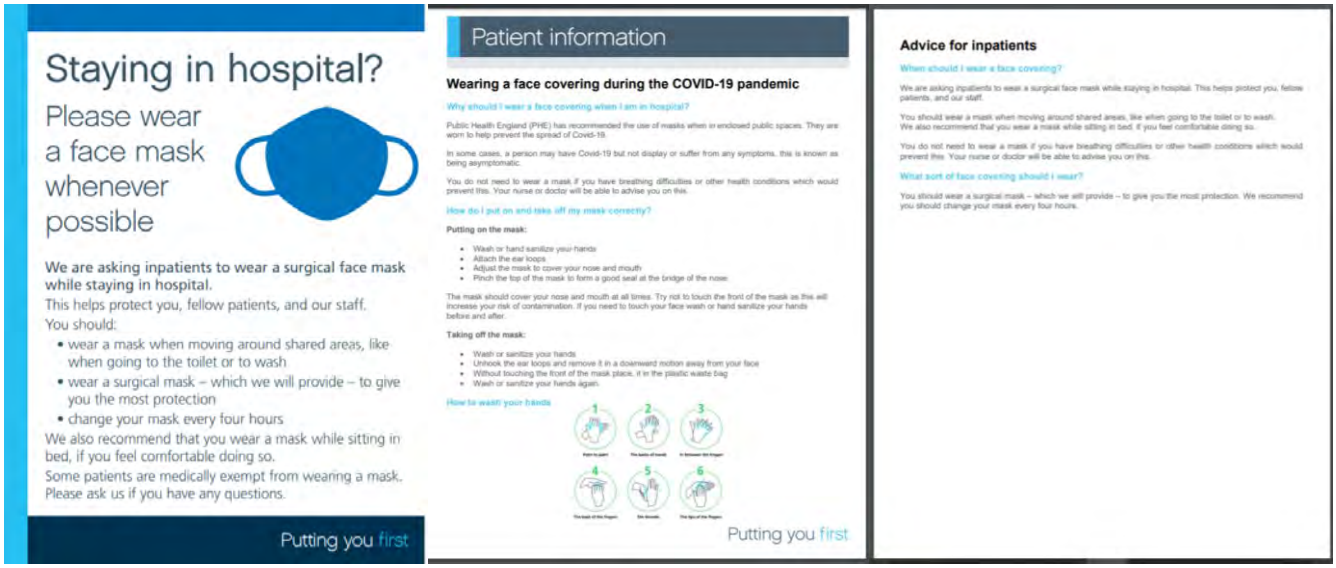
- Patient movements and interactions with fellow patient around ward environment away from their bed space
- Patient non-concordance (including through lack of mental capacity) leading to increased risk of transmission to patients and staff.

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

- Lateral flow rapid tests and SAMBA machines live (24/7) for all admitted patients enable prompt confirmation of patient's infection status both on admission and throughout hospital stay.
- Daily review of patients in each ward by Matrons enables the identification of small number of individuals who are "suitable to outlie" in the event of operational pressure. This week (21st January) eCare has been updated to record and report this (see screenshots below).

NB: This addresses a wider issue than COVID as patient moves is a theme reflected in other learning workstreams.

- Robust Test and Trace system in place coordinated by the Tactical team including an on-call arrangement for the weekends.
- Lateral flow testing kits available for all patient facing staff (on a voluntary basis) with take-up to date over 3,000 staff submitting results centrally. Opportunities to report on outcomes will now be considered as part of the COVID IPC dashboard development however data quality issues mean that this data is not yet available.
- All respiratory patients requiring AGPs are on F7, G9 or in ITU. In an exceptional case where a patient is known to be negative and requires an AGP in an alternative location (e.g. because their clinical condition requires them to be placed elsewhere) they will have a Consultant review beforehand to make sure there is a low suspicion of C-19 and they will be nursed in a dedicated side-room.
- Staff COVID vaccination programme commenced and progressing to plan.
- Inpatients are now asked to wear masks while in hospital when moving about shared areas and, if able and comfortable to do so, whilst sitting in bed. This is emphasised through posters and supported by a patient information leaflet (below) which also includes how to access and how to wear them. The leaflet explains Public Health England's recommendation on the use of masks when in enclosed public spaces to help prevent the spread of Covid-19.



Staying in hospital?

Please wear a face mask whenever possible

We are asking inpatients to wear a surgical face mask while staying in hospital.

This helps protect you, fellow patients, and our staff.

You should:

- wear a mask when moving around shared areas, like when going to the toilet or to wash
- wear a surgical mask – which we will provide – to give you the most protection
- change your mask every four hours

We also recommend that you wear a mask while sitting in bed, if you feel comfortable doing so.

Some patients are medically exempt from wearing a mask. Please ask us if you have any questions.

Putting you first

Patient information

Wearing a face covering during the COVID-19 pandemic

Why should I wear a face covering when I am in hospital?

Public Health England (PHE) has recommended the use of masks when in enclosed public spaces. They are worn to help prevent the spread of Covid-19.

In some cases, a person may have Covid-19 but not display or suffer from any symptoms, this is known as being asymptomatic.

You do not need to wear a mask if you have breathing difficulties or other health conditions which would prevent this. Your nurse or doctor will be able to advise you on this.

How do I put on and take off my mask correctly?

Putting on the mask:

- Wash or hand sanitize your hands
- Attach the ear loops
- Adjust the mask to cover your nose and mouth
- Pinch the top of the mask to form a good seal at the bridge of the nose

The mask should cover your nose and mouth at all times. Try not to touch the front of the mask as this will increase your risk of contamination. If you need to touch your face wash or hand sanitize your hands before and after.

Taking off the mask:

- Wash or sanitize your hands
- Unhook the ear loops and remove it in a downward motion away from your face
- Without touching the front of the mask place, it in the plastic waste bag
- Wash or sanitize your hands again.

How to wash your hands

Putting you first

Advice for inpatients

When should I wear a face covering?

We are asking inpatients to wear a surgical face mask while staying in hospital. This helps protect you, fellow patients, and our staff.

You should wear a mask when moving around shared areas, like when going to the toilet or to wash. We also recommend that you wear a mask while sitting in bed, if you feel comfortable doing so.

You do not need to wear a mask if you have breathing difficulties or other health conditions which would prevent this. Your nurse or doctor will be able to advise you on this.

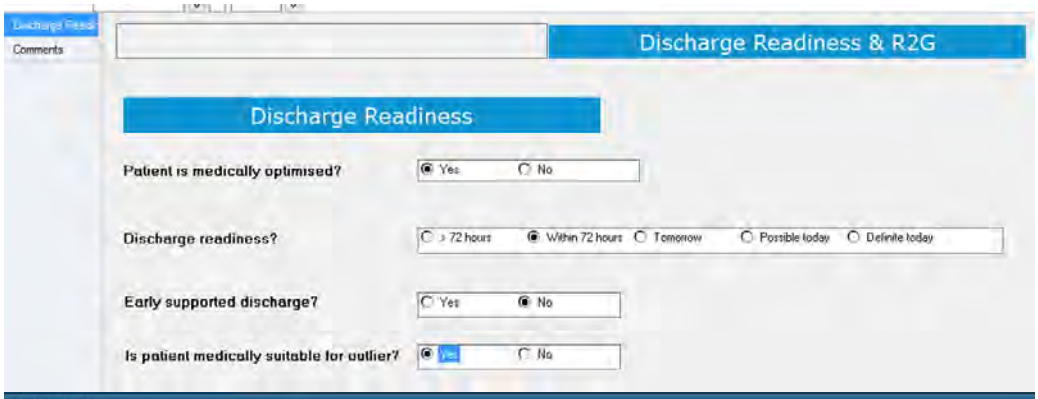
What sort of face covering should I wear?

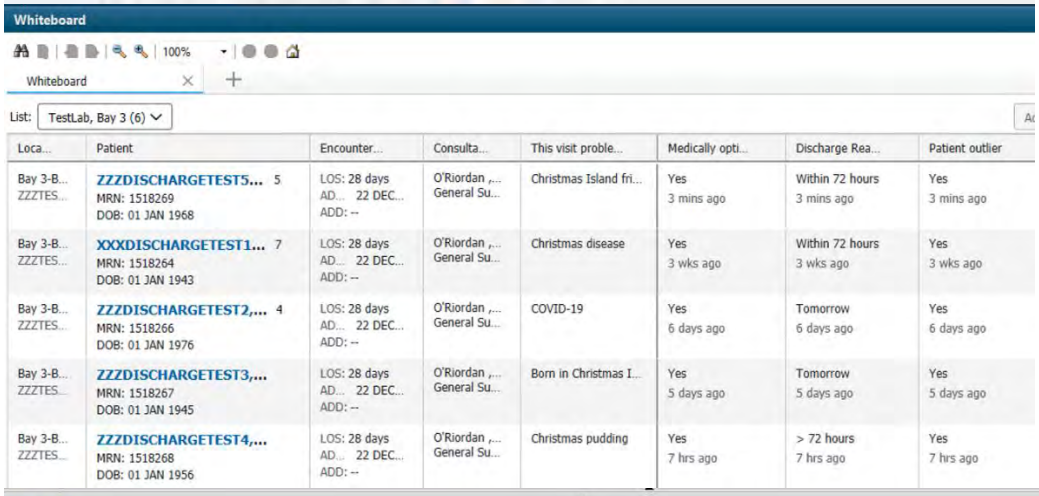
You should wear a surgical mask – which we will provide – to give you the most protection. We recommend you should change your mask every four hours.

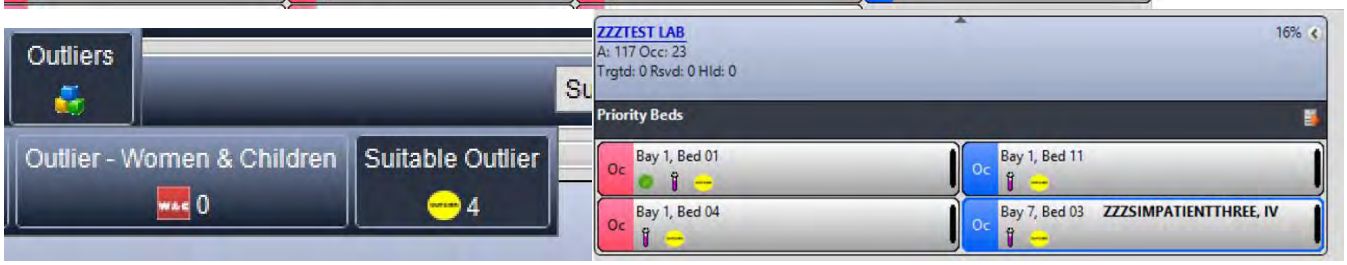
‘Suitable to outlie’ eCare record

The requirement will be recorded at the Board Round and an indicator will be added to the Whiteboard view. This will also add an icon to the Capacity Management patient flow system which can then be filtered to find all suitable patients across the organisation.

See screenshots below of training slides (no real patient listed)







15.3. Safe staffing guardian report

For Approval

Trust Board – January 2021

Agenda item:	15.3			
Presented by:	Dr Nick Jenkins, Executive Medical Director			
Prepared by:	Francesca Crawley, Guardian of Safe Working			
Date prepared:	January 2021			
Subject:	Safe Staffing Guardian Report – Quarterly Report October – December 2020			
Purpose:	x	For information		For approval

Executive summary:

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

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

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

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

Recommendation: For the board to endorse the quarterly report

QUARTERLY REPORT ON SAFE WORKING HOURS

DOCTORS AND DENTISTS IN TRAINING

1st October 2020 – 31st December 2020 Executive Summary

Introduction

The purpose of the report is to provide evidence of safe rostering and compliance with the TCS, to highlight any difficulties which have arisen, and to explain how they are being addressed. A system of Exception Reporting is in place and uses Allocate software.

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

All trainees taking up appointments are on the New Contract. Locally employed Doctors are on contracts that mirror the new Contract.

Summary data

Number of doctors in **training on 2016** TCS (total):	143 (includes p/t trainees)
Amount of time available in job plan for guardian to do the role:	1 PAs / 4 hours per week
Admin support provided to the guardian (if any):	0.5WTE
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee[1]
Amount of job-planned time for Clinical Supervisors:	0, included in 1.5 SPA time[1]

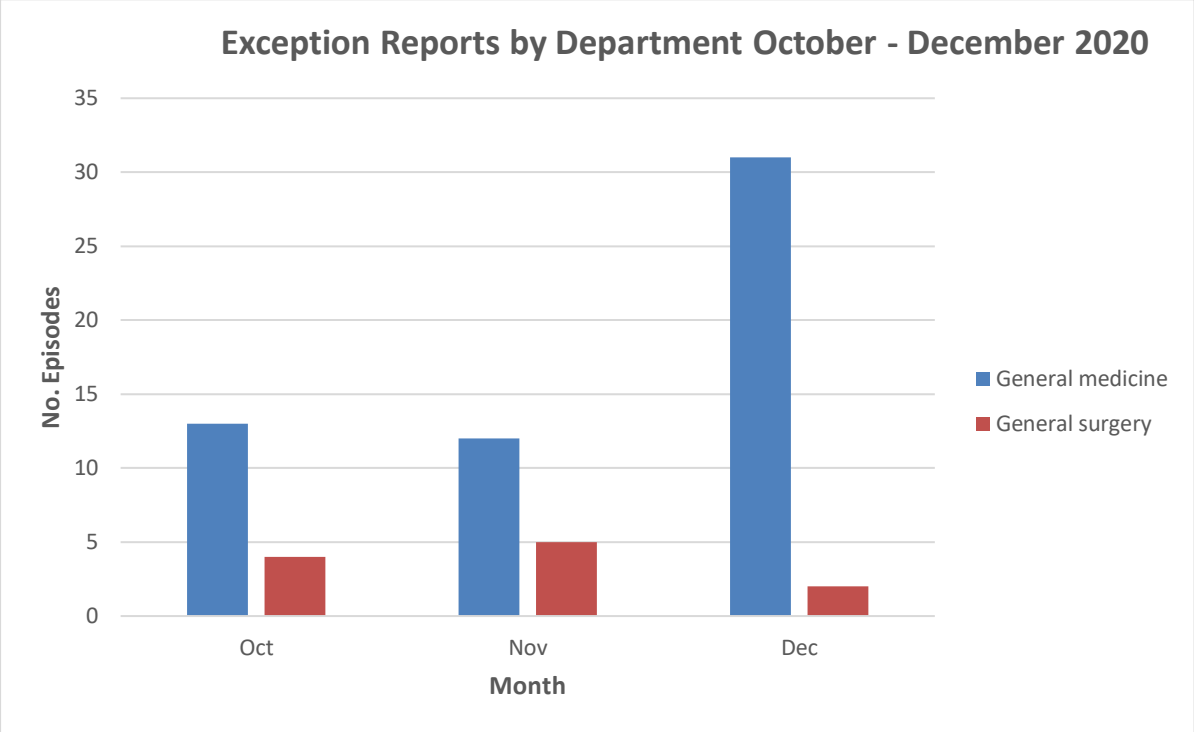
1. Exception reporting: 1st October – 31st December 2020

a) Exception reports (with regard to working hours)

The purpose of exception reporting is to ensure prompt resolution and/or remedial action to ensure that safe working hours are maintained. If there are consistent problems a work schedule review should be carried out. A process is in place on Allocate for the Junior Doctors to fill in the report, which at present requires discussion with a consultant before, during or the day after the period of situation occurred. A narrative of the situation which led to exceeding the contractual obligation is also required. Details are sent to the Guardian and Clinical /Educational Supervisor.

Exception Reports by EXCEPTION TYPE						
Department	Grade	Pattern of Hours worked	Educational Opportunities or available Support	Support available during Service Commitments	Hours of Work	Total overtime hours claimed
Medicine	F1			1	23	28.75
	F2		1		28	40.75
	GP/ST/CT				2	2.25
	ST3+				1	1.75
Surgery	F1				9	9.5
	F2				2	3.5
Total			1	1	65	86.5

Exceptions reports by month and department



b) Work schedule reviews for period 1st October 2020 – 31st December 2020

Work schedule reviews for individuals may be requested by either the doctor, or the education/clinical supervisor, service manager or guardian in writing.

The work schedules were reviewed in April and May by PGME, the College Tutors and Service Managers. The additional areas required by the updated T&C's for mandatory training and inductions have been added for the August intake.

2) Immediate Safety Concerns: 1st October 2020 – 31st December 2020

As outlined in the Terms and Conditions, immediate safety concerns (ICS) should be reported (orally) as an ISC to the consultant in charge on the day of the incident, a datix to be completed and then an exception report submitted within 24 hours.

There have been no ISC in this period.

3) Locum Bookings: 1st October 2020 – 31st December 2020

TABLE 1: Shifts requested between 1st October 2020 – 31st December 2020 by 'reason requested'

Locum Bookings by REASON REQUESTED									
Department	**Maintain Minimum Numbers, Shadow Shift and Induction Cover**	**Leave (Annual, Carers, Study and Interview, bereavement)**	**Sickness and Reduced Duties**	**Extra**	**COVID-19 Additional Dependency**	**COVID-19 Sickness**	**COVID-19 Self-Isolation**	**Vacancy**	**Grand Total**
Anaesthetics		1	13	10			1		25
Emergancy Medicine	5	41	14	137	10			188	395
ENT	1		3	3					7
General Medicine	15	35	28	70	37	4	4	22	215
General Surgery	18	8	57	9		3	32	44	171
Obs & Gynae	2	2	46					11	61
Ophthalmology		7	5				1	3	16
Paediatrics	2		18						20
T&O	4			2		2	3	4	15
Total	47	94	184	231	47	9	41	272	925

TABLE 2: Shifts requested between 1st October 2020 – 31st December 2020 by 'Agency / In house fill'

Filled by NHS / Agency		
Department	**NHS**	**Agency**
Anaesthetics	25	
Emergency Medicine	386	109
ENT	7	
General Medicine	205	
General Surgery	171	
Obs & Gynae	61	
Ophthalmology	16	
Paediatrics	13	7
T&O	15	
Grand Total	899	116

4) Vacancies – 1st October 2020 – 31st December 2020

Department	Grade	October	November	December
Emergency Dept	ST3+	8	7	6
Anaesthetics	ST3+	1	0	0
General Surgery	ST3+	0	1	1
Medicine	ST3+	1	0	0
Medicine	ST1-2	1	1	0
O&B	ST3+	1	1	2
Paediatrics	ST4+	0.4	0.4	0.4
T&O	ST3+	1	0	0
Total		**13.4**	**10.4**	**9.4**

5) Fines – 1st October 2020 – 31st December 2020

There is a system of financial penalty now in place where exception reporting demonstrates the following:

- a breach of the 48-hour average working week across the reference period agreed for that placement in the work schedule
- a breach in the maximum 72-hour limit in any seven days
- the minimum 11 hours rest requirement between shifts has been reduced to fewer than 8 hours.

There have been no fines this quarter and the total breach fines paid by the Trust from August 2017 to date are £13,137.75. The Guardian Fund currently stands at £7,033.14.

Matters Arising

- Again, I would like to thank the juniors who have again had rota changes and placement changes to support the hospital during covid-19. This has not been easy for several of them but again, they have been magnificent in their cooperation and flexibility.
- The boards should also be aware that our mental health trust, NSFT have allowed deployment of Foundation Doctors doing psychiatry placements back to WSFT. This has supported the provision of safe rota.
- The BMA have contacted me to thank WSFT and particularly Helen Kroon in HR and the service managers in medicine for the process of listening to and engaging the juniors throughout the pandemic.
- There has been an issue raised about safe cover of surgery out of hours and the CD for surgery, the service manager and various other parties are working towards a solution. At the moment, due to the reduced number of surgical in patients, this is less of an issue. I will report to the board once a resolution is reached.

15.4. Nursing establishment review

For Approval

Trust Open Board meeting – 29 January 2021

Agenda item:	15.4			
Presented by:	Susan Wilkinson, Executive Chief Nurse			
Prepared by:	Daniel Spooner, Deputy Chief Nurse Sinead Collins, Business manager for corporate nursing Julie Wiggin, Personal Assistant corporate nursing			
Date prepared:	November 2020			
Subject:	Nursing establishment review September/October 2020			
Purpose:	X	For information		For approval

Executive summary:

The aim of this establishment review is to provide the board with assurance that the current nursing establishment is fit for purpose and meets the needs of our patients and staff at West Suffolk Hospital (WSH). This review provides recommendations for adjustments in establishments where appropriate. Expectations from the National Quality Board and NHSI/E is that formal establishment reviews are completed biannually.

This establishment review used nationally endorsed and evidence-based tools to audit patient acuity and dependency within our inpatient areas and community inpatient beds. Data was triangulated with clinical/professional judgement and nurse sensitive indicators (pressure ulcers, falls and medication incidents) resulting in recommendations for each of the audit areas.

The review focused on 20 inpatient areas within the trust. Areas such as ITU, ED and outpatients have been excluded from this review and will have separate reviews in the near future to ensure nurse staffing is appropriate.

The output of this audit, and subsequent triangulation, recommends the following:

- Eleven wards/departments require no change in establishment
- Five wards would benefit from an uplift in establishment
- Four wards would benefit from an adjustment to the skill mix of the establishment in favour of registered nurses (RNs)

The net financial implications of this review equate to approximately £655,936

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**

Putting you first

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	 *Deliver personal care*	 *Deliver safe care*	 *Deliver joined-up care*	 *Support a healthy start*	 *Support a healthy life*	 *Support ageing well*	 *Support all our staff*
	X	X	X			X	X
Previously considered by:	N/A						
Risk and assurance							
Legislation, regulatory, equality, diversity and dignity implications	N/A						

Recommendation:

- The board are asked to consider the recommendations within this paper and be assured, that the assessments and recommendations made here, are in line with best practice expectations and robust establishment reviews practices.
- The board is requested to recognise and authorise the recommendations within this paper and consider the investment of £655,936 in nursing staffing
- This process will inform a biannual establishment review process ensuring robust oversight and governance of nurse establishment setting. The next round of audit is anticipated to commence in January/February 2020, to begin a rhythm of winter and summer reviews accounting for seasonal variations. Further outputs of this audit are unlikely to require this level of investment following the adjustment of skill mixes that have been recommended in this review.

SECTION 1 – INTRODUCTION

Following the Francis Report (2013) and the government's published response to the inquiry, 'Hard Truth's', it is expected that boards receive assurance on the Nurse Staffing Position bi-annually. In November 2013, the National Quality Board (NQB) published staffing guidance and this was strengthened by the publication of NICE guidance (2014), which supported providers and commissioners to make the right decisions about nursing, maternity staffing capacity and capability. The expectations set out in the guidance aimed to create a supportive environment where staff are able to provide compassionate care, of high quality and with the best possible outcomes for patients.

This national guidance was further strengthened by the NQB (2016) to support NHS providers to deliver the '*right staff, with the right skills, in the right place at the right time'.* This document contains recommendations to support trusts in making informed, safe and sustainable workforce decisions, and identifies examples of best practice in the NHS.

It is well considered in nursing research and literature that appropriate staffing levels and the right skill mix both influences, and significantly impacts patient safety and patient harms (Needleman, 2017; Aiken et al 2017). However, despite these recommendations, variations in ward geography, skill mixes and patient profiles, there is no agreed national standard for nurse to patient ratios (NICE, 2014). This can lead to ambiguity around establishment settings and workforce planning. NHSI (2018) published the 'developing work force safeguards' document to provide recommendations to support making safe and sustainable workforce decisions. Robust staffing establishments reviews should triangulate evidence-based tools with professional judgement and patient outcomes, to ensure the right staff are in the right place at the right time (Figure 1).

This staffing review has used these principles within these recommendations to inform the outcomes of this establishment review process. Within West Suffolk Hospital (WSH) establishment reviews have been conducted regularly at a divisional level, however this review will focus on all the inpatient areas in the trust (excluding critical care services) and become a regular biannual Trust wide review. The process described in the following sections will provide the first iteration of a biannual series of acuity and dependency audits that will provide assurance that nursing establishments are meeting the needs of the patients at WSH. Areas/wards that are assessed as not meeting the needs of the patient group will have recommendations applied to address such a shortfall.

Figure 1. Taken from 'Developing Workforce Safeguards' (NHSI, 2018

SECTION 2 – AIMS

This establishment review was undertaken for the following reasons:-

- To comply with Care Quality Commission requirements under the Essential Standards of Quality and Safety, including outcomes 13 (staffing) and 14 (supporting staff).
- To provide assurance from ward to board that staffing establishment are meeting the current need, acuity and dependency of the patients that are cared for within WSH.
- To commence a program of biannual nurse staffing reviews in concordance with expectations from NHSI and NQB. Ensuring that changes in ward provision, patient group and skill mix are sustainable and not detrimental to patient care.
- To ensure that nursing establishments are not purely based on historical models of care and budget setting
- To collaborate with senior nursing teams to improve engagement and confidence in agreed establishments

SECTION 3 – ESTABLISHMENT REVIEW METHODOLOGY

A review of all relevant literature and guidelines was undertaken prior to commencement of this exercise and included:

- NICE Guidance on Safer Staffing for nursing in adult inpatient wards in acute hospitals (2012)
- Safer Nursing Care Tool (SNCT) Shelford Group
- National Quality Board (2016) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time (Safe sustainable and productive staffing)
- NHSI (2018) Developing Workforce Safeguards: Supporting providers to deliver high quality care through safe and effective staffing

3.1 Safer Nursing Care Tool (SNCT) Output

The Safer Nursing Care Tool (SNCT), developed by the Shelford group, is the only nationally endorsed staffing tool by NICE and NHSI. The Safer Nursing Care Tool has been developed to help NHS Hospital staff measure patient acuity and dependency to inform evidence-based decision making on staffing and workforce provision. The tool, when allied to nurse sensitive indicators (NSIs) like falls and pressure ulcers, offers a reliable method against which to deliver evidence-based workforce plans. It uses an assessment of patient acuity and dependency scores and applies a nominal multiplier to suggest a whole time equivalent (WTE) to a ward/department (appendix A). This WTE is then applied to skill mix ratio of registered nurses (RNs) and nursing assistants (NAs) to propose an appropriate work force.

Training

To ensure reliability in data collection three senior staff from each ward were selected to be responsible for audit and data collection. In recognition of staff turnover and that an establishment review utilising this approach had not occurred recently, virtual workshops were provided to the audit teams to ensure that subjective interpretation of patient acuity and dependency was reduced as much as possible. The virtual workshops were rolled out two weeks before the audit commenced and was delivered to sixty-four members of the senior nursing team.

Audit Dates

The audit commenced on 7th September 2020 and ran for twenty working days, a full description of the audit process and quality assurance can be found in appendix B.

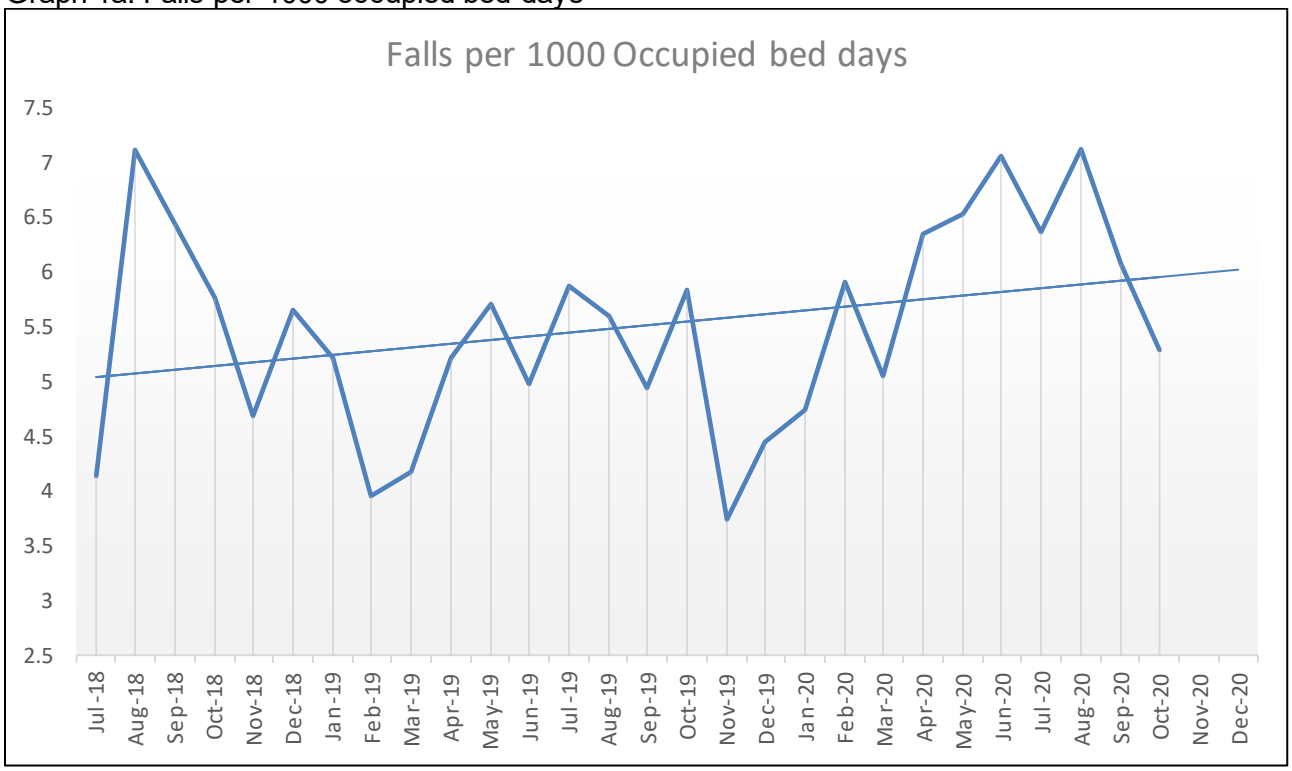
Data Analysis and Nurse Sensitive Indicators (NSI)

Following the output of the audit, the data was compared with current skill mix and then best practice skill mix, which is considered to be 60/40 RN/NA skill mix. In higher acute areas like AAU and stroke a commonly applied ratio is closer to 70/30 RN/NA skill mix. These ratios were then applied to the WTE output, and compared with current establishments, resulting in a suggested uplift or decrease in staffing levels (appendix C).

A number of wards currently have a higher ratio of NA than RNs, this is more prevalent in the medical ward areas. Anecdotally this was the result of 'bay-based nursing' which was rolled out to many wards areas in 2018. This model of care was introduced to address a large RN vacancy at the time, and to provide increased presence of support staff in ward bays to reduce falls, hospital acquired pressure ulcers (HAPUs) and improved observations of care. It is not clear if this transition to a higher ration of NAs has been successful in reducing harms. On review of trends in patient falls and HAPU in the last three years, including the year before implementation of 'bay based nursing', there does not appear to be any improvement trend in any of the NSIs used in this review.

Appendix D illustrates the total number of incidences since 2017, of falls, HAPU and medication incidences. However, it is recognised that over recent years the bed base has increased with acquisitions of community beds and also escalation wards turning into full time substantive wards. Considering this the measure of NSI against occupied bed days was also considered and illustrated below (Graph 1a and 1b). Data was only available from July 2018.

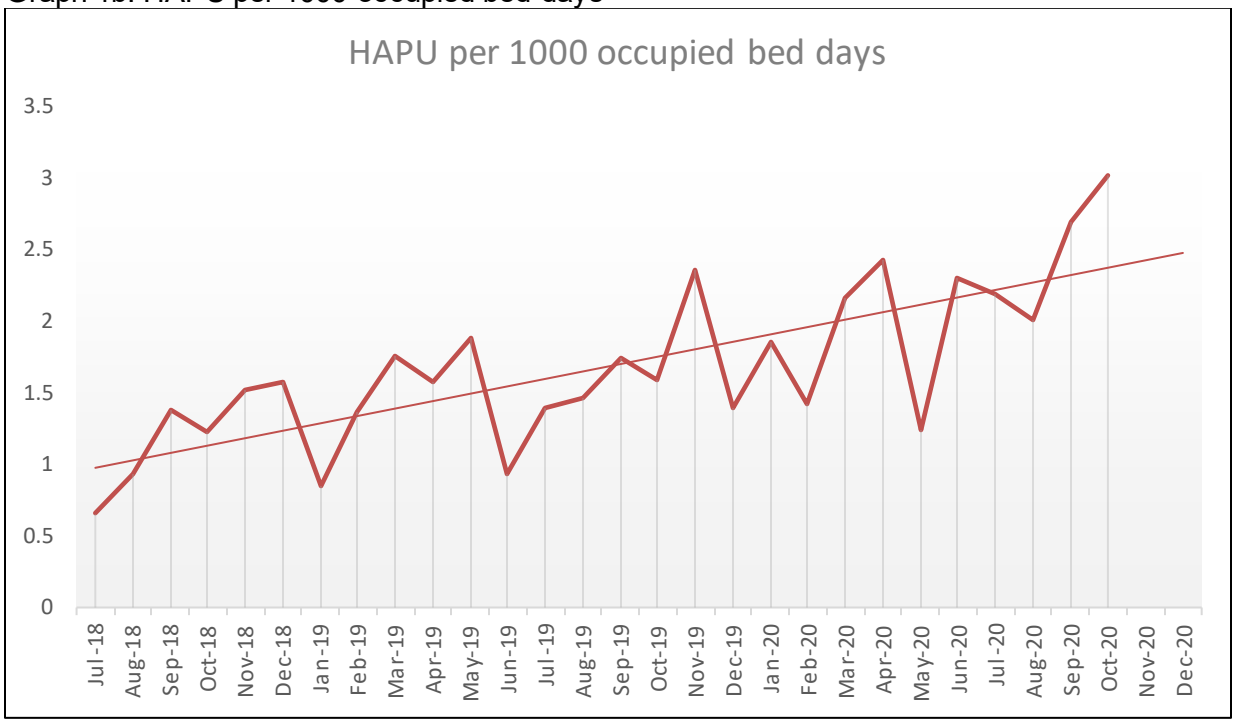
Graph 1a: Falls per 1000 occupied bed days



While the majority of months fall below the national average of 6.63, there is small but gradual rise in in falls since July 2018.

Over the past two and half years, incidences of HAPU has seen a more obvious rise in cases since occupied bed data was collected in July 2018 (there is no national bench mark). This could be attributed to a change in case mix or service provision, change in local population or covid (in recent months). It could also be attributed to the change in skill mix post 'bay based nursing' where RNs were reduced in favour or more NAs. This would support the preposition that reducing RN/NA ratio in favour of NAs may adversely impact patient safety (Needleman, 2017; Aiken et al 2017).

Graph 1b: HAPU per 1000 occupied bed days



3.2 Professional Judgment (PJ) Calculation

This section compares current budgeted establishments and the professional judgement calculation to understand if current budgets are aligned with current nursing roster provision. Telford's (1979) early work using expert health care professional judgement to agree the most appropriate size and mix of ward nursing teams has stood the test of time. Simply put, this technique helps managers convert duty rota decisions into whole time equivalents (WTE's).

This method is simple to use and is an excellent starting point for organisations, although it can be too subjective if decided alone. Table 2 shows the total funded current operational WTE for each Ward. The PJ recommended WTE is further analysed against the SNCT in appendix C. The reason for inclusion here is to inform the narrative of whether current rosters are in line with the current budgeted establishment. On the whole the net total is in keeping with expectation. There are some exceptions however these variances are related to roles that are within the ward budget but not with the standard shift delivery, for example specialist nurses, ward clinic nurses or peripatetic roles.

Table 2

WARDS	FUNDED WTE	PJ WTE	VARIANCE
AAU	45.61	49.76	4.15
F1	21.9	23.57	3.67
F3	47.99	41.9	-6.09
F4	28.68	34.04	5.36
F5	35.09	34.04	-1.05
F6	38.76	34.04	-4.72
F7	50.67	52.38	1.71
F8	41.71	39.28	-2.43
F9	45.09	44.52	-0.57
F10	37.26	36.66	-0.60
F12	16.08	15.71	-0.37
F14	13.8	15.71	1.91
G1	23.33	20.95	-2.38
G3	45.07	44.52	-0.55
G4	44.87	44.52	-0.35
G5	45.15	44.52	-0.63
G8	48.11	47.14	-0.97
Cardiac Suite	43.64	39.28	-4.36
Kings Suite	24.33	22.42	-1.91
Rosemary Ward	25.90	26.19	0.29
	723.04	711.15	-9.89

The calculation method for Professional Judgement (PJ) is found in Appendix E.

3.3 Safer Nursing Care Tool (SNCT) Output

Table 3 shows the total current funded WTE for each Ward, the proposed WTE from the SNCT and the variance between the two. This is for illustration purposes only and caution should be applied when reviewing this data in isolation as significant variances (for example F4 and F7) may be attributed to changes for example; within the ward layout, or reduced activity, which is not reflective of normal or predicted future patient activity. These variances will be explored in the ward by ward recommendations in section 5, where this date will be triangulated with professional judgement and NSIs.

Table 3

WARDS	Current FUNDED WTE	Proposed SNCT WTE	VARIANCE
AAU	45.61	40.1	-5.51
F1	21.9	15.9	-6.00
F3	47.99	46.4	-1.59
F4	28.68	10.3	-18.38
F5	35.09	33.7	-1.39
F6	38.76	39.9	1.14
F7	50.67	24.2	-26.47
F8	41.71	33.0	-8.71
F9	45.09	42.3	-2.79
F10	37.26	33.7	-3.56
F12	16.08	10.2	-5.88
F14	13.8	5.7	-8.10
G1	23.33	13.0	-10.33
G3	45.07	35.8	-9.27
G4	44.87	43.9	-0.97
G5	45.15	50.3	5.15
G8	48.11	43.0	-5.11
Cardiac Suite	43.64	33.0	-10.68
King Suite	24.33	25.4	1.07
Rosemary	25.9	27.8	1.90
TOTAL	**723.04**	**607.6**	**-115.48**

There are a number of limitations to the SNCT which will affect the output and WTE recommendations (Griffiths et al, 2020):

- The SNCT does not consider the nuances of ward activity, for example clinics based on wards or ward attenders
- Additional specialist or peripatetic roles with wards (stroke outreach), are not considered
- Layout and geography of ward environments, variations in side room provision, size of bays and the ward footprint may dictate additional nursing requirements not captured in the SNCT
- Small wards or those with a majority of side rooms will often result in a proposed under establishment

Because of these variations it is important that the output of the SNCT is triangulated with professional clinical judgement and NSIs. This approach is advocated by the authors of the SNCT and the expectations within the developing workforce safeguards document (NHSI, 2018).

SECTION 4 – TRIANGULATION AND RECOMMENDATIONS.

In order for this establishment review to fully comply with the NQB and NHSI expectations, outcome meetings were established with all ward sisters and matrons to review the outputs of the SNCT. At these meetings, individual ward NSIs (appendix F), clinical knowledge and professional judgement where used to triangulate and inform recommendations for their clinical area. Reviewing the SNCT outputs also included reviewing the patient profile against expected acuity and dependency of best practice wards (for example, comparing acute medicine with a best practice acute medical ward. This comparison would indicate if the patient scoring system was in line or around expected levels. Any significant deviations may suggest inaccuracies in patient acuity scoring. The outcomes of these review meetings would result in a number of outcomes including;

- No change to establishment
- Skill mix change
- Staffing uplift
- Staffing decrease

i. Acute Assessment Unit (AAU)

This emergency medical admissions unit consists of four assessment bays, five high dependency trollies and three five bedded bays. This area receives patients directly from general practice referrals and also from the emergency department. This is a rapid assessment area that ensures patients have their first assessment by the medial team prior to admission to the main inpatient wards. Also, within the AAU there is an ambulatory emergency care (AEC) service. This area is comprised of a waiting area, 'fit to sit' reclining chairs and assessment areas. Staffing for this area was removed from the WTE to ensure trollied area was only included in the SNCT comparison.

The SNCT applies a higher multiplier for assessment units in recognition of the acute nature of presenting patients and the higher patient turnover of such an area. When applying best practice skill mix of 70/30% RN/NA the SNCT suggests that there is an opportunity to reduce staffing levels overall with an increase of RNs and a significant reduction in NAs. However, on review the ward teams are happy with the current skill mix as they have utilised the band 4 assistant practitioner (AP) role. The AP role while unregistered is an extended role that is able to provide additional support to the registered nurse. The successful utilisation of these roles decreases the need for any change in RN numbers.

WARD	Beds	Split WTE		WTE	Current Skills Mix (RN:NA) (%)	Current Ratio RN : Patient	PJ WTE	SNCT (Sept 2020) WTE	Suggested Skills Mix (RN:NA) (%)	Split WTE		Difference		Difference
		RN	NA							RN	NA	RN	NA	WTE
AAU	20 + 1 SR + 2 AB	22.42	23.19	45.61	52:48	Day – 1:5 Night – 1:5	49.76	40.1	70:30	28.1	12	5.68	-11.19	-5.51

Recommendation: No change to current establishment.
Cost pressure: None.

ii. Ward F1 (Paediatrics)

Paediatric inpatient services are based on Rainbow ward with a co-located children's assessment unit (CAU). There are a fifteen bedded unit with the option to flex to twenty beds (dependent on staffing and patient acuity) and have a two bedded high dependency room. They cover a wide range of clinical services from general paediatrics to orthopaedics, psychology and physiotherapy

and have strong connections with other specialist children's units such as Addenbrooke's and the Norfolk and Norwich University hospitals.

The SNCT suggests a reduction nursing levels but these staffing tools do not account for the extraneous ward activity, such as pre-assessment, ward attenders, paediatric sedation clinic, as well as high dependency beds. During this audit period activity within the ward has been very low and is unlikely to capture known increase in activity in the winter months.

WARD	Beds	Split WTE		WTE	Current Skills Mix (RN:NA) (%)	Current Ratio RN : Patient	PJ WTE	SNCT (Sept 2020) WTE	Suggested Skills Mix (RN:NA) (%)	Split WTE		Difference		Difference
		RN	NA							RN	NA	RN	NA	WTE
F1	15	14.73	7.17	21.9	74:26	Day – 1:8 Night – 1:8	23.57	15.9	70:30	11.1	4.8	-3.63	-2.37	-6.00

Recommendation: No change to current establishment. Repeat audit in November and/or December to better understand seasonal provision.

Cost Pressure: None

iii. Ward F3

F3 is a Trauma & Orthopaedic ward with thirty-four beds within its footprint; consisting of five six bedded bays and three additional side rooms. Additional ward activity includes emergency ENT assessment and a trauma assessment room. F3 also specialises in the care of spinal injured patients. The ward team also deliver a cervical collar washing service twice a week that requires a bed and two trained staff.

The SNCT suggests an increase in RNs and reduction in NAs. However, the ward received an uplift in RNs this financial year and do not feel an additional RN on shift would provide benefit. No reduction in NAs has been recommended in this audit given the number of dependent patients in the ward profile and the high incidents of HAPU observed in this ward. A review of the patient acuity and dependency prevalence supports this and the patient profile is predominately level 1b patients dictating a high need for basic nursing care which NAs are able to provide.

WARD	Beds	Split WTE		WTE	Current Skills Mix (RN:NA) (%)	Current Ratio RN : Patient	PJ WTE	SNCT (Sept 2020) WTE	Suggested Skills Mix (RN:NA) (%)	Split WTE		Difference		Difference
		RN	NA							RN	NA	RN	NA	WTE
F3	30 + 4 SR	22.15	25.84	47.99	46:54	Day – 1:8 Night – 1:11	41.9	46.4	60:40	27.8	18.6	5.65	-7.24	-1.59

Recommendation: No change to current establishment. However possible reduction in NAs if repeated audit suggests a similar trend

Cost pressure: None

iv. Ward F4

F4 is normally a thirty-two bedded elective ward for a number of specialities including orthopaedics, ENT, general surgery, urology and gynaecology. Staffing levels are matched to elective activity, which often reduces at weekends.

The SNCT suggests as significant reduction in staff both RN and NA. At the time of audit, the ward had been relocated to F2 which was a much smaller footprint requiring a significantly smaller nursing establishment. Coupled with low activity due to the recovery plan post covid19, bed occupancy was significantly reduced for this period, therefore the validity of the outcome based on current budgeted establishment is not valid to be translated into a long-term establishment for F4.

WARD	Beds	Split WTE		WTE	Current Skills Mix (RN:NA) (%)	Current Ratio RN : Patient	PJ WTE	SNCT (Sept 2020) WTE	Suggested Skills Mix (RN:NA) (%)	Split WTE		Difference		Difference
		RN	NA							RN	NA	RN	NA	WTE
F4	30 + 3 SR	15.76	12.92	28.68	55:45	Day – 1:9 Night – 1:11	34.04	10.3	60:40	6.2	4.1	-9.56	-8.82	-18.38

Recommendation: No change to current establishment given validity of results
Cost Pressure: None

v. Ward F5

F5 is a thirty-three bedded surgical ward, five bays of six beds and three side rooms, which specialises in elective major bowel surgery, urology and major abdominal surgery. The ward manages an element of emergency work in transferring stable patients from F6 and at times, direct admissions from ED.

The SNCT proposes a minimal change to the overall budgeted establishment. Most patients are level 0 but have a diverse range of specialities including: Orthopaedic, surgical, emergency, elective, medical and gynae. Patient acuity and activity increases in the evening and night as patients return from theatre. The clinical team feel that the ward is vulnerable at night and would benefit from additional clinical skills. Currently only three RNs are rostered at night and given this acute nature of the ward going into the evening, additional clinical skills would be needed. The clinical teams are confident that that this can be met with innovative use of emerging roles like that of the nursing associate or associate practitioner.

WARD	Beds	Split WTE		WTE	Current Skills Mix (RN:NA) (%)	Current Ratio RN : Patient	PJ WTE	SNCT (Sept 2020) WTE	Suggested Skills Mix (RN:NA) (%)	Split WTE		Difference		Difference
		RN	NA							RN	NA	RN	NA	WTE
F5	30 + 3 SR	22.16	12.93	35.09	63:37	Day – 1:8 Night – 1:11	34.04	33.7	60:40	20.2	13.5	-1.96	0.57	-1.39

Recommendation: Increase night staffing by 1 x WTE band 4.
Cost pressure: £96,553

vi. Ward F6

F6 is a thirty-three bedded emergency surgical ward, compromising of three, six-bedded bays and three side rooms and accepts emergency general surgery patients. The ward also provides a RN and a NA to the AAU daily to provide care and assessment of patients referred from the community/GP or from the emergency department (this was removed from the WTE calculation so that ward provision was compared only.

When applying the skill mix ratio of 70/30, the SNCT is suggesting that the ward requires an increase in staffing levels with a higher number of RNs. This would be consistent with the clinical judgement of the ward. On review of the acuity of the ward this is consistent with best practice bench marks. The ward currently has only 3 RNs on a night shift which would be light given the acute nature and size of this ward. When bench marking against other emergency surgical wards of similar sizes a higher nurse to patient ratio at night is often observed.

WARD	Beds	Split WTE		WTE	Current Skills Mix (RN:NA) (%)	Current Ratio RN : Patient	PJ WTE	SNCT (Sept 2020) WTE	Suggested Skills Mix (RN:NA) (%)	Split WTE		Difference		Difference
		RN	NA							RN	NA	RN	NA	WTE
F6	30 + 3 SR	23.99	14.77	38.76	62:38	Day – 1:8 Night – 1:11	34.04	39.9	70:30	27.9	12	3.91	-2.77	1.14

Recommendation: Increase RN staffing by 1x RN at night
Cost pressure: £114,999.00

vii. Ward F7

F7 is a short stay medical ward with an intended length of stay (LOS) for up to seventy-two hrs. It has a total of thirty-four beds; there are five bays with six beds in each bay and there are four side rooms. Pre Covid19 the F7 was a short stay medical ward, providing high turnover, rapid treatment and discharge of medical patients. During the pandemic, the ward's patient profile has been changed to care for patients with either positive or possible covid 19 diagnosis with the addition of a NIV service.

The SNCT suggests a significant decrease in staffing, however this would not be appropriate at this time. The reason for the proposed reduction is that during September bed occupancy was significantly reduced by about 50%, and positive covid patients and the need for NIV was also reduced. Triangulating insight from NSIs the ward is in the top quarter of wards with high incidences of patient harms indicating that the current staffing establishment, even pre Covid19, may not be meeting the needs of the patient group. Current RN/NA skill mix is in favour of a higher number of NAs like many of the medical wards. Adjusting this skill mix by increasing the RNs, with an equal reduction of NAs will improve the RN/NA in favour of RNs. This is more in line with best practice observations and will potentially increase patient safety on this ward.

WARD	Beds	Split WTE		WTE	Current Skills Mix (RN:NA) (%)	Current Ratio RN : Patient	PJ WTE	SNCT (Sept 2020) WTE	Suggested Skills Mix (RN:NA) (%)	Split WTE		Difference		Difference
		RN	NA							RN	NA	RN	NA	WTE
F7	30 + 4 SR	22.33	28.34	50.67	44:56	Day – 1:7 Night – 1:7	52.38	24.2	60:40	14.5	9.7	-7.83	-18.64	-26.47

Recommendation: Change in skill mix by increasing 1 x RN LD and reduce by 1 x NA LD
Cost pressure: £29,049.32

viii. Ward F8

F8 is a twenty-five bedded acute respiratory medical ward. This compromises of two six bedded bays and two five bedded respiratory therapy bays for high dependency respiratory patients, alongside three side rooms.

SNCT proposes a staff reduction in both RNs and NAs. On review with senior staff, during the period of this audit the patient group traditionally nursed here has been altered due to managing Covid 19 within WSH. Patients requiring 'non-invasive ventilation' (NIV), which require a higher nursing ratio have not been cared for on this ward, to maintain non covid respiratory pathway. This potentially suggests that the acuity of this ward has been reduced from normal activity. The ward is also due to relocate to G9 which will have a significantly different footprint. Any alterations to current staff may not meet the needs of the new ward layout. It would be essential that on moving to the new ward layout, the audit is repeated to ensure that this change in service provision continued to meet the staffing requirements of the patient group.

WARD	Beds	Split WTE		WTE	Current Skills Mix (RN:NA) (%)	Current Ratio RN : Patient	PJ WTE	SNCT (Sept 2020) WTE	Suggested Skills Mix (RN:NA) (%)	Split WTE		Difference		Difference
		RN	NA							RN	NA	RN	NA	WTE
F8	24 + 3 SR	23.68	18.03	41.71	57:43	Day – 1:6 Night – 1:6	39.28	33.0	60:40	19.8	13.2	-3.88	-4.83	-8.71

Recommendation: No change to current establishment. To re audit and consider output once within new ward location

Cost pressure: None

ix. Ward F9

Ward F9 is a thirty-three bedded medical ward specialising in gastro, liver and general medicine. The ward is comprised of five, six bedded bays and three side rooms.

The SNCT suggests a small net decrease in WTE however there is a clear recommendation around an adjustment in skill mix. This is consistent with clinical review, given the complex and varied patient group including patients requiring intensive detoxing regimes. Adjusting the skill mix in favour of registered nurses in line will bring the ward closer to best practice skill mix.

WARD	Beds	Split WTE		WTE	Current Skills Mix (RN:NA) (%)	Current Ratio RN : Patient	PJ WTE	SNCT (Sept 2020) WTE	Suggested Skills Mix (RN:NA) (%)	Split WTE		Difference		Difference
		RN	NA							RN	NA	RN	NA	WTE
F9	30 + 3 SR	19.33	25.76	45.09	43:57	Day – 1:8 Night – 1:11	44.52	42.3	60:40	25.4	16.9	6.07	-8.86	-2.79

Recommendation: Change in skill mix by increasing 1 x RN LD and reduce by 1 x NA LD

Cost pressure: £29,049.32

x. Ward F10

F10 is a general medical ward with twenty-three beds including three side rooms.

The SNCT suggests that the numbers of registered nurses are largely appropriate for this ward however the tool identifies opportunities to reduce NA numbers and best practice RN/NA is already observed if not higher than expected. Professional judgement identifies that while RN feel appropriate there is a consistent need for additional NA staff to care for patients who require one to one observations or interventions. Triangulating this with dementia prevalence data, F10 patients profile leads significantly towards care of the elderly seeing a high incidence of cognitive impaired patients (table 4). This is almost double the trust average of around 30%. Given the patient profile and reduced staffing numbers at night, a proposal of an increase in NA at night by one would reduce the need for additional temporary staffing when patients requiring 1:1 or increased observation is consistently required.

Table 4.

2020/2021 Ward Quarterly Percentage - Dementia / Delirium / Cognitive Impairment																			
Ward	G1	G3	G4	G5	G7	G8	G9	F3	F4	F5	F6	F7	F8	F9	F10	F12	F14	AAU	CCS
Q1	6%	51%	57%	47%	14%	56%	41%	16%	25%	7%	12%	20%	33%	22%	58%	45%	0%	18%	12%
Q2	6%	43%	66%	42%	17%	54%		29%	3%	4%	2%	39%	27%	26%	64%	32%	0%	20%	21%

WARD	Beds	Split WTE		WTE	Current Skills Mix (RN:NA) (%)	Current Ratio RN : Patient	PJ WTE	SNCT (Sept 2020) WTE	Suggested Skills Mix (RN:NA) (%)	Split WTE		Difference		Difference
		RN	NA							RN	NA	RN	NA	WTE
F10	23 + 3 SR	19.23	18.03	37.26	63:37	Day – 1:6 Night – 1:8	36.66	33.7	60:40	20.2	13.5	0.97	-4.53	-3.56

Recommendation: Increase NA at night by one 7 days a week.
Cost pressure: £86,477.34

xi. Ward F12

F12 is an eight bedded isolation ward. All beds are single side rooms with en suite facilities. It is well understood in nursing literature that nursing an increased number of single rooms decreased efficiency and increases nursing workload, as patients are not able to be observed in a single environment like a multiple bedded bay for example.

The SNCT suggests a reduction in both NAs and RNS. However, NHSI advises caution on applying this tool to small, side room heavy wards. The acuity data was fed into to an additional tool provided by NHSI and the results were comparable to the current staffing establishment. Although a small reduction was proposed in the tool, this would result in single nurse caring for these patients on a shift which would not be appropriate or safe to do so. Professional judgement from the clinical teams is that current establishment is meeting the needs of this patient group. This is supported with low incidents of NSI, suggesting that the current nursing establishment are able to deliver safe and effective care well.

WARD	Beds	Split WTE		WTE	Current Skills Mix (RN:NA) (%)	Current Ratio RN : Patient	PJ WTE	SNCT (Sept 2020) WTE	Suggested Skills Mix (RN:NA) (%)	Split WTE		Difference		Difference
		RN	NA							RN	NA	RN	NA	WTE
F12	8 SR	10.23	5.85	16.08	64:36	Day – 1:4 Night – 1:4	15.71	10.2	65:35	6.6	3.6	-3.63	-2.25	-5.88

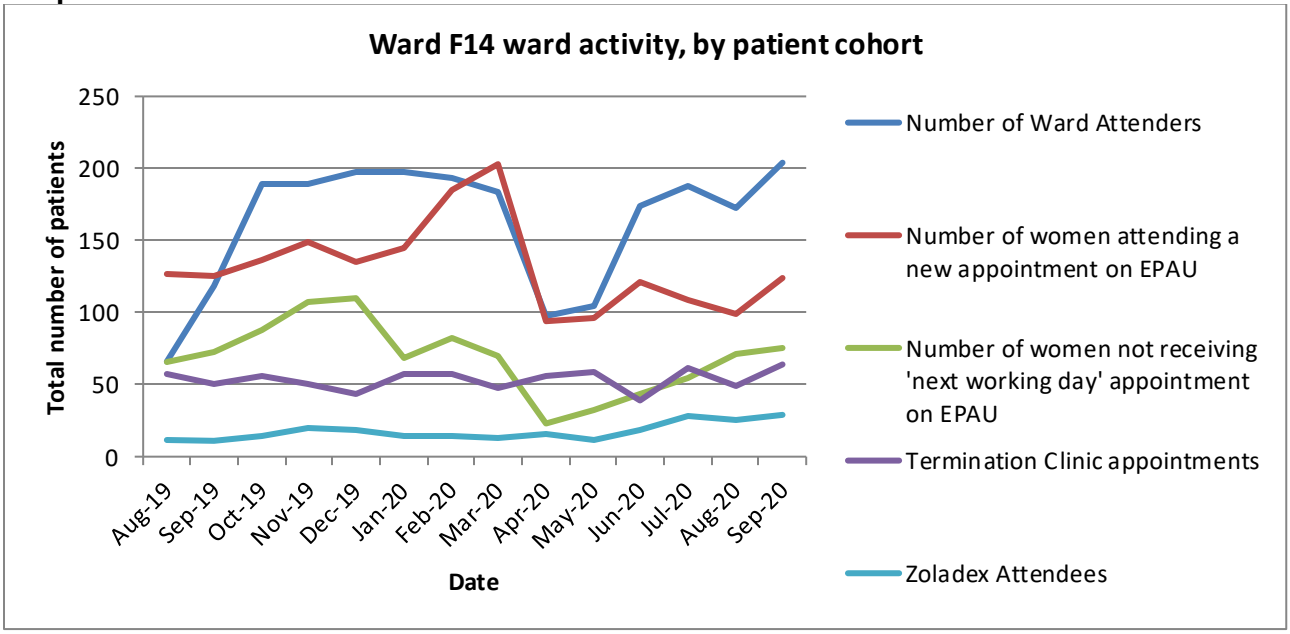
Recommendation: No change to current establishment
Cost pressure: None

xii. Ward F14

F14 is a gynaecology ward that has eight beds, compromising of a four bedded bay, a two bedded bay and two side rooms. Additional activity within the ward includes ward attenders to various ward-based clinics like the early pregnancy assessment (EPU), termination of pregnancy (TOP) clinic and emergency assessment of patients referred from the community or the emergency department. These ward attenders can present throughout the twenty-four-hour period.

The SNCT output advises a reduction in staffing however, it should be noted that this ward would fall into the 'small ward' category and its nursing need may not be fully captured in the SNCT. The SNCT acuity data was fed into the 'small ward' tool and the outcome did not produce a significant difference to current establishment. On review of overall ward attendance data, following a reduction in inactivity during April and May (due to Covid 19), activity is now exceeding pre-covid levels (graph 5). Currently, NA provision is only three days a week. The impact of no NA support is felt on the days where this is not provided, resulting in a two-tiered service. To future proof the service and maintain current service delivery and patient care, providing NA cover every weekday (excluding weekends) will ensure that patients receive a consistent service delivery and patient experience.

Graph 5.



WARD	Beds	Split WTE		WTE	Current Skills Mix (RN:NA) (%)	Current Ratio RN : Patient	PJ WTE	SNCT (Sept 2020) WTE	Suggested Skills Mix (RN:NA) (%)	Split WTE		Difference		Difference
		RN	NA							RN	NA	RN	NA	WTE
F14	4 bb + 2 bb + 2 SR	12.6	1.2	13.8	91:09	Day – 1:4 Night – 1:4	15.71	5.7	90:10	5.1	0.6	-7.5	-0.6	-8.10

Recommendation: Increase NA cover to 7-day cover
Cost Pressure: £24,100.00

xiii. Ward G1

G1 is a ten bedded medical oncology ward comprised of all single rooms, and one additional room ring fenced for assessment of acute oncology/haematology admissions. This is occasionally used as surge capacity if required. The staff rotate between the day unit and the mobile oncology unit. The WTE for these additional areas have been removed so the audit WTE comparison is based on ward provision only.
The SNCT suggests a significant reduction in RNs (8 WTE), however as mentioned in the F12 review the SNCT is not a great predictor of small wards with side rooms. The SNCT acuity data was fed into the 'small ward' tool and the outcome did not produce a significant difference to current establishment. On review of the acuity data, it appears that a high number of patients were scored as zero, which may not reflect the complex drug regimens (chemotherapy) provided within the wards. Given the possible validity of data, no change to current establishment has been recommended.

WARD	Beds	Split WTE		WTE	Current Skills Mix (RN:NA) (%)	Current Ratio RN : Patient	PJ WTE	SNCT (Sept 2020) WTE	Suggested Skills Mix (RN:NA) (%)	Split WTE		Difference		Difference
		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	13.0	70:30	9.1	3.9	-8.26	-2.07	-10.33

Recommendation: No change to current establishment. Review of patient scoring and quality control in next round of audit
Cost pressure: None

xiv. Ward G3

G3 is a thirty-three bedded general medical ward with a focus of diabetes and endocrinology ward. During the audit the ward had a bay closed for 14 days due to infection control procedures, meaning that the bed occupancy was low during the audit period. This is reflected in the significant variation in the current establishment WTE (45.07) and the SNCT WTE (35.8).

The SNCT advises a small increase in RNs and a significant reduction in NAs. Due to the low bed occupancy during the audit period, the output should not inform the long-term establishment as it would not be planning for usual occupancy. This ward, like many of the medical wards, has a higher ratio of NAs to RNs and triangulating this with NSIs sees a higher number of patient harms including falls and pressure ulcers. Taking this into consideration adjusting the skill mix to favour RNs like wards of similar size and establishment has been recommended.

WARD	Beds	Split WTE		WTE	Current Skills Mix (RN:NA) (%)	Current Ratio RN : Patient	PJ WTE	SNCT (Sept 2020) WTE	Suggested Skills Mix (RN:NA) (%)	Split WTE		Difference		Difference
		RN	NA							RN	NA	RN	NA	WTE
G3	30 + 3 SR	19.51	25.56	45.07	43:57	Day – 1:8 Night – 1:11	44.52	35.8	60:40	21.48	14.32	1.97	-11.24	-9.27

Recommendation: Change in skill mix by increasing 1 x RN LD and reduce by 1 x NA LD
Cost Pressure: £29,049.32

xv. Ward G4

G4 is a thirty-two bedded medical ward that compromises of five, six bedded bays and two side rooms. The patient profile here is predominately care of the elderly with a high number of patients that are cognitively impaired, requiring complex discharge process and high levels of physical care needs.

The SNCT suggests a small net reduction in staff, but a significant variance in RN and NA numbers when applying best practice, bench marked staffing ratios. There is almost an equal increase in RNs against a reduction in NA. This is a common theme among the medical wards. On review with the clinical teams, and applying professional judgement, adjusting this skill mix in the day could positively impact patient safety. Triangulation with NSIs identifies that both falls and HAPU are high in this area. This will in part will be driven by the patient group cared for here. Recommendations for this area will be to address the skill mix in favour of RNs.

WARD	Beds	Split WTE		WTE	Current Skills Mix (RN:NA) (%)	Current Ratio RN : Patient	PJ WTE	SNCT (Sept 2020) WTE	Suggested Skills Mix (RN:NA) (%)	Split WTE		Difference		Difference
		RN	NA							RN	NA	RN	NA	WTE
G4	30 + 2 SR	19.51	25.36	44.87	43:57	Day – 1:8 Night – 1:11	44.52	43.9	60:40	26.3	17.6	6.79	-7.76	-0.97

Recommendation: Change in skill mix by increasing 1 x RN LD and reduce by 1 x NA LD
Cost Pressure: £29,049.32

xvi. Ward G5

G5 is an acute elderly care medical ward containing thirty-three beds made up of five, six bedded bays and three side rooms for patients. Patients on G5 tend to be complex due to renal co morbidities

(transplant/vasculitis/dialysis) but also often have multiple associated conditions such as diabetes, cognitive impairment, confusion/acute delirium.

The SNCT as with many of the majority of the medical wards suggests and uplift to RN staffing and reduction in NAs. This ward has high incidence of falls and HAPU and would benefit from an increase in skill mix in favour of RNs. On review with the clinical teams this uplift would be more beneficial in the day shift and do not feel and change night staffing is required.

WARD	Beds	Split WTE		WTE	Current Skills Mix (RN:NA) (%)	Current Ratio RN : Patient	PJ WTE	SNCT (Sept 2020) WTE	Suggested Skills Mix (RN:NA) (%)	Split WTE		Difference		Difference
		RN	NA							RN	NA	RN	NA	WTE
G5	30 + 3 SR	19.39	25.76	45.15	43:57	Day – 1:8 Night – 1:11	44.52	50.3	60:40	30.2	20.1	10.81	-5.66	5.15

Recommendation: Change in skill mix by increasing 1 x RN LD and reduce by 1 x NA LD
Cost Pressure: £29,049.32

At the time of completing this paper decisions have been made for this ward to relocate to another location, following the completion of the refurbishment of G9. This ward will be part of a three way move and will be moving to a smaller footprint of 27 beds. As this will be a reduction of 6 beds no change to this establishment will be made. The ward, once in its new footprint, will participate in the next round of audit and recommendations will be made in this new environment.

xvii. Ward G8

G8 is a thirty bedded Acute Stroke Unit compromising of twenty-four stroke beds and six general medicine beds. Within the allocated stroke beds there and four hyper acute stroke beds. Staffing requirements for stroke units are informed by the British Association of Stroke Physician (BASP) standards recognising the intensive nursing and patient care required in both the acute phase of a stroke and the subsequent rehabilitation phase. The ward is not currently meeting these recommendations. The ward also provides a stroke outreach service that is a peripatetic role often called to the emergency department and inpatient areas to assess new and developing strokes.

The SNCT data suggests an adjustment of skill mix in favour of RNs. However, applying the national stroke guidance would significantly further increase the WTE. It should be noted that the stroke service is able to perform well in the SNAPP data, maintaining an 'A' rating overall. Areas of improvement have been identified these include care planning and risk assessment, which is a RN role. Given that the ward is providing a grade A stroke service on current numbers directly applying National stoke staff guidance may not be an appropriate response in this round of establishment setting. However, a mediated response to national requirements and the SNCT should be taken.

On review with the clinical team no reduction in NAs has been recommended recognising that the NAs play an important role in additional rehabilitation interventions within this unit. The benefits of a greater staffing skill mix would be multifactorial; promoting an enriched rehab environment, improving functional outcomes and wellbeing and facilitating patient flow through the hospital. NSIs indicate that G8 has the highest number of falls in the organisation which in part is driven by the patient group, however an increase in RNs would further improve patient safety by proactive mitigation of patient risk and care planning. While this uplift would not fully meet the recommendations of the BASP, it is recognising that current provision is below the expectation to maintain a high performing stroke unit.

WARD	Beds	Split WTE		WTE	Current Skills Mix (RN:NA) (%)	Current Ratio RN : Patient	PJ WTE	SNCT (Sept 2020) WTE	Suggested Skills Mix (RN:NA) (%)	Split WTE		Difference		Difference
		RN	NA							RN	NA	RN	NA	WTE
G8	24 + 2 SR + 4 HAS	27.5	20.61	48.11	57:43	Day – 1:5 Night – 1:8	47.14	43.0	70:30	30.1	12.9	2.6	-7.71	-5.11

Recommendation: Increase in 1 RN during day shift and 1 RN during the night. Review NA provision in next round of audit to consider reducing if data is output is consistent

Cost pressure: £217,875.63

xviii. Cardiac Centre

The cardiac centre comprising of seven Coronary Care Unit (CCU) beds, fifteen cardiac inpatient beds and a cardiac catheterisation lab. The CCU has seven beds, (four beds in the bay and three side rooms). These beds are designated to patients with acute cardiac issues, who require high dependency nursing and an increase in nurse to patient ratio. In addition, the ward has the ability to provide remote cardiac monitoring (telemetry) to 16 patients that may be cared for anywhere within WSH.

Due to acute nature of this ward a higher RN/NA ration has been applied (70/30). The SNCT suggests a reduction overall reduction in WTE, in-particular the RNs. To apply a reduction to the nursing WTE would impact the ability for a supervising role that would be able to oversee of each of the areas within the cardiac centre. This role is integral to the coordination of the inpatient beds the catheterisation lab and the activity within. Following a recent adverse event, the unit is reviewing the effectiveness of the current telemetry service and will present a separate business case following this review.

WARD	Beds	Split WTE		WTE	Current Skills Mix (RN:NA) (%)	Current Ratio RN : Patient	PJ WTE	SNCT (Sept 2020) WTE	Suggested Skills Mix (RN:NA) (%)	Split WTE		Difference		Difference
		RN	NA							RN	NA	RN	NA	WTE
Cardiac Suite	15 + 4 CCU + 3 SR	30.84	12.81	43.64	72:28	Day – 1:5 Night – 1:5	39.28	33.0	70:30	22.4	10.56	-8.44	-2.25	-10.68

Recommendation: No changes to current establishment, unit to review safety and efficacy of current telemetry provision.

Cost pressure: none at this time

xix. Kings Suite

The King Suite is twenty bedded re-ablement, assessment unit situated within Glastonbury Court nursing home. The unit has been commissioned by West Suffolk NHS Foundation Trust and the unit has all individual rooms all with en-suite facilities. It is a nurse-led unit coordinating care in close collaboration with Allied Health Professionals (AHPs), that provide rehabilitation services.

It should be noted that the SNCT is intended for acute inpatient beds, advice from the authors of the SNCT is that it can be applied to community beds but consideration should be given to the RN/NA patient ration and the typical 60/40 split will likely provide too many RNs. For the purpose of this a 50/50 RN/NA skill mix has been applied. The output suggests that the current establishment is meeting the needs of the unit. This is complemented when looking at NSI which illustrate low incidences of HAPU for example which is commendable given the patient group.

WARD	Beds	Split WTE		WTE	Current Skills Mix (RN:NA) (%)	Current Ratio RN : Patient	PJ WTE	NHPPD (Sept 2020) WTE	SNCT (Sept 2020) WTE	Suggested Skills Mix (RN:NA) (%)	Split WTE		Difference		Difference
		RN	NA								RN	NA	RN	NA	WTE
Kings Suite	20	11.69	12.64	24.33	48:52	Day – 1:10 Night – 1:10	22.42	24.3	25.4	50/50	12.7	12.7	1.01	0.06	1.07

Recommendation: No change to current establishment
Cost pressure: None

xx. Rosemary Ward

Rosemary Ward is thirty-three bedded unit caring for patients needing re-ablement, sub-acute care, end of life care or discharge planning. It is a nurse led unit with GP's visiting daily and a consultant with overarching responsibility for all the patients. It has a mixture of bays, and single rooms. Currently the ward is using twenty of their potential thirty-three bed capacity. These are community beds and all patients should be medically optimised for discharge.

It should be noted that the SNCT is intended for acute inpatient beds, advice from the authors of the SNCT is that it can be applied to community beds but consideration should be given to the RN/NA ratio and the typical 60/40 split will likely provide an over establishment of RNs. Like Glastonbury Court, for the purpose of this audit, a 50/50 RN/NA skill mix has been applied. The output suggests that the current establishment is meeting the needs of the unit. This is complemented when looking at NSI which illustrate low incidences of HAPU. It should also be noted that a staffing uplift has already been agreed to accommodate the opening of additional beds for winter. So further recommendation is not required at this time

WARD	Beds	Split WTE		WTE	Current Skills Mix (RN:NA) (%)	Current Ratio RN : Patient	PJ WTE	NHPPD (Sept 2020) WTE	SNCT (Sept 2020) WTE	Suggested Skills Mix (RN:NA) (%)	Split WTE		Difference		Difference
		RN	NA								RN	NA	RN	NA	WTE
Rosemary Ward	20	12.43	13.47	25.9	48:52	Day – 1:7 Night – 1:10	26.19	24.35	27.8	50/50	13.9	13.9	1.47	0.43	1.90

Recommendation: No staffing changes and re-audit in January to review acuity and dependency with uplift in bed capacity
Cost pressure: None

SECTION 5 – NATIONAL AND REGIONAL BENCHMARK (CHPPD)

Due to variations in service provision, bench marking staffing data is challenging, however, *Care Hours per Patient Day* (CHPPD) was developed to provide a single, consistent and nationally comparable way of recording and reporting deployment of staff on inpatient wards (NHSE);

- It produces a single comparable figure that represents staffing levels and patient requirements
- It enables wards within a trust, and wards in the same specialty at other trusts, to be compared. As CHPPD is calculated after dividing by the number of patients, the value does not increase due to the size of the ward, enabling comparisons between wards of different sizes
- It offers the ability to differentiate registered nurses and midwives from healthcare support workers for reporting purposes, ensuring skill-mix is well-described and the nurse-to-patient ratio is considered in staff deployment, along with an aggregated overall score

It should be noted that the CHPPD required to deliver safer care can vary in response to local conditions, for example the layout of wards or the dependency and care needs of the patient group it serves. Therefore, higher levels of CHPPD may be completely justifiable and reflect the assessed level of acuity and dependency. While lower levels of CHPPD could identify a patient safety risk, it may also be a reflection on organisational efficiencies or innovative staffing deployment.

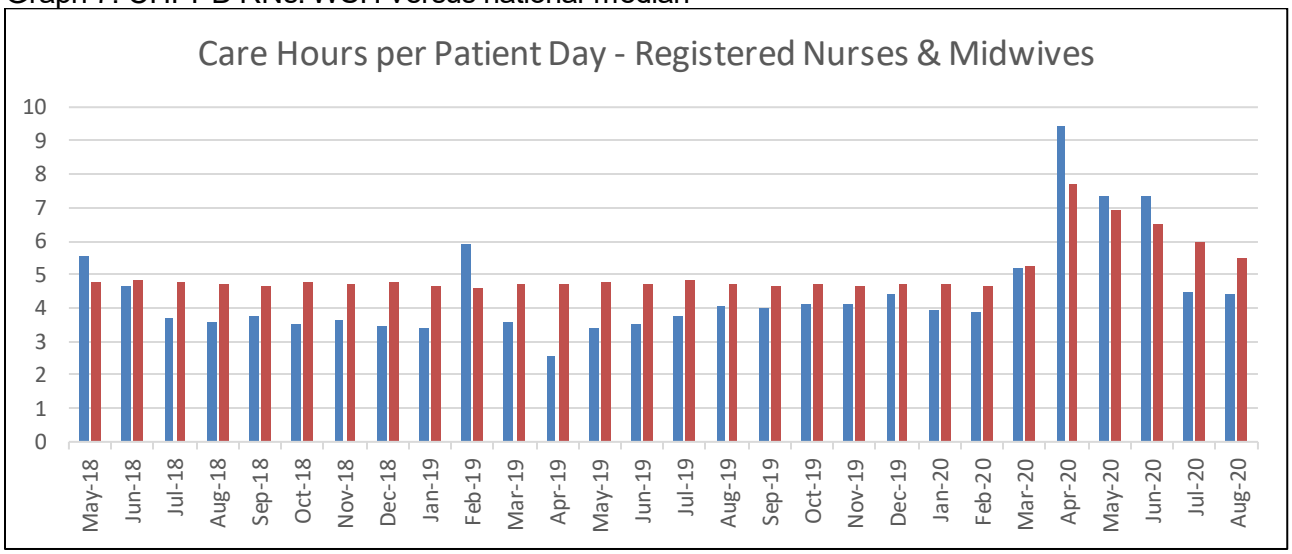
With this in mind CHPPD comparisons were made against the other best buy hospitals that have a very similar ward layout and the results are demonstrated in table 6. For the month of September 2020. WSH illustrates the lowest provision of CHPPD compared with other best buy organisations.

Table 6: CHPPD comparison of best buy Trusts

Best Buy Hospital	CHPPD
Frimley Park (London)	10
James Paget (Gt Yarmouth)	8.7
Queen Elisabeth (Kings Lynn)	8.4
Hinchingbrooke (Cambridgeshire)	8.2
Princess Alexandra (Harlow)	8.0
West Suffolk (Bury St Edmunds)	7.9

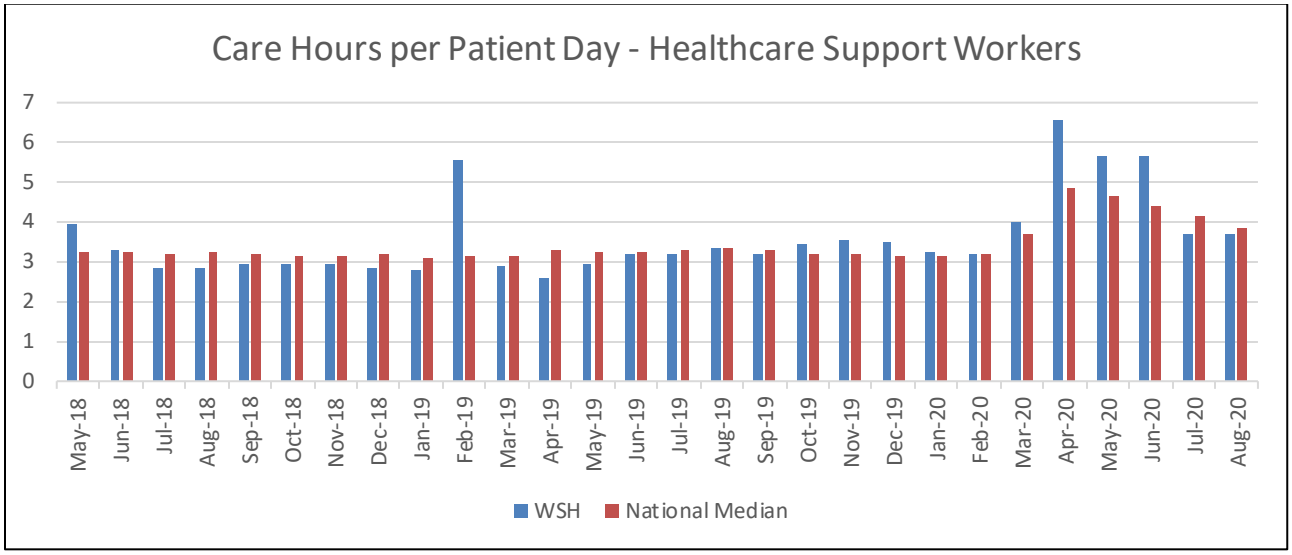
Observed limitations of the model hospital data is that currently it only demonstrates single months. To better understand comparisons over time, the data was reviewed with the assistance of a WSH financial analysist to extrapolate CHPPD data, to provide comparisons with WSH and the national median over a continuous period of time (graph 7). The data demonstrates that WSH consistently provides care hours by RNs below the national median There is an anomaly in Feb 19, and a significant rise in CHPPD at April 2020, this will be driven by low bed occupancy during the first wave of Covid 19, where it is understood that WSH was less affected than many other organisations nationally, resulting in a period of low bed occupancy.

Graph 7. CHPPD RNs: WSH versus national median



On review of NA (healthcare support workers) the CHPPD, in 2018/19 CHPPD was below national median and is either equal to or above national median from October 2019 (graph 8).

Chart 8. CHPPD NAs: WSH versus national median



SECTION 6 – SUMMARY OF RECOMMENDATIONS

This review has provided a recommendation for all of the twenty areas that have been reviewed. The recommendations a briefly summarised in the table below in table 8.

Table 8.

Directorate	**No change to establishment**	**Skill mix adjustment**	**Increase in WTE**	**Decrease in WTE**	Areas reviewed
Medicine	6	4	2	0	12
Surgery	2	0	2	0	4
Community	2	0	0	0	2
W & C	1	0	1	0	2
Total	**11**	**4**	**5**	**0**	20

55% of the wards reviewed have not had any recommendations to change the current establishment. 25% wards reviewed have recommended an uplift and the remaining 20% have adjusted their skill mix.

SECTION 7– FINANCIAL IMPLICATIONS

Costing related to changes in skill mix and uplift have assumed 20% head room, Band 5 RNs and Band 2 NAs (unless specified to be a B4 nursing associate). Unsocial hours have also been calculated if adjustments include night shift and weekend working. A full breakdown of costings can be found by division in appendix H. Table 9 illustrates the overall net cost pressure by division.

Table 9. Divisional recommendations and associated cost

Directorate	Net cost pressure
Medicine	£420,284
Surgery	£211,552
Community	£0
W & C	£24,100
Total	**£655,936**

The total cost from the recommendations within this review is £655,936.

- This is primarily driven by the medical directorate where the biggest increase is in RNs due to the adjustment of the skill mix in many of the wards in favour of the RNs. However, the reduction in NAs offsets this cost to some degree.
- The biggest single cost pressure is related to the stroke ward where this is no reduction in NAs despite an increase in RNs. This is a mediated response between the SNCT and the recommendations of the BASP.
- The implications within surgery is driven by increasing WTE at night on two wards
- The cost within the women's and children directorate is a driven by increasing NA cover from three days a week to seven.

Staffing establishments are required to be both safe and sustainable and it is recognised that the total recommendation is a significant but necessary investment in nursing. The paper proposes the following options for recommendations with an applied 5x5 risk rating approach to patient safety.

Option 1: Invest the full amount of the recommendations addressing all the perceived risk, in a phased approach over next financial year Risk rating: 6: Increasing nursing spend additional challenge to financial sustainability **Cost: £655,936**
Option 2: Invest in priority areas where biggest risk is perceived by both professional judgement and audit outcome data (namely the four skill mix change wards within medicine and F6). All other areas to be reviewed in next round and to assess trends in the SNCT data Risk rating 12: Areas identified that have recommendations to change WTE may not see improvement to risk and adverse events; **Cost: £231,196**
Option 3. Acknowledge the recommendation but make no changes to the current establishment. Risk rating: 16 • Increased turnover of nursing staff due to ward pressures • Continued increase in adverse patient safety incidences • Unable to deliver quality and safety agenda due to persistent nurse staffing challenge

SECTION 8– CONCLUSION

This review has looked solely at ward staffing levels and has brought together information from a number of sources. The principles of this review have been consistent with the recommendations of the NQB and the expectations of the developing workforce safeguards document (NHSI, 2018).

Many of the wards involved in this audit have nursing establishments that are meeting the needs of their patient group and service provision, this is informed by the SNCT and the professional judgement of staff working within these environments.

A theme within this review is that many wards had skill mixes that are not consistent with best practice expectations. Anecdotally this skill mix in favour of NAs has not been perceived as favourable by the clinical teams, particularly with introducing innovations that have improved safety but decreased perceived efficiency of the RN team (ePrescribing for example). The move towards 'bay-based nursing' introduced in recent years does not appear to have had a sustained improvement in NSIs as demonstrated by HAPU and Falls data. Evidence would suggest that adjusting the skill mix in many medical areas would potentially improve NSI and reduce patient harms within our organisation.

Although only two surgical wards require an uplift, the cost is reasonably high. Uplifts within these two acute surgical areas are recommended at night in recognition of the acute phase of surgery and patients that are less than 24 hours post operation. Current staffing is considerably light considering the size of the wards. The surgical teams however highlighted the skills that non-traditional roles like that of a band 4 nursing associate will both benefit patient care but also not carry a RN premium.

Additional benefits of increasing RNs within the skill mix is that it would provide the opportunity for ward managers who are funded as supernumery, to provide increase levels of supervision, innovation, quality improvement and staff support. Currently the ward managers are supporting staffing shortfalls clinically and are unable to consistently provide the leadership and quality improvement that the supernumery status is intended to provide. Improving the ability of the ward managers to be truly supervisory would complement the ward accreditation program that is planned to launch in 2021.

Nest Steps:

- The board are asked to consider the recommendations within this paper and be assured that the assessments made here are in line with best practice expectations and robust establishment reviews practices.
- The board is requested to recognise and authorise the recommendations and options within this paper and consider the investment of up to £655,936 into nurse staffing
- This process will inform a biannual establishment review process ensuring robust oversight and governance of nurse establishment reviews. The next round of audit is anticipated to commence in January 2020, to begin a rhythm of winter and summer reviews accounting for season variations. Further outputs of this audit are unlikely to require this level of investment following the adjustment of skill mixes that have been recommended in this review.

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APPENDIX A: SNCT acuity and dependency indicators and multipliers

Illustration of the patient discriminators and multipliers used in data collection of the SNCT audit.

Level 0 (Multiplier =0.99*) Patient requires hospitalisation Needs met by provision of normal ward cares.	**Care requirements may include the following** • Elective medical or surgical admission • May have underlying medical condition requiring on-going treatment • Patients awaiting discharge • Post-operative/post-procedure care - observations recorded half hourly initially then 4-hourly • Regular observations 2 - 4 hourly • **Early Warning Score** is within normal threshold. • ECG monitoring • Fluid management • Oxygen therapy less than 35% • Patient controlled analgesia • Nerve block • Single chest drain • Confused patients not at risk • Patients requiring assistance with some activities of daily living, require the assistance of one person to mobilise, or experiences occasional incontinence
Level 1a (Multiplier =1.39*) Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.	**Care requirements may include the following** • Increased level of observations and therapeutic interventions • **Early Warning Score** - trigger point reached and requiring escalation. • Post-operative care following complex surgery • Emergency admissions requiring immediate therapeutic intervention. • Instability requiring continual observation/invasive monitoring • Oxygen therapy greater than 35% +/- chest physiotherapy 2-6 hourly • Arterial blood gas analysis - intermittent • Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest or extra ventricular drains • Severe infection or sepsis

Levels of Care	Descriptor
Level 1b (Multiplier = 1.72*) Patients who are in a STABLE condition but are dependant on nursing care to meet most or all of the activities of daily living.	**Care requirements may include the following** • Complex wound management requiring more than one nurse or takes more than one hour to complete. • VAC therapy where ward-based nurses undertake the treatment • Patients with Spinal Instability / Spinal Cord Injury • Mobility or repositioning difficulties requiring the assistance of two people • Complex Intravenous Drug Regimes - (including those requiring prolonged preparatory / administration / post-administration care) • Patient and / or carers requiring enhanced psychological support owing to poor disease prognosis or clinical outcome • Patients on End of Life Care Pathway • Confused patients who are at risk or requiring constant supervision • Requires assistance with most or all activities of daily living • Potential for self-harm and requires constant observation • Facilitating a complex discharge where this is the responsibility of the ward-based nurse
Level 2 (Multiplier = 1.97*) May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility / unit	• Deteriorating / compromised single organ system • Post operative optimisation (pre-op invasive monitoring) / extended post-op care. • Patients requiring non-invasive ventilation / respiratory support; CPAP / BiPAP in acute respiratory failure • First 24 hours following tracheostomy insertion • Requires a range of therapeutic interventions including: • Greater than 50% oxygen continuously • Continuous cardiac monitoring and invasive pressure monitoring • Drug Infusions requiring more intensive monitoring e.g. vasoactive drugs (amiodarone, inotropes, gtn) or potassium, magnesium • Pain management - intrathecal analgesia • CNS depression of airway **and** protective reflexes • Invasive neurological monitoring
Level 3 (Multiplier = 5.96*) Patients needing advanced respiratory support and / or therapeutic support of multiple organs.	• Monitoring and supportive therapy for compromised / collapse of two or more organ / systems • Respiratory or CNS depression / compromise requires mechanical / invasive ventilation • Invasive monitoring, vasoactive drugs, treatment of hypovolaemia / haemorrhage / sepsis or neuro protection

APPENDIX B: SNCT audit process and quality control

1. Nominate somebody to quality control the data collection. This may be a Practice Facilitator, a member of your Critical Care Outreach Team or a senior member of the corporate nursing team. *The Matron team were responsible for quality assuring data collection and where paired with wards which they were not directly responsible to reduce confirmation bias*

2. Identify no more than three leaders per ward to complete the scoring daily for the duration of the data collection period. *Achieved*

3. The three leaders should include the Sisters / Charge Nurses. If no Sister / Charge Nurse is available, a nominated member of staff should be agreed with the Senior Nurse for the Directorate. *Achieved*

4. The data collection should take place at least twice per year in January and June. *Data collection was collated in September in recognition that there had not been a review for a significant amount time*

5. Data should be recorded on every patient from Monday until Friday for a total of 20 days as a minimum. *Achieved*

6. Acuity and dependency data should be collected for each patient in each bed at 1500hrs, as part of a bed to bed ward round review. *Achieved*

7. Where paper-based data collection is utilised, data collection forms should be stored in a folder on the ward / unit to await collection / input to the electronic system. *Achieved and was coordinated by the corporate nursing admin team*

8. Patient flow data should be collected for the 24-hour period leading to the data collection time; e.g., all admissions / discharges between 1500hrs that day and 1500hrs the previous day. *Achieved*

9. Nurse Sensitive Indicator data can be collected retrospectively by a senior nurse or directly pulled from the electronic incident reporting system. *Achieved and used in the outcome meetings to provide narrative and inform recommendations*

10. Data sheets should be collected weekly from participating wards / departments where central data entry management systems are in place. Achieved as per point 7.

11. Data should be entered onto the database as speedily as possible after collection or where this is completed electronically follow your local policy based on these principles. Achieved as per point 7.

12. Feedback results to Sisters and Charge Nurses, Matrons, Directors of Nursing and operational management teams as soon as possible. *Achieved*

APPENDIX C: SNCT output compared with current skill mix and professional judgement calculations

WARD	Beds	Split WTE		WTE	Current Skills Mix (RN:NA) (%)	Current Ratio RN : Patient	PJ WTE	SNCT (Sept 2020) WTE	Suggested Skills Mix (RN:NA) (%)	Split WTE		Difference		Difference WTE	Suggested Ratio RN : Patient
		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	40.1	70:30	28.1	12	5.68	-11.19	-5.51	Day – 1:3.4 Night – 1:6.1
F1	15	14.73	7.17	21.9	74:26	Day – 1:8 Night – 1:8	23.57	15.9	70:30	11.1	4.8	-3.63	-2.37	-6.00	Day – 1:2.2 Night – 1:13
F3	30 + 4 SR	22.15	25.84	47.99	46:54	Day – 1:8 Night – 1:11	41.9	46.4	60:40	27.8	18.6	5.65	-7.24	-1.59	Day – 1:5.3 Night – 1:8.6
F4	30 + 3 SR	15.76	12.92	28.68	55:45	Day – 1:9 Night – 1:11	34.04	10.3	60:40	6.2	4.1	-9.56	-8.82	-18.38	Day – 1:3.4 Night – 1:x
F5	30 + 3 SR	22.16	12.93	35.09	63:37	Day – 1:8 Night – 1:11	34.04	33.7	60:40	20.2	13.5	-1.96	0.57	-1.39	Day – 1:6.2 Night – 1:12.4
F6	30 + 3 SR	23.99	14.77	38.76	62:38	Day – 1:8 Night – 1:11	34.04	39.9	70:30	27.9	12	3.91	-2.77	1.14	Day – 1:4.9 Night – 1:8.8

F7	30 + 4 SR	22.33	28.34	50.67	44:56	Day – 1:7 Night – 1:7	52.38	24.2	60:40	14.5	9.7	-7.83	-18.64	-26.47	Day – 1:4.5 Night – 1:12.1
F8	24 + 3 SR	23.68	18.03	41.71	57:43	Day – 1:6 Night – 1:6	39.28	33.0	60:40	19.8	13.2	-3.88	-4.83	-8.71	Day – 1:5.5 Night – 1:11.1
F9	30 + 3 SR	19.33	25.76	45.09	43:57	Day – 1:8 Night – 1:11	44.52	42.3	60:40	25.4	16.9	6.07	-8.86	-2.79	Day – 1:5.5 Night – 1:9.5
F10	23 + 3 SR	19.23	18.03	37.26	63:37	Day – 1:6 Night – 1:8	36.66	33.7	60:40	20.2	13.5	0.97	-4.53	-3.56	Day – 1:5.3 Night – 1:10.5
F12	8 SR	10.23	5.85	16.08	64:36	Day – 1:4 Night – 1:4	15.71	10.2	65:35	6.6	3.6	-3.63	-2.25	-5.88	Day – 1:3 Night – 1:x
F14	4 bb + 2 bb + 2 SR	12.6	1.2	13.8	91:09	Day – 1:4 Night – 1:4	15.71	5.7	90:10	5.1	0.6	-7.5	-0.6	-8.10	Day – 1:2.9 Night – 1:x
G1	11 SR	17.36	5.97	23.33	72:28	Day – 1:4 Night – 1:6	20.95	13.0	70:30	9.1	3.9	-8.26	-2.07	-10.33	Day – 1:3.5 Night – 1:x
G3	30 + 3 SR	19.51	25.56	45.07	43:57	Day – 1:8 Night – 1:11	44.52	35.8	60:40	27.5	8.3	7.99	-17.26	-9.27	Day – 1:5.3 Night – 1:8.6
G4	30 + 2 SR	19.51	25.36	44.87	43:57	Day – 1:8	44.52	43.9	60:40	26.3	17.6	6.79	-7.76	-0.97	Day – 1:5.1

						Night – 1:11									Night – 1:8.6
G5	30 + 3 SR	19.39	25.76	45.15	43:57	Day – 1:8 Night – 1:11	44.52	50.3	60:40	30.2	20.1	10.81	-5.66	5.15	Day – 1:4.9 Night – 1:7.7
G8	24 + 2 SR + 4 HAS	27.5	20.61	48.11	57:43	Day – 1:5 Night – 1:8	47.14	43.0	70:30	30.1	12.9	2.6	-7.71	-5.11	Day – 1:4.1 Night – 1:6.9
Cardiac Suite	15 + 4 CCU + 3 SR	30.84	12.81	43.64	72:28	Day – 1:5 Night – 1:5	39.28	33.0	70:30	22.4	10.56	-8.44	-2.25	-10.68	Day – 1:4.4 Night – 1:9.1
Kings Suite	20	11.69	12.64	24.33	48:52	Day – 1:10 Night – 1:10	22.42	25.4	60:40	15.2	10.2	3.51	-2.44	1.07	Day – 1:4.9 Night – 1:12.6
Rosemary Ward	20	12.43	13.47	25.9	48:52	Day – 1:7 Night – 1:10	26.19	27.8	60:40	16.6	11.2	4.17	-2.27	1.90	Day – 1:4.4 Night – 1:10.4

APPENDIX D: Nurse Sensitive Indicators

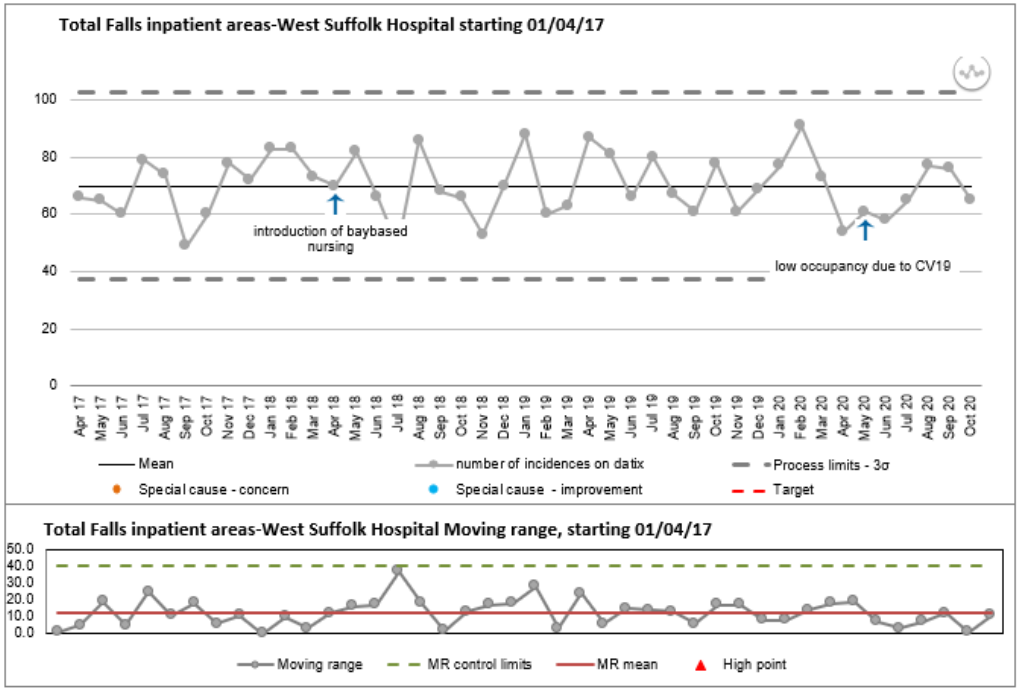
Data has been taken from the Datix system. Data included here is only the inpatient areas that have participated in this review. Areas such as clinics, outpatients and community teams have been removed to illustate the inpatient of staffing chanages within the inpatient area

Falls April 2017 – October 2020

Statistical Process Control (XmR) tool

Chart title	Total Falls inpatient areas		Target		
Team/unit name	West Suffolk Hospital		Maximum number	110.0	
Your measure	number of incidences on datix		Start date	01/04/17	please select date <= 28th
What does improvement look like?	Low is good		Planned duration (days, weeks, months)	12/02/00	Months
			Set baseline (choose baseline period 12 - 20*)		Months

Date	number of incidences	Date	number of incidences	Date	number of incidences	Date	number of incidences
Apr 17	66.0	Aug 19	67.0				
May 17	65.0	Sep 19	61.0				
Jun 17	60.0	Oct 19	78.0				
Jul 17	79.0	Nov 19	61.0				
Aug 17	74.0	Dec 19	69.0				
Sep 17	49.0	Jan 20	77.0				
Oct 17	60.0	Feb 20	91.0				
Nov 17	78.0	Mar 20	73.0				
Dec 17	72.0	Apr 20	54.0				
Jan 18	83.0	May 20	61.0				
Feb 18	83.0	Jun 20	58.0				
Mar 18	73.0	Jul 20	65.0				
Apr 18	70.0	Aug 20	77.0				
May 18	82.0	Sep 20	76.0				
Jun 18	66.0	Oct 20	65.0				
Jul 18	49.0						
Aug 18	86.0						
Sep 18	68.0						
Oct 18	66.0						
Nov 18	53.0						
Dec 18	70.0						
Jan 19	88.0						
Feb 19	60.0						
Mar 19	63.0						
Apr 19	87.0						
May 19	81.0						
Jun 19	66.0						
Jul 19	80.0						



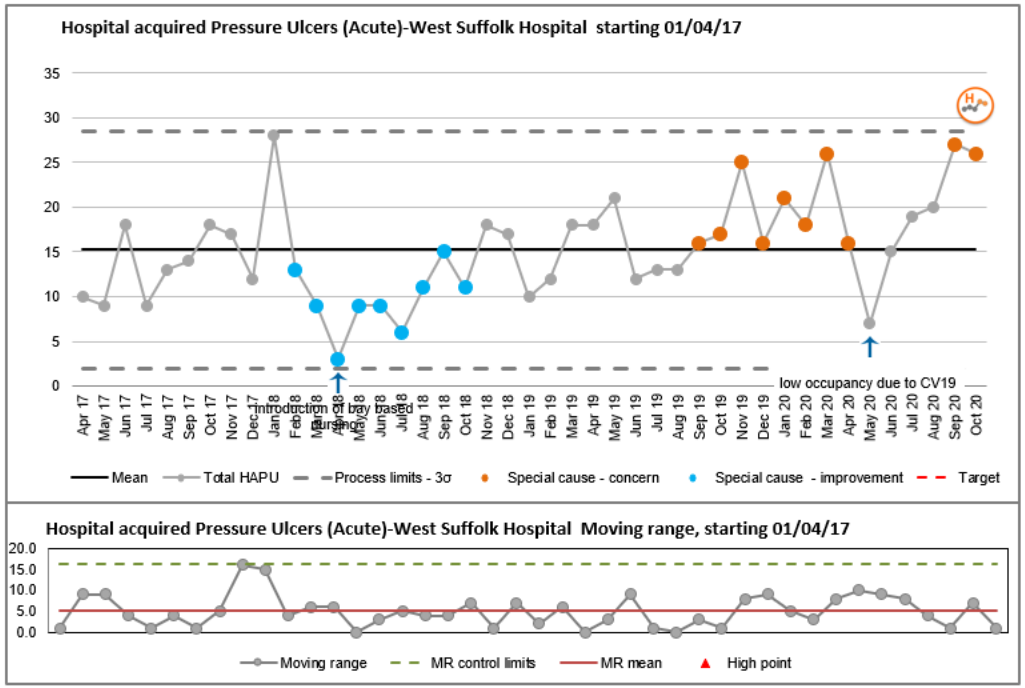
There is no observed decline or improvement in incidences of falls using this SPC. These erratic incidences indicate no control either way.

Hospital Acquired Pressure Ulcers (all categories) April 2017- October 2020

Statistical Process Control (XmR) tool

Chart title	Hospital acquired Pressure Ulcers (Acute)	Target			
Team/unit name	West Suffolk Hospital	Maximum number	35.0		
Your measure	Total HAPU	Start date	01/04/17	please select date <= 28th	
What does improvement look like?	Low is good	Planned duration (days, weeks, months)	12/02/00	Months	Set baseline (choose baseline period 12 - 20*) Months

Date	Total HAPU	Date	Total HAPU	Date	Total HAPU	Date	Total HAPU
Apr 17	10.0	Aug 19	13.0				
May 17	9.0	Sep 19	16.0				
Jun 17	18.0	Oct 19	17.0				
Jul 17	9.0	Nov 19	25.0				
Aug 17	13.0	Dec 19	16.0				
Sep 17	14.0	Jan 20	21.0				
Oct 17	18.0	Feb 20	18.0				
Nov 17	17.0	Mar 20	26.0				
Dec 17	12.0	Apr 20	16.0				
Jan 18	28.0	May 20	7.0				
Feb 18	13.0	Jun 20	15.0				
Mar 18	9.0	Jul 20	19.0				
Apr 18	3.0	Aug 20	20.0				
May 18	9.0	Sep 20	27.0				
Jun 18	9.0	Oct 20	26.0				
Jul 18	6.0						
Aug 18	11.0						
Sep 18	15.0						
Oct 18	11.0						
Nov 18	18.0						
Dec 18	17.0						
Jan 19	10.0						
Feb 19	12.0						
Mar 19	18.0						
Apr 19	18.0						
May 19	21.0						
Jun 19	12.0						
Jul 19	13.0						



While there is a recognised improvement from February 2018, due to high incidences in previous months, from April 2018 there has been a steady increase in HAPU. The orange points indicate sustained cause for concern which begin at September 2019. Following a reduction in incidences in April and May 2020 (driven by low bed occupancy) the total number of incidents are now above pre covid levels.

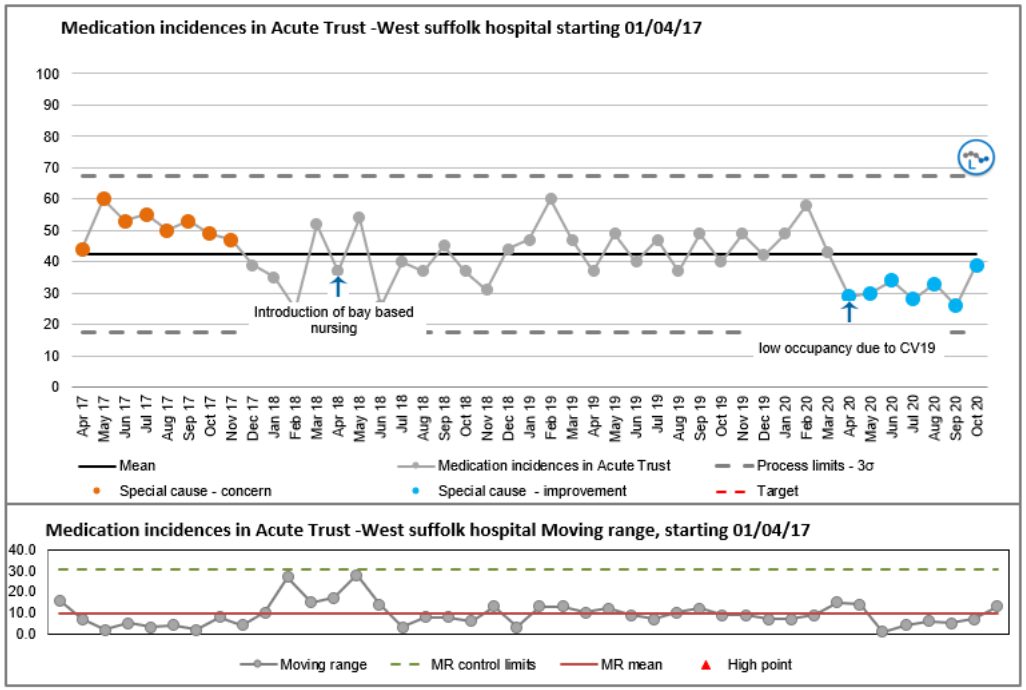
Medication incidences April 2017-October 2020

Medication incidences refers to all incidences relating to medications, this can include prescription and preparation errors therefore cannot be wholly attributed to nursing involvement.

Statistical Process Control (XmR) tool

Chart title	Medication incidences in Acute Trust	Target			
Team/unit name	West suffolk hospital	Maximum number	100.0		
Your measure	Medication incidences in Acute Trust	Start date	01/04/17	please select date <= 28th	
What does improvement look like?	Low is good	Planned duration (days, weeks, months)	43	Months	Set baseline (choose baseline period 12 - 20*) Months

Date	Medication incidences in	Date	Medication incidences in	Date	Medication incidences in	Date	Medication incidences in
Apr 17	44.0	Aug 19	37.0				
May 17	60.0	Sep 19	49.0				
Jun 17	53.0	Oct 19	40.0				
Jul 17	55.0	Nov 19	49.0				
Aug 17	50.0	Dec 19	42.0				
Sep 17	53.0	Jan 20	49.0				
Oct 17	49.0	Feb 20	58.0				
Nov 17	47.0	Mar 20	43.0				
Dec 17	39.0	Apr 20	29.0				
Jan 18	35.0	May 20	30.0				
Feb 18	25.0	Jun 20	34.0				
Mar 18	52.0	Jul 20	28.0				
Apr 18	37.0	Aug 20	33.0				
May 18	54.0	Sep 20	26.0				
Jun 18	26.0	Oct 20	39.0				
Jul 18	40.0						
Aug 18	37.0						
Sep 18	45.0						
Oct 18	37.0						
Nov 18	31.0						
Dec 18	44.0						
Jan 19	47.0						
Feb 19	60.0						
Mar 19	47.0						
Apr 19	37.0						
May 19	49.0						
Jun 19	40.0						
Jul 19	47.0						



Again, this SPC indicates that there has been no sustained improvement in medication incidences prior to the arrival of Covid 19. Since May 2020 there have been an improvement trend (blue points), potentially driven by low bed occupancy as no significant change in practice has occurred at this point

APPENDIX E: Professional Judgement model/calculation

This model demonstrates the calculation of WTE from roster models a traditional and commonly used method of establishment setting

Example Professional Judgement (PJ) Staffing Formula
Step 1. Calculate the number of working hours needed:

Day shift: 0700 to 1930 = 11.5 hrs. x 3 nursing staff x 7 days = 241.5 hrs. (excludes breaks)
Night shift: 1900 to 0730 = 11.5 hrs. x 3 nursing staff x 7 days = 241.5 hrs. (excludes breaks)
Total = 483 hrs.

However, these hours assume that nurses are never sick or don't take holidays, etc. A 'timeout' adjustment to cover paid, unpaid, sick and study leave, therefore, is necessary. The 22% allowance used in the formula below was obtained from a 'time-out' study of 300+ general wards in the UK. However, if you wish then you can substitute a local figure (probably obtainable from your personnel department).

Step 2. Adding the time-out allowance.

483 hrs. x 1.22 (time-out) = 589.26hrs/37.5hrs (1 WTE) = 15.7 WTE's

SNCT Calculation

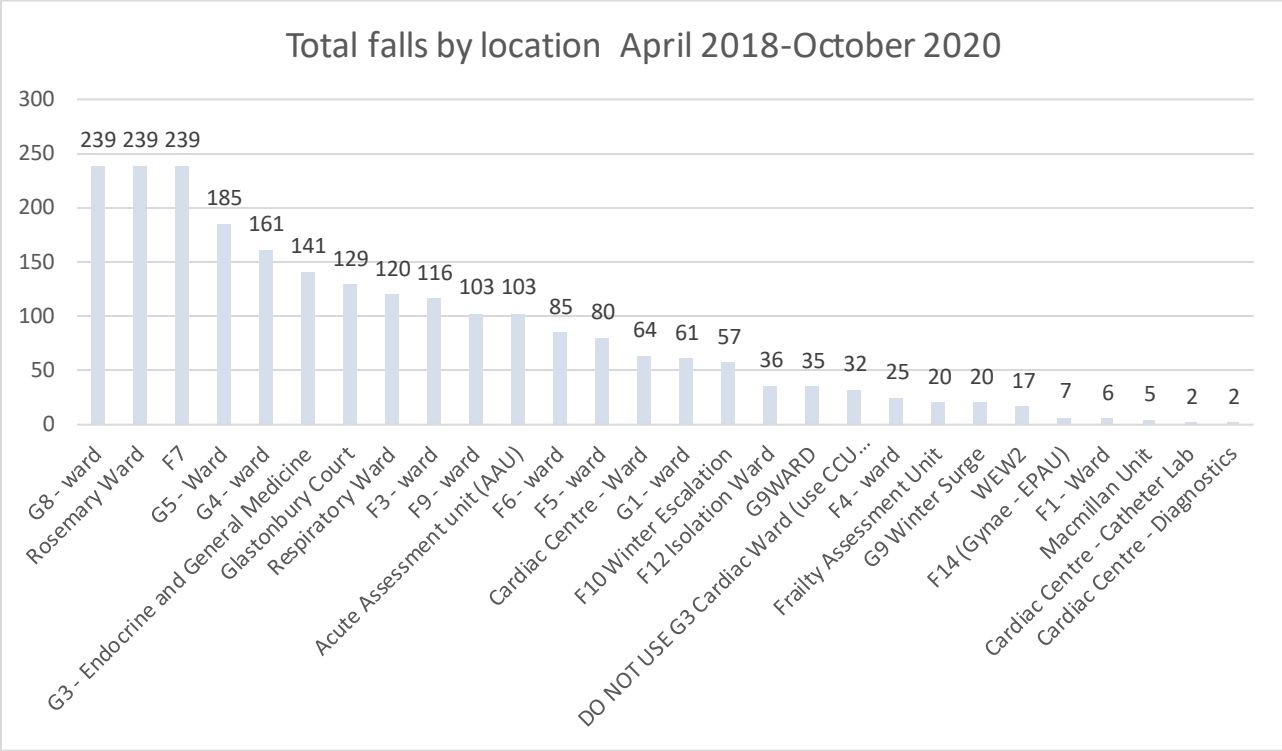
(SNCT Level 0) x 0.99	(SNCT Level 1a) x 1.39	(SNCT Level 1b) x 1.72	(SNCT Level 2) X 1.97

NHPPD Calculation

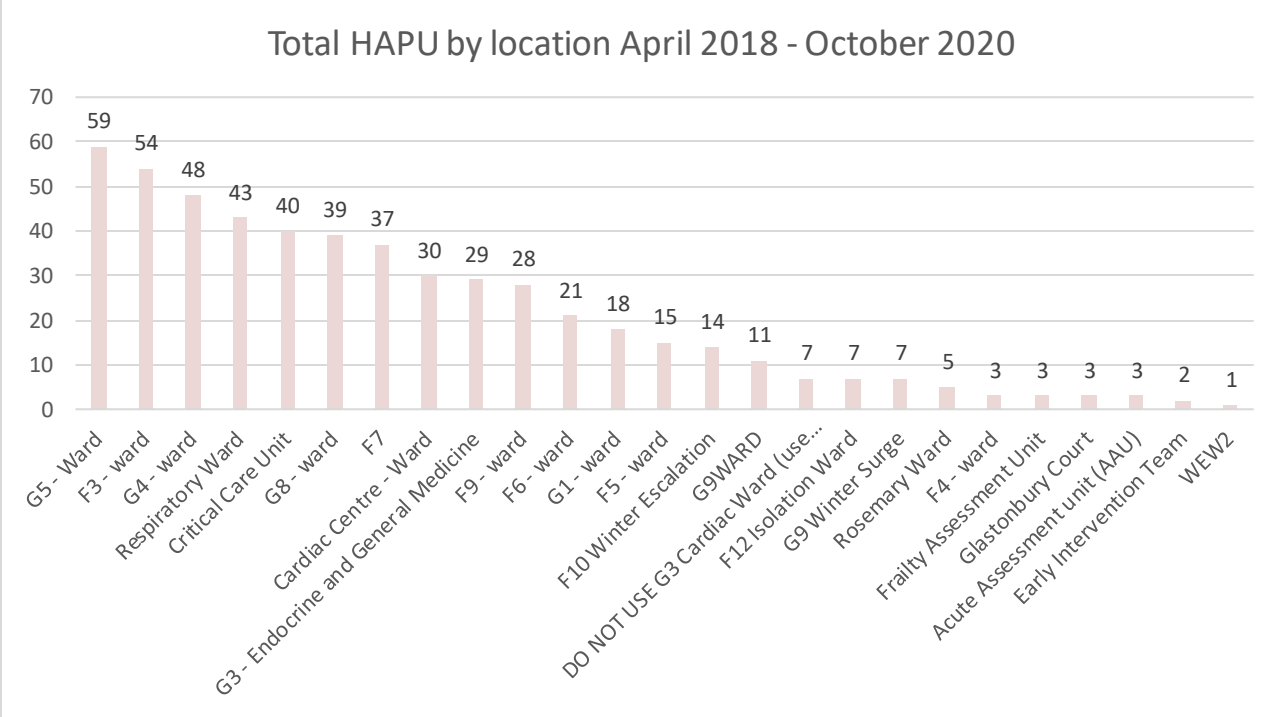
(NHPPD Cat D) x 5.00 (alongside rest of calc.)	(NHPPD Cat C) x 5.75 (alongside rest of calc.)	(NHPPD Cat B) x 6.00 (alongside rest of calc.)	(NHPPD Cat A) X 7.50 (alongside rest of calc.)

APPENDIX F Ward by ward detail of Nursing Sensitive indicators

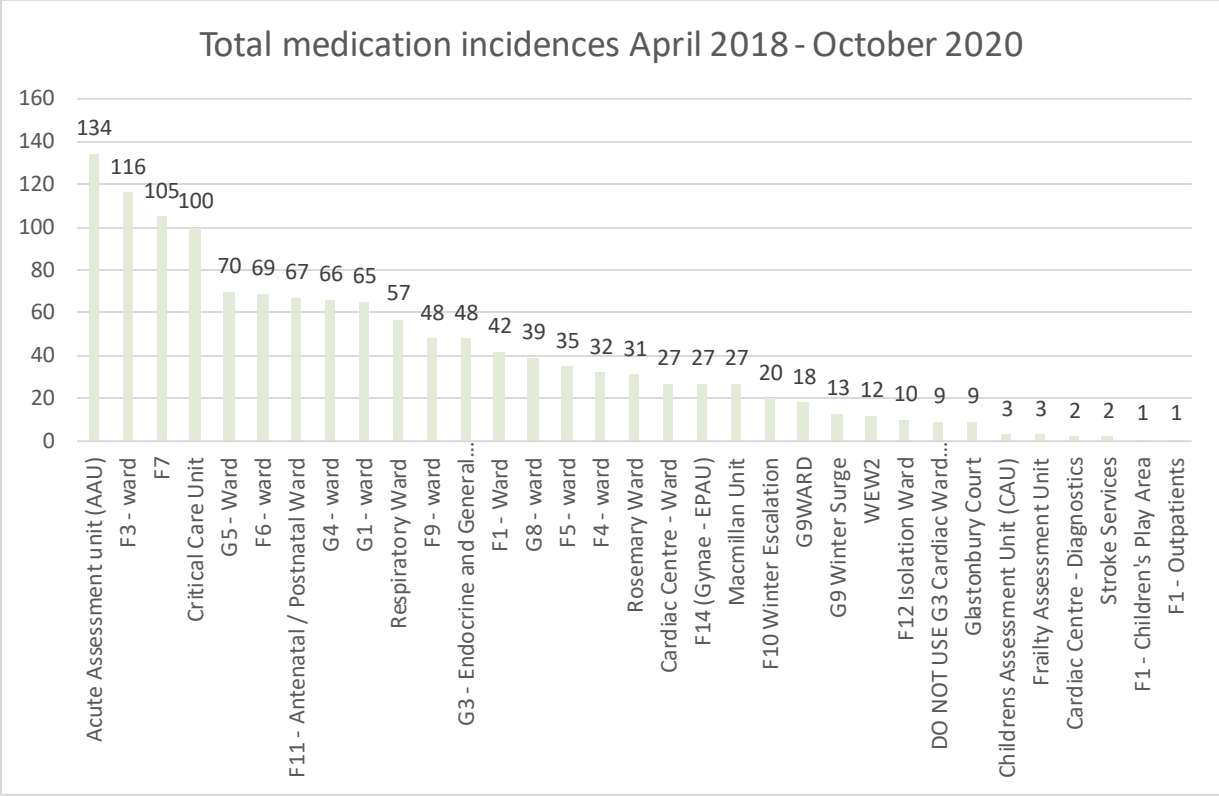
Falls



HAPU



Medication incidences



APPENDIX H: Financial Costings

Directorate: All areas							
Propsed change to establishment							
WARD	Increase (Description)	Increase (WTE)	Increase (£)	Decrease (Description)	Decrease (WTE)	Decrease (£)	Net Change (£)
F7	1 x B5 RN per LD	2.58	101,304.41	1 x HCSW per LD	(2.58)	(72,255.09)	29,049.32
F8	Not required	-	-	Not required	-	-	-
F9	1 x B5 RN per LD	2.58	101,304.41	1 x HCSW per LD	(2.58)	(72,255.09)	29,049.32
F10	1 x HCSW at night	2.58	86,477.34	Not required	-	-	86,477.34
F12	Not required	-	-	Not required	-	-	-
G1	Not required	-	-	Not required	-	-	-
G3	1 x B5 RN per LD	2.58	101,304.41	1 x HCSW per LD	(2.58)	(72,255.09)	29,049.32
G4	1 x B5 RN per LD	2.58	101,304.41	1 x HCSW per LD	(2.58)	(72,255.09)	29,049.32
G5	1 x B5 RN per LD	2.58	101,304.41	1 x HCSW per LD	(2.58)	(72,255.09)	29,049.32
G8	1 x B5 per LD and 1 x B5 at night	5.16	217,875.63	Not required	-	-	217,875.63
G7	Not required	-	-	Not required	-	-	-
F3	Not required	-	-	Not required	-	-	-
F4	Not required	-	-	Not required	-	-	-
F5	1 x B4 at night	2.58	96,552.61	Not required	-	-	96,552.61
F6	1 x RN B5 at night	2.58	114,999.06	Not required	-	-	114,999.06
F14	Increase HCSW to 7 days a week	1.24	39,500.00	Not required	-	-	39,500.00
Glas	Not required			Not required	-	-	-
Rose	Not required			Not required			-
TOTALs		27.04	1,061,926.68		(12.90)	(361,275.44)	700,651.24

Assumptions

All WTE include 20% headroom to cover for sickness/ annual leave/ training unless specifically stated

All monetary impacts calculated using AfC 20/21 rates at midpoint of band

All RN assumed to be B5

All HCSW assumed to be B2

All "Long Day" shifts assumed to be 7:00 - 19:30 with 1hr break

All "Night" shifts assumed to be "Long Night" shifts 19:00 - 07:30 with 1hr break

All "Day" WTE costed using enhanced day rate uplift of 121% for B2, 115% for B5 (costings separately available)

All "Night" WTE costed using enhanced day rate uplift of 145% for B2, 133% for B5 (costings separately available)

Enhanced rates

Band	Day	Night
2	121%	145%
5	115%	133%

15.5. Nursing staffing report

For Approval

Trust Board – January 2021

Agenda item:	15.5			
Presented by:	Susan Wilkinson, Executive Chief Nurse			
Prepared by:	Daniel Spooner Deputy Chief Nurse			
Date prepared:	November 2020			
Subject:	Quality and Workforce Report & Dashboard – Nursing November/December			
Purpose:	X	For information		For approval

Executive summary:

This paper reports on safe staffing fill rates and mitigations for inpatient areas for November and December 2020. 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 on to review vacancy rates, nurse sensitive outcomes, and recruitment initiatives.

Highlights

- Nursing fill rates have fallen below 90% in December across many areas
- Sickness and isolation rates increased in both staff groups over this period
- Vacancy rate has remained static in December
- Additional staffing mitigation mobilised in December

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 November and December'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 November and December 2020.

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 November and December within the data submission deadline. Table 1 shows the summary of overall fill rate percentages for these months and for comparison the previous two months.

	Day		Night	
	Registered	Care Staff	Registered	Care staff
Average fill rate for September 2020	99%	89%	96%	107%
Average fill rate for October 2020	100%	93%	97%	109%
Average fill rate for November 2020	101%	97%	99%	110%
Average fill rate for December 2020	94%	84%	94%	98%

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

Although Trust fill rate has on the whole maintained >90%, 46% of our reported wards have fallen below 90% for RN day shifts in December. A full list of ward by ward fill rates can be found in appendix 1a and 1b. This is driven by sickness, staff isolation and a reduction in temporary staff fill, which is often observed over the festive period. The matron of the day (MOD) mitigates short notice staffing shortfalls and the Trust has mobilised additional staff to support inpatient areas during December and January. At times this has not completely mitigated all risk. In incidences such as these, Datixs have been completed to represent the pressures at Trust level. As a result of continued pressures throughout the festive period, nurse staffing is in the process of being placed on the Trust risk register.

3. Care Hours per Patient Day (CHPPD)

CHPPD is a measure of workforce deployment and is reportable to NHS Digital as part of the monthly returns for safe staffing (Appendix 1)

CHPPD is the total number of hours worked on the roster by both Registered Nurses & Midwives and Nursing Support Staff divided by the total number of patients on the ward at 23:59 aggregated for the month (lower CHPPD equates to lower staffing numbers available to provide clinical care).

Benchmarking CHPPD with other organisations is difficult as patient mix, establishments and ward environments all contribute the outcome. Ward by ward CHPPD can be found in appendix 1. By itself, CHPPD does not reflect the total amount of care provided on a ward nor does it directly show whether care is safe, effective or responsive. It should therefore be considered alongside measures of quality and safety (NHSI, 2020).

4. Sickness

Sickness levels for Nursing/Midwifery and support staff were impacted in the initial months of Covid 19, both April and May saw an increase in absences in both nursing and support staff, these are demonstrated in chart 2. In December the Trust begun to see an increase in admission of Covid 19 positive patients and also an increase in community prevalence of Covid 19 infections within Suffolk. The impact on staff sickness and staff requiring to self-isolate began to rise in December and this is demonstrated in chart 2 and chart 3. Incidence of sickness amongst NAs in December is comparable to April in the height of the first wave of Covid 19. These challenges have continued in to January 2021 and it is expected that these figures will have risen in next month's report.

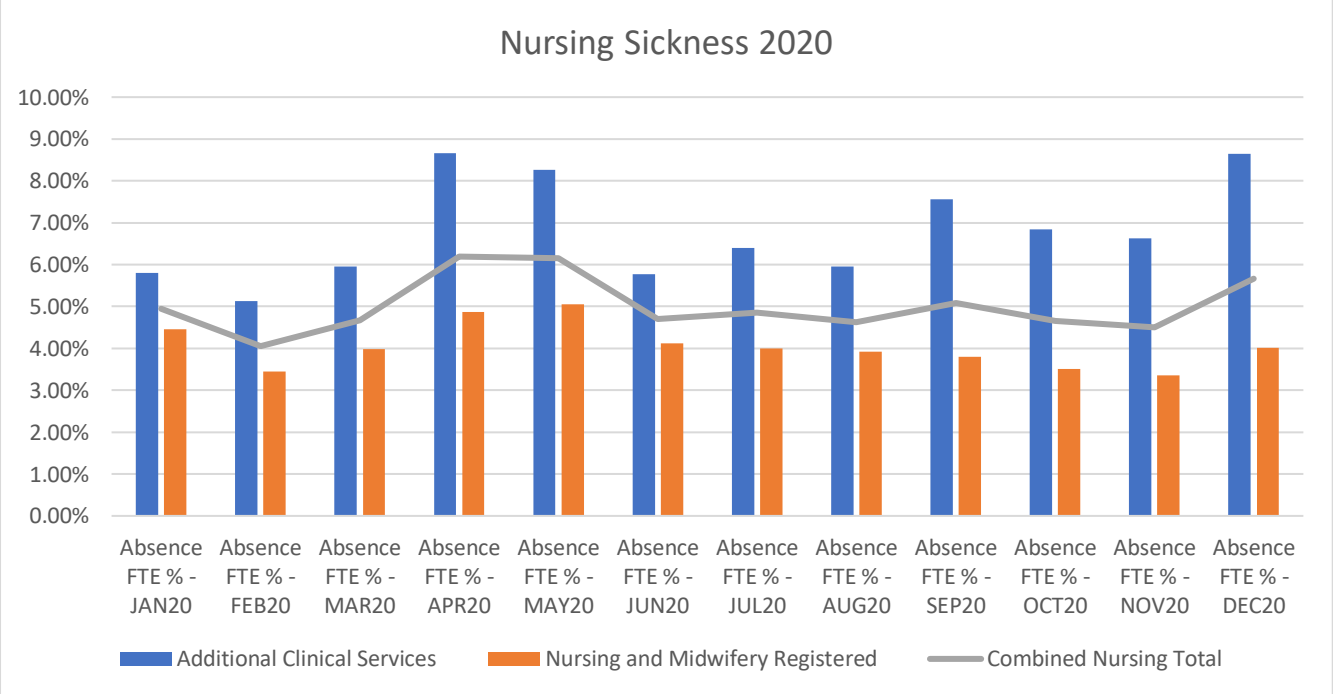


Chart 2.

	June	July	Aug	Sept	Oct	Nov	Dec
Unregistered staff (support workers)	5.69%	6.41%	5.82%	7.48%	4.22%	6.63%	8.65%
Registered Nurse/Midwives	4.78%	4.37%	4.31%	4.02%	2.71%	3.36%	4.02%
Combined Registered/Unregistered	5.10%	5.90%	4.84%	5.20%	3.23%	4.50%	5.66%

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). At the end of November, the roll out of lateral flow testing for staff began. This has enabled the swifter identification of asymptomatic staff testing positive for covid. This has led to an increase in staff isolation compounded by the increased prevalence described above.

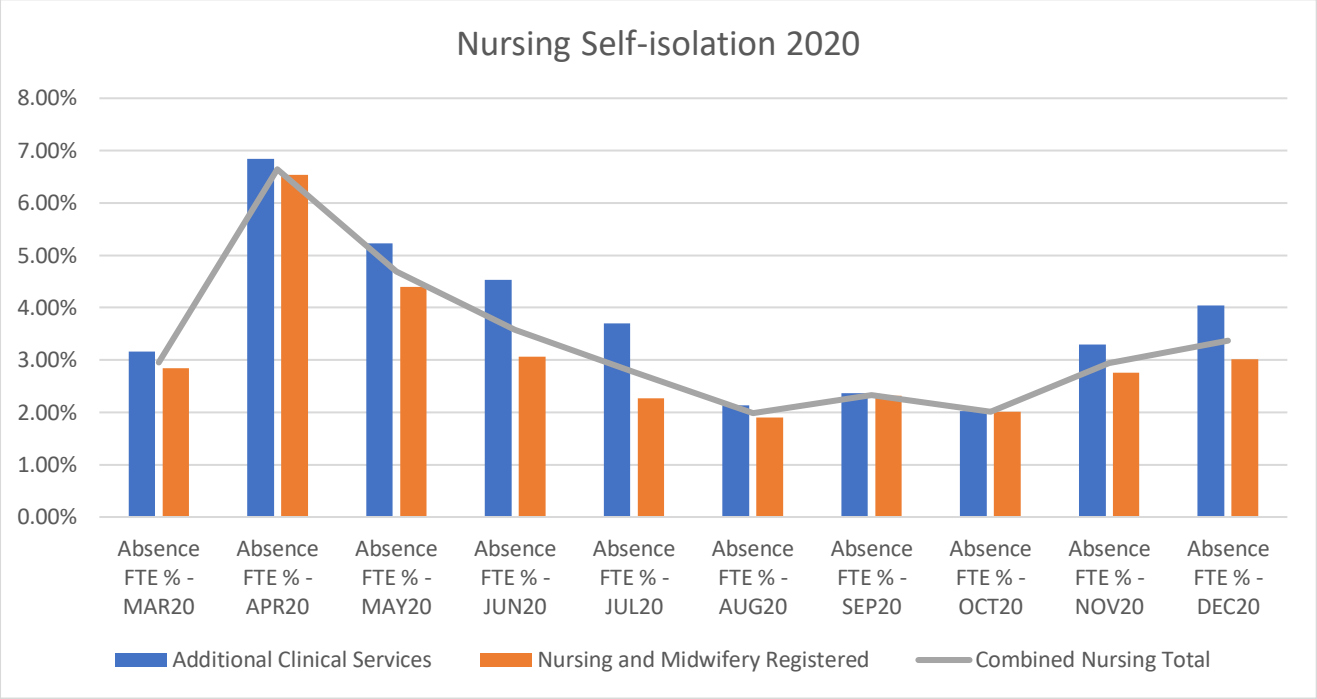


Chart 3

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 repairs have challenged flow and staffing. In this report period no wards were closed due to ward relocations or structural repair, however wards have been closed to admission due to local covid outbreaks these included;

- November: Newmarket, G5, G4
- December: G8, G3, F10, Glastonbury court

Staffing is reviewed daily across all divisions by the 'Matron of the day'. This role is the escalation point for all wards to raise issues regarding staffing shortfall or concerns. The Matron ensures that all areas are supported and staff are redeployed from areas of low activity or acuity to support where needed.

6. Recruitment and retention

Vacancies: Registered nursing (RN):
Using budgeted versus contracted staff there is a shortfall of 121.6 RNs, which is a large increase from October. However, this is further improved by substantive staff that have been reflected in the coronavirus support costs, the movement of costs to covid support have doubled as more wards have converted to covid wards (Table 4). In December the winter escalation ward became live increasing net vacancies. It should be noted that the cross charging and representation of substantive staff against covid19 cost makes identifying

an overall trust vacancy rate challenging. However, using the data available the vacancy percentage of RN/RMs is 6.4%, and is static when comparing October and December data.

	Ward Nursing	Sum of Actuals Period 4 (July)	Sum of Actual Period 5 (Aug)	Sum of Actual Period 6 (Sept)	Sum of Actual Period 7 (Oct)	Sum of Actual Period 8 (Nov)	Sum of Actual Period 9 (Dec)	Sum of CURRENT MONTH VARIANCE
RN Substantive	Ward	518.6	537.0	542.8	555.2	576.7	531.8	121.6
	CV19 Costs	68.0	50.2	42.4	38.2	44.1	82.4	(82.4)
Total: RN Substantive		**586.6**	**587.2**	**585.2**	**593.4**	**620.8**	**614.2**	**39.2**

Table 4

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

Vacancies: Unregistered Nursing assistants (NAs): The vacancy rate of unregistered support staff is demonstrating an under establishment of 0.5 WTE.

	Ward Nursing	Sum of Actuals Period 4 (July)	Sum of Budget Period 5 (Aug)	Sum of Budget Period 6 (Sept)	Sum of Budget Period 7 (Oct)	Sum of Budget Period 8 (Nov)	Sum of Budget Period 9 (Dec)	Sum of CURRENT MONTH VARIANCE
Nursing Unregistered Substantive	Ward	307.5	320.2	330.7	330.7	334.5	299.3	85.3
	CV19 Costs	102.5	80.1	42.4	33.3	37.3	84.8	(84.8)
Total: NA Substantive		**409.9**	**400.3**	**373.2**	**364.0**	**371.9**	**384.0**	**0.5**

Table 5

Overseas Nurse (OSN) recruitment:

Five nurses arrived mid November from Nigeria and following their two-week isolation, joined an induction program in December. Interviews for OSN continue, with the plan to land 5 RNs every month. Currently 12 OSN are in the pipeline and are expected to land in March and April. A further 22 interviews are scheduled to maintain provision of this stream into 2021.

New starters

	October	November	December
Registered Nurses	14	10	10
Non-Registered	12	11	11

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

In November ten RN/RM commenced in the trust: of these five were for adult nursing, three were midwives and two for community services. An additional three RNS were completing their induction to join West Suffolk professionals. Of the non-registered staff ten will be joining the acute trust and one for the community services. In December ten RNs commenced in the trust. One of these was employed for

community services. Of the non-registered staff, eleven joined the trust and one of these was for community services.

7. Quality Indicators

Falls

Falls per 1000 bed days reduced in November, but saw a sharp rise in December (Chart 6). A full list of falls and locations can be found in appendix 3. While all falls were deemed as minor/no harm in November, four falls were recorded as moderate and severe harm in December. These will follow the SIRI process to understand causative and contributary factors. It is possible that staffing shortfalls have contributed to the rise in falls.

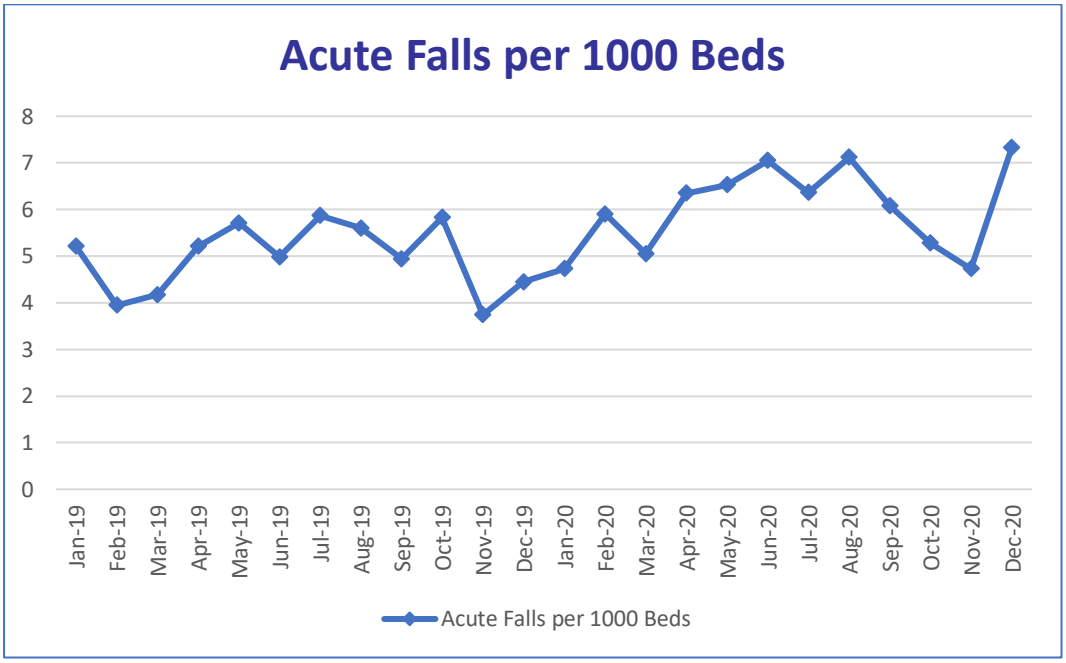


Chart 6

Pressure Ulcers

October saw one of the highest month on month incidences of hospital acquired pressure ulcers (HAPU). This number has reduced in November and December (chart 7a). This reduction is mirrored in occupied bed days which follows a similar pattern (Chart 7b). This indicates that the reduction is not attributed to low bed occupancy. A full ward breakdown of incidences and locations can be found in Appendix 3.

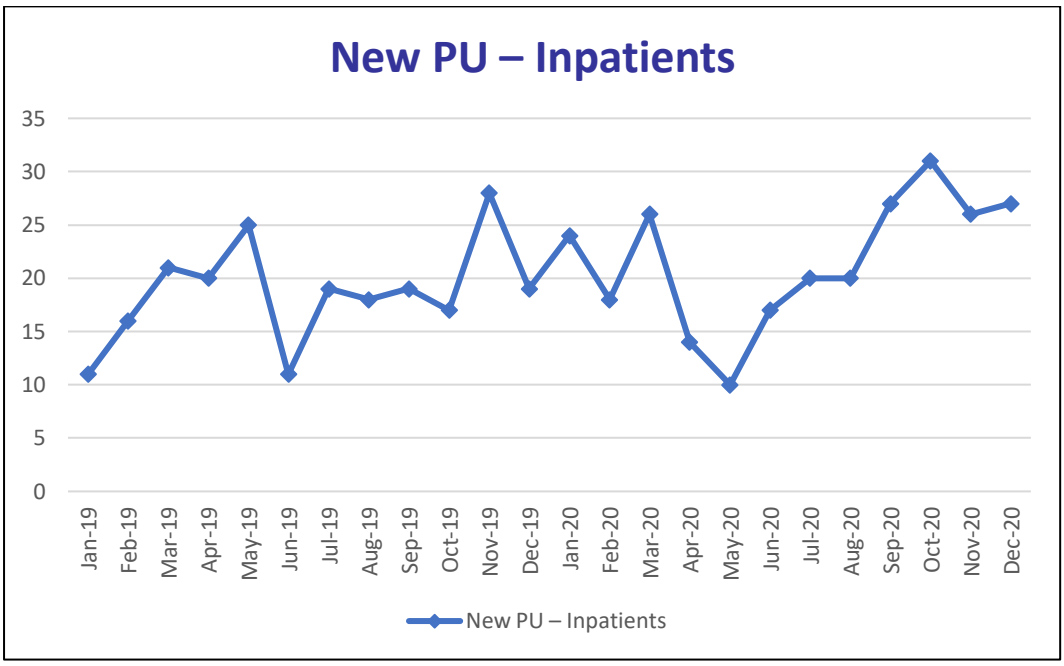


Chart 7a

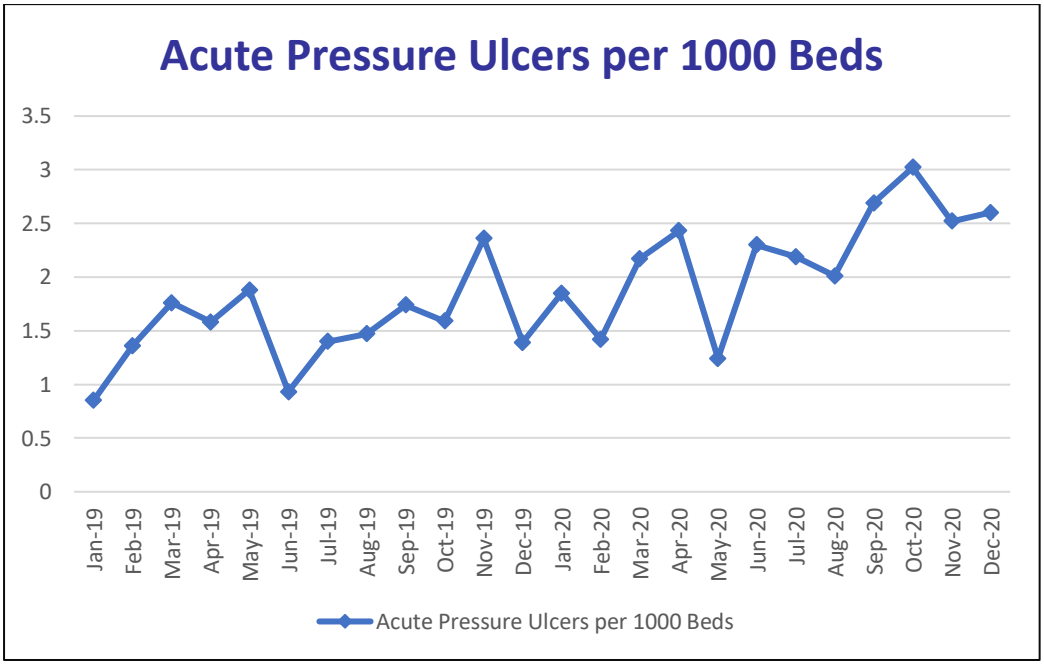


Chart 7b

8. Compliments and Complaints

Table 8 demonstrates the incidence of complaints and compliments for this period. An increase in formal complaints overall for December and the highest received this year and since the pandemic has started. An emerging issue over these months is around communication with relatives. This is likely due to the staffing shortfall that has been observed in December and is reflected in the reduction in fill rates. The 'keeping in touch/clinical helpline' should address this and will be returning to service in January, which will be a welcome assistance for staff, patients and their relatives.

	Compliments	Complaints
April 2020	14	8
May 2020	14	9
June 2020	8	3
July 2020	7	21
August 2020	18	21

September	20	20
October	11	17
November	34	13
December	44	22

Table 8

9. Adverse Staffing Incidences

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

- In November there were 17 incidences: No reports of patient harm
- In December there 48 incidences: No reports of patient harm

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

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

Table 9.

10. Maternity Services

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

Red Flag events

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

There were twelve red flag incidents reported in November; ten due to the labour suite co-ordinator not being supernumerary, two related to staffing shortages that delayed care. All due to Covid related staff absence.
There were twelve red flag incidents reported in December – seven delayed inductions of labour due to reduced staffing, two labour suite co-ordinators not being supernumerary and three reports of short staffing, however when investigated, escalation policies were activated, all women received 1:1 care in labour, no delay of care and no adverse outcomes. Staff shortages all due to Covid related staff absence.

Midwife to Birth ratio

In November 2020 the Midwife to Birth ratio was 1:27 this is within the limit of a safe ratio, Birthrate+ recommend a Midwife to Birth ratio of 1:27.7. In December 2020 the Midwife to Birth ratio was 1:25.

To note, Midwife to birth ratio does not reflect the acuity of women/babies in our care. In November there was an extraordinary number of inductions of labour -52.8% which will increase the acuity and December the

peaks in activity unfortunately corresponded with reduced staffing levels. Staffing is reviewed at least four times a day, however the majority of the workload is unpredictable.

Supernumerary status of the labour suite co-ordinator

This is a requirement for CNST ten steps to safety and was highlighted as a 'should' from the CQC report 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 November 2020 we achieved 70% compliance and December 2020 91%. There were some significant shortages in shifts and the majority were last minute which resulted in the shifts not being filled. The escalation policy was activated, however there is a time delay from on-call staff being called to them physically being present on the unit. To note all women received one to one care in labour. The midwifery senior team are currently working with our NHS Improvement officer to find long-term resolution to this problem. A recruitment drive for further labour suite co-ordinators has been completed and awaiting start dates.

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

As per NQB (2016) recommendations and strengthened by the developing workforce safeguards document (NHSE, 2018), acute providers are expected to formally review nursing establishments biannually. The biannual acuity and dependency audit commenced in September and concluded in October. During this month, review meetings were arranged with the nursing leaders of the areas to triangulate the outcomes of the audit with professional judgement and nurse sensitive indicators such as falls and pressure ulcers incidences. The recommendations of this review will be presented to the board in January 2021.

12. Resource Management

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

In December, a nursing resource management audit was completed by RSM. The final report is expected in January 2021 and action plan will be updated to address any recommendations from the report. A summary of this report and planned actions will be provided in next month's report.

13. Covid 19 additional assurance

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

- Extension of agency lead time to encourage temporary staff fill
- Repatriation of non-patient facing clinical staff to clinical areas (ITU, inpatient wards)
- Utilisation of AHP to support RN team in F7 and G9 respiratory services
- AHP teams to extend scope of intervention to assist basic care needs of their patient group
- Quality Impacts Assessment for all changes to ward demographic and patient group

- Bespoke competency training to ward teams if patient group changes: for example, NIV training on G9, acute surgical care on F4.
- Expectation of ward managers to fully support clinical duties during December and January and to be reflected on e-Roster.
- Working across the ICS to explore mutual aid and utilisation of clinical staff from across the system.
- Exploration of temporary register for our OSN cohort
- Proposal of bank incentive scheme for RNS to encourage additional uptake in shifts

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 1a. Fill rates and CHPPD. November 2020 (adapted from unify submission)

Name	Day Reg Planned Hrs	Day Reg Actual Hrs	Day Unreg Planned Hrs	Day Unreg Actual Hrs	Night Reg Planned Hrs	Night Reg Actual Hrs	Night Unreg Planned Hrs	Night Unreg Actual Hrs	Day Reg Fill Rate	Day Unreg Fill Rate	Night Reg Fill Rate	Night Unreg Fill Rate
C121 Newmarket Hospital Rosemary Ward	693.00	925.00	975.75	1,417.50	690.00	931.50	429.50	1,082.50	133%	145%	135%	252%
C145 Community - Glastonbury Court	691.00	703.25	1,029.50	1,092.25	684.50	678.00	512.50	594.52	102%	106%	99%	116%
Acute Assessment Unit W560	2,056.00	2,010.75	2,315.50	1,854.50	1,697.50	1,759.50	1,380.00	1,419.00	98%	80%	104%	103%
Cardiac Centre W522	2,656.00	2,555.00	1,286.00	1,174.00	1,720.00	1,721.50	690.00	627.50	96%	91%	100%	91%
Escalation 1920 F10 W509	1,375.50	1,319.50	1,371.00	1,095.25	1,035.00	961.50	1,035.00	1,015.00	96%	80%	93%	98%
Respiratory Ward W506	1,380.00	1,396.50	1,368.50	1,122.25	1,380.00	1,332.50	1,029.50	1,025.50	101%	82%	97%	100%
Ward F12 W594	524.50	520.00	318.50	320.77	685.50	625.50	340.50	348.50	99%	101%	91%	102%
Ward F7 W561	1,368.50	1,455.75	2,022.00	1,636.25	1,380.00	1,257.00	1,698.00	1,633.50	106%	81%	91%	96%
Ward F9 W517	1,385.75	1,258.75	2,065.75	1,728.50	1,035.00	1,025.25	1,380.00	1,632.50	91%	84%	99%	118%
Ward G1 W502	2,510.63	2,391.27	960.50	934.17	690.00	691.00	345.00	323.75	95%	97%	100%	94%
Ward G3 W591	1,381.00	1,435.00	2,065.50	2,088.17	1,023.50	1,012.75	1,035.00	1,737.50	104%	101%	99%	168%
Ward G4 W592	1,396.00	1,371.50	2,001.00	1,964.00	1,020.50	978.50	1,393.52	1,505.43	98%	98%	96%	108%
Ward G5 W562	1,492.60	1,372.13	2,063.50	1,773.73	1,035.00	932.50	1,373.50	1,281.00	92%	86%	90%	93%
Ward G8 W516	2,065.25	1,937.33	1,704.00	1,697.83	1,380.00	1,382.00	1,035.00	1,227.47	94%	100%	100%	119%
Critical Care Services W519	2,750.75	2,938.00	319.00	405.50	2,736.50	2,874.75	-	178.50	107%	127%	105%	100%
Ward F3 W510	1,380.00	1,357.50	2,033.50	1,958.00	1,035.00	1,036.00	1,380.00	1,394.00	98%	96%	100%	101%
Ward F4 W511	908.50	1,031.00	753.00	677.50	690.00	678.50	563.50	430.17	113%	90%	98%	76%
Ward F5 W512	1,442.00	1,269.75	1,382.00	1,165.50	1,034.00	973.00	690.00	724.00	88%	84%	94%	105%
Ward F6 W513	1,949.00	1,888.50	1,559.50	1,355.00	1,035.00	1,042.67	689.50	680.50	97%	87%	101%	99%
Midwifery Services W580	4,031.83	3,739.00	1,325.48	1,186.25	2,897.50	2,516.50	1,054.00	901.50	93%	89%	87%	86%
Neonatal Unit W583	1,068.00	1,149.00	88.50	89.00	1,080.00	890.50	264.00	264.00	108%	101%	82%	100%
Ward F1 W500	1,158.25	1,371.00	621.00	747.83	1,037.75	1,143.00	-	184.00	118%	120%	110%	100%
Ward F14 Gynae W503	720.00	746.50	144.00	144.00	720.00	743.00	-	-	104%	100%	103%	100%
									101%	97%	99%	110%

Appendix 1b. Fill rates and CHPPD. December 2020 (adapted from unify submission)

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each day	RNS/RMs	Non registered (care staff)	Overall
C121 Newmarket	687.00	1,020.00	1,013.75	1,546.00	713.00	941.50	542.50	1,239.50	148%	153%	132%	228%	800	2.5	3.5	5.9
C145 Community	711.00	702.50	1,072.25	1,009.75	713.00	707.00	517.50	504.25	99%	94%	99%	97%	620	2.3	2.4	4.7
Acute Assessmen	2,134.50	1,823.58	2,474.58	1,515.08	1,782.50	1,651.00	1,426.00	1,188.00	85%	61%	93%	83%	676	5.1	4.0	9.1
Cardiac Centre W	2,645.00	2,487.50	1,273.50	1,244.65	1,782.50	1,618.50	713.00	575.00	94%	98%	91%	81%	636	6.5	2.9	9.3
Ward F10 W509	1,426.00	1,249.50	1,407.00	1,050.00	1,066.50	985.50	1,066.50	932.00	88%	75%	92%	87%	663	3.4	3.0	6.4
Respiratory Ward	1,426.00	1,413.00	1,426.00	1,443.00	1,425.50	1,201.00	1,069.50	1,066.50	99%	101%	84%	100%	797	3.3	3.1	6.4
Ward F12 W594	555.50	647.50	332.75	217.67	713.00	632.50	356.50	333.00	117%	65%	89%	93%	237	5.4	2.3	7.7
Ward F7 W561	1,417.00	1,513.50	2,122.50	1,457.83	1,426.00	1,336.58	1,759.25	1,467.25	107%	69%	94%	83%	684	4.2	4.3	8.4
Ward F9 W517	1,422.50	1,257.92	2,124.00	1,599.00	1,069.50	978.50	1,426.00	1,483.00	88%	75%	91%	104%	830	2.7	3.7	6.4
Ward G1 W502	2,662.65	2,309.58	984.50	819.00	713.00	702.50	356.50	243.00	87%	83%	99%	68%	346	8.7	3.1	11.8
Ward G3 W591	1,414.00	1,242.92	2,139.00	1,908.42	1,069.50	985.00	1,065.00	1,613.50	88%	89%	92%	152%	821	2.7	4.3	7.0
Ward G4 W592	1,436.50	1,379.67	2,106.50	1,928.00	1,066.50	994.50	1,347.50	1,236.00	96%	92%	93%	92%	846	2.8	3.7	6.5
Winter Escalation	1,276.50	962.50	1,284.00	892.00	759.00	610.50	989.00	804.00	75%	69%	80%	81%	692	2.3	2.5	4.7
Ward G8 W516	2,087.58	1,668.28	1,760.00	1,361.25	1,426.00	1,221.50	1,069.50	1,009.17	80%	77%	86%	94%	668	4.3	3.5	7.9
Renal Ward - F8 W	1,425.00	1,190.00	2,118.00	1,340.48	1,069.50	934.50	1,426.00	1,114.00	84%	63%	87%	78%	585	3.6	4.2	7.8
Critical Care Servi	2,779.50	2,911.75	341.00	439.25	2,841.00	3,026.25	-	207.50	105%	129%	107%	100%	254	23.4	2.5	25.9
Ward F3 W510	1,518.00	1,395.50	2,052.50	1,929.50	1,058.00	1,022.50	1,391.50	1,299.50	92%	94%	97%	93%	856	2.8	3.8	6.6
Ward F4 W511	759.00	839.50	828.00	509.50	678.50	622.00	552.00	517.50	111%	62%	92%	94%	312	4.7	3.3	8.0
Ward F5 W512	1,721.00	1,414.00	1,411.00	1,212.00	1,069.50	930.50	713.00	681.00	82%	86%	87%	96%	698	3.4	2.7	6.1
Ward F6 W513	2,015.92	1,786.42	1,621.50	1,396.00	1,065.50	985.75	713.00	749.50	89%	86%	93%	105%	908	3.1	2.4	5.4
Midwifery Service	4,113.75	3,513.72	1,395.50	1,209.50	2,951.50	2,406.60	1,103.00	846.50	85%	87%	82%	77%		-	-	-
Neonatal Unit W5	1,101.50	1,275.50	144.00	114.00	984.00	1,020.00	252.00	228.00	116%	79%	104%	90%	97	23.7	3.5	27.2
Ward F1 W500	1,181.25	1,457.50	678.50	673.50	1,069.50	1,275.75	-	138.00	123%	99%	119%	100%	92	29.7	8.8	38.5
Ward F14 Gynae	744.00	760.00	144.00	156.00	737.00	719.50	-	23.50	102%	108%	98%	100%	95	15.6	1.9	17.5
Total	38,660.7	36,221.8	32,254.3	26,971.4	29,249.5	27,509.4	19,854.8	19,499.2	**94%**	**84%**	**94%**	**98%**	13213	4.8	3.5	8.3

Appendix 2. Ward by ward vacancies (December 2020)

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

Ward/Department	Registered Nursing			
	Budgeted Establishment	Actual Establishment	Vacancy rate (WTE)	Percentage Vacancy rate
AAU	30.1	26.6	3.6	12%
Accident & Emergency	64.0	61.4	2.7	4%
Cardiac Centre	40.7	37.6	3.1	8%
Glastonbury Court	11.7	11.8	(0.1)	-1%
Critical Care Services	45.0	39.4	5.7	13%
Ward F14	12.8	10.4	2.4	19%
Hospital Midwifery	57.7	39.9	17.7	31%
Continuity of Carer Midv	27.3	28.7	(1.4)	-5%
Neonatal Unit	20.8	20.1	0.7	3%
Rosemary ward	12.4	14.4	(2.0)	-16%
Ward F1 Paediatrics	26.2	20.5	5.8	22%
Ward F12	10.2	9.5	0.7	7%
Ward F3	22.2	18.7	3.5	16%
Ward F4	14.2	12.8	1.4	10%
Ward F5	22.2	18.8	3.3	15%
Ward F6	24.0	18.7	5.3	22%
Ward F7	22.3	23.1	(0.8)	-3%
Ward F9	19.3	16.4	2.9	15%
Ward G1	27.7	23.3	4.4	16%
Ward G3	19.5	18.7	0.8	4%
Ward G4	19.5	19.5	0.6	3%
Ward G8	27.5	25.8	1.7	6%
Ward - F8	19.4	20.5	(1.1)	-6%
Ward F10*	19.2	15.4	3.8	20%
Ward - G9	23.7	22.0	1.7	7%

*no current budget assigned. Vacancy based on roster requirement

Ward/Department	Non Registered Nursing (HCSW)			
	Budgeted Establishment	Actual Establishment	Vacancy rate (WTE)	Percentage Vacancy rate
AAU	28.3	22.1	6.2	22%
Accident & Emergency	26.5	22.2	4.3	16%
Cardiac Centre	15.7	16.7	(1.0)	-6%
Glastonbury Court	12.6	12.4	0.2	2%
Critical Care Services	1.9	1.9	0.0	0%
Ward F14	1.0	1.0	0.0	0%
Hospital Midwifery	15.6	14.4	1.2	8%
N/A	N/A	N/A	N/A	N/A
Neonatal Unit	4.3	4.4	(0.1)	-2%
Rosemary ward	13.5	17.8	(4.4)	-32%
Ward F1 Paediatrics	7.2	7.5	(0.4)	-5%
Ward F12	5.9	5.2	0.7	11%
Ward F3	25.8	24.3	1.6	6%
Ward F4	13.9	9.6	4.3	31%
Ward F5	12.9	11.9	1.0	8%
Ward F6	14.8	14.9	(0.1)	-1%
Ward F7	28.3	21.3	7.1	25%
Ward F9	25.8	20.5	5.3	20%
Ward G1	10.5	9.4	1.1	11%
Ward G3	25.6	23.2	2.4	9%
Ward G4	25.4	23.7	1.7	7%
Ward G8	20.6	19.1	1.6	8%
Ward - F8	25.8	25.0	0.8	3%
Ward F10*	18.0	22.3	(4.3)	-24%
Ward - G9	18.0	16.7	1.4	8%

Appendix 3:

Ward by Ward breakdown of Falls and Pressure ulcers November/December 2020

HAPU

November 2020	Cat 2	Cat 3	Unstageable	Total
Total	**21**	**1**	**3**	**25**
G8 - ward	4	1	0	5
F9 - ward	3	0	0	3
G3 - Endocrine and General Medicine	1	0	2	3
Respiratory Ward	3	0	0	3
Critical Care Unit	2	0	0	2
F3 - ward	2	0	0	2
G4 - ward	2	0	0	2
Cardiac Centre - Ward	1	0	0	1
F14 (Gynae - EPAU)	1	0	0	1
F6 - ward	1	0	0	1
Renal Ward (previously G5)	0	0	1	1
F7	1	0	0	1

December 2020	Cat 2	Cat 3	Unstageable	Total
Total	**22**	**1**	**4**	**27**
F10	3	0	1	4
F7	4	0	0	4
Renal Ward (previously G5)	3	0	0	3
Respiratory Ward	2	1	0	3
F5 - ward	2	0	0	2
F9 - ward	2	0	0	2
Cardiac Centre - Ward	1	0	0	1
Critical Care Unit	1	0	0	1
F3 - ward	0	0	1	1
G1 - ward	1	0	0	1
G3 - Endocrine and General Medicine	0	0	1	1
G4 - ward	1	0	0	1
G8 - ward	1	0	0	1
Glastonbury Court	1	0	0	1
Short Stay and Frailty - G5	0	0	1	1

Falls

November 2020	None	Negligible	Minor	Total
Total	**58**	**3**	**9**	**70**
Rosemary Ward	11	0	0	11
Acute Assessment unit (AAU)	5	0	1	6
G8 - ward	5	0	0	5
F7	4	0	1	5
Cardiac Centre - Ward	3	0	1	4
G1 - ward	4	0	0	4
G3 - Endocrine and General Medicine	4	0	0	4
G4 - ward	3	1	0	4
Emergency Department	2	1	0	3
F5 - ward	3	0	0	3
Glastonbury Court	2	0	1	3
F14 (Gynae - EPAU)	2	0	0	2
F6 - ward	2	0	0	2
F9 - ward	1	0	1	2
Respiratory Ward	1	0	1	2
Community Paediatric SLT	1	0	0	1
Community Specialist Services	0	0	1	1
Critical Care Unit	1	0	0	1
CT Scanning Department	1	0	0	1
F10 Winter Escalation	1	0	0	1
F3 - ward	0	0	1	1
F4 - ward	1	0	0	1
Macmillan Unit	0	0	1	1
Support to go home	0	1	0	1
Physiotherapy Department	1	0	0	1

December 2020	None	Negligible	Minor	Moderate	Major	Catastrophic	Total
Total	**84**	**4**	**11**	**2**	**1**	**1**	**103**
Rosemary Ward	14	0	1	0	1	0	16
Acute Assessment unit (AAU)	8	1	1	0	0	0	10
G8 - ward	8	0	0	0	0	0	8
F7	7	0	0	0	0	1	8
Respiratory Ward	4	1	2	0	0	0	7
Short Stay and Frailty - G5	3	1	2	0	0	0	6
F6 - ward	4	0	0	1	0	0	5
F9 - ward	4	0	1	0	0	0	5
G3 - Endocrine and General Medicine	5	0	0	0	0	0	5
F10	4	0	0	0	0	0	4
Glastonbury Court	2	1	1	0	0	0	4
F5 - ward	3	0	0	0	0	0	3
G4 - ward	2	0	1	0	0	0	3

Cataract Clinic	2	0	0	0	0	0	2
Emergency Department	2	0	0	0	0	0	2
G1 - ward	2	0	0	0	0	0	2
Renal Ward (previously G5)	1	0	1	0	0	0	2
Cardiac Centre - Ward	1	0	0	0	0	0	1
Clinical Decision Unit	1	0	0	0	0	0	1
Eye Treatment Centre - First Floor	0	0	1	0	0	0	1
F12 Isolation Ward	1	0	0	0	0	0	1
F4 - ward	1	0	0	0	0	0	1
Gynaecology Outpatients	0	0	0	1	0	0	1
Macmillan Unit	1	0	0	0	0	0	1
Nuclear Medicine Department	1	0	0	0	0	0	1
Radiology Department	1	0	0	0	0	0	1
Support to go home	1	0	0	0	0	0	1
Physiotherapy Department	1	0	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.

Appendix 5: Nursing resource management improvement plan

Utilising Nursing Resource Improvement Plan							Version date: 21.01.2021 V2.4
Find no.	Improvement required	Improvement action	Action Owner	Overall status RAG	Completion date	Actual completion date	Current status / overall RAG rationale
1.1	Improved confidence and knowledge in using eRostering and expectations of robust roster management	Review rostering training program. Scope adequacy of eRostering training with senior nursing team (survey monkey)	DS/LR		1.2.21		21.1.21 Action not progressed formally. Individual training needs captured at check and challnge meetinsg
1.2		Implement roster check and challenge meetings with ward teams. Including KPIs, with clear TOR and deliverables	DS		12.10.20	9.10.20	TOR completed and circulated to Matrons. First check and challenge meetings scheduled for 9.10.2020
2.1	eRosters to be update live	Review and update rostering policy with clear accountability and responsibilities	DS/LR		31.1.20		Policy to be updated on completion of RSM audit complete date amended to 31.1.21. 21.1.21: delay in publication of RSM audit findings. Expected final eport due end of January.
2.2		Review and scope roster access to ensure all that are responsible for staff management/moves are able to	LR		1.11.20	21.1.00	21.1.21: no concerns raised around access at roster review meetings, action to be closed and managed on case by case basis
2.3		Include unify fill rate discussion in check and challenge to explore inconsistencies of roster management	DS		12.10.20	9.10.20	Check and Challenge meetings commenced in October. Unify review and narrative included to inform board paper.
2.4		Review redeployment function as feedback from staff is that 'Blue boxing' is onerous and not ser friendly therefore not used	LR		1.12.20	7.12.20	Complete: Redeployment process has been improved by introducing quicker way to use this functionality. roster team to scope alternate simpler way to redeploy staff.
3.1	Shifts to be filled by temporary staffing are clearly escalated and filled efficiently by WSP	Define and agree staffing shortfall escalation process for forward planning	DS		31.1.21		Policy to be updated to capture changes of this improvement plan. Date amended to 31.12.20. will meet review deadlines. As per action 2.1. date extended to capture actions and recommendation of RSM audit
3.2		implement 8 week roster lead time (current 6 weeks)	LR		1.1.21	11.11.20	Complete: 8 week roster lead time implemented commenced on roster starting 17th January. Communication to nursing staff completed. Reiterated at Check and challenge meeting 11.11.20
4.1	Ensure WSP working practices are maximised to provide more capacity to source temporary staff	Implement electronic time sheet management for bank shifts	CN/LR		1.12.20	1.12.20	On track to commence on 1.12.2020. Rationale and benefits discussed in Check and Challenge meeting. Comms and 'how to guide' to be sent week commencing 16.11.20. Complete: live as of 1st December. Coms completed, wash up and implementation review to be establsihed
4.1.1		Arrange wash up review post implementation of electronic time sheets, addressing any staff feedback	CN/LR		31.12.20	18.2.20	9.12.20: meeting scheduled for 18.12.20 18.12.20: wash up meeting demeonstrates, positive implementation with good compliance and from majority of areas.
4.2		Clarify time owing or adjust shift times in rostering policy	DS/CS		1.12.20	18.12.20	DS to review with CS to establish working practices and clarity to inform rostering policy. 11.12.20: Meeting established for 18.12.20: Complete: agreed that additional hours <6 should time adjusted not additional bank shift. Will be refelcted in
5.1	Clarity on nurse vacancies	Ward to board reporting to use single point of information. Data cleanse to be complete from finance	NM/DS		1.11.20	24.10.20	Data cleanse complete by finance team. Removing anomalies for cross charging non nursing covid costs. September staffing paper displaying accurate figures
5.2		Finance training to be delivered to all ward managers	NM		1.12.20	3.11.20	Complete: 4x sessions scheduled in November 2020. delivered by Deputy Director of Finance to Ward Managers and Matrons. First session delivered 3.11.2020
5.3		Programme of Biannual establishment reviews to be rolled out	DS		1.12.20	9.12.20	1st interaction of audit completed in October 2020. Output meetings completed with the nursing team to add professional judgement. Establishment recommendations to go to board, via execs Establishment review completed and presented to scrutiny. Pending outcome and approval of investment
6.1	Improved daily oversight and management of staffing risks	SafeCare to be reintroduced to be tool for oversight/risk management	LR/DS		28.2.21		Areas for inclusion have been scoped and agreed. CNIO confirmed that data pull can come from eCare. DS to clarify expectations with SafeCare and amend launch date, delayed due to competing priority of CV19 wave 3. Completion date extended to 28.2.21
6.2		Increased reporting of red flag events on Datix	DS		1.11.20	22.9.20	Datix template updated with mandatory field to demonstrate staffing shortfalls and NQB red flag events. Discussed and informed at NMCC in September
6.3		Implement and deliver rapid response pool for addressing late notice short falls	DS/LR		1.11.20		Partial: proposal approved by exec team. Waiting for serco to comfirm payment method for shifts 09/12/2020 - calculations have been obtained to update Healthroster and ESR. Len Rowland needs to review calcualtions and liase with SBS to implement. Delays with payment process remain with Serco. Len R to escalate

15.6. Quality improvement programme board report

For Approval

Trust Open Board – January 2021

Agenda item:	15.6			
Presented by:	Steve Dunn, Chief Executive Sue Wilkinson, Executive Chief Nurse			
Prepared by:	John Connelly, Head of PMO			
Date prepared:	18 January 2021			
Subject:	Improvement programme board report			
Purpose:		For information	X	For approval

The Improvement programme board meeting, held on 11th **January 2021**, considered the following:

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

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

Eleven change requests submitted for approval at January IPB were approved including:

1. Three plans move from Green to Black (Complete):
- Plan No 10: Duty of Candour
- Plan No 18: Local induction for bank and agency staff
- Plan No 42: Team meetings to share information with staff

2. One plan moves from Black to Red:
- Plan No 61: Fitting security enabled doors to the paediatric O/P department

3. The completion dates for seven plans are extended:
- Plan No 7: RTT information extended to 28.02.21
- Plan No 31: Community pain assessments extended to 31.03.21
- Plan No 33: Pathology extended to 31.01.21
- Plan No 43: Displaying wellbeing information for patients and staff extended to 31.05.21
- Plan No 45: Promote Freedom to Speak Up Guardian extended to 30.06.21
- Plan No 61: Fitting security enabled doors in paediatric O/P department extended to 28.02.21
- Plan No 73: Senior leaders have skills to access /use patient outcome data extend to 31.05.21

- Housekeeping agenda items 8, 9 and 10 deferred given hospital pressures

- Maternity item Ockenden Report added to Improvement Plan with Trust reference number rather than CQC category (must/should) and reference number as Trust improvement programme evolves. Similarly, HSIB listed in Forward Plan scheduled for progression via SRO Cluster

- CCG Chief Nursing Officer to meet with WSFT Community Service Head of Nursing to review Plan 31 – Recording Pain Assessments in the Community

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

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

Previously considered by:	
Risk and assurance:	
Legislation, regulatory, equality, diversity and dignity implications	See individual references throughout the document

Recommendation:

1. Note the report and contents
2. Approve the updated Trust improvement plan (Annex A)

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale
1	The trust must take definitive steps to improve the culture, openness and transparency throughout the organisation and reduce inconsistencies in culture and leadership. To include working relationships and engagement of consultant staff across all services.	1. Implement Trust-wide staff engagement project to elicit feedback to inform decision-making, including establishment of a BAME Staff Network. 2. Establish an executive team development programme, including 360. 3. Utilise the medical engagement scale to better understand and support improvement for the factors underpinning clinical engagement. 4. Establish a staff psychological support service to enhance well-being support for our teams. 5. Provide an organisational development update to the Board.	Stephen Dunn	Jeremy Over	Green	**28.02.21** ~~31.03.21~~ ~~30.11.20~~	**IPB Update 11.01.21: Key actions presented below (1 - 9) in response to stated improvement actions. The work to continue and em** **1. 'What Matters to You' captured feedback from over 2,000 staff with 5 key themes arising. Shared Trust-wide through Green Shee** **2. Draft People Plan for WSFT incorporating WMTY, Just Culture and national People Plan developed and shared at TEG on 5.10.20 Board.** **3. Board Development programme in place; proposal for next steps with Chair. Revised Executive Director objectives for 2020/21 t received.** **4. Plan for M.E.S in place. Intention to do this in partnership with BWLG who have raised queries that ideally need to be resolved pr** **5. Staff Psychological Support service established and operational. Recruitment to expand the team in progress. Feedback from s our model and approach as part of a wider system-wide bid for resources.** **6. BAME and Disabled staff networks set-up. Comms support to improve profile in place. Annual E&D report to TEG and Board in** **7. 4xHRBPs recruited and commencing during period Sept-Nov 2020, aligned to clinical divisions.** **8. Workforce director report submitted to Board with positive feedback on 2.10.2020 with further feedback sought for development** **9. Plan submitted to H.E.E. detailing actions to respond to the concerns raised by the review.** IPB Update 14.12.20: The request to IPB is to extend the completion timeframe to 28.02.21 as further work is required around the MES and commenced in Dec '20. Key actions presented below (1 - 9) in response to stated improvement actions. The work to continue and embed t Other Updates via SRO Cluster and Planning Reviews: - Merseycare NHS Trust presented their 'Just and Learning Organsation' findings at the 5 o'clock club. We have reserved ten places on the - HR Business Partners recruited to support cultural improvemt with review and implementation of HR policies that is consistent. - The detail of the improvement actions has been enhanced following feedback from CQC. - 2020 national NHS staff survey launched this month. Concern re. survey 'fatigue' coming quickly on the heels of WMTY. - Weekly COVID workforce and staff support engagement meeting continues to meet - Medical Director leading on clinical director role development
2	The trust must ensure the culture supports the delivery of high quality sustainable care, where staff are actively encouraged to speak up raise concerns and clinicians are engaged and encouraged to collaborate in improving the quality of care.	1. Recruitment a new Lead Freedom to Speak Up Guardian, who in turn will develop a network of Speak Up ambassadors. 2. Implement lessons learned from external review of whistle blowing matters	Stephen Dunn	Jeremy Over	Green	**28.02.21** ~~31.03.21~~ ~~30.11.20~~	**IPB Update 11.01.21:** **1. Interviews for FTSU Guardian completed 11.08.2020. Amanda Bennett & James Barrett appointed. Publicised in Green Sheet 2.1(place.** **2. Further Speak Up plans and improvements detailed in separate project plan within IPB pack.** **3. External review in progress. Information gathering phase still ongoing.** **4. Proposal for the future oversight and governance arrangements for workforce and culture to be developed, to include option of a will consider whether the new Involvement Committee will fulfil that function.** **5. Staff consultation programme undertaken to support Pathology transfer. Dedicated HR support in place. Transfer took place 1.** **6. Anaesthetics team have fed back to execs following consideration of report's recommendations. Support being provided to new ACSA recommendations in place and in delivery.** **7. Task and Finish Group to enhance support for staff in stressful times established. Survey launched to all staff in November. Re** Update 14.12.20: Request to IPB is to extend completion timeframe to 28.02.21. Most actions complete but actions for Anaesthetics and Su place and planning underway. This includes communications – meeting took place 26.11.2020 between FTSU Guardians, Communications Update 12.10.20: - 100 staff TUPE back from ESNEFT & PHE. Expression is favourable amongst staff to rejoin Trust from 01.11.20 which is cost effective op - Anaesthetics: AXA accreditation actions in focus. Update: 07.10.2020: Other Updates via SRO Cluster and Planning Reviews:- The detail of the improvement actions has been enhanced this month following feec

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale
3	The trust must ensure that processes for incident reporting, investigation, actions and learning improve are embedded across all services and that risks are swiftly identified, mitigated and managed. The trust must ensure that incident investigations and root cause analysis are robust and that there are processes for review, analysis and identification of themes and shared	1. Review of current incident pathways and their compliance to highlight areas for improvement. Include the outcome of this review in the design of new pathways as an integral element of the implementation of the Patient safety & improvement framework (PSIRF) 2. Ensure all divisions are supported to achieve these outcomes through the central patient safety / clinical governance team	Susan Wilkinson	Lucy Winstanley	Green	**31.01.21** ~~30.06.20~~ ~~31.12.20~~	**IPB Update 11.01.21:** IPB Update 14.12.20: Please refer to November IPB update below. There are no further updates this month. Update 10.11.20: IPB have approved requests to extend plan target date to 31.01.21 and to move the plan RAG to Green. Update 09.11.20: Request to IPB is to move the plan RAG from Amber to Green and to extend the end date to 31.01.21. The plan has beer CCG and NHSE. -PSIRP pilot site work is due to start and complete by end October -Project leads and HoNs are conferring to develop a new way to ensure learning is shared at ward level -Number of actions in plan has been revised accordingly. Update 18.10.20: Plan updates made to accommodate issue of wider shared incidents learning which can be accommodated via cross cutti Update 12.10.20: Request to IPB is to approve the move the overall Plan RAG to Amber as work is progressing within constraints of: - National PSIRF programme - WSFT review of Patient Safety and Quality Expectation PSIRF document accounting for organisational changes complete 31.12.20 1. Trusts Patient Safety and Learning Strategy document is on intranet - will be informed/updated with outputs from internal PS&Q review an - WSFT PSIRF Project group formed first meeting first week August 20. - Co-production with PSIRF being developed at ICS meeting in partnership with Trust. - Regional and National meetings have recommenced following Covid-19. Heads of PS, Clin Gov, Human Factors, LfD and QI have established an internal informal forum and will continue to work closely together t
4.1	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - clinical audit is monitored and reviewed to drive service improvement.	1. Review and define opportunities to improve the current organisational pathways for recording and reporting on local and national audit participation including consideration of a new bespoke audit information system. 2. Working with divisions, develop a structure to enable the inclusion of audit actions within wider divisional improvement plans 3. Widen the scope of clinical effectiveness to address all elements of national best practice including but not limited to NICE guidance, Royal college publications, HSIB and other national best practice publications	Nick Jenkins	Rebecca Gibson	Red	**31.03.21** ~~01.07.20~~ ~~31.12.20~~	**IPB Update 11.01.21:** **Progress has been made this month but the plan cannot move to Amber until the interim appointment is made as there may be a le** **However, key lines of progress include:** **- Appointment made to Clinical Audit post. Start date to be agreed.** **- Agency has provided details of a potential interim solution and the aim is to agree a contract when the start date for the substanti** **- Maternity meeting took place in December. Output will be encompassed in Maternity Quality & Safety strategy currently under de** **- HSIB plan – paper being written to go to next CSEC meeting to address non Maternity publications. (Maternity publications alread** IPB Update 14.12.20: - B6 Clinical Audit & effectiveness Posts interviews 16.12.20. Going out to agency in the interim. (Update – Nursing l actions guide has been written and is being trialled in Maternity. Update – Jane Lovedale is arranging meeting in December to discuss learr other divisions in the new year). - Best practice / HSIB Options to use the national HSIB publications as a pi+S8lot for wider best practice re already reviewed locally in Maternity and, once the audit post is filled (either permanent of through the agency backfill), will progress in the n resource. Update 09.11.20: - Request to IPB is to approve plan completion date extension to 31.03.20 - Recruitment to new Clinical Audit Support role is underway but is unlikely to be in post before Christmas. Interim solutions to cover the role
4.2	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - mortality reviews are monitored and reviewed to drive service improvement.	1. Set up the National Medical Examiners service which will review all deaths and agree a reporting pathway into the trust for any cases requiring further review. 2. Supported by the appointment of a Learning from deaths (LfD) caseload manager; 3. Implement the LfD strategy including the specific action to streamline and centrally capture learning from local M&M reviews	Nick Jenkins	Jane Sturgess	Green	**31/03/21** ~~01/07/20~~ ~~31/10/20~~	**Update 11.01.21:** **- LfD team resourcing being enhanced with appointment of Specialist Nurses (Falls & Sepsis) and Junior Doctor. New appointmen starting in January.** **- New ME to LfD caseload pathway presentation 21.12.20 to LfD group was cancelled as monthly meeting cancelled due to large nu introduced and plan to re-audit in 3 months. All mandatory cases have been reviewed as safety net is in place and working.** **- New strategy for communication between ME's, Families and LfD Team has been presented to Medical Staffing Committee (Chief representative, quality and complaints, LFD Chair Group. Next steps, SOP's being written and patient ready. Will be presented to M** **- PALS to LfD case transfer pathway still in discussion. Had a further meeting and agreed there will be a complex case review mon pathway and progressing.** - New ME's / ME Officers now embedded. Update 12.10.20: 1. Medical Examiners service set up with agreed case transfer pathways in to Trust where cases require further review 2. Medical Examiner's now in post. One MEO to be appointed to complete recruitment. LfD Caseload Manager interviews w/c 05.10.20. 3. Embedded strategy will be evidenced by 3 - 6 month service evaluation given potential impact of Trust PS&Q review to further change pa timeframe extended to March '21 given interdependency with QI team. However, processes in place and actions complete to ensure that mc plan is green. S24

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4.3	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - incidents are monitored and reviewed to drive service improvement.	1. Through participation in the national pilot for the implementation of the Patient safety & improvement framework (PSIRF) design pathway for monitoring, investigation and review of outcomes from incident reporting 2. Implement the trust patient safety & learning strategy developed in 2019	Susan Wilkinson	Lucy Winstanley	Green	**31.01.21** ~~30.06.20~~ ~~31.12.20~~	**See No 3**
4.4	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - complaints are monitored and reviewed to drive service improvement.	1. Undertake NHSE&I patient experience framework assessments across the whole Trust 2. Review of divisional reporting of actions and learning from complaints, including accurate recording of service improvement linked directly to changes as a result of feedback	Susan Wilkinson	Cassia Nice	**Blue**	31.10.20	**IPB Update 14.12.20: The PALS service compliance regarding the timely response to complaints has achieved the 90% target every** The Cluster update 17.11.20: Blue now approved by IPB. BAU now being monitored via board attendance and papers being provided quart Update 09.11.20: Request to IPB is to move Plan 4.4 to Blue (BAU) as 3 board papers have been collected demonstrating attendance. A m where a paper is presented reporting on experience metrics such as PALS enquiries, compliments, formal complaints and Friends & Family Papers are sent to the group ahead of the meeting to allow for discussion around themes and trends, allowing learning and service improver Update 20.10.20: Plan is reported as on track to move to BAU on schedule. Update 12.10.20: The overall RAG is expected to move to BAU (Blue) in November based on 3 months compliance data being collected in terms of attendanc appendix at the November IPB to demonstrate BAU. - The plan is to return to IPB in November with an ongoing BAU assurance plan e.g. review sample of learning and testing the implementatic Update 14.09.20: - All actions complete - Team attending divisional board meetings to evidence BAU - Quaterly 'You Said/We Did' ward posters prepared to demonstrate engagement with patient feedback. There will be a running programme a direct result of feedback.
5	The trust must ensure that effective process for the management of human resources (HR) processes, including staff grievances and complaints, are maintained in line with trust policy. To include responding to concerns raised in an appropriate and timely manner and ensuring support mechanisms in place for those involved.	The management of HR processes, including investigations, will be strengthened by embedding the following in practice: 1. Monitoring time lines for each case 2. Reviewing cases that are not progressing in a timely fashion, taking action where possible. 3. Actions to be recorded on the database and effectiveness reviewed at subsequent fortnightly Case Review meetings. 4. Escalate cases where there is a significant delay to the Executive Director of Workforce for review in regular meeting with Deputy Director of Workforce 5. Consider use of external investigators where there is a lack of internal investigatory resources 6. HR Policies will be reviewed to ensure a more kind and compassionate approach that is aligned to a 'just' culture.	Jeremy Over	Claire Sorenson	Green	**31.03.21** ~~31.10.20~~	**IPB Update 11.01.21: The December IPB update is still current and correct.** **IPB Update 14.12.20:** **- 10 Trust representatives attended Merseycare/Northumbria University training in November - "restorative just and learning cultur** **- Meetings began 10/12/20 to develop our WSH plan to commence the implementation of this cultural change within the Trust** **- Investigation toolkit, flow chart, guides, template letters, ToR template, Commissioning Manager's checklist, Support Manager/HF** **part of the implementation plan. The review of policies and processes is underway, starting with the Disciplinary processes and po** **- Escalation of cases with significant delay is an embedded way of working** **- Fortnightly Case Review meetings are in place to commence in January.** IPB Update 09.11.20: - Recruited 4 HRBP all in place by 2.11.20. Supports cultural movement. Update 12.10.20: - HR Business Partners are currently being appointed to lead on adopting and embedding kind, compassionate and inclusive processes an - HR Business Partners will be aligned and support all divisions and corporate services across the Trust. - HR Business Partners will also support a planned review and development of HR policies to ensure they are written and advise kind and c Trust [Policies for Review by January 2021: Disciplinary, Capability, Improving Health, Wellbeing and Attendance, Grievance, Bullying and Harass be identified for review in February and March 2021. - Merseycare HR policies received and will be reviewed as a benchmark for our own HR policies - Formulataion of an Investigation Toolkit is progressing and due to complete in November '20, utilising a working group. - The wider HR Team will support our managers to ensure delivery of compassionate and timely HR Investigations, effectively supporting st

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6	The trust must ensure that robust processes are embedded for patient follow up appointments and those on surveillance pathways. To include systems and process for regular oversight and assurance that patients are not being lost to follow up across all specialties within the organisation.	1. Review, re-design and embed processes for booking and monitoring of all follow up patients, including ward attenders. 2. Develop and embed Standard Operating Procedures for patients on a surveillance pathway. 3.Identify and deliver training for process changes to relevant staff groups for both follow ups and surveillance. 4. Design and embed electronic and reportable surveillance worklist within each department. 5. Design process for accountability and escalation of issues for all surveillance pathways. 6. Work through an audit process of patients who are on the missing follow up list. 7. Design a new tool with cerner for a follow up PTL that can combines the qualities of the missing follow up list with those of the specialities own worklists	Helen Beck	Hannah Knights	Amber	**31.03.21** ~~01.08.20~~	**IPB Update 11.01.21: Key meetings to be held as from mid-January. The December IPB update is still current and correct.** **Cluster Update 17.12.20: Plan has now been rationalised and remains Amber. In order to go Green all reportable electronic waiting January.** IPB Update 14.12.20: - Follow ups – Demo of new data quality dashboard has been reviewed and a package offer is awaiting with financials. This includes a possi outpatient booking have been completed, they are currently being reviewed with service leads and full training will commence for roll out ear - Message Centre: The roll out of the use of message centre for appointments is the first priority and this will be implemented before the end - Surveillance – All SOPs for each surveillance pathway are now finalised. Databases are currently still held within local departments howev implemented to allow orders/requests to be booked as surveillance. - Next steps; each department to report surveillance numbers in weekly access meetings, divisional boards and PRM from January onwards December 2020 - Plan will be ready to move to Green when the Follow Up and Surveillanve waiting lists are electronic. Update 18.11.20: A package offer from MBI regarding the new dashboard is being awaited, which looks like it will cover all requirements. Us on SOPs. A new worklist tool from MBI is being looked at for clinic follow-ups. The new surveillance database is useful as an MDT/clinical t reporting mechanism has been identified and the Information Team are working on this. IPB Update 09.11.20: Move to Amber approved. Update 03.11.20: Request to IPB is to approve plan to move from Red to Amber. All processes are in place to progress key actions in the pl +S19
7	The trust must take definitive steps to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant.	The main themes from the actions plans are: 1. RTT Reporting – update to the reporting solutions to remove as many as possible of the manual workarounds within RTT reporting. Requires support from Cerner on technical fixes and testing by the WSFT Information Team. 2. RTT Training – working with users of the system and patient pathway trackers to ensure accurate information recorded relating to RTT pathways. 3. Data Quality – work to ensure there is a programme in the organisation to focus specifically on DQ. 4. Theatres Information – development of the initial theatres dashboard after end user pilot to version 2.	Craig Black	Nickie Yates	Green	**28.02.21** ~~31.12.20~~	**IPB Update 11.01.21:** **Data Quality:** **- The request to IPB is to extend the completion date to 28.02.21 as the earliest expected timeframe that the DQ strategy papers ca have been completed also.** **- The DQ Manager recruitment process will also be progressed in January and the post will be filled as per relevant notice period f** **RTT Training:** **The RTT Training launch is planned for early January and so this will also complete within the revised timeframe (subject to confir** IPB Update 14.12.20: Data Quality: - Approval of Data Quality Strategy expected at Dec 20 TEG. Still awaiting some feedback regarding nursing and clinical aspects of strategy - Strategy Job Description for Data Quality Manager progressing RTT Training: - NHSE/I are supplying package regarding e-learning solution nationally for RTT Training. This will replace previous plans to procure from e NHSE/I link can be actioned. Current plan end date and RAG status maintained this reporting period. 'IPB Update 09.11.20: SRO to provide verbal update. IPB Update 12.10.20: SRO to provide verbal update Update 07.09.20: Request IPB approval based on+S16 progress regarding collation of RTT training data and data quality work to move Plan - Next steps rationalise plan before next SRO Cluster' Update 03.08.20:
8	The trust must continue to develop information technology systems and integration across the community services	1. Submit Business case for approval at Trust Board 2. Appoint Project Manager 3. Establish programme reporting governance to Digital Board 4. Undertake technical reviews at Community Sites 5. Undertake infrastructure upgrades including service migration, provision of laptops and remote access solution 6. Monitor programme delivery	Craig Black	Mike Bone	Blue	31.12.20	Update 31.07.20: Change Control: End date moved to 31.03.21 with additional item No 5 in MB Plan version 31.07.20 for IPB approval 10.0 Update 03.08.20: 1. Business Case approved at Trust Board in March 20 2. Project manager appointed 3. Programme Reporting to the Digital Board is now an embedded process 4. Reviews of technical requirements in Community completed 16.07.20 which can be evidenced. 5. Infrastructure upgrades have been signed off and are being implemented. 6. Programme delivery being monitored via Digital Board and key risks and mitigations identified including partner (NEL CSU) Community da Move Plan 8 to Black. IPB approval required. Update 10/08/20: IPB approved move to Black as all CQC requirements have been met although it is acknowledged improvement of Comm **Update 10.08.20: The plan contains actions with defined outcomes in line with the agreed actions and these are already operational that improvement and change in Community IT will be permanantly ongoing.**

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10	The trust must ensure that the duty of candour is carried out as soon as reasonably practicable, in line with national guidance	1. Continue to highlight key areas of non (or late) compliance via the IQPR and divisional performance reporting pathways. 2. Seek staff feedback on reasons for non (or late) compliance with DoC to identify opportunities for improvement using QI methods 3. Enable staff to fully achieve the remit of the Being Open framework through provision of training and support recognising that the patient / family conversations can be emotive and distressing both for the families but also the clinicians providing that message on behalf of the organisation	Susan Wilkinson	Lucy Winstanley	Black	**31.12.20** ~~31.10.20~~ ~~31.08.20~~	**IPB Update 11.01.21: The request to IPB is to move the plan to Black (Complete). The Duty of Candour improvement work will be c** IPB Update 14.12.20: The request to IPB is that the overall RAG for the plan is moved from Red to Green. The service is BAU in terms of th in previous updates. The expectation is that the plan will move to Complete (Black) in line with the current end date in the context of a reviev Update 20.10.20: Development of webinars and other training forums are being considered as a short-term solution for DoC training until a more robust trust-v IPB Update 12.10.20: Co-production approach with support from Suffolk Healthwatch agreed to oversee assurance process. Update 12.10:20 Plan subject to same constraints as Plan 3 with development of the Trust's Patient Safety and Quality Agenda. -- DoC Mandatory training and education will be provided for consultants, senior nursing staff, senior managers and executive directors rega has been harm or a serious incident as part of Trust wide safety education syllabus - Review of PS&L strategy now reflects data sources, training requirements and consideration of document through PSIRF - Registration of DoC Improvement Plan, Datix review and introduction of data in PRM all complete, - IQPR/compliance monitoring on track but not embedded - Matrons and CD meetings will be part of escalation mechanism - Daily briefings have been key in improving timeliness of completion / also reporting in PRM - DoC work is continuing. The actions are designed to improve what currently doing. Challenge is to understand how better to support staff t this is being addressed in the new strategy. Request to move to Amber will be subject to achieving agreed compliance levels
11	The trust must ensure effective processes are in place to meet all the requirements of the fit and proper persons regulation	1. Put in place clear procedures that ensure full compliance with all FPP requirements and record keeping, including recruitment, ongoing declarations and appraisal. 2. Implement structured reporting and audit of compliance through the audit committee.	Jeremy Over	Angie Manning	Green	**28.02.21** ~~30.11.20~~	**IPB Update 11.01.20: Update provided at December IPB is still current and correct.** **IPB Update 14.12.20:** **Request to IPB is to extend completion date to 28.02.21.** **- Draft audit report has come through and WSH responses have been added and sent to the Executive Director of Workforce and C** **- More robust reporting checklist has been developed and has been sent to the Executive Director of Workforce and Communicatio** **- Necessity for minor changes to the policy has been identified** **- The final versions of these will need to be ratified at the Audit Committee** IPB Update 12.10.20: - Awaiting final audit report. Met with auditors historical data issue to be resolved. Update 12.10.20: Internal audit complete. Currently awaiting auditor report. The completion timeframe is 30.11.20 at which time any actions in response to th Update 09.09.20: The request to the IPB is to agree to move the project end date to 30.11.20 from 31.08.20 at which point the plan should r Person processes that have been put in place. Time will be required for auditor feedback and to make any suggested changes to processes can commence for a period to move the plan to BAU. Update 13.07.20: The small number of identified gaps within personal files have been of senior appointments have been rectified. Adequate executive (acting) and NED appointments Update 21.07: 1. Remaining action in plan to fully document recruitment process for NED's and Executives to be completed by 31.08.20. Th from September 20
12	The trust must ensure that mandatory training attendance, including training on safeguarding of vulnerable children and adults, improves to ensure that all staff are aware of current practices and are trained to the appropriate level	1. Build, review and implement the mandatory training recovery plan with tracking to ensure 90% compliance	Jeremy Over	Denise Pora	Amber	**31.05.21**	**IPB Update 11.01.21: Mandatory training recovery plan to be reviewed and reset in the light of cancellation of all face-to-face refre** IPB Update 14.12.20: - Two actions outstanding including tracking process for which deadline is 31.05.21. Still dependent on implementatic - Mandatory Training recovery plan implementation contines with end date 31.03.21. Update: Overall MT compliance risen by 1% based on 08.10.20 data Update 12.10.20: Multiple additional activities are in place to improve Mandatory Training compliance including Moving and Handling, Resus opportunities have been capitalised but there are still risks regarding room capacity and a greater staffing capacity risk with winter approachi monitored to enable staff to take the required time off to complete their mandatory training. Update 09.09.20: Compliance slightly down on last month. Mandatory training requirements have increased due to additional winter pressur capacity issues (facilitators and accommodation). Exploring options for new ways of delivery including OOH and external providers. Issues addressed via MTSG.

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13	The trust must ensure staff complete patient risk assessment to identify patients at risk of deterioration and risk assessments for day to day care activities.	Put eCare change requests in place to amend: 1) Changes to triage form, mandate safeguarding concerns yes/no box 2) Changes to triage form, mandate falls history/risk of yes/no box, to then generate ED falls assessment if yes ticked 3) Changes to ED safety checklist, to mandate all fields, to add n/a column, to move pressure area assessment from 2nd hr to 1st hr, to add drop down box on pressure area assessment to choose from skin intact, DTI, category 1-4 (to be able to choose more than one) 4) To mandate observation, pain score fields on triage form for both adult & paediatrics 5) To communicate changes to staff 6) To complete weekly audits to monitor compliance 7) To request compliance data from the information team	Susan Wilkinson	Ian Pridding	Blue	31.8.20	**Update 12.10.20:** **SW to provide 3 months data for LN. LN to provide external assurance re ED data. Assurance visit will be planned reporting back t** **- Plan 13 will move to appendix 6 for BAU Plans from November as holding place for Blue (BAU) Plans within the pack.** **- Appendix 6 will inform Appendix 2 Schedule of Embeddeness to include BAU quarterly reviews** Update 14.09.20: Request to IPB to move Plan 13 to Blue (embedded) as 3 months compliance data is in place and process to address compliance issues en - All actions complete and 3 months compliance data now received from information team. - A 4% - 7% dip was identified overnight between+S26 9pm - 4am with the lowest compliance at 93% on Fridays. - This is being addressed by the co-ordinators - Weekly compliance audits are in progress - Safety checklist also added to the Perfect Ward App
14	The trust must ensure staff record medication temperatures and escalate any concerns in line with its medications policy.	1) Pharmacy to audit all fridge temperatures in Emergency Department. Actions to address issues resulting from temperature audit: - Introduction of trays into the fridge to keep stock together to minimise time looking for drugs - Pharmacy Assistant responsible for stock replenishment to return all excess fridge stock to pharmacy to improve airflow within the unit - Assess requirement of rigid cold blocks in fridge and remove if unnecessary - Installation of more accurate external fridge thermometers on advice of pharmacy - Request monthly audits from pharmacy to ensure continued compliance 2) Ambient temperature monitoring Ensure appropriate systems and processes are in place to monitor ambient room temperatures in areas where drugs are stored and appropriate escalation	Susan Wilkinson	Dona Bowd	**Blue**	31.08.20	**IPB Update 14.12.20: Request to IPB is move plan to BAU (Blue) based on external assurance visit findings:** **Monitoring and assurance** **• Daily checks of fridge and ambient room temperatures.** **• Monthly perfect ward audits.** **• Outcomes of pharmacy audits.** **• Evidence of fridge, ambient room checks; evidence in range; evidence of escalation when out-of-range and appropriate actions re** **Cluster Update 16.11.20:** **Plan changed to BLUE pending approval at next IPB.** IPB Update 09.11.20: Expectation is that this plan will move to BAU at December IPB subject to assurance visit 20.10.20 report and IPB approval. Update 12.10.20: Evidence gathering process underway. Expectation is that plan moves to BAU November 2020. Update 14.09.20: All actions complete. Data gathering in progress including daily manual checks and monthly Perfect Ward audits.
15	The trust must ensure that staff records in relation to equipment and medication checks are completed.	1) Review of documentation for equipment and medication checks Departmental review of existing documentation with a view to simplifying checklists and improve compliance. 2) Review of online checking duplication of paper and online checking was causing confusion and impact on compliance. 3) Long term strategy to replicate improved paper checklist on to the online system. 4) All changes communicated to staff via email and hot topic	Susan Wilkinson	Dona Bowd	Black	**31.11.20** ~~31.10.20~~ ~~30.09.20~~ ~~31.03.20~~	**IPB Update 11.01.21: In process of capturing 3 months assurance data.** **IPB Update 14.12.20: Request to IPB is to move plan to Complete (Black) as system issues have been resolved with go live date 23**. Update 09.11.20: Request to IPB is to extend the completion date by one month to 30.11.20. Revised plan is to go live 09.11.20 with final IT tweaks resolved. following the site visit 20.10.20 Update 20.10.20: The project is delayed due to technical problems. Online checks cannot continue until November and so the plan has mov IPB. Update 12.10.20: Request to IPB is to extend project completion timeframe by one month to 31st October. Changes in IT staffing mean that live date 1st November 2020. Update 14.09.20: - Final action on plan now green. No further delays are expected and so IT will finalise and upload online customised chacking template for E plan, as agreed at August IPB.

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale
16	The trust must improve medicines management, particular in respect of management of controlled drugs, storage of patients' own medications and monitoring ambient room temperatures in drugs rooms.	Controlled drugs and storage of patients own mediciation 1. Review of existing policiies (confirmed as fit for purpose) 2. Ensure staff awareness of procedures and put in place systematic review of compliance 3. Ensure effective action is taken to address individual or themes of non-compliance Ambient room temperatures 1. Email communication to all staff to remind to escalate high temperatures to Unit Manager (regular escalations since communication.) 2. Issue included in weekly hot topics discussed at all handovers. 3. Unit manager informs pharmacy of any escalations to ensure appropriate actions if required. 4. Long term strategy: Trust wide consideration of centralised temperature monitoring	Susan Wilkinson	Simon Whitworth	**Blue**	31.10.20	**IPB Update 14.12.20: Request to IPB is to move plan to BAU (Blue) based on external visit report.** **Monitoring and assurance** **- Completed checklists.** **- Perfect ward provides assurance for compliance with completion of checklists.** **- Monthly audit for quality of checks.** **- Check lists fit for purpose and evidence safe practice, effective governance.** **- Audits used to confirm safe/effective practice and improve/further develop practice** Cluster Update 16.11.20: Actions approved as BAU at cluster level, although plan RAG reverted to Black pending external assurance IPB Update 09.11.20: The expectation is that the plan will move to Blue (BAU) at the December IPB subject to external assurance site visit and evidencing 3 mont Update 12.10.20: Request to IPB is to move plan to Black (complete). All actions complete preparing to move to BAU assurance process in November. - Plan to run 3-month BAU audit from Nov '20 with Perfect Ward App calibrated is on track with the pharmacy team piloting use of the audit t
18	The trust must ensure that all bank and agency staff have documented local inductions.	West Suffolk Professionals 1. A generic trust induction checklist is to be enhanced and re-implemented for all new agency and bank workers. This will be followed up with a local area induction to be completed during first worked shift. 2. Agency and Bank workers will complete local area induction on the commencement of their first shift. 3. If additional shifts are undertaken in different areas, it is the expectation of the trust that a local induction will be conducted for each new area worked. 4. All bank staff training is to be reviewed and recorded on OLM. Medical Staffing 1. All Agency staff are given induction booklets before their first day, which they are required to sign and return a statement confirming they have read and understood this on their first day. 2. Bank medical staff are formed by current training and trust doctors	Jeremy Over	Chris Nevill / Helen Kroon	**Black**	**31.12.20**	**IPB Update 11.01.21: Request to IPB is to move the the to complete status (Black) as all actions are complete including the training for new starters.** **IPB** Update 14.12.20: 4/5 actions now complete and plan remains on track to complete within timeframe. - The process has now been implemented to ensure a generic Trust induction checklist is recorded on OLM. Cluster update 16.11.20: New induction process has been communicated to wards and new starters. Bank worker training review (originally IPB Update 09.11.20: Relevant induction forms are now in place as part of the initial engagement with all new starters on the bank Update 12.10.20: The end date for the plan will revert to 31.12.20 as there are no training interdependencies with the Mandatory Training Plan. The expectatic as planned. The Medical Staffing plan has been reviewed. These actions are also complete. Three months compliance is data required to move to BAU prior to their first day and that a return is signed on the first day of work confirming that the induction booklet has been read. The Trust will al process. Update 08.09.20: - A detailed review of Plan No 18 has been undertaken since the last IPB with the new WSP management team. The outcome is that the cu actions black or green with no red actions. - However, the request t+S51o IPB is that the project end date is extended to 31.05.21 as the review of training action will complete in line w - The plan will now be reviewed with the Medical Staffing lead regarding the three relevant improvement actions. The WSP plan provides a
19	The trust must ensure that medicines are stored securely within the main and day surgery theatre department.	1. Identify storage requirement and purchase cupboards 2. Local audits planned whilst areas accessible re Covid-19 3. Identify cupboard locations and estates to hang cupboards 4. Risk assessments can then take place 5. Perfect Ward App to be introduced to ensure compliance	Helen Beck	Irene Fretwell	Black	**31.3.21**	**IPB Update 11.01.21: Still awaiting CCG response which will form part of evidencing before plan can move to BAU.** **IPB Update 14.12.20: The decision has been taken that drugs will not be stored on the difficult airway trolley and so the risk assess sharing the risk assessment was a specific action following the external assurance visit. All actions complete. Agreement required** Further update 09.11.20: Move to Black approved by IPB IPB Update 09.11.20: Request to IPB is to approve plan move from Green to Black. Project lead has confirmed that the outstanding actions updating the risk register. Update 22.10.20: CQC auditors have carried out an assurance visit on theatres, surgery and wards and gave very positive feedback, recom as complete and the remaining actions closed so that the plan can progress to BAU.

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale
20	The trust must improve monitoring ambient room temperatures in drugs rooms.	1. MDT meeting to access temperature monitoring options available 2. Prepare baseline assessment of ambient temperatures in Clinical Area 3. Investigation cost associated with automated temperature monitoring equipment and Air conditioning 4. Ordering of Max/Min room temperature thermometers 5. Creation of Ambient temperature monitoring record book for clinical areas 6. Creation of Ambient temperature monitoring email address for wards to use to report temperature exclusions 7. Distribution of max/min room temperature thermometers to inpatient clinical areas 8. Ordering of second batch of Max/Min room temperature thermometers 9. Distribution of second batch of max/min room temperature thermometers to inpatient clinical areas 10. Creation of MedicBleep ambient	Susan Wilkinson	Simon Whitworth	**Blue**	28.2.20	**IPB Update 14.12.20: Request is to move plan to BAU (Blue) based on external assurance visit report findings.** **Evidence for delivery** **• Outcome and recommendations from pharmacy temperature audit.** **• Communications to staff via email and hot topics.** **• Examples of escalations from staff to unit manager (email examples available)** **- Examples of escalations from unit manager to pharmacy (email examples available).** **Monitoring and assurance** **• Daily checks of fridge and ambient room temperatures.** **• Monthly perfect ward audits.** **• Outcomes of pharmacy audits.** **• Evidence of fridge, ambient room checks; evidence in range; evidence of escalation when out-of-range and appropriate actions re** Cluster Update 17.11.20: Plan and Actions approved as BAU at cluster level. Changed to BLUE pending approval at next IPB meeting in Dec-20 Update 20.10.20: The expectation is that the plan will move to Blue (BAU) at the December IPB subject to the findings of the external assurance visit 20.10.20
21	The trust must improve monitoring of women's records and ensure that a greater number of records are audited monthly.	Audit programme to be put into place including sampling methods and timescales	Susan Wilkinson	Karen Newbury	**Blue**	28.2.20	**Cluster update 17.11.20: IPB approved as Blue.** **Update 09.11.20: The request to IPB is to move the Plan to Blue (BAU) based on the external assurance report presented at the Oct** IPB Update 12.10.20: Move 21, 23, 25 and 26 to BAU (Blue). Plan No's 22 and 24 are not ready to move to BAU. Update 12.10.20: Maternity Deep Dive completed 25.09.20. Report will be presented at October IPB as part of BAU assurance process. Update 10.08.20: Deep dive approach agreed at IPB as part of assurance to move plans to Blue (BAU).
22	The trust must ensure that carbon monoxide monitoring assessments and records are in line with trust policy..	Monitor compliance through audit and (when required) action to address non-compliance	Susan Wilkinson	Karen Newbury	Complete	**28.02.21** ~~01.12.20~~	**IPB Update 11.01.21:** **Re-introducing Co2 by beginning of Jan '21 and will then be subject to 3 month audit as part of BAU process.** Update 20.10.20: RAG status remains Black (complete) as monthly check must continue until carbon monoxide monitoring recommences (still on hold due to Update 12.10.20: Actual test for Co monitoring levels is still on hold nationally due to Covid as this is an aerosol generated procedure. Mitigation is limited to a with question and answer documented. Action implemented, assurance testing ongoing. Recognised that pandemic has impacted on our ability to deliver this monitoring - this is m Update 08.07.20: The RAG for Plan 22 cannot move from Black to Blue (BAU) given national stop on carbon monoxide monitoring assessm
23	The trust must ensure that women are asked about domestic violence in line with trust policy.	Monitor compliance through audit and (when required) action to address non-compliance	Susan Wilkinson	Karen Newbury	**Blue**	28.2.20	**Update 09.11.20: The request is to move the Plan to Blue (BAU) based on the external assurance report presented at the October IP** Update 12.10.20: Maternity Deep Dive completed 25.09.20. Report will be presented at October IPB as part of BAU assurance process.
24	The trust must ensure that they implement a nationally recognised monitoring vital observations tool for women attending triage on labour suite and the maternity day assessment.	1. Project plan for the implementation of MEOWS first in the maternity areas (complete) and then in the wider hospital for peripartum ladies (including the wider group of miscarriage, termination and ectopic pregnancies) 2. Continue to monitor compliance through audit and (when required) action to address non-compliance	Susan Wilkinson	Karen Newbury	Complete	**28.02.21** ~~01.12.20~~ ~~28.02.20~~	**IPB Update 11.01.21: The plan is expected to move to BAU when audits are delivered by a Head of Nursing from outside the depart** **Regional Midwife. KN/SW to discuss and agree plan.** Cluster Update 17.11.20: New target date to move into BAU: 31.01.21. Update 20.10.20: Currently continuing monthly auditing. Update 12.10.20: Maternity Deep Dive completed 25.09.20. Report will be presented at October IPB as part of BAU assurance process.

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale
25	The trust must ensure they implement a national recognised monitoring vital observations tool for new born babies on the labour suite and F11 ward.	1. Project plan for the implementation of NEWTTS (complete) 2. Continue to monitor compliance through audit and (when required) action to address non-compliance	Susan Wilkinson	Karen Newbury	Blue	28.2.21	**Update 09.11.20: The request is to move the Plan to Blue (BAU) based on the external assurance report presented at the October IP** Update 12.10.20: Maternity Deep Dive completed 25.09.20. Report will be presented at October IPB as part of BAU assurance process.
26	The trust must ensure they carry out daily checks of resuscitation equipment.	1. Key actions are to remove paper checking of resuscitation equipment and replace with electronic checking	Susan Wilkinson	Karen Newbury	Blue	31.1.21	**IPB Update 09.11.20: The request IPB is to approve the Plan move to Blue (BAU) based on the external assurance report presented** IPB Update 12.10.20: Aproved to move to BAU. Update 12.10.20: Plan is to move overall RAG to Blue (BAU) at end of October when 3 months data will have been collected. A booklet for Action implemented, assurance testing ongoing
27	The trust must ensure clinical guidelines are up to date.	1. Through the divisional leadership review and update all clinical guidelines and issue through the approval pathway 2. Put in place systematic system to support the management, reporting and monitoring of clinical guidelines across the Trust to ensure they are kept up to date	Susan Wilkinson	Karen Newbury	Black	**31.10.20** ~~08.02.20~~	**IPB Update 11.01.21: The current RAG status is Black as all guidelines in the original ask have been updated. Maternity have gone needed updating and completed these actions also. However, there is recognition that a more formal process needs to be in place** IPB Update 14.12.20: There are a further three guidelines that have gone out of date and have been updated and will go through the goverr cluster and subsequent IPB approval, the plan could move to BAU in January '21. Update 09.11.20: The request to IPB is to approve the plan move from Green to Black as all the guidelines have now been updated. Update 20.10.20: Plan remains Green and on track to meet completion date. Update 12.10: Request to IPB is to move Plan RAG from Amber to Green. Only three guidelines remain to be completed and the expectatic Update 23.06.20: 29/36 guidelines updated in maternity. Project plan being prepared to roll-out new technology to support management of cl Update 23.06.20: Clarity needed re divisional engagment via Tri Update 21.07.20: - Maternity guidelines nearing completion Update 18.08.20: - Tri-divisional representatives will feed in on this as the matter is organisation-wide - Discussed at the Quality Group 18.08.20
29	The trust must ensure diagnostic test results are available in a timely manner.	Review reporting arrangements for relevant diagnostics services. Ensure appropriate escalation procedures are in place for delays. Address the negative impact of COVID on diagnostic testing and reporting.	Helen Beck	Helen Beck	Blue	31.12.20	**Further update 09.11.20: Move to Blue approved by IPB** IPB Update 09.11.20 Request to IPB is to move this plan to BAU as final action to provide clarification regarding the SOP is complete. Three of the assurance process. Update 12.10.20: Update 12.10.20: Radiology performance report received for Sept 20 for presentation at Oct IPB as part of BAU assurance - Plan is to share Diagnostics waiting times with patients. Update 14.09.20: IPB approve move to Black Update 03.09.20: - Request to IPB is to move the Plan to Black (Complete) as all actions are complete and can now be audited. - SOP regarding timely results for clinics has been reviewed and performance reporting has also been resolved.
30	The trust must ensure there is an effective process in place for monitoring patients requiring a follow up appointment and for those on surveillance pathways.	See No 6	Helen Beck	Hannah Knights	Amber	**31.03.21** ~~01.08.20~~	**See plan No. 6**

Find no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale
31	The trust must ensure staff complete and record patient pain assessments in patient records.	1. Issue reminder to teams regarding the importance of undertaking pain assessments for end of life patients 2. Review of core template on SystmOne to ensure that it is fit for purpose 3. Written guidance on completion of core assessment template on SysmOne 4. Share written guidance with clinical teams 5. Identify SuperUsers to support training on the correct use of the core template and embedding within teams 6. Update staff via CREWS divisional quality report 7. Include audit of completion of Pain Assessment via Perfect Ward App	Helen Beck	Michelle Glass	Red	**31.03.21** ~~31.12.20~~ ~~01.03.20~~	**IPB Update 11.01.21: The request to the IPB is to extend the completion date for this plan to 31.03.21. Whilst progress has been ma rates of compliance, based on the latest dataset, are not demonstrating improvement. Identified an issue that pain scores are bein will be to resolve this matter. Expectation is that reported compliance will improve when data for December '20 is received in mid-J be reviewed at the next SRO Cluster. Planned refresher training has also been delayed due to COVID pressures.** Cluster Update 17.12.20: Meeting to revise plan to be organised for January. IPB Update 14.12.20: Request to IPB is to revert plan to Red RAG. Revised plan required given compliance rates. Improvement in complia (See Dec 20 Sandra Webb update below). - Communications will be developed following Quality Reviews undertaken by the Senior Nursing Team to promote compliance with teams. Update 19.11.20: RAG status changed to RED as plan not delivering what was expected. New action plan in development for eventual re-su IPB Update 09.11.20: The action points continue to be progressed. Please see next slides for details regarding Plan no. 31 progress as this Update 12.10.20: Request to IPB is to move plan to Green as the Task and Finish Group has met as planned and agreed when pain assess arrangements. Full details are available. The agreements have also been included in a communications document as a user guide. Update 01.10.20: The plan to achieve compliance is to engage and listen to a group of clinicians regarding what and how often a pain assessment should be u rates will be agreed with clinicians through engagement commencing 02.10.20. Agreed compliance rates will then be monitored including th
32	The trust must ensure all staff complete mandatory training including safeguarding training.	See No 12	Jeremy Over	Denise Pora	Amber	31.5.21	**See plan no. 12**

16. Histopathology business case (presentation)

To receive presentation prior to decision on commercially sensitive information in closed session

For Report

Presented by Craig Black and Sarah Rollo

NHS
West Suffolk
NHS Foundation Trust

West Suffolk NHS Foundation Trust Investment

A PROPOSAL TO REPLACE THE OUTMODED EQUIPMENT IN THE HISTOPATHOLOGY LAB

Jan 2021

Any Images of equipment taken from manufacturers websites are for illustrative purposes only

Putting you first

A Summary to date

NHS
West Suffolk
NHS Foundation Trust

- Little or no investment via capital or managed service contracts
- 74 Assets in Cellular Pathology with average age of 17 years
- Increase in machine downtime and breakdowns
- Increase in costs for repairs and parts
- Amber rated active risks on the risk register
- Over the last 3 years £20,142.16 spent on parts, repair and rental

Proposed Equipment for replacement

- Microtomes
- Cryostat
- Tissue Processors
- Haematoxylin and Eosin (H&E) Autostainer/Coverslipper
- Advanced Immuno-Autostainer

Microtome

NHS
West Suffolk
NHS Foundation Trust

Paraffin processed wax-embedded tissue blocks are cut on a microtome. This dextrous process produces a wax ribbon of tissue at a thickness of three microns (one cell thick) that is placed onto glass slides for staining.

Current state

Future state

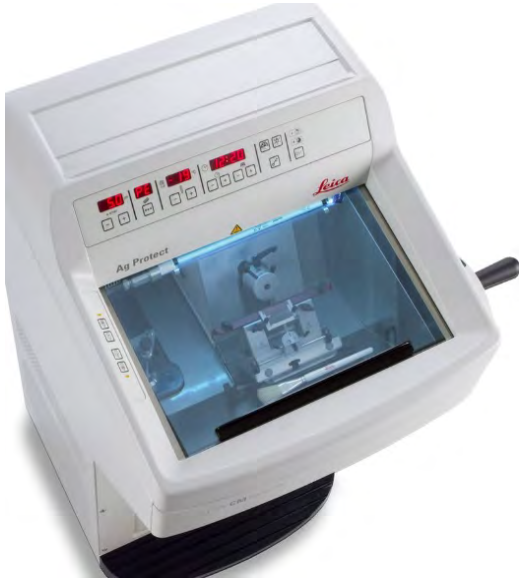
Cryostat

NHS
West Suffolk
NHS Foundation Trust

A cryostat is a microtome in an enclosed environment with a temperature of roughly minus forty degrees Celsius. This allows for the sectioning of frozen tissue samples, as opposed to the routinely formalin fixed tissue samples, and subsequent rapid staining of tissues to provide rapid diagnostic results. Frozen section service is crucial to provide urgent, rapid, intra-operative management of a patient while they are under general anaesthetic.

Current state

Future state



Tissue Processor

NHS
West Suffolk
NHS Foundation Trust

Processing machines dehydrates tissue specimens and infiltrates them with paraffin wax. This process completes fixation of tissues and strengthens them so they are in a fit state to section cut.

Current state

Future state

H&E Autostainer and Coverslipper

- This is an automated machine for routine Haematoxylin and Eosin (H&E) staining to allow visualisation and differentiation of multiple tissue structures and cell nuclei. A glass coverslip is added to the stained slide to produce a permanent tissue section, representative of the patient tissue which can then be examined microscopically.

Current state

Future state

Option 1

Option 2

Advanced Immuno-Autostainer

NHS
West Suffolk
NHS Foundation Trust

This is an automated platform that carries out immunohistochemistry (IHC). This is an additional technique which can be used to demonstrate specific elements in tissue sections that are not visible in the original H&E section. IHC is an advanced diagnostic technique where specific antibodies are applied to the tissue sections to detect antigens within the tissue. This can be used for cancer diagnosis, tumour profiling, and hormone receptor status which would guide patient diagnosis, prognosis and management.

Current state

Future state

Outcome from Estates

Changes include;

- Removal of bench top and installation of AC unit in room 20/20
- Removal of portable table and storage cabinet in room 20/22
- Removal of benchtop in room 20/11
- Extended worktop in room 20/24
- Use of room 20/18 for Administrative duties

Estimated total costs £10,000

Thank you for listening

Open Trust Board Meeting – 29 January 2021

Agenda item:	16			
Presented by:	Craig Black			
Prepared by:	Mark Johnson, Sarah Rollo and Suzette De Coteau-Atuah			
Date prepared:	22 January 2021			
Subject:	Proposal for the acquisition of modern histopathology equipment			
Purpose:		For information	✓	For approval

Executive summary:

A proposal to replace the outmoded equipment in the histopathology lab which will facilitate delivery of a quality service, accreditation and recruitment and retention of staff. A presentation will be delivered by Sarah Rollo, Deputy Manager, Cellular Pathology at WSFT.

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

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

Previously considered by:	The deputy manager, cellular pathology delivered the presentation to the Executive Director's meeting of 20 January 2021. After which the decision to bring it to Trust board was made.
Risk and assurance:	Outdated equipment may jeopardise the quality of results produced and may have an impact on diagnosis and treatment of patients.
Legislation, regulatory, equality, diversity and dignity implications	The histopathology lab is currently not accredited by UKAS (United Kingdom Accreditation Service). A lack of accreditation may affect the ability of the lab to maintain services, recruit and retain staff.

Recommendation:

The Trust board considers case for replacing the outdated histopathology equipment and agree to its funding.

Purpose

This is a proposal for the acquisition of laboratory equipment, for routine and advanced histopathology diagnostics in the histopathology department of the pathology Service. This is to provide either a like for like or enhanced replacement of the current equipment.

Context

The principal drivers are:

- With the recent dissolution of NEESPs and the transfer of all pathology services including histopathology to WSFT, we must ensure that the local histopathology service is not only fit for purpose but future-proofed.
- Currently, the histopathology service is not accredited. Modern, more efficient equipment is critical in order to provide a safe and effective service which will facilitate accreditation.
- The outmoded and potentially unsafe equipment and the impact that any failures may have on the health and wellbeing of staff and ability to treat patients effectively.
- The legal and reputational impact on the Trust.

The diagnostic tools will enable the department to meet contractual turnaround times, increase the flexibility of laboratory processes and allow the implementation of LEAN processes. This will positively impact patient flow, patient referral pathways such as the two weeks wait diagnostic cancer pathway, breast and cervical screening services. Improved laboratory processes made possible by the addition of the new laboratory equipment, will have the potential to minimise diagnostic delays seen for these areas of patient care.

Proposal

The equipment sought are:

1. **Microtomes**

Paraffin processed wax-embedded tissue blocks are cut on a microtome. This dextrous process produces a wax ribbon of tissue at a thickness of three microns (one cell thick) that is placed unto glass slides for staining.

2. **Cryostat**

A cryostat is a microtome in an enclosed environment with a temperature of roughly minus forty degrees Celsius. This allows for the sectioning of frozen tissue samples, as opposed to the routinely formalin fixed tissue samples, and subsequent rapid staining of tissues to provide rapid diagnostic results. Frozen section service is crucial to provide urgent, rapid, intra-operative management of a patient while they are under general anaesthetic.

3. **Tissue Processors**

Processing machines dehydrates tissue specimens and infiltrates them with paraffin wax. This process completes fixation of tissues and strengthens them so they are in a fit state to section cut.

4. H&E Autostainer and Coverslipper

This is an automated machine for routine Haematoxylin and Eosin (H&E) staining to allow visualisation and differentiation of multiple tissue structures and cell nuclei. A glass coverslip is added to the stained slide to produce a permanent tissue section, representative of the patient tissue which can then be examined microscopically.

5. Advanced Immuno-Autostainer

This is an automated platform that carries out immunohistochemistry (IHC). This is an additional technique which can be used to demonstrate specific elements in tissue sections that are not visible in the original H&E section. IHC is an advanced diagnostic technique where specific antibodies are applied to the tissue sections to detect antigens within the tissue. This can be used for cancer diagnosis, tumour profiling, and hormone receptor status which would guide patient diagnosis, prognosis and management.

Assessment

Benefits and issues are detailed below to demonstrate the need to replace the current equipment.

Pros	Cons
1. The provision of more timely results to referring clinicians enabling them to diagnose, treat and discharge more effectively. 2. The provision of an enhanced level of care to our patients, shorter waiting times and clearer information on diagnosis and care. This will be achieved by providing quicker access to infectious disease results, which can then be used to clinically determine the requirement for further invasive diagnostic tests. 3. To replace outmoded technology which hampers good quality patient care and staff recruitment and retention. 4. To facilitate recruitment and retention of staff including a transition to a more stable workforce which is less dependent on locum agency staff. 5. The machines are moveable so could be easily relocated. 6. Replacing the equipment will facilitate more seamless compliance with ISO	1. The equipment frequently breaks down. 2. The repair of equipment is costly and happens more frequently. 3. Downtime of equipment creates backlog which results in work being delayed and making it difficult for staff to clear the backlog. 4. Downtime also reduces staff productivity 5. If the technology used within the laboratory is not kept current this has a knock-on effect on recruitment. 6. Recruiting and retaining of staff can be challenging as the old equipment is not attractive or not familiar to prospective staff. 7. The current shortage of staffing could impact the implementation of new technology.

standards. 7. Comparability or standardisation of machines with one supplier with benefits for training and maintenance contracts. 8. The equipment will be able to integrate with the digital pathology solution currently being developed.	

Recommendation

Approval of funding for the acquisition of modern laboratory equipment, for routine and advanced histopathology diagnostics in the histopathology department of the pathology service. This is to provide either a 'like for like' or enhanced replacement of the current outmoded equipment.

17. Car parking tariff report

To APPROVE the recommendations

For Approval

Presented by Craig Black

Trust Board 29 January 2021

Agenda item:	17			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Clare Farrant, Travel and Sustainability Manager			
Date prepared:	26 October 2020			
Subject:	Update regarding car parking tariffs and concessions 2020/21			
Purpose:		For information	X	For approval

Executive summary:
On 29th November 2019 the closed Trust Board approved the annual review and increase to car parking tariffs and concessions for 2020/21. In December 2019 the government released information on their commitment to setting out a new approach to NHS parking charges.

In addition, Government guidance in response to Covid 19 has been to provide free parking for NHS staff for the duration of the coronavirus outbreak.

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

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

Previously considered by:	Scrutiny Committee 16 December 2020 – recommendation in lieu of final government guidance Trust Board 31 July 2020 no change – details of Government guidance not available Trust Board 27 March 2020 no change – details of Government guidance not available Trust Board 31 January 2020 – request to hold agreed tariff increases approved Trust Board(closed) 29th November 2019 - Tariff review agreed TEG 18th November 2019 – additional information requested for EOL and NNU Scrutiny Committee 13th November 2019 - approved all recommendations
Risk and assurance:	Car Park Contract Management
Legislation, regulatory, equality, diversity and dignity implications	Car Park Management Policy PP (18)016, British Parking Association (BPA) Guidelines, Equality Impact Assessment

Recommendation:
The Scrutiny Committee is asked to consider and approve:

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

Timeline

- 23 March 2020 — Eligibility criteria for access to on-site parking removed and temporary access set up for any staff requesting on-site parking.
- 25 March 2020 — Parking became free on site for all pay as you go staff.
- 1 April 2020 — Staff salary deductions were stopped by payroll.
- 9 April 2020 — Car parking became free for all patients and visitors and all barriers on site were set in the raised position.
- 29 June 2020 — Parking charges reintroduced for patients and visitors at 2019-2020 tariffs.
- 29 June 2020 — Free parking for patients and visitors displaying a valid blue badge (one of the four identified groups).
- 31 August 2020 — All temporary access for staff ended, for staff eligible to park on-site parking remains free of charge.

Proposal

Continue to provide free parking for NHS staff for the duration of the coronavirus outbreak in line with government guidance.

Patient and visitor parking tariff to remain at current rates, which is the 19/20 tariff, until the Trust reinstates charging for staff, at which time it is proposed to review all tariffs.

Concessions for the 4 groups advised in the government manifesto 2019 are reviewed and in lieu of any further guidance the Trust implements:

- **Blue Badge holders** – continue to be free of charge
- **Frequent outpatient attenders** – introduce free parking from 1 March 2021 for patients currently offered a concessionary rate including Macmillan patients, cardiac patients and phototherapy patients.
- **Parents of children in hospital overnight** – from 1 March 2021 introduce free parking between 19:00 – 07:00
- **Staff working night shifts** – all staff parking charges continue to be free of charge in line with government guidance.

Recommendation

The Trust Board is asked to approve the proposal to hold the current tariffs and concessions until further details of the government's plans are received.

When staff charges are reinstated and government guidance (regarding free hospital parking to key patient groups and NHS staff in certain circumstances) has been published an update paper will be taken to Scrutiny Committee to include the 2021-2022 tariff review and the guidance relating to the four identified groups.

11:00 BUILD A JOINED-UP FUTURE

18. Integration report

To APPROVE report

For Approval

Presented by Helen Beck and Kate Vaughton

West Suffolk NHS Foundation Trust Board Meeting

Friday 29th January 2021

Agenda item:	18			
Presented by:	Kate Vaughton, Director of Integration			
Prepared by:	Jo Cowley, Senior Alliance Development Lead, WSCCG Sandie Robinson, Associate Director of Transformation, WSCCG Lesley Standring, Head of Operational Improvement, WSFT			
Date prepared:	19/10/2020			
Subject:	West Suffolk Integration Update			
Purpose:	X	For information		For approval

Executive summary: This paper provides an update on the progress being made with integration in the West Suffolk system including specific transformation projects. This is a combined paper on Alliance development and transformation.

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

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

Previously considered by:	*WSCCG Govering Body*
Risk and assurance:	
Legislation, regulatory, equality, diversity and dignity implications:	

Recommendation:
The Board are asked to note the progress being made on individual initiatives and collaborative working across the system.

West Suffolk Integration Update

West Suffolk NHS Foundation Trust Board Meeting

29th January 2021

1.0 Introduction

1.1. This paper provides a quarterly update for the Board about activity to transform services and outcomes for people within the West Suffolk Alliance area. A number of different teams contribute to the report, from across the CCG, the hospital and Alliance partners.

2.0 Winter pressures

2.1. The Alliance has moved to daily coordination calls to manage winter pressures across the system. This has involved rapid agreement and decision making between partners in order to respond to growing pressures within the health system, particularly within the hospital and across the residential and domiciliary home care sectors.

2.2. A key focus has been ensuring people are moved out of hospital to an appropriate setting as soon as they are ready to go. Newmarket Hospital has been repurposed as a centre for looking after people, who although they do not need hospital treatment, are testing positive for Covid-19 and are unable to return to their normal place of residence for a period. This is called a “designated setting” and provides additional bed capacity.This work has also meant that people are now able to be cared for closer to their homes, rather than travelling to other settings in the county, which had been the previous option.

2.3. Bridging care has also been increased to support people where there is a gap between leaving hospital and their regular care being reinstated, and additional nursing beds purchased with wrap around services to increase the number of beds that can be used in the community. This has been a challenge as homes are sometimes not able to take new residents due to local Covid-19 infections and have been struggling with staffing due to their own teams being unwell.

2.4. The Red Cross already play a valuable role in supporting people when they have been in hospital, by helping them to get home and settled to a warm house with food in the fridge. This winter NHSE have provided funding for this service to be enhanced within the hospital so more people can be supported, including people who have not been in hospital, but who might benefit from the support the Red Cross can provide, identified by the Integrated Neighbourhood Teams. The Red Cross team have proved to be flexible and are ready to help where needed, including transporting people in and out of hospital and supporting people with welfare checks where they are anxious and shielding.

3.0 Community response to current Covid demand

3.1. In response to the current level of Covid demand and acute hospital pressures, the West Suffolk system have developed a suite of enhanced community offers that aims to reduce avoidable footfall into WSFT and support more people at home. In summary the key features include:

- A single commitment from all to support WSFT to prioritise their Covid response where necessary. This means that more minor injury and illness, the majority of End of Life support at home and non-emergency exacerbations of long term conditions, including increasing frailty, are managed out of hospital.

- Enhanced urgent access to community equipment supporting more people at home in a timely way.

- A dedicated ICS-wide 25 bedded Covid virtual ward as a step down from acute care, led and supported by a hospital consultant but managed by the community teams.

- Increased and targeted for urgent minor injury activity only utilisation of the x ray facilities at Thetford, Botesdale, Sudbury and Newmarket for potentially up to 60 additional people who currently attend A&E with a 0 LOS. This has the agreement and support from the radiology department.

- Increased community phlebotomy cover at clinic bases and access to rapid pathology assessment supported by changes to the operational model.

3.2. All of the above is supported by telehealth and remote monitoring, extended access to the Covid car to 3 vehicles across East and West, GP Federation telephone advice line for community staff and a communication programme to public and health and care staff.

4.0 Enhanced Integrated Neighbourhood Team (INT)

4.1. This builds on the locality-based health and social care teams and extends their core offer to provide a 24/7 model of wraparound support to people who would otherwise require admission into an acute hospital or a Community Assessment Bed.

4.2. The principles are similar to virtual ward but with a focus on proactive and intensive management of people from a step-up community perspective. The core features of this approach include:

- Early identification of the most frail and vulnerable/at risk by the INT.

- Early Supported Discharge of non-Covid patients who have been identified for community assessment bed or identified as suitable for home specialist intervention once medically optimised and would benefit from a home based approach to have an improving trajectory.

- Case management support from the community matron 7/7 supported by a dedicated Neighbourhood Team Coordinator who manages the MDTs, patient flow, transfer of care, INT interfaces etc.

- The offer of an enhanced and local step up process that enables an individual to remain at home where they are most comfortable.

- Personalised health and care support plan.

- Direct access to specialist support from community specialist services and hospital consultants.

- Enhanced monitoring remotely through telehealth.

- Overnight care support – this is an important feature and the most limiting factor to the model if absent.

- Dedicated and focused reablement approach that utilises expertise from all parts of the health and care system.

- Wrap around support from Hospice for End of Life care.

- Ongoing and consistent GP cover to support ongoing medical needs.

4.3. Based on a test and learn over the summer, this will become a key element of our longer term model of care recognising people recover better at home with the right level of wrap around support. Patients in the Covid virtual ward may step down to this enhanced INT approach.

5.0 Progress with the Covid-19 vaccination programme in Primary Care

5.1. The vaccination programme started in West Suffolk in the week of 14th December 2020, with two of the West Suffolk Primary Care Networks (PCNs) offering vaccinations in Bury and Woolpit. This was the first time PCNs could participate, and there was a massive team effort between the five Bury practices, Woolpit Health Centre, their internal teams, alongside staff from the WSCCG and volunteers from the community, in order to get them mobilised.

5.2. Staff from the WSCCG assisted surgeries in booking the clinics and worked with the District Council to delay planned roadworks outside of Woolpit Health Centre for the traffic flow to and from the Centre was not impeded. This was a brilliant example of teamwork across multiple public sector agencies to support the most vulnerable members of our community.

5.3. Clinicians and supporting staff all noted how pleased people where to get their initial vaccine, with many comments from elderly people about the difference this would start to make to their lives.

5.4. As the programme expands Primary Care Teams are working out how best to respond though PCN wide and/or GP surgery-based clinics. Due to the nature of the programme, they have to be flexible in their planning, and this is supported by the Primary Care Team in the WSCCG.

5.5. One element that has been identified by the PCNs is a need for volunteers to support clinics for several weeks and months ahead. Alliance partners are helping to source volunteers, either from their own workforce, for example Abbeycroft Leisure (where staff are furloughed and happy to volunteer) or the CCG where staff members are redeployed for some or all of their week to help with the clinics. Community Action Suffolk and the District Councils are making links with good neighbour schemes, although of course some of these are already linked in and helping.

6.0 Early Supported Discharge service

6.1. The Early Supported Discharge service is a service for stroke patients in the West Suffolk Alliance and Ipswich and East Suffolk Alliance areas and provides intensive support for people from hospital to community to help them recover from the effects of their stroke.

6.2. The tender was gained by a collaborative group from the West Suffolk Alliance lead by West Suffolk NHS Foundation Trust with partners in health (including East Suffolk and North Essex Foundation Trust), adult social care and the voluntary sector. Alliance working was considered the best way of providing this service by collaborating rather than competing leads to an enriched service model, sharing of expertise and greater resilience. The partnership will take over the running of the service from the 1st April 2021. By working with our partners, we have learnt:

- From a service user perspective, a good experience is much broader than just the immediate health aspect
- Seamless transfers of care provision rely on good relationships and networks as well as good systems and processes
- Using everyone's expertise results in better outcomes
- Partnering improves resilience and efficiencies
- Shared learning improves staff satisfaction and wellbeing
- Cultural and behavioural changes are key
- Strong leadership and commitment to partnering is essential

- Openness, transparency, trust and fairness of approach for difference resolution
- Engaging all stakeholders earlier improves outcomes, identifies risks earlier; and
- Collaboration finds solutions.

6.3. This new workstream partnership is committed to take every opportunity to work as a system rather than in organisational silos. There will be a focus on integrated working with the voluntary sector and to provide a service that is not restricted by borders or boundaries. Development of stroke specific services via App / web access explaining funded and unfunded options to engage with alternative therapy such as eco-therapy, emotional support, counselling, befriending, peer support, practical employment support as identified through the Personal Care Plan are going to play a part in the process of tailoring patient focussed service delivery.

7.0 Voluntary and Community Sector funding

7.1. Community Ambitions Funding – NHS Charities Together announced a £30 million grants programme aimed at supporting partner organisations across STP/ICSs in England. The programme recognises the NHS relies on partnerships in the voluntary, community and care home sectors and aims to encourage and support these partnerships across geographical areas that support communities affected by Covid-19. The expectation is the funding should be used for projects that benefit the NHS and VCSE sector across each STP/ICS.The Trust is asked to note the progress being made through the West Suffolk Alliance and the Trust's wider partnership working.

7.2. Individual organisations are not able to submit applications directly to NHS Charities Together. Instead a single application for funds must be made for the whole ICS area by the lead NHS Charity who then has responsibility for submitting the application form on behalf of the ICS. That application must be absolutely finalised by 31st March 2021 but submitted before that date. Of the total £30 million available nationally, £445,532.77 has been made available to the Suffolk and North East Essex ICS.

7.3. In the Suffolk and North East Essex ICS, the funding is called Community Ambitions and the decision was made at the ICS Board to target the funding towards projects addressing deprivation and/or working with people from Black, Asian and Minority Ethnic communities. Partnership bids were encouraged, and bidding organisations also needed to have an NHS partner.

7.4. Twenty-one applications were submitted by voluntary and community sector organisations and funding panels were held on the 15th December 2020 and included representatives from each Alliance. In all, six projects were chosen with two from West Suffolk: **Shared Parenting** and **Ladies of Suffolk, Essex and Norfolk** (Note: They are funded specifically to work initially in the West Suffolk Alliance area). The total funding allocated for West Suffolk was around £108,000 to be spent over two years (which is slightly more than our anticipated share of the total funding pot).

7.5 An application to NHS Charities Together will now be submitted, showing how across our three Alliance areas, the funding that has been allocated to our ICS area will be used. In the meantime, local and ICS colleagues will be working with the successful projects to see how they can work together, and what help they might need to get up and running.

7.6. Once the funding has been approved further details about the proposed West Suffolk Alliance projects will be made available to the Governing Body.

8.0 Governance Review

8.1. In December 2020, the NHS published a discussion paper '*Integrating Care – Next steps to building strong and effective integrated care systems across England'*. The paper reinforces the direction of travel the West Suffolk CCG has taken working through the Alliance and proposes some changes to governance that are in line, and build on, our existing plans.

8.2. The areas that the governance review is covering include:

8.2.1 Establishing the Alliance as a core element of the new emerging ICS wide governance structure. The initial stage of this is for the Alliance to become a sub committee of the CCG, although as the national plans evolve this too may change. What is certain though is that the Alliance will have a core part to play in the local system as the leader for the "place" based element of the NHS proposals.

8.2.2. Ensuring the principles for the Alliance are fit for purpose in this new stage of Alliance development – a working group of the System Executive Group is developing the thinking and proposals in order to strengthen Alliance principles.

8.2.3. Developing a Professional Hub to bring together clinicians and other professionals to ensure a strong clinical and professional voice within the Alliance, including in pathway redesign. The Alliance is committed to maintaining the best elements of the current arrangements whereby professionals are confident that their experience and expertise are central to decision making and change programmes.

8.2.4. Community voice – agreeing how we put people's experiences and input at the heart of what we are doing as an Alliance. A small working group is developing a set of actions which will co-produce our approach, including how we recruit and support people who get involved. There are several opportunities for people to get involved in the Alliance, and we also want to find a way of getting more informal input and feedback.

9.0 Recommendation

9.1. The Trust is asked to note the progress being made through the West Suffolk Alliance and the Trust's wider partnership working.

19. Future system board report

To APPROVE report

For Approval

Presented by Craig Black

WSFT Open Board Meeting – 29th January 2021

Agenda item:	19			
Presented by:	Craig Black, Executive Director for Resources			
Prepared by:	Gary Norgate, Programme Director			
Date prepared:	25/01/2020			
Subject:	Update on the Future System Programme			
Purpose:	X	For information		For approval

The following paper was written as a general update for the Programme Board. It is included here to provide the WSFT Board with an overview of progress:

Welcome to this month's Future System Programme Board. Since last month's discussion of the content for the strategic outline case, we have finalised the first draft of the document and started to present it to key stakeholders. Feedback is broadly supportive, but not without reasonable challenge, the following paper outlines some of these challenges and our responses along with a general update on progress.

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:

Estates – Since ratifying the choice of Hardwick Manor as our preferred site for a new Hospital, our Estates team have been busy working with our planning colleagues to identify all of the risks that could cloud a planning application, e.g. Veteran Trees, endangered wildlife, specific highway restrictions etc. Having identified a detailed risk list, the team are now working on the mitigations which include; negotiations with local land owners on the potential to lease space for storage and on joint initiatives which may yield a wider range of highways options. Following our announcement of Hardwick Manor, we have held three public events at which we encouraged discussion of objections, all of which have been noted and are reflected in our risk list. The Estates team have submitted changes to the local plan, highlighting that we are unlikely to progress with Westley as a site for a new Health and Care facility and that our preference is to retain our Hardwick Lane site and Hardwick Manor for this purpose. As part of the SOC process we have been encouraged to reflect the impact of modern methods of construction and the need to produce net zero carbon. Our architects, Ryder, and other members of our technical team, are helping in both areas and have provided input into the SOC. Ryder have also helped us gain additional information into the co-produced Texas hospital that inspired us in the creation of our own co-production approach (see Annex A)
Finally, the Estates team are providing expert input into the clinical workstream as it considers the design of generic / repeatable rooms.

Clinical Design – Phase 1 of the clinical modelling is now complete. The next phase, which will be completed over the following 6-8 weeks, will focus on training our clinical contributors on the areas that they will need to consider when embarking on the more detailed design requirements of the outline business case. Three sets of 4 different workshops have been scheduled:

1) Understanding the business case requirements and process
2) Realising the service vision – (including opportunities for both vertical and horizontal integration).
3) Understanding Flow – exploring the association between different rooms

4) Demand and Capacity planning.

Feedback on our SOC rightly highlighted the need for a full discussion of the benefits that could stem from system-wide provider collaboration. The strategic outline does not require this level of detail, however, realising the efficiency and experiential gains outlined in the case are dependent upon the system working together, hence, Helena Jopling is working on the creation of a framework for a clinically led exploration of said benefits and a dedicated period of time has been built into the project plan to ensure this is completed.

In addition, a clinical peer review of the clinical model took place on 12th January and the development of the designs for repeatable rooms (facilities management, clerical and administration) is underway. Next steps include relating the digital blueprint to the clinical model and the development of the community model that will underpin the clinical model (meetings are planned with the Alliance and transformation teams).

Financial and Economic Cases – The financial and economic cases within the SOC have been built observing the need for capital and revenue affordability. The revenue case has been built using activity growth rates that have been agreed with the clinical commissioning group, this approach ensures alignment whilst leaving a flat future revenue profile. The capital envelope is, however, unknown and the programme team have adopted an approach of benchmarking the capital cost of its preferred option (new facility built to modern standards with an optimised clinical model on Hardwick Manor) to that of Princess Alexandra Hospital in Harlow (a HIP1 Trust currently progressing its outline business case). Having presented this case to Department of Health and NHSI/E, the Trust have been challenged to ensure it includes an option with a minimal capital cost limited. Significantly constraining capital investment and the approach it drives is considered untenable over the necessary appraisal period (60 years) and as such it will only be discussed in the narrative, rather than being worked into a full economic option.
At this stage, all of the investment costs of the potential programme are centred upon the build of a new facility, this is obviously not where we want to end up (as per our strategic principles we want investment to follow service), however, it is in line with the business case process that suggests our financial cases at this stage should be c.30% developed. In submitting the SOC at this point in time, the programme team hope to:

- Encourage a discussion on the phasing of our programme (our building has a limited future life, we believe we have a strong, well developed case that supports prompt investment)
- Tease out the size of our capital envelope – so we know what we are working with.
- Inform the local system of the potential revenue impact of the programme

Structure – Although not strictly a workstream within the Future System Programme, we cannot ignore the impact that the infrastructure challenges faced by WSFT have upon the strategic case and timeline for the construction of a new hospital. In the last month, the report from Attain, our consultant partners, has been worked on and developed to a point where its first issue is imminent. Next steps will be to consider the benefits to be gained from system-wide provider collaboration – activities that will be progressed as a part of the clinical workstream of the Future System programme, as discussed above. In parallel, The Trust continues to develop its plans for additional maintenance, strengthening and repair and has received planning permission for the erection of additional ward space which will be provided in a way that means it could be re-used as part of a future system build.

All in all, a month in which the strategic outline case has been socialised and for which support has been secured. This is an excellent milestone to have met, however, work continues apace with clinical design and estates planning to ensure we maintain momentum towards securing funding for our new facility.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**		**Invest in quality, staff and clinical leadership**		**Build a joined-up future**		
	X		**X**		**X**		
Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	 *Deliver personal care*	 *Deliver safe care*	 *Deliver joined-up care*	 *Support a healthy start*	 *Support a healthy life*	 *Support ageing well*	 *Support all our staff*
	X	X	X	X	X	X	X
Previously considered by:	Part of Scrutiny Committee work program.						
Risk and assurance:							
Legislation, regulatory, equality, diversity and dignity implications	None						
Recommendation: Board to note the report and next steps							

Ryder

West Suffolk NHS Foundation Trust
West Suffolk Hospital

Texas Model Case Study Report

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Contents

This document has been designed to be viewed / printed A4 double sided.

Project number
10303:00

Revision
P01

Date
17 December 2020

Author
Jing Zhi Tan

Checked
Mark Carter

UT Southwestern Medical Center
William P. Clements Jr. University Hospital

Client
University of Texas Southwestern Medical Center

Location
Dallas, Texas

Completion
September 2014

Cost
$800m

Architect
CallisonRTKL

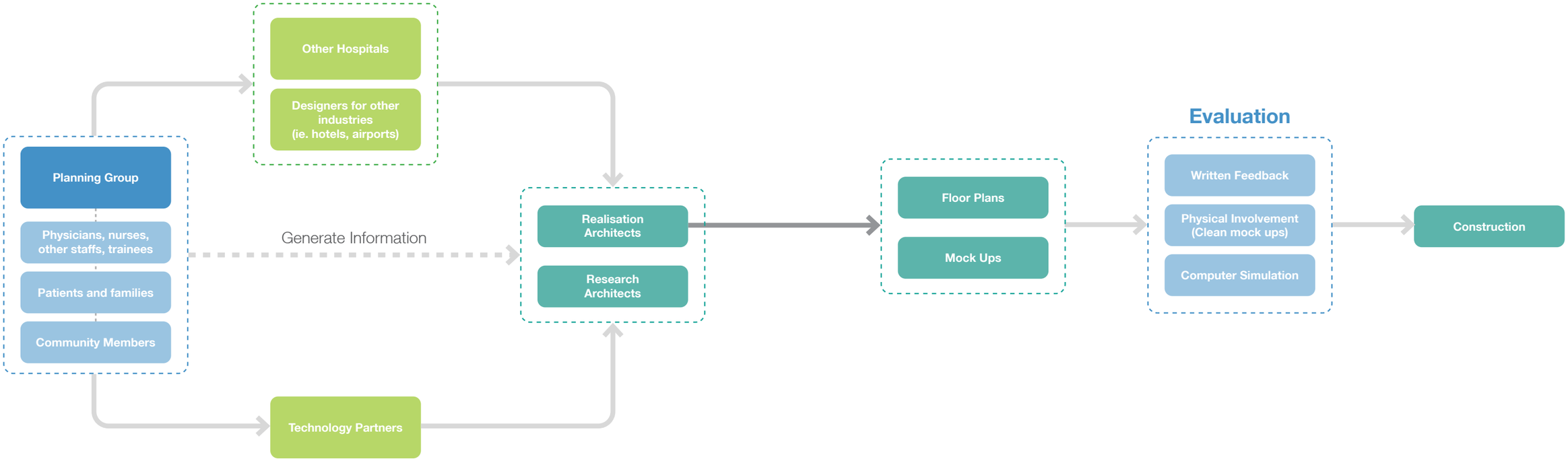
Structural Engineer
Walter P Moore

Construction Management
Aecom

Awards
Rising Star Award 2015

Area
120,774sqm

Project Specification
13 Hospital floor
464 Beds
9290sqm OB / GYN
3716sqm Emergency department
4 Endoscopy rooms
10 Cath labs
1858sqm Lab
55,773sqm Diagnostic and treatment
1858sqm Academic space
3252sqm Kitchen
4645sqm Material management building
11,892sqm Mechanical systems



Introduction
The new University of Texas Southwestern Medical Center hospital is a replacement for the existing St. Paul Hospital, which was constructed in 1963. Initial plans were to build an expansion to the existing hospital, but the team eventually chose to build a replacement hospital on a nearby 34 acre site.

Stakeholder Engagement Process
The stakeholder engagement process involved 12 planning groups (comprising 150 physicians, nurses, other hospital team, trainees, patients, and community members) who met weekly for three months. Patients and their families were consulted as well for direct feedback. The planning groups were led by the executive committee who are doctors in the hospital itself.

Stakeholders were encouraged to take the lead in the process and provide as much information as possible before the architects began to design.

During the design process, hospital teams gave written feedback for the plans and mock ups produced. On top of that additional exercise took place where hospital teams cleaned mock ups to determine preferred and easy to clean finishes.

Using digital technology, the team used computer simulation to track employee movements to produce optimal adjacencies and in turn spend less time on circulation, more time with patients.

Learning Outcomes

Patients and families
Separate discharge exits for leaving patients
Comfortable furnitures in patient rooms
Digital connectivity in medical settings

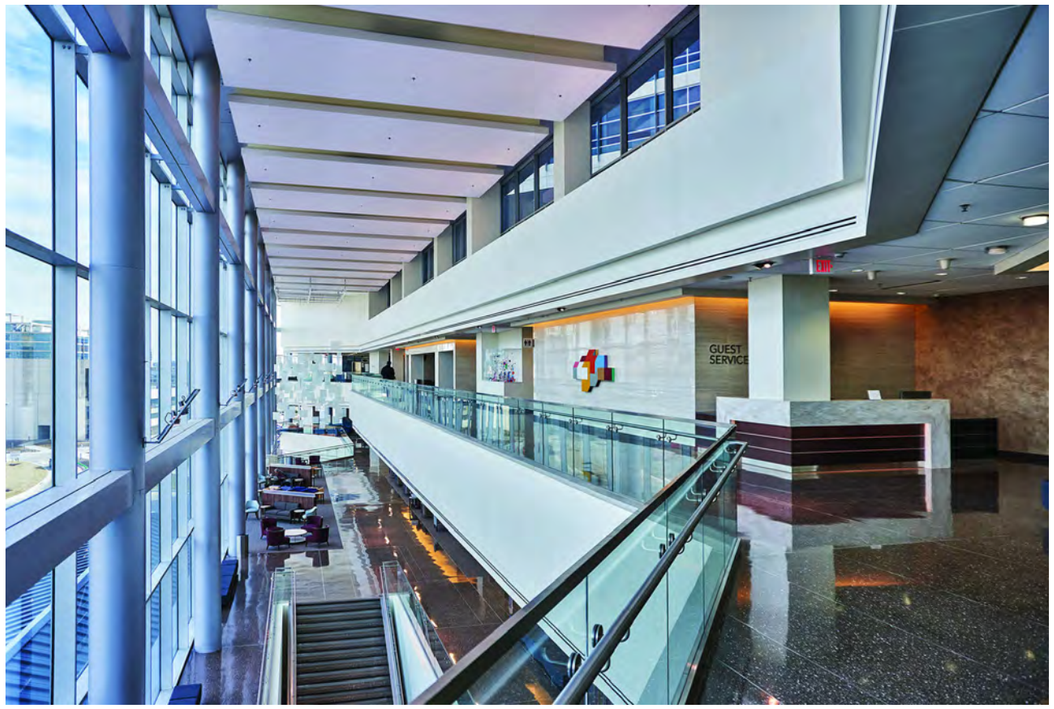
Other hospitals / industries
Functional waiting areas
Sustainable furniture and materials
Moving and storing supplies circulation
Easy to use wayfinding aids

Hospital teams
Identify optimal adjacencies for store rooms and waiting areas
Input to select materials that are easier to clean

Lessons Learnt

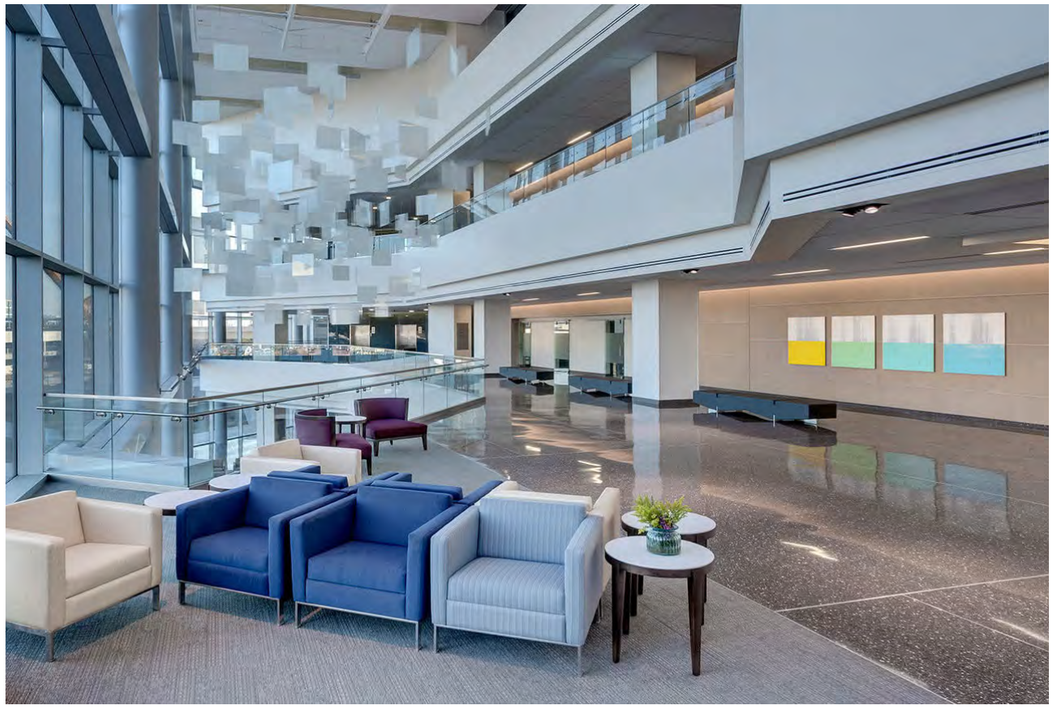
Early engagements
The medical centre selected technology partners early in the process and involved them as design partners. They actively engaged and invested in making the hospital a showcase for their products. Since the technology specifications and operational logistics were finalized collaboratively early on, change orders were significantly reduced.

Frontline stakeholder engagements
The process could have involved the frontline employees more in deciding how the employees deliver and stock materials. It would have helped significantly on deciding dimensions of shelves and disposal bins



Hospital Expansion
UT Southwestern is in the midst of constructing a $480 million expansion of its flagship Clements University Hospital that will add 300 beds to the existing 464 beds.

The 12 storey third tower is scheduled to open in 2020, serving as the clinical home for the Peter O'Donnell Jr. Brain Institute. It will also consolidate acute inpatient care services currently provided at Zale Lipshy University Hospital and add operating rooms, interventional suites, a recently expanded emergency department, and two new parking facilities.



11:20 GOVERNANCE

20. Governance report

To APPROVE the report, including subcommittee activities

For Approval

Presented by Richard Jones

Board of Directors – 29 January 2021

Agenda item:	20			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	22 January 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. **Register of interests** (for information)
   The register of directors' interests is formally reviewed and updated on an annual basis (**Annex B**). At each Board meeting declarations are also received for items to be considered.

3. **Summary of governance arrangements during Covid** (for information)
   Annex C provides a summary of the changes made to key governance activities during the current Covid restrictions. These are kept under review and the Board will receive an update in April 2021.

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

5. **Charitable funds annual report and accounts** (for approval)
   To approve delegated authority to the audit committee to review and approve the charitable funds annual report and accounts for 2019/20.

6. **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 7 December considered:

   - Operational challenges, including Winter planning, COVID planning and recovery and EU exit
   - Site options as part of the future systems programme
   - Human factors, the final session in the workshop series was completed

   The meeting planned for 4 January 2021 was cancelled due to operational pressure but feedback was sought on the draft patient safety incident response framework (PSIRF). Plans to introduce body worn cameras by members of the security team were also circulated for feedback. An update will be provide at the Board meeting.

7. **Health and safety committee report** (for approval)
   The committee met on 22 January. As part of the agenda the health, safety and welfare policy (**Annex D**) was reviewed and updated. These updates included recognition of different arrangements in place for our community sites. The Board is asked to approve the updated policy, recognising that further work will be undertaken to recognise arrangements across the

community.

8. **Dissolution of The Pathology Partnership limited** (for information)
   As approved by the Board in November the required submission to Companies House has been made for the dissolution of the limited company.

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 and specifically:

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

Annex A: Scheduled draft agenda items for next meeting – 26 February 2021

Description	Open	Closed	Type	Source	Director
Declaration of interests	✓	✓	Verbal	Matrix	All
Deliver for today					
Patient story	✓	✓	Verbal	Matrix	Exec.
Chief Executive's report	✓		Written	Matrix	SD
Operational report, including 7-day services update	✓		Written	Action	HB
Integrated quality & performance report	✓		Written	Matrix	HB/SW
Finance & workforce performance report, including CIP programme for 2021/22	✓		Written	Matrix	CB
Risk and governance report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
Invest in quality, staff and clinical leadership					
People plan, including: - People plan update - Staff recommender scores (if published) - Consultant appointment report - "Putting you first award"	✓		Written	Matrix	JMO
Quality, safety and improvement report - Quality and learning report (Q3), including learning from deaths and patient safety incident response framework (PSIRF) - Maternity services quality and performance report - Improvement programme board report - Nurse staffing report	✓		Written	Matrix	SW / NJ
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	SW
Build a joined-up future					
Digital programme board report	✓		Written	Matrix	CB
Future system board report	✓	✓	Written	Matrix	CB
Strategic update, including Alliance, System Executive Group and Integrated Care System (ICS). Including timetable for strategy review.	✓	✓	Written	Matrix	SD
Communication strategy review	✓		Written	Matrix	JMO
Governance					
Governance report, including - Agenda items for next meeting - Use of Trust's seal - TEG report - Audit Committee report, including Charitable funds annual report - Council of Governors	✓		Written	Matrix	RJ

- Annual report and operational planning guidance - Risk appetite statement - Planning for annual governance review - Review of NED responsibilities					
Scrutiny Committee report		✓	Written	Matrix	LP
Board assurance framework		✓	Written	Matrix	RJ
Confidential staffing matters		✓	Written	Matrix – by exception	JMO
Reflections on the meetings (open and closed meetings)		✓	Verbal	Matrix	SC

REGISTER OF DIRECTORS' INTERESTS

The Codes of Conduct and Accountability for NHS Trusts requires all Trusts to draw up and maintain a register of director's interests. This register consequently lists all interests, defined by the Codes as relevant and material for all its Board and non-Board directors.

The definition of interests is as follows:

- Directorships held in private companies or plcs.
- Ownership or part ownership of private companies, businesses or consultancies, likely or possibly seeking to do business with the NHS.
- Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.
- A position of authority in a charity or a voluntary body in the field of health and social care.
- Any connection with a voluntary or other body contracting for NHS services.

	Declared Interest	Date Reviewed / Amended
Trust Chairman		
Sheila Childerhouse	Partner in T&D Childerhouse farming company Trustee of the East Anglia's Children's Hospices Director of Charles Burrell & Sons (dormant company) Associate Oliver & Co Sole Trader as Childerhouse Consulting	29 January 2021
Non Executive Directors		
Richard Davies	I am currently working part-time for the University of Cambridge, assisting with the COVID operations Helpdesk. The Cambridge University Clinical School has a contract with the WSFT to provide clinical student teaching.	29 January 2021
Angus Eaton	Group Chief Risk Officer for Hastings plc. As an insurer there is the potential that Hastings or its subsidiaries could have financial or commercial arrangements with the NHS. Non-Executive Director of The Motor Insurance Bureau (10 September 20)	29 January 2021
Rosemary Mason *(appointed 24/08/20)*	Director Quay House (Portsmouth) Ltd	29 January 2021

	Declared Interest	Date Reviewed / Amended
Gary Norgate *(resigned 31/05/20)*	Nil	29 January 2021
Louisa Pepper	Trustee for Suffolk Community Foundation Trustee for Daval Charitable Trust	29 January 2021
Alan Rose	Chairman, Howard House Patient Participation Group, Felixstowe Governor on Board of Anglia Ruskin University Wife is a public governor of ESNEFT (Colchester and Ipswich Hospitals)	29 January 2021
David Wilkes *(appointed 31/07/20)*	Non-Executive Director Pauls Malt Ltd	29 January 2021
Chief Executive		
Stephen Dunn	Trustee of "Brightstars" charity Director of Helpforce Community Honorary Commander, USAF Lakenheath	29 January 2021
Executive Directors		
Helen Beck	Director of S L Beck non-clinical Consultant Ltd, established 31 July 2020	29 January 2021
Craig Black	Nil	29 January 2021
Nick Jenkins	Nil	29 January 2021
Jeremy Over	Nil	29 January 2021
Rowan Procter *(left Trust 29 June 2020)*	Nil	29 January 2021

	Declared Interest	Date Reviewed / Amended
Kate Vaughton	Nil	29 January 2021
Susan Wilkinson *(appointed 1 June 2020)*	Nil	29 January 2021
Trust Secretary		
Richard Jones	Director of Friars 699 Limited (which changed its name to "The Pathology Partnership Limited") Councillor of Brockley Parish Council	29 January 2021

Annex C: Summary of governance activities during COVID restrictions

New committee structure

In light of the operational challenges that the Trust is currently experiencing as a result of Covid the decision was taken to delay the phased implementation of the new committee structure. This reflected the divisional pressure and impact of the change at this challenging time and the leadership of the Covid response by a number of members of the team critical to delivery of the information requirements to support the change.

We will review this position later in February will a plan to go live with the phased introduction from March/April. An update will be provided at the Board meeting in February.

Health and safety

Activity	Status	Potential impact of stopping activity	Work required to recover the position in future and/or structure required to be in place in the interim to mitigate impact
Risk assessments – management of new / current Red risks via face-to-face Exec led meetings	Change	Loss of Executive oversight of progress to address current red risks through agreed actions Lack of Executive approval of newly reported red risks	Follow the existing pathway but use virtual/email – ADO sign-off; exec approval and sharing with relevant leads/specialists.
Green and Amber Risk assessments	Change	Green and Amber risk assessments not reviewed according to policy.	Each ADO in conjunction with the Risk Office to determine the priority risk assessments which will need to be reviewed.
CAS audits and departmental deep dive audits	Change	Lack of oversight of basic indicators of safety at ward level Lack of oversight of compliance with regulatory requirements	Audits to recommence when able (perfect ward COVID audits still ongoing in defined areas). Limited assurance audits being developed to provide a level of assurance in the interim, without visits to clinical areas
Quality walkabouts, health and safety workplace inspections and regulatory compliance audits	Change	Potential quality, safety or H&S issues not being highlighted or addressed.	To recommence when able. Limited assurance audits being developed to provide a level of assurance in the interim, without visits to clinical areas

Patient experience

Process for managing complaints

Locally the following has been put into place to manage in the interim:

- All new complaints received will still be triaged, recorded and RAG rated for severity and impact.
- All Green complaints will be acknowledged and will be aimed to be resolved informally/via PALS if possible. If unable to resolve informally, a response timescale will not be agreed with the complainant and an explanation provided within the acknowledgement letter.
- All Amber/Red complaints will be acknowledged and accepted as normal process however a response timescale will not be agreed with the complainant and an explanation provided within the acknowledgement letter.
- All local resolution meetings will continue however will be held virtually if possible. All complainants requesting a face to face meeting will be advised that these will be postponed until COVID situation has eased.
- Staff are being offered to discuss the complaint via MS teams and record their response with complaints team instead of writing their response to speed up response times and free up time. This has already been taken up by some staff.
- Furthermore, staff are not being asked to respond to by a specific date however we are requesting a timescale as to when they believe they will be able to complete their response so we can meet the complainants expectations.
- Complainants will continue to receive regular update letters on the progress of their complaint.

Clinical Helpline update

The clinical helpline will be restarting on Monday 18 January 2021. It will be operational 7 days a week, 10am – 6pm. The clinical helpline will have a new number (01284 713155) to group together the main services provided by the patient experience team (Clinical Helpline, Keeping in Touch and PALS).

The clinical helpline is made up of staff nurses, PT's, specialist nurses, midwives and more, giving a wide range of skills, experience and knowledge on the helpline. With the help from our IT colleagues, we have provided equipment to enable shielding staff to help on this service by working at home. Training has been delivered to ensure policies and procedures are adhered to and support services have been set up for all staff helping on the service such as; an on call manager facility, team medic bleep group, clinical lead point of contact and regular team meetings/check ins.

Information governance (IG)

Activity	Status	Potential impact of stopping activity	Work required to recover the position in future and/or structure required to be in place in the interim to mitigate impact
Information Governance reporting and FOI	Partial	FOI's all acknowledged but stating that responses may exceed the 20 days depending on the area we need info from. Data security incidents continue to be submitted	Minimal impact – if anything is requested as urgent they will be managed on a case by case basis.

Patient Safety & Quality team

Most things same as usual except Green incidents:

Green incidents (as recorded in the Staff briefing and will be in the Grreensheet)

During the current period of increased operational pressure, we are not asking staff to complete the investigation narrative on Datix for incidents reported as Green (minor harm, no harm or near miss) and Green incident will be closed centrally by the patient safety & quality team.
It is important that all staff continue to report on Datix and you can be assured that all incidents across the trust are:

- reviewed on a daily basis by the patient safety & quality team
- any requiring immediate action are escalated to the daily safety huddle.
- all incidents are considered as part of the weekly thematic review
- thematic review is shared with the divisional leads.

What this means for reporters is that they won't get the usual automated case-specific investigation feedback from Datix. Instead a generic narrative will explain that more thematic learning feedback will be available through local ward / department forums and via the senior Matrons and clinical leads.
Please note:

- Incidents classified as Amber / Red (moderate harm or above) will still require investigation as well as a Duty of Candour conversation and this will continue to be coordinated by the Patient safety & quality team.
- A very small number of green incidents which require reporting to an external regulatory body (e.g. MHRA, IR(ME)R or the Information Commissioner) will still need to be completed and the local trust lead will contact the relevant investigator to confirm this.

The Trust is participating in a national pilot of the Patient Safety Incident Response Framework (PSIRF) as part of the NHS Patient safety strategy which will include new ways of investigation and shared learning for all staff. The new ways of working during COVID will form part of this and, later on this year, the trust aims to develop a shared learning platform on the updated trust intranet for all staff to access this. If you are interested in learning more about the national strategy and PSIRF this can be found here:
https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/

https://www.england.nhs.uk/patient-safety/incident-response-framework/

Datix auto-feedback narrative says

"*Thank you for taking the time to report this incident. Your continued commitment to recording and reporting harm or potential harm enables us to maintain a safe workplace for both patients and staff alike.*

During the current period of increased operational pressure, we are not asking staff to complete the investigation on Datix for incidents reported as Green (minor harm, no harm or near miss) and so this Green incident has been closed centrally by the patient safety & quality team.

PLEASE BE ASSURED all incidents across the trust are reviewed on a daily basis by the patient safety & quality team and any requiring immediate action are escalated to the daily safety huddle. In addition, all incidents are considered as part of the weekly thematic review which is shared with the divisional leads.

What this means for you as a reporter is that you won't get the usual investigation feedback from Datix. We will instead seek to provide more thematic learning feedback through local ward / department forums and via your senior Matrons and clinical leads".

Trust Policy and Procedure **Document ref. no: PP(21)018**

Health, Safety and Welfare Policy

For use in:	All clinical and non-clinical areas of the West Suffolk NHS Foundation Trust including the Community Service
For use by (staff groups):	All Staff (clinical and non-clinical)
For use for:	Health, Safety and Welfare Arrangements
Document owner:	Head of Health, Safety and Risk
Status:	Approved

Purpose of the Policy:
The purpose of this policy is to fulfill the Trusts legal obligations under the Health and Safety at Work etc. Act 1974, other relevant legislation and to document the Trust's statement of intent with regards to health, safety and welfare standards.

Contents

Executive Summary:
The Trust's Health, Safety and Welfare Policy is in place to detail and reflect the Trust's organisational arrangements for health and safety management. The responsibilities set out in this policy are intended to ensure that:

- work will be carried out safely, consistent with good practice and is in accordance with all relevant statutory provisions,
- identifies health and safety responsibilities for all levels of staff and clearly shows the escalation route for health and safety issues.

This policy describes the key health and safety arrangements for the Trust. These enable clearer monitoring of the Trust's health and safety performance which will be the main function of the Health and Safety Committee. The Committee reports to the Corporate Risk Committee and where necessary escalates risks to the Board via the Trust Executive Group (TEG).

Statement of Intent
It is the policy of the West Suffolk NHS Foundation Trust (the Trust) to comply with the Health and Safety at Work etc. Act 1974 and other relevant legislation as appropriate to ensure, so far as is reasonably practicable the health, safety and welfare of all its staff, patients, and others (persons not in the Trusts employment) who may be affected by the Trust's undertakings therefore, the Trust seeks to provide:

a) a safe working environment with access to adequate welfare facilities;
b) work equipment, plant and systems of work which are without risk to health, are suitable, safe and maintained in good working order;
c) arrangements for ensuring safety and absence of health risks in connection with the use, handling, storage and transport of articles and substances;
d) such information, instruction, training and supervision as is necessary to ensure the health and safety at work of all employees and others on the premises;
e) maintenance for any place of work under the Trust's control to ensure it is in a safe condition without any health risks, including appropriate means of access and egress.
f) Adequate systems for identifying and assessing all hazards and risks associated with their activities and putting in place adequate control measures.

Whilst the Chief Executive Officer accepts full responsibility for ownership of this policy, all employees have a personal responsibility to ensure a proactive approach to Health and Safety matters that impact on the Trust. The Board of Directors have identified a lead Director with specific responsibility for health, safety and welfare, and the Head of Health, Safety and Risk as the competent advisor to whom reference should be made in the event of any difficulties in the implementation of this Health and Safety policy and procedures.

Signature of Chief Executive: (Dr Stephen Dunn)

Date of Signing:

1. Introduction:

The West Suffolk NHS Foundation Trust ("the Trust") recognises its duty to ensure 'so far as is reasonably practicable', the health, safety and welfare of staff, patients, visitors and others arising from Trust work activity.

The Trust is committed to achieving and maintaining high standards of Health, Safety and Welfare by recognising the importance of clearly defined management responsibility and arrangements. This policy sets out the minimum standards which all employees of the organisation are to work to, and encompasses the following:

- Organising arrangements
- Structure and responsibilities for health and safety
- Arrangements for health and safety
- Grievance Procedure
- Disciplinary Procedure
- Monitoring Arrangements

The Trust is committed to continuous improvement for Health and Safety by the implementation and maintenance of an effective Health and Safety policy. This policy applies to all of the Trust's properties and sites and other locations where Trust staff carry out duties. However, at some locations staff may need to refer to local arrangements where elements of this policy are not fully aligned with local arrangements. Reference to these local arrangements are made in a number of relevant sections of the policy.

This policy will be communicated to all staff, including permanent, temporary, voluntary workers, agency or locum. The Trust also recognises its statutory obligations in ensuring a safe environment for all employees, patients, contractors and visitors within the Trust.

1.1 Definitions:

Reasonably practicable	This means balancing the level of risk against the measures needed to control the real risk in terms of money, time or trouble. However, you do not need to take action if it would be grossly disproportionate to the level of risk.
Competent person	Someone who has sufficient training, experience or knowledge and other qualities that allow them to assist you properly. The level of competence required will depend on the complexity of the situation and the particular help needed.
Employee	Any person who holds a contract of employment directly with the Trust
Contractors	A person or firm that undertakes a contract to provide materials or labour to perform a service or do a job for the Trust. This includes bank staff, agency staff, staff employed by other Trusts, organisations and agencies occupying Trust premises
Risk Assessment	A careful examination of what, in the workplace, could cause harm to people, so that you can weigh up whether enough precautions are in place or if more should be done.
Hazard	A hazard is anything which has the potential to cause harm, such as chemicals, electricity, working at height etc.
Risk	The risk is the likelihood that the hazard will cause harm, it also considers the consequences, extent and outcome of a hazardous event occurring.
Significant risk	Risks, which are significant, are those that are not trivial in nature and are capable of creating a real risk to health and safety which any reasonable person would appreciate and would take steps to guard against. What can be considered as "insignificant" will vary from site to site and activity to activity depending on specific circumstances.

Suitable and sufficient	that all significant hazards have been identified, the risks have been properly evaluated considering likelihood and severity of harm, measures necessary to achieve acceptable levels of risk have been identified, actions have been prioritised to reduce risks, the assessment will be valid for some time, actual conditions and events likely to occur have been considered during the assessment, everyone who may be harmed has been considered
Young person	Is anyone under the age of 18 and above the minimum school leaving age.
Approved code of practice (ACOP):	Describe preferred or recommended methods that can be used (or standards to be met) to comply with regulations and the duties imposed by the Health and Safety at Work etc. Act 1974

1.2 Related Trust policies

To support the Health, Safety and Welfare Policy on the statutory requirements under current legislation, the following policies have been produced for the Trust's undertaking:

- Smoke Free Environment Policy **PP004**
- The Use of Mercury Policy **PP005**
- Fire Safety Policy **PP014**
- Equality, Diversity & Inclusion Supporting Equal Opportunities Policy **PP021**
- Management of Medical Equipment Policy **PP024**
- Display Screen Equipment Policy **PP025**
- Handling Patients and Safe Handling of Loads **PP026**
- Control of Substances Hazardous to Health (COSHH) Policy **PP039**
- Security Policy **PP050**
- Disciplinary Rules Policy **PP053**
- Freedom to speak up – Whistleblowing – staff concerns about patient care & other matters **PP056**
- Workplace Policy on Substance Misuse **PP068**
- Policy For Recruitment and Retention of People with Disabilities **PP077**
- Bullying and Harassment Policy **PP080**
- Management of Violence and Aggression Policy **PP082**
- Sharps Injury and Accidental Exposure to Body Fluids **PP083**
- Control of Asbestos at Work Policy **PP089**
- Strategy and Policy for Risk Management **PP093**
- Incident Reporting and Management Policy **PP105 and 105b**
- Lone Working Safety Policy **PP134**
- Supporting a Positive Mental Health Culture Including the Management of Stress in the Workplace **PP149**
- Waste Management Policy **PP179**
- Prevention and Management of Risks to Latex **PP195**
- Slips, Trips and Falls (Staff and Others) **PP282**
- Central Alerting System (CAS) Policy and Procedure **PP283**
- Policy for the Management of First Aid at Work Provision **PP285**
- Health and Wellbeing at Work **PP288**
- Driving for Work **PP318**
- Electricity at Work **PP330**

1.3 **Organising Arrangements**
The responsibility for ensuring the day-to-day safe conditions of work rests with Managers and Supervisors at all levels. The Trust will ensure that suitable and sufficient training is given to this group of staff, as well as providing technical advice and support on health, safety and welfare issues.

The Health, Safety and Welfare Policy will not be successful unless it actively involves staff. Managers will co-operate fully with safety representatives, health and safety link persons and COSHH link persons and should make available to them the facilities and training necessary to ensure full participation and competency which is required to undertake such roles.

The Trust is committed to consulting and working with staff in health and safety matters through the Trust's Health and Safety Committee. The Committee reports to the Corporate Risk Committee and where necessary escalates risks to the Board via the Trust Executive Group (TEG). A copy of this policy will be brought to the attention of all staff and will be available through Heads of Departments, Ward Managers and via the Trust's Intranet.

2. Roles and Responsibilities for Health and Safety

2.1 Chief Executive:
The Chief Executive has overall responsibility for ensuring that the Trust complies with its legal obligation under the Health and Safety at Work etc. Act 1974, the Management of Health and Safety Regulations 1999 and all other associated regulations. The Chief Executive will achieve this by:

(a) Ensuring the Trust has a positive health and safety culture which is reflected in high standards of health, safety and welfare across the Trust;

(b) Monitoring health and safety standards by receiving information from the Executive lead for Health and Safety and information via the Quality and Risk Committee and through attendance at the Audit Committee;

(c) Ensuring significant health, safety and welfare issues are reported to the Trust Executive Group (TEG) for consideration, and if necessary to the appropriate Board Committee for action;

(d) Receiving and addressing any enforcement notices or recommendations issued by the Health and Safety Executive (HSE), Fire Authority, Environmental Health, CQC and any other statutory bodies;

(e) Agreeing health and safety objectives for the forthcoming year whilst ensuring that adequate resources are available to ensure these are met.

2.2 Executive Lead for Health and Safety
The nominated Executive Lead for Health and Safety in the Trust is the Executive Chief Nurse.

The Executive Lead for Health and Safety will assist in ensuring that high standards of health and safety are achieved and maintained throughout the Trust. They are also responsible for monitoring the Trust's health and safety performance while promoting health and safety at an Executive level. Other specific duties will include ensuring that the following are carried out:

(a) A three yearly review of the Health, Safety and Welfare Policy by the Health, Safety and Risk Manager supported by the Health and Safety Committee members. The Health, Safety and Welfare Policy once reviewed will be considered by TEG before going for approval to the Board and signing by the Chief Executive.

(b) Raising issues of concern to the Chief Executive and to TEG that the Health, Safety and Risk Manager and Health and Safety Committee deem to be of a serious nature and require escalation.

(c) That the Trust meets its duties under Health and Safety Law which is in accordance with developing and supporting a positive health and safety culture throughout the Trust.

(d) Ensuring that Safety Representatives within the Trust and other organisation representatives are consulted on relevant health and safety matters.

(e) Ensuring that the Trust has adequate resources in place to promote, monitor and manage health and safety.

2.3 Trust Board:
The Trust Board will receive from TEG details of health, safety and welfare matters which are of serious concern and cannot be resolved at a local level for deliberation and recommendation.

The Trust Board will receive details of any enforcement action taken against the Trust and ensure appropriate action is taken to address the stipulations of any such enforcement action.

The Trust Board requires and will receive assurance through the Trust's reporting and accountability arrangements that effective health, safety and welfare arrangements are in place and where necessary, mitigating action is being taken to address any areas of weakness.

Board members will receive mandatory health and safety training at two yearly intervals.

2.4 Trust Executive Group (TEG):
TEG will receive details from the Executive Lead for Health and Safety and/or the Corporate Risk Committee of any health and safety issues which are of a serious nature and that cannot be resolved locally of which require deliberation and recommendation. Where necessary such issues will be escalated to the Trust Board.

TEG will receive a report from the Health and Safety Committee on an exception basis detailing issues of concern which are not progressing in a satisfactory manner. This report will be submitted to the next available Trust Executive Group meeting following the Health and Safety Committee meeting.

2.5 Corporate Risk Committee (CRC):
The CRC will receive and review the minutes and summary report of the Health and Safety Committee. Issues outside of the scope of the Health and Safety Committee will be escalated to and reviewed by this committee which is also responsible for monitoring health and safety performance.

2.6 Health and Safety Committee:
The Health and Safety Committee will receive assurance of compliance to health and safety legislation and details of non-compliance. In receiving such information, the Health and Safety Committee will provide a report to the Corporate Risk Committee detailing issues which require action and escalation. Each Division represented at the Health and Safety Committee enables operational health and safety issues to be discussed, representatives to then agree actions applicable to their area and actions/issues/outcomes to be communicated to the relevant Division forum.

Sub-groups of the Health and Safety Committee will be formed when the need is identified, and will be responsible for looking at specific hazards within the organisation. These sub-groups will report to the Health and Safety Committee.

The Health and Safety Committee meets on a quarterly basis, and has the following as standard agenda items (also detailed in the Terms of Reference for this Committee):

- Apologies for absence
- Minutes of the previous meeting
- Matters Arising and action sheet
- Report from Head of Health, Safety and Risk (quarterly)
- Report from Moving and Handling Advisor (quarterly)
- Report from Occupational Health (quarterly)
- Report from Fire Advisor (quarterly)
- Report from Local Security and Management Specialist (quarterly)
- Report from the Operational Estates and Environment Manger (quarterly)
- Report from the Asbestos Management Group (annually)
- Report from the Radiation protection Committee (annually)
- Report from the Medical Gases Committee (annually)
- Departmental/service issues for escalation to the committee

- New legislation and guidance
- Policies for consideration – new or amendments
- Any correspondence from external governing agencies e.g. HSE
- Any other business
- Reflection and issues for escalation
- Date of next meeting

The Head of Health, Safety and Risk will present significant issues, identified within the meeting via a report, to the Corporate Risk Committee. Significant risks will be escalated out with this reporting cycle to TEG and, if required, the Board for deliberation and recommendation.

2.7 Trust Secretary and Head of Governance:
Will ensure that the Trust has access to adequate competent health and safety advice. Ensuring the continued competence of this resource will be supported by the Trust Secretary and Head of Governance who has line management responsibility for the Head of Health, Safety and Risk. The Trust Secretary and Head of Governance will assist in the day to day formulation of health and safety initiatives when required and is responsible for escalating health and safety issues to the Executive Lead for Health and Safety.

2.8 Executive Directors:
Are responsible for achieving and maintaining high standards of health and safety within their area of responsibility. Where necessary they should seek advice on health and safety matters from the Head of Health, Safety and Risk. If a Director is unable to resolve a health and safety related matter they should escalate it to TEG.

2.9 Associate Directors of Operations (ADO's), Clinical Directors and Estates and Facilities Management Team:
Are responsible for promoting and ensuring high health and safety standards within their areas of responsibility. They should ensure that Managers working within their area of responsibility are aware of this requirement and must ensure that they have the training and competence required.

Will ensure risk assessments are reviewed in accordance with the requirements of the Risk Assessment Policy and Procedure (PP132). They are responsible for ensuring that hazards are controlled appropriately in their area of responsibility by taking action on hazards identified that cannot be resolved by the Lead Clinician, Head of Department, Service Manager or Matron. Where they are unable to resolve or reduce a risk to a suitable level it should be escalated to the appropriate Executive Director.

3. Lead Clinicians, Senior Operations Managers, Heads of Nursing, Heads of Department, Service Managers, Matrons and Managers:
Are responsible for ensuring that the Health, Safety and Welfare Policy is implemented within their areas of responsibility. They are responsible for ensuring that arrangements agreed by the Executive Lead for Health and Safety are carried out and that Regulations and/or Approved Codes of Practice (ACOP's) are followed and implemented. More detailed responsibilities include:-

- Co-ordination of the health, safety and welfare arrangements for their designated area. The Trust supports the role of 'Safety Representatives' from a recognised union, and will support and train nominated key individuals to become 'Health and Safety Link Persons'. Managers must nominate a Health and Safety Link Person for their areas of responsibility and contact the Risk Office to book the nominated person onto the RSPH Level 2 Award in Health and Safety in the Workplace. The responsibilities of the 'Safety Representative/Safety Link Person' are detailed on pages 8, 9 and 10 of this Policy, and should only be undertaken by those who have received the necessary training. **N.B a manager's accountability for health and safety cannot be delegated.**
- If applicable Managers must also nominate a key individual to become a COSHH (Control of Substances Hazardous to Health) Link Person and must support this role. They must contact the Risk Office or the COSHH Co-Ordinator once the COSHH Link Person has been identified and arrange for the COSHH Link Person to attend the training required to enable them to undertake this role. The responsibilities of this role are detailed on page 10.

- The production and regular review of safety procedures whilst ensuring that staff are made aware of Safety Protocols and Standard Operating Procedures (SOPs). Departmental safety procedures must be in alignment with the Trust's Health, Safety and Welfare Policy.
- Ensuring that safe systems of work are in operation and that legal requirements affecting health and safety are met.
- Liaising with the Head of Health, Safety and Risk on matters affecting health, safety and welfare within the workplace.
- Liaising and consulting with Safety Representatives and Health and Safety Link persons for their area of responsibility on matters affecting health, safety and welfare.
- Ensuring that entries within the Datix risk register are kept up to date and regularly reviewed.
- Ensuring that all staff, including those who come into the area as part of their daily work, are aware of the general outline of the Health and Safety at Work etc. Act 1974. This will include ensuring that staff, have an understanding of their individual duties.
- Ensuring that health and safety workplace inspections are carried out regularly by the Health and Safety Link Person and captured on Datix risk register.
- Reviewing workplace inspection reports and leading on workplace inspection action plans via Datix to ensure all actions are initiated and completed.
- Managing hazards and associated risks in their areas of responsibility by undertaking suitable and sufficient risk assessments using the Trust's agreed procedure within their areas to identify and assess hazards.
- Recommending, implementing and monitoring the effectiveness of control measures to minimise risk within their areas of responsibility.
- Escalating risks that cannot be adequately controlled to their immediate manager.
- Ensuring that all staff (and others in their areas affected by The Trust's operations) are made aware of the contents of relevant risk assessments; and that staff receive appropriate information, instruction, training and supervision to enable them to work safely.
- Ensuring that all new members of staff working in their area are given a suitable local induction which covers risks within the area and bring to their attention relevant risk assessments and control measures and that this can be demonstrated through documentation.
- Ensuring that all new staff attends the Trust induction and other mandatory training.
- Ensuring the recording and reporting on Datix of all incidents, dangerous occurrences, occupational health issues such as dermatitis and asthma, and near misses that occur, in line with the Trust's Incident Reporting Policy and Procedure PP105.
- Ensuring investigations of incidents are undertaken and that action is taken to prevent a recurrence. All investigations are recorded on Datix. A further investigation form is to be completed and sent to the Risk Office for all RIDDOR reportable incidents.
- Ensuring that when faults, breakdowns and malfunctions of equipment occur, the equipment is withdrawn from use immediately clearly marked "do not use" and arrangements made for repair, replacement or condemning. Ensure maintenance is specified in accordance with the manufacturers' recommendations and ensure that this is carried out.
- Identifying the health and safety training needs for the staff for which they are responsible, and that appropriate arrangements are made to fulfil these needs. Special attention must be given to risk situations and the appropriate training is given to staff identified.
- Ensuring that adequate information, instruction, training and supervision is provided to staff during working activities.
- Making staff aware of information received from suppliers on equipment and hazardous substances and their proper use within the working environment, through the risk assessment process.
- Making sure that equipment, particularly of an electrical or mechanical nature, is examined and tested by the Estates and Facilities Division before being used – all new electrical equipment and electrical equipment brought in from home (desk fans etc.) must be portable appliance tested (PAT) before it is first used.
- Ensuring that adequate arrangements are made for appropriate liaison with contractors and others who come onto the property.
- Any health, safety or risk related issues that they are unable to resolve should be escalated to the appropriate ADO and/or Clinical Director.

3.1 The Risk Office will:

- Provide competent advice to the Trust on health, safety and welfare related matters.
- Liaise and meet with the Health and Safety Executive (HSE) regarding health and safety matters and standards at the Trust.
- Prepare and present health and safety reports to the Health and Safety Committee, Corporate Risk Committee and any other Committees as required.
- Undertake regular deep dive audits of the Trusts risk management arrangements and produce corresponding reports to be monitored by the Corporate Risk Committee.
- Monitor and review the Datix risk register.
- Provide RSPH Level 2 award training to health and safety link staff so they understand the role and can undertake their duties.
- Provide Induction training to all new starters
- Provide health and safety training to any staff completing the Care Certificate
- Provide any other adhoc health and safety training as required
- Liaise with Safety Representatives, Health and Safety Link Persons and COSHH Link Persons to ensure that information is shared and good standards of practice are developed and maintained.
- Undertake audits on specific health and safety related topics to ensure compliance with legislation and best practice.
- Undertake a rolling programme of regulation compliance audits and produce corresponding reports to the Health and Safety Committee
- Ensure that safety alerts (CAS) are managed appropriately within the Trust via the Datix system.
- Notify the HSE via telephone for any workplace fatalities or their online form of any RIDDOR reportable incidents which have occurred on the Trusts premises and are in connection with work.

3.2 Union appointed Safety Representatives

Safety Representatives appointed through their Unions under the Safety Representatives and Safety Committee Regulations 1977 are required to keep themselves informed of:

- The legal requirements relating to the health and safety of persons at work.
- The particular hazards of the workplace.
- Relevant Health and Safety Policies of the Trust.
- Attend appropriate training which will be provided by the unions.

3.3 Health and Safety Link Persons

Each department within the Trust should have a nominated Health and Safety Link Person(s). Any employee is welcome to put themselves forward for this role to their manager or the manager of the department should nominate one of their employees. Health and Safety Link Persons are a vital link between all departments of the Trust, as communication of health and safety issues is key to ensuring a uniform and positive approach is taken.

The role is supported with a Level 2 health and safety qualification. In order to achieve the qualification the nominated member of staff must attend the RSPH Level 2 Award in Health and Safety in the Workplace, which is a one-day training session. This training should be refreshed every 2 years. Please contact the Risk Office on ext. 3944 or 3909 for details of courses.

Functions of the Health and Safety Link person will include:

a) To be qualified to the Royal Society for Public Health (RSPH) level 2 qualification in Health and Safety in the Workplace
b) Encouraging co-operation between managers and employees in developing and implementing control measures to ensure the health and safety of all employees, patients and others.
c) Bringing to the attention of managers any unsafe acts or conditions that pose a risk within the working environment or working practices. It is important that the Health and Safety Link Person take up matters with managers without delay.
d) Establishing close working relationships with other representatives to examine hazardous situations of a similar nature to develop a common approach and to act in a uniform, responsible manner.
e) Making representations to their manager on general matters affecting the health, safety and welfare of employees at the workplace.
f) Undertaking the task of workplace inspections. Frequency of Inspections will depend upon the department grade. Red=quarterly, Amber=6 monthly and Green =Yearly. The inspection will be

focusing on the health and safety arrangements for the area concerned. Completed inspections will be transferred onto Datix in the form of a risk assessment so actions can be monitored. Issues of concern should be raised to the manager, and if necessary to the Risk Office.

g) To have a health and safety folder containing the required documents:
   - Health and Safety Policy
   - Hard copies of departmental risk assessments
   - Copies of previous workplace inspections, audits etc.
   - Any other relevant policy e.g. COSHH, DSE, Slips, Trips and Falls
h) May represent their department via consultation with the enforcing authorities.
i) Should initiate and undertake risk assessments for significant and foreseeable risks or as requested by their Manager. These risk assessments must be captured on Datix risk register
j) To regularly attend the Health and Safety Link Persons meetings for an update on health and safety initiatives in the Trust and also for short training sessions in how to undertake these duties.

3.4 COSHH Link Persons

Each department within the Trust where relevant should have a nominated COSHH Link Person. Employees are welcome to put themselves forward for this role to their manager or the manager of the area should nominate one of their employees. COSHH Link Persons are a vital link between all areas of the hospital as communication of COSHH issues is key to ensuring a uniform and positive approach is taken. The role is supported with a training session on current legislation and Trust COSHH policies and procedures. This training should be refreshed every 2 years. Please contact the Risk Office on ext. 3944 or 3909 for details of courses. Please see COSHH Policy and Procedure (PP039) for further information including the functions of the role.

3.5 Employees Responsibilities

It shall be the duty of every employee, while at work, to take reasonable care for the health and safety of themselves and of other persons who may be affected by their acts or omissions. Employees are required to co-operate with the Trust on health and safety matters. Where an employee feels a health and safety measure needs to be improved they should raise this with their Line Manager initially.

It will be the responsibility of all employees to bring to the Trusts attention any defective equipment or any potential or actual hazards they have identified, which might present a serious and imminent danger to health and safety of themselves and others within the Trust.

Every employee who has been made aware of the hazards related to their job **shall use** any machinery, workplace equipment, dangerous substances, transport equipment, clinical safety devices and personal protective equipment provided to them by the Trust, in accordance with the information, instruction and training provided, to ensure the effectiveness of the control measures.

Employees must not intentionally or recklessly interfere with or misuse anything provided in the interests of health, safety or welfare in pursuance of any of the relevant statutory provisions.

3.6 Occupational Health & Wellbeing Service

The Trust provides an Occupational Health and Wellbeing Service to all its employees. This comprises of a specialist advisory service which supports management and employees to reduce the risk to health in the workplace. The service comprises of the following provisions:

a) Employment health screening will be carried out after a job offer has been made. This will enable a health assessment to be carried out to ensure that the appointed candidate is physically and mentally fit to fulfil the role. The manager will be contacted by the Occupational Health and Wellbeing Service if any reasonable adjustments are required.
b) Undertake regular health surveillance for members of staff identified at risk, through the risk assessment process in line with the Trust's Policy and Procedure for conducting Risk Assessments (PP132) and the COSHH (PP039).
c) Immunisation against infection is offered to all members of staff identified at risk by their Manager.
d) Return to work assessment following illness or injury.
e) Risk assessments of new or expectant mothers in-conjunction with their working activities within the Trust.

f) On request, Occupational Health practitioners will undertake workplace inspections, to review the working environment and identify potential occupational hazards. Advice will be provided on the appropriate workplace precautions needed. A report will be submitted to the department head and the appropriate ADO for action. Where appropriate the Health, Safety and Risk Manager will be notified.
g) Any information relating to the health of members of staff shall remain confidential within the Occupational Health & Wellbeing Service. Further information on occupational health procedures can be obtained from the Occupational Health and Wellbeing Service Policy (PP046).
h) Occupational health will investigate along with the department manager any incidents of ill health including but not limited to: occupational dermatitis, occupational asthma, work related upper limb disorder, hand arm vibration, biological and radiation incident as listed in the RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences) regulations 2013.
i) The Occupational Health & Wellbeing Service provides a quarterly report to the Health and Safety Committee (Standing Agenda Item) and other Committees as required.

4. Arrangements for Health and Safety
This section provides summaries of the main arrangements the Trust has with regards to key areas of health, safety and welfare.

4.1 Consultation
The Trust communicates matters of health, safety and welfare through Managers, Safety Representatives and Health and Safety Link Persons who are expected to pass on information and enact policies and procedures.

On Trust wide issues which need to be communicated to all staff, the organisation will use the internal newsletter called the 'Green Sheet' and, if required, a staff briefing via email with the provision of a contact name and number for further consultation.

The minutes from the Health & Safety Committee are circulated to all members of the committee.

4.2. Health and Safety Training
The Trust, so far as is reasonably practicable will ensure that employees are provided with the necessary information, instruction, training and supervision to ensure their health, safety and welfare whilst at work. Mandatory training for all staff groups is set out and detailed in the Mandatory Training Policy (PP244). Please see appendix A of this policy which details role specific health and safety training requirements, please contact the Risk Office on ex. 3944 or 3909 for training details.

Local Area Induction
No employee should carry out duties which have a health and safety risk, until they have received adequate training in understanding the hazards involved and the precautions to be taken to eliminate or reduce the risk. It is the Departmental Manager's responsibility to ensure that health and safety training is given to all new employees to the area. The local induction should include local fire procedures, first aid, incident reporting on datix, relevant risk assessments, safe systems of work (standard operating procedures) and any other training necessary to ensure safety.

Trust Induction
All new employees will be required to attend the Trust induction. Information on attendance is provided to new employees within their starter pack, supplied by the Human Resources. Managers have the responsibility to ensure that new members of staff within the department attend.

Manager Training
All managers within The Trust are required to attend the Trusts induction and to undertake the two yearly cycle of e-learning refresher training. Any change in policy / practice / legislation etc. will be addressed through targeted update training to all relevant staff.

4.3 Health and Safety Workplace Inspection Arrangements
All clinical and non-clinical areas will be subjected to regular departmental workplace inspections. These inspections will be carried out by the departments Health and Safety Link Person. Following the inspection, a report will be produced which will, if necessary, include a corresponding action plan. This report and action plan will be captured on Datix risk register in the form of a risk assessment. It is the responsibility of the Head of Department/Manager of the area to ensure that any actions arising from a workplace inspection are resolved within a reasonable timeframe. Items that cannot be dealt with at department level or that require capital expenditure should be referred to the Health and Safety Committee for deliberation and escalation if appropriate. The frequency of the inspections is determined by the risk rating of the risk assessment so amber is 6 monthly and green is yearly.

4.4 Risk Assessments
The Health and Safety at Work etc Act of 1974 requires employers to ensure so far as is reasonably practicable the health, safety and welfare of its employees and others who could be affected by it activities. One way to do this is to have a robust system for identifying and managing risks as required by the Management of Health and Safety at Work Regulations 1999 (MHSWR) Regulation 3, which places an absolute duty on the WSFT to make a suitable and sufficient assessment of

(i) The risks to the health and safety of employees to which they are exposed whilst at work; and
(ii) The risk to the health and safety of others arising from the activities of the organisation. For the WSFT, others includes: • Patients • Visitors • Contractors

Many other regulations require specific risk assessments to be undertaken for example the Control of Substances Hazardous to Health Regulations (COSHH 2002) require chemicals which are hazardous to health to be risk assessed.

The purpose of a risk assessment is to ensure that all significant and foreseeable hazards are identified within the workplace or posed by a particular task which are arising from the Trust's activities, environment or outside influences and assess the level of risk it presents. Once this information has been gathered it will enable the Trust to evaluate if enough protective measures are in place, or if more should be done to prevent harm to employees, patients and others and to develop further risk reduction programmes where required.

It is the responsibility of **all** managers to ensure that risk assessments are carried out within the area of their responsibility, to ensure all risk assessments (past and current) have been captured on Datix risk register, and to act upon those assessments when control measures are found to be inadequate. Further guidance on risk assessments, hierarchy of controls and the management of them can be found within the Trust's Risk Assessment Policy and Procedure (PP132).

4.5 Safety Alerts
Safety alerts, emergency alerts, drug alerts, dear doctor letters and medical device alerts and any other relevant notices are issued by NHS England and NHS Improvement, MHRA, Chief Medical Officer (CMO) and Department of Health & Social Care.

The aim of the Central Alerting System (CAS) is to bring all alerts together into one electronic system to provide an effective method in which they are issued to the Trust

The Health, Safety and Risk Manager is the Trusts nominated CAS Liaison Officer whose role it is to ensure that alerts have been received, acknowledged, disseminated and captured on Datix, to progress chase and record actions taken. It is imperative that all alerts are disseminated promptly throughout the organisation and the necessary actions taken by the allocated lead.

A quarterly report is provided to the Corporate Risk Committee to provide assurance to the Trust that robust systems for dealing with safety alerts are in place. The Trust has a CAS database on Datix which is used to manage alerts; further guidance can be found within the CAS Policy and Procedure (PP283).

4.6 First Aid
The Trust recognises its responsibility under the Health and Safety (First Aid at Work) Regulation 1981, to provide first aid assistance to staff and others should they suffer injury or illness while at work or on any of the Trusts premises.

The WSFT has a number of trained first responders and first aiders in many of the departments.
Both clinical and non-clinical areas which do not have a designated first aider should dial 2222 to request emergency assistance and will use the Trust's Emergency Department for first aid treatment or medical assistance should it be required. Further guidance can be found within the first Aid at Work Policy (PP285).

Please note
The arrangements set out above may not be applicable in all locations used by the Trust. If this is the case staff should discuss with their line manager and refer to their local arrangements.

4.7 Reporting Incidents and Accidents
The procedure for reporting all clinical, non-clinical incidents, accidents and near misses is contained in the Incident Reporting and Management Policy (PP105 and 105b). It is the responsibility of **all** staff to report incidents, accidents and near misses using Datix within the Trust and other areas if connected to the organisation's undertaking.

The Head of Health, Safety and Risk will be responsible for ensuring quarterly summaries of health and safety incidents are produced for submission to the Health and Safety Committee for discussing preventative action.

4.8 Serious Incident requiring investigation (SIRI)
The principal definition of a Serious Incident Requiring Investigation (SIRI) is an incident that occurred in relation to NHS-funded services and care resulting in one of the following:

1. Unexpected or avoidable death or severe harm to one or more patients, staff or members of the public
2. A never event- all never events are defined as serious incidents although not all never events necessarily result in severe harm or death.
3. A scenario that prevents or threatens to prevent an organisations ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population.
4. Allegations or incidents of physical abuse and sexual assault or abuse
5. Loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation

SIRI's are required to be reported to the West Suffolk Clinical Commissioning Group using STEI (Strategic Executive Information System). The reporting of SIRI's provides an opportunity to learn for the future and the main purpose of this requirement is to ensure that NHS organisations take appropriate action following incidents, that the incidents are properly investigated and that any lessons learnt from them are shared.

All incidents, especially serious ones must be reported at once to the appropriate Manager/Supervisor within that area. The incident must be recorded on Datix by the Senior Officer, in conjunction with the member of staff wherever possible. The incident will then be reviewed by the Head of Patient safety and Clinical Effectiveness in consultation with the Executive Director Chief Nurse to make an assessment of the need to report it to the West Suffolk Clinical Commissioning Group.

4.9 Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013
The Trust is required to report the following types of incidents when they result from a **work related accident** to the Health and Safety Executive (HSE) under the RIDDOR Regulations:

a) The '**death**' of any person, whether or not they are at work, resulting from an accident arising out of or in connection with Trust activities.
b) Incidents where an individual has sustained a **'specified'** injury, for example, fracture (excluding fingers, thumbs and toes) any amputation, burns covering 10% of the body, crush injury to the head

or torso causing damage to the brain or internal organs, scalping, loss of consciousness caused by head injury or asphyxia. Resulting from an accident arising out of or in connection with Trust activities.

c) Any incident whereby a member of staff has sustained an injury and is away from work or unable to do the full range of their normal duties for more than **'seven'** consecutive days. Resulting from an accident arising out of or in connection with Trust activities.
d) Any **'dangerous occurrences'** that had the potential to cause significant injury which involved for example, lifting equipment, pressure systems, electrical short circuit etc. Resulting from an accident arising out of or in connection with Trust activities.
e) An employee at work suffers one of a number of specified diseases, provided that a doctor diagnoses the disease and the person's job involves a specified work activity. Only then will the Risk Office be provided with such information to allow the reporting process to commence.
f) Any accident or incident which resulted or could have resulted in the release or escape of a **'biological agent'** likely to cause severe human infection or illness, (Hepatitis, Tuberculosis etc.). Resulting from an accident arising out of or in connection with Trust activities.

When calculating "more than seven consecutive days" the day of the accident should not be counted, only the period after it. Any days the injured person would not normally have been expected to work, such as weekends, rest days or holidays, must be included. The Trust has **15 days** to report over 7 day RIDDOR reportable incidents.

During normal office working hours (Monday – Friday), any incident that meet the RIDDOR criteria, will be reported to the HSE by the Risk Office following notification from the Datix system.

Any member of staff who believes that an incident may be RIDDOR reportable must contact the Risk Office in the first instance as instructed on Datix. The Risk Office will then confirm if the incident is RIDDOR reportable or not. If the incident is RIDDOR reportable then the Manager for the area must complete a further investigation form. A signed and dated copy of the form must then be sent to the Risk Office.

4.10 Accident and Incident Investigations

The Trust recognises that investigations of incidents, accidents and near misses are a vital part of the Trust's risk management system. This will ensure that corrective action is taken to eliminate or reduce the risk from hazards within the activity therefore; avoiding further injuries, property damage and loss. On each occasion of a reported incident or accident an incident investigation must be completed on Datix in accordance with the Trust's Incident Reporting and Management Policy (PP105 and 105b).

Incidents, which have been categorised as 'Green' will be investigated / finally approved by the Line Manager or Ward Manager who is responsible for the area in which the incident occurred. Incidents categorised as 'Amber' will be investigated / finally approved by Heads of Departments, Service Managers or consultant who may at times conduct the investigation with the Matron for that area.
The lead investigator with an Clinical Director or ADO will investigate / finally approve incidents categorised as 'Red'. SIRI's will be investigated by a nominated person. For further guidance see the Incident Reporting and Management Policy and Procedure (PP105 and 105b).

4.11 Control of Substances Hazardous to Health Regulation 2002 (COSHH)

The Trust so far as is reasonably practicable is required to comply with these Regulations which apply to all work in which people are exposed, or are likely to be exposed, to substances hazardous to health. People can encounter at work a wide range of substances capable of damaging their health. The COSHH Regulations lay down the essential requirements and a step by step approach for the control of hazardous substances including biological agents, and for protecting people exposed to them.

The COSHH Regulations require the Trust to risk assess how a substance is stored, transported and used on any site under the Trusts control. The assessment must be completed by a competent person and be suitable and sufficient, please see the COSHH Policy and Procedure (PP039) for more information, and details of Sypol the Trusts COSHH Management System.

Each Department is required to have a COSHH Link Person who is responsible for:

- completing COSHH assessments relevant to their area;
- for ensuring that the storage of such chemicals is appropriate;

- for ensuring that the correct personal protective equipment (PPE) is provided and used by staff.

The Risk Office will provide advice, support and assessor training for completing COSHH assessments. The Occupational Health Department will carry out health surveillance and maintain the health surveillance records.

Heads of Department will be responsible for ensuring that, they and their employees receive adequate information, instruction and training on the use of hazardous substances and a record of this training is kept. The staff members local Induction must include details of health and safety and more specifically the member of staff's responsibilities as required by COSHH.

The use of personal protective equipment (PPE), e.g. RPE, goggles, protective clothing as the means of protection will only be considered as a last resort where other more robust measures are not reasonably practicable as per the COSHH Regulations Hierarchy of control.

All incidents, accidents and near misses involving a hazardous substance will be reported on the Datix system and appropriately investigated and finally approved.

The Trust is required under the COSHH Regulations to carry out regular air monitoring in the locations where hazardous substances are used to ascertain whether the control measures are working appropriately. Maintenance on the control measures shall be carried out in accordance with manufactures instructions and records shall be kept.

4.12 Procurement
Where there is a proposal to purchase or change a substance, piece of equipment or device the Purchasing Department and any person responsible for purchasing will carry out a risk assessment to ensure the risk to health is prevented or reduced to its most reasonably practical level. Advice can be sort from the Risk Office and/or Occupational Health& Wellbeing Service. This process is detailed in the Policy for Product Evaluation/Assessments (PP228) and the COSHH Policy and Procedure (PP039).

4.13 Procedure for Reporting Hazards
In the event of identifying an uncontrolled hazard within the workplace, all staff must notify the appropriate Line Manager/Head of Department. Defects of a physical nature for example damaged floor surface, faulty lights or other amenities must be reported to the Estates Helpdesk by telephoning **5555**, and the hazard will be dealt with by the Estates and Facilities Division. Steps must be taken to isolate the hazard until the Estates and Facilities Division take action.

If the hazard involves work equipment, including electrical or medical equipment, it **must** be immediately clearly labelled 'Faulty, Do Not Use or Out Of Order' and withdrawn from use and quarantined within the department. Then contact the Estates Helpdesk on ex. **5555**.

Please note
The arrangements set out above may not be applicable in all locations used by the Trust. If this is the case staff should discuss with their line manager and refer to their local arrangements.

4.14 Plant and Machinery
Good maintenance regimes are an essential part of machinery and equipment safety and are enacted by the Estates and Facilities Division as well as EBME for clinical equipment. The Trust recognises its statutory duty to maintain work equipment as specified within the Provision and Use of Work Equipment Regulations 1998 (PUWER) and the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). It is important that all equipment and plant is checked regularly and tested in accordance with the appropriate legislation and manufactures recommendations. All records of testing and checking are kept within the Estates and Facilities Division.

Employees also have a responsibility in notifying their Supervisors or Managers whenever they feel that plant or equipment is unsafe to use. Managers should ensure that all staff receive adequate information, instruction and training in the safe use of any equipment or machinery they are required to use within the Trust or the community. A record of this training must be kept.

4.15 Electrical Safety
The Trust has a legal duty to maintain electrical items and systems under the Electricity at Work Regulations 1989. The Trust is therefore required to assess work activities which involve electrical systems or which utilise electricity to ensure such work is carried out safely.

All portable electrical equipment within the Trust will be subjected to a portable appliance test (PAT), this testing will be completed by the Estates and EBME Departments

All new and brought from home/outside the Trust non-medical electrical appliances must be PAT tested by and registered with Estates before being put into use. Please contact the Estates and Facilities help desk on ext. **5555** to request testing for any new / brought from home electrical appliances.

If a member of staff is of the opinion that an electrical appliance is faulty, they should isolate the power supply, clearly label "Do not use", remove the appliance from service and report it to the Estates helpdesk on ext. **5555**.

All items of medical electrical equipment will be maintained by the Electro-Biomedical Engineering Department (EBME). This will be conducted in accordance with EBME schedules which are produced by a computerised maintenance system. Should Clinical Managers require a copy of the schedule then this is available on request from the EBME Manager.

In the event of a malfunction with an item of medical equipment, remove the equipment from use and clearly label "Out of Order". Clean in accordance with the Management of Medical Equipment Policy PP024) and report the fault to the EBME Department on ext. **2867** as soon as possible. A replacement will be issued where possible. Further information and guidance on the medical electrical equipment can be obtained within the Policy and Procedure for the Management of Medical Equipment (PP024).

4.16 Asbestos
The Trust is required under the Control of Asbestos Regulations 2012 to ensure so far as reasonably practicable, that there is no uncontrolled release of Asbestos fibres into the atmosphere within Trust properties and to manage and monitor any Asbestos materials that are knowingly located within Trust properties.

The Trust fulfils these requirements by the appointment of a Nominated Officer for Asbestos whose task it is to record, manage and monitor all Asbestos on the Trust premises. The Nominated Officer for Asbestos collates this information into a register which must then be consulted whenever dealing with suspected asbestos containing materials.

If any member of staff suspects that an asbestos containing material (e.g. a panel) has been damaged they are to contact either the Estates and Facilities Division Helpdesk on 5555 or contact the "Nominated Officer – Asbestos" direct on ext.3974 who will inspect and make the decision as to what precautions are to be put in place and any cleaning, removal or air testing procedures that are required.

Any and all work relating to asbestos and asbestos containing materials has to be approved by the "Nominated Officer – Asbestos" who shall issue a permit-to-work before any works may commence. Further guidance can be found in the Control of Asbestos at Work Policy and Procedure (PP089).

4.17 Contractors
Contractors working on The Trust's premises will be required to comply with the Estates and Facilities 'Code of Conduct' suite of documents. These documents set out the Health and Safety requirements and the rules for contractors to follow while working on site. All of which are provided when tendering for work. They will be made aware of any local Trust/Department rules and safety standards and must conform to these whilst working within any particular part of the hospital site and where applicable community sites.

All contractors must register with the Estates and Facilities Department on arrival to the Trust site and obtain an ID badge which must be worn at all times when on site. Once registered with Estates and Facilities, contractors will then undergo a site induction before they can commence work.

Contractors will be required to report all incidents and accidents taking place on the Trust premises to the

Project manager (responsible for compliance of the contractual terms) or Works Officer, as appropriate.

4.18 Radiation

It is a responsibility of the Trust to keep and maintain a safe environment with regard to the safe use of radiation within the hospital. There are a wide number of types of radiation (ionising and non-ionising) to be found within the hospital, including:

- X-rays and Gamma Rays (Ionising Radiation)
- High intensity light (e.g. lasers and some other optical sources) (Non Ionising Radiation)
- Magnetic Fields (MRI scanning) (Non Ionising Radiation)
- Ultraviolet light (Non Ionising Radiation)
- High frequency sound waves (ultrasound) (Non Ionising Radiation)

As with any other type of equipment in use around the Trust and Community, there are basic principles which should be applied:

- **Do not** attempt to operate <u>any</u> equipment for which you cannot produce documented evidence of having been trained.
- **Do** follow the instructions of the staff in charge of the equipment or radiation procedure.
- **Do** follow the instructions issued by nuclear medicine for any patient who has received a radioisotope dose, and contact the Nuclear Medicine Dept. On ext. **3379** if in any doubt.
- **Do** note that isotope patients cannot go into the MRI within 24 hours of receiving a dose, as the spill monitoring equipment cannot be taken near the magnet.
- **Do** take note of and obey any warning notices which are displayed near any such equipment.
- **Do not** wander into any room which has been identified as a controlled area. This applies especially to the **MRI unit, CT scanning, Nuclear Medicine, all x-ray rooms** and **rooms containing medical lasers.**
- **Do not** approach within 2 metres of any mobile x-ray unit which is in use on the ward or in theatre without wearing the correct personal protective equipment (PPE) i.e. lead apron
- **Do** advise the occupational health service if you are pregnant or suffering from any condition which you consider may place you at risk, occupationally, from any of the above sources of radiation. Please inform the radiographer if you are pregnant if required to go into a controlled area.

Overall responsibility for radiation safety within the Trust is held by the Chief Executive, and the Imaging Services Manager is responsible to the Chief Executive for ionising radiation and for the magnet safety of the MRI scanners only.
Further information can be found in the Trusts radiation safety policies:

Artificial Optical Radiation (including lasers) PP306
Ionising Radiation Safety PP307
Medical Exposure to Ionising Radiation PP308'

4.19 Water Management and Legionella / Pseudomonas control

The Trust regularly undertakes a 'Water Hygiene Risk Assessment' to comply with the HSE's control of legionella bacteria in water systems Approved Code of Practice L8, HSG274, HTM 04-01 and BS8580. The risk assessment will cover Legionella, Pseudomonas and scalding, and will be representative of the site, systems and services present at each site and will clearly identify all hazards and risks. From this an action plan is drawn up to address any issues with the water services across the site, which is controlled by the Estates and Facilities Department.

The Trust's water supply is chemically treated as part of its Legionella and Pseudomonas control plan. As part of the control measure to ensure the water is safe, the water supply is regularly sampled and analysed by the Trust water treatment specialist.
The in-house Estates team undertake water tank inspections, cleaning, descaling of shower heads and temperature readings of supply as part of its Planned Preventive Maintenance (PPM) regime to monitor and control the water services across the Trust. To prevent stagnation of water supplies in areas not used the Estates and Housekeeping staff carry out daily water flushing of all taps, bathrooms & WCs in these areas. It is a requirement to record these actions in the event of an incident with the water supply in these areas.

All staff are reminded to use water supplies in a responsible manner and to report any leaks or dripping taps to the Estates and Facilities Division Helpdesk ext.5555 for repair. For any further information on the water supply services please contact the Estates and Facilities Department.

4.20 Fire
Fire safety is really important in our hospital where it could be hazardous and time consuming to move patients to a place of safety in the event of a fire evacuation.

Most fires are preventable with good housekeeping, good oxygen management, effective maintenance and by keeping sources of heat / ignition (such as electrical equipment) away from anything that is flammable (such as paper, cardboard, bed linen, alcohol-based hand sanitiser etc.). Remain vigilant and deal with or report fire safety concerns to firesafetygroup@wsh.nhs.uk or Security.

Always ensure that you know:

- How to raise the alarm if you believe there is a fire
- How to close fire doors
- What your responsibilities are e.g. to assist with patient evacuation etc.
- Where the fire exits are and how to get to them
- Where your assembly point is (either inside or outside the building)

In the event of a fire alarm activation in core hours (Monday to Friday 9am to 5pm, Saturday, Sundays and bank holidays 9am to 2pm) Switchboard will not call the Fire and Rescue Service unless they have received a call to the emergency number (ext. 2222) confirming there is a fire, or the Fire Response Team confirms there is a fire or 10 minutes have elapsed.

Adhere to all Trust rules/policies such as on the use of equipment, cooking, smoking etc. Complete your mandatory fire training on an annual basis (this is face to face with the Trust's Fire Safety Adviser the first and subsequent alternate years and via e-learning in-between years – contact Education and Training to book). Further information is available in the Trust Fire Safety Policy (PP014).

Please note
The arrangements set out above may not be applicable in all locations used by the Trust. If this is the case staff should discuss with their line manager and refer to their local arrangements.

4.21 Waste Management
The Trust has a duty of care to appropriately manage and dispose of the waste that it generates (clinical and non-clinical). The Trust has a comprehensive Waste Management Policy (PP179), which sets out all elements of waste disposal within the Trust. Waste Management is also identified as an objective within the Trust's Environmental Objectives and Targets Programme, and includes the on-going review of recycling opportunities, to identify those that may be feasible for the Trust.

Waste must be managed, handled and disposed of in a manner that ensures:

1. Risks to health, safety and the environment are controlled.
2. All applicable legislation is complied with.
3. The most viable disposal options are selected.

Therefore, the Trust's aims to:

1. Ensure that waste is segregated in an effective manner that meets the requirements of legislation and the HTM Safe Management of Healthcare Waste.
2. Minimise the total volume of waste produced
3. Increase our recycling rate to lower Trust carbon emissions associated with waste disposal
4. Protect the environment.
5. Ensure the security of waste against scavenging, infestation and human interference.
6. To meet the requirements of other Trust policies, NHS guidance, standards and legislation.

4.22 Infection Control

Effective infection prevention and control is an essential component of a quality health care service. The Trust's aim is to:

- Reduce infection and its related morbidity and mortality.
- Provide a safe working environment for staff.
- Reduce the cost of patient care by preventing hospital associated infection.

Infection prevention is of major importance in hospitals because patients are more susceptible to infection due to underlying disease, medical and surgical procedures and immunosuppression. Good infection prevention practices together with prudent use of antibiotics are both central to the fight against the increasing prevalence and variety of multi-resistant organisms

Infection prevention is the responsibility of all health care workers and detailed explanations are contained in the Pink Book. Particular attention must be paid to hand decontamination, as this is the single most effective method of reducing hospital-associated infections.

4.23 Personal Protective Equipment (PPE)

The Trust will provide employees with suitable Personal Protective Equipment (PPE) as protection against workplace hazards, where other risk control systems are not reasonably practicable. The Trust recognises that PPE is the last resort in the hierarchy of controlling workplace hazards and that other more robust measures are favourable.

The Personal Protective Equipment Regulations 2002, requires the Trust to make an assessment of the PPE required for a particular task, to ensure that the PPE provides suitable protection to the user, that it can be worn correctly and does not cause unnecessary discomfort.

To identify the suitable PPE, a risk assessment must be conducted on the proposed activity. This will assist in the task of identifying the correct control measures.

The Trust is required by statute law to provide PPE to staff and persons affected by the Trust's undertaking, 'free of charge'. In relation to safety footwear the Trust will pay up to a fixed figure whereby suitable footwear can be purchased for that sum. If staff prefers a more expensive brand of safety footwear then the individual will be required to pay the difference. Further information and guidance on PPE within the Estates and Facilities Division can be obtained from the Estates and Facilities internal policy and procedure documents.

Suitable training and information will be provided to employees for the correct use and storage of PPE. Records of PPE issued to staff, including training in its correct use, shall be documented by the line manager.

All staff have a responsibility to take reasonable care of their PPE, to wear their PPE in-accordance with the training and information provided to them, and to report any defects of such equipment to their line manager immediately. The Trust may seek to recover the cost of any PPE which has been damaged or lost through neglect. Additionally, employees should wear clothing and footwear that are suitable for the nature of the work they carry out.

4.24 Moving and Handling

The Trust is committed to promoting safe moving and handling activities in order to minimise the risk of injury to both patients and staff. The Trust has in place a moving and handling team who provides advice and training across the Trust

Further guidance on safer handling principles, responsibilities and management of risk assessments relating to moving and handling can be found in the Handling Patients and Safe Handling of Loads Policy and Procedure (PP026).The manual handling risk assessments can be found on the intranet under Trust information and Manual Handling.

Lists containing details of the Trust's moving and handling equipment (including bariatric equipment) can be found on the Trust intranet under Trust Information and Manual Handling.

4.25 Slips, Trips and falls (Staff and Others)

There is a need to consider and include slip, trip and fall hazards (if applicable) within generic risk assessments. Situations may arise where there is a need to ensure that a specific risk assessment is carried out on a slip, trip or fall hazard to enable the risk to be appropriately managed. For full responsibilities and procedures in the prevention and management of slips, trips and falls please see the Trust's Non-Clinical Slips, trips and falls (staff and others) Policy and Procedure (PP282).

It is the responsibility of all staff to ensure that the work they undertake does not cause or create slip, trip and fall hazards. Where slip, trip and fall hazards are unavoidable then appropriate control measures must be put in place. It may be appropriate for the hazard or task to be assessed and either the Risk Office on ext. 3944 /3909 or Occupational Health on ext. 3424 will assist with this if required.

Any slip, trip or fall hazards that cannot safely be controlled must be cordoned off and warning signage put in place. The hazard must be reported to the Department Manager and the Estates and Facilities Division Helpdesk on ext. 5555 immediately.

Where applicable departments must have procedures in place for quickly and effectively dealing with any spillages that might occur. Where the potential spillage involves a hazardous substance then the relevant COSHH (Control of Substances hazardous to Health) assessment should be used to develop the procedure and identify any equipment that is required to contain and clear up the spillage i.e. chemical specific spill kits.

The Estates and Facilities Division will ensure that contractors working on Trust sites are aware of all relevant policies and procedures including the Estates and Facilities Division Working at Height policy and related Code of Practice. The Estates and Facilities Division will ensure that contractors have an appropriate risk assessment and method statement (RAMS) in place before commencing any work.

The Estates and Facilities Division will ensure that access and egress from all sites is maintained and so far as is reasonably practicable is free from slip, trip and fall hazards. A slip test may also be carried out by the Housekeeping Department to determine how slippery a floor is. If the floor is deemed to be slippery then action will be taken to address this. Staff are reminded to wear appropriate footwear. Any concerns should be reported to the Estates and Facilities Division Helpdesk on ext. 5555 immediately.

All staff are reminded to take notice and care where a wet floor sign, barrier or tape is in place to cordon off an area. These items should not be removed or moved by unauthorised staff.

All slips, trips and fall incidents should be reported using the Trust's Datix incident reporting system. Where appropriate, photographs of the area where the incident took place should be taken.

4.26 Display Screen / Workstation Assessments

It is the responsibility of the Manager/Head of Department to ensure that all workstations and relevant display screen equipment used by staff (WOW's, laptops etc) is assessed to identify possible risks to users, this includes permanent home workers. The Trusts Occupational Health and Wellbeing Service will offer advice and support to Managers on risk reduction for the user of Display Screen Equipment. The Occupational Health and Wellbeing Service offer DSE training sessions-please see the Green Sheets or contact Occupational Health& Wellbeing Service for further details. DSE training is also available as e learning and users must be encouraged to complete this training.

Where hazards are identified as a result of the assessment; it is the Manager/Head of Department's responsibility to ensure that these risks are reduced to the lowest extent reasonably practicable. See Policy on Working with Display Screen Equipment (PP025) for guidance on workstation assessments and further information.

4.27 Eyesight Test

Members of staff identified as display screen equipment users by their Manager will be given a 'Request for Eye Test Voucher', (Appendix 7 of Policy PP025). The member of staff is required to take this letter to the Occupational Health and Wellbeing Service where they will be given a voucher to take to the Spec Savers of their choice.

4.28 Stress

The Trust recognises its legal duty of care to its employees and is aware that this applies to physical and mental health problems that can be caused by or exacerbated by workplace practices. So far as is reasonably practicable the Trust will do all that it can to ensure the health of its members of staff and that they are not exposed to risk.

It is acknowledged that people are affected by both occupational and personal pressures, the two being inextricably linked. As such, it is possible to offer help and support in one area which will bring about benefits in the other. The benefits will accrue to the person, their family and friends and to their employer.

ADO's are responsible for ensuring that: Good Human Resource (HR) management procedures are carried out throughout their areas of responsibility see Policy PP149 (Policy to Support A Positive Mental Health Culture including the Management of Stress in the Workplace) paragraph 5 and risk assessments that take account of mental and psychological hazards are carried out.

The Occupational Health and Wellbeing Service provides a confidential service which is available to provide support to managers and members of staff who self-refer. For further information please refer to Stress (Management in the workplace) Policy (PP149) and Occupational Health and Wellbeing Service Policy (PP046).

4.29 Lone Working

The Trust recognises that some staff work by themselves for significant periods of time without close or direct supervision e.g. in the community, in isolated work areas and out of hours. The Trust's Lone Working Safety Policy (PP134) applies to all situations involving lone working and should be consulted by staff who will be lone working.

The risks from lone working must be assessed in a systematic and on-going way to ensure that suitable safe systems of work are put into place to reduce any risks. Managers / Department Heads must ensure that lone workers undertake face to face lone worker training, which is available to all staff to enable them to recognise risks within their workplace and provide practical advice to maintain their personal safety at all times. Please contact the Local Security Management Specialist on ext. 3533 for further details.

4.30 Driving for Work

The Trust is committed to identifying and minimising those risks associated with road safety and actively encourages safe driving in order to reduce the number of accidents and to comply with its legal obligations.

It is the managers responsibility to ensure that a risk assessment has been carried out, that the driver of the vehicle is suitably insured (business insurance), competent to drive, holds a suitable and valid driving license and is familiar with the vehicle and the task.

It is the driver's responsibility to ensure that they are physically fit to drive, hold a suitable and valid driving licence, the vehicle has a valid MOT certificate and it appropriately insured (business insurance). See Driving for Work Policy (PP 318) for further information and the staff sign off declaration.

4.31 Security Awareness

Effective security arrangements at The Trust are essential to ensure a safe environment is provided to patients, staff and others; and ensuring that the Trust's assets and buildings are properly safeguarded.

This objective needs to be achieved whilst recognising the need for continued health care service provision; thus must enable accessibility to the site for staff, patients and others without compromising the integrity of the site.

The Security Policy and Procedure (PP050) details how security measures are implemented within the Trust. The desired outcome is to heighten security awareness; as well as creating a pro security culture amongst staff resulting in a culture where we all accept responsibility for ensuring security for ourselves, colleagues, patients, others, Trust's assets and our own belongings.

All staff are advised to leave valuables and large amount of money at home whenever possible and must wear their ID badges when in an official capacity, (inclusive of training and educational attendance), whilst on Trust property.

Please note
The arrangements set out above may not be applicable in all locations used by the Trust. If this is the case staff should discuss with their line manager and refer to their local arrangements.

4.32 Management of Violence & Aggression
Everyone has a duty to behave in an acceptable and appropriate manner. Staff have a right to work, as patients have a right to be treated, in an environment that is safe and secure. The Trust has a statutory obligation to ensure (so far as is reasonably practicable), a safe and secure environment for its staff. Violent and abusive behaviour and criminal acts will not be tolerated. The risks of violence to staff must be assessed and where possible action will be taken, to protect staff, patients and others. The Management of Violence and Aggression Policy and Procedure (PP082) gives guidelines which detail the Trust's strategy in tackling violence and aggression against all staff. This policy has been introduced in the context of the mandatory requirement to report cases of physical assaults which could lead to media attention i.e. major assaults to NHS Protect and an annual report submitted for all violence and aggression incidents. It details the avenues that are available for staff, and the Trust alike, to seek legal redress.

Violent, abusive behaviour and criminal acts will not be tolerated. The risks of violence to staff must be assessed and where possible action will be taken, to protect staff, patients and others, as per the new national legal frameworks established by NHS Protect. A copy of the generic Violence and Aggression risk assessment can be found as an attachment to the Violence and Aggression Policy and Procedure (PP082).It is mandatory that front line staff attend conflict resolution training. Managers are to ensure that all staff who have regular and consistent contact with members of the public, patients and others, attend this mandatory training. Courses can be booked via the Estates and Facilities Division on ext.3669

Where staff, patients and others are the victims of, or witness an act of violence or aggression, this should be reported using Datix the Trusts on line incident reporting system where it can then be dealt with appropriately. Please see the Violence and Aggression Policy and Procedure (PP082) for further details on contacting the RPI team and or the police.

A zero tolerance panel has been formulated to ensure acts of physical and non-physical violence and aggression towards the staff are reviewed and appropriate action taken The panel's duties are:

- To review security incidents presented by the Local Security Management Specialist(LSMS)
- To consider evidence including statements from all parties involved in the incident
- Agree an action plan taking into account of all mitigating factors
- Monitor success of action plans agreed
- Monitor themes and trends and identify areas of learning within the Trust
- Support the LSMS in provision of information to the Health and Safety Committee

Please note- if the above is not applicable then staff should refer to local arrangements

4.32 Major incident / Majax
Every Acute Trust has to plan for its response to events which may jeopardise the delivery of its services. These can be summarised as events which prevent or limit the Trusts access to staff, equipment or the site.

The Trusts responsibility in planning for such events is to:

- Fulfil the requirements as a Category 1 responder under the Civil Contingencies Act 2004 and under the Health and Safety at Work Act 1974
- Implement national policy and guidance in the local context
- Incorporate all associated Resilience outputs into Trust EPRR planning; to include Risk, Security, Fire, Health & Safety, Comms, and operational delivery
- Ensure that the Trusts own plans for dealing with pressures recognise the requirements of regional plans
- Utilise Regional NHSE/I Strategic End-states, Objectives, Planning Assumptions and Constraints to facilitate Trust planning

- Focus planning to identify and mitigate risk, and to report on residual risk
- Demonstrate a high level of preparedness and to plan in conjunction with local NHS and other partners
- Establish and maintain working relationships with other health services, major organisations locally and with other key stakeholders
- Train and exercise as a Trust and with partners
- Develop command and control structures that allow appropriate links to local resilience arrangements
- Participate in local and SHA Business Continuity and Emergency Planning forums

For further details of EPRR outputs please see the Trust EPRR Strategy, Trust Business Continuity Policy and the Command, Control and Coordination (C3) Plan.

For further details of emergency planning please see policy and procedure Business Continuity (PP256).

Please note
The arrangements set out above may not be applicable in all locations used by the Trust. If this is the case staff should discuss with their line manager and refer to their local arrangements.

4.34 Protection of Young Persons
Under Health and Safety Law, every employer must ensure (so far as reasonably practicable), the health and safety of all their employees, irrespective of age. As part of this, there are certain considerations that need to be made for young people (persons under the age of 18). Under the Management of Health and Safety at Work Regulations 1999, the Trust will ensure that any young person employed by the Trust are protected at work from any risks to their health and safety, which are a consequence of their lack of experience, or absence of awareness of existing or potential risk or the fact that young persons have not yet fully matured.

A risk assessment must be carried out using the young person risk assessment template (appendix C) by the young person(s) line manager before work commences and with the young person. The risk assessment will take into account
the following aspect where the work is:

- Beyond their physical or psychological capacity
- Involves exposure to substances chronically harmful to human health, e.g. toxic, carcinogenic, skin or respiratory sensitising or have effects likely to be passed on genetically, or likely to harm the unborn child
- Involving harmful exposure to radiation
- Involving the risk of accidents which it may be reasonably assumed cannot be recognised or avoided by the young person owing to their insufficient attention to safety or lack of experience or training; or
- In which there is a risk to health from extreme cold or heat, noise or vibration

4.35 Temporary Workers
The Trust will provide any person employed through West Suffolk Professionals adequate information, instruction, training and supervision to enable them to carry out their role. Any person employed through West Suffolk Professionals must abide by the Trusts Policies and Procedures.

4.36 New or expectant mothers
There is a legal requirement under the Management of Health and Safety at Work Regulations 1999 to assess the risks specific to new and expectant mothers. The Health and Safety Executive (HSE) define a new or expectant mother as an employee who is pregnant, who has given birth within the previous six months or who is breast feeding.

The Trust will on written notification stating that the member of staff is pregnant conduct a risk assessment in accordance with the Maternity and Adoption Policy (PP169) and the Occupational Health and Wellbeing Service Policy (PP046) to identify if the new or expectant mother, or her baby are at risk from any processes, working conditions, physical, biological or chemical agents in the work place. This risk

assessment once completed should be reviewed on a regular basis with the employee.

Where, reasonable to do so in reducing the risks the Trust will if necessary alter the member of staffs working conditions or hours of work. If it is not reasonable to alter the working conditions or hours of work, or if it would not avoid such risk, the Trust shall, subject to the Employment Rights Act 1996 sections 66, 67 and 68 suspend the employee from work on full pay for so long as is necessary to avoid such risks.

5. Grievance Procedure

All employees and in certain circumstances, former employees have the right to seek redress for grievances which are relevant to their employment with the West Suffolk NHS Foundation Trust. This right applies equally to all staff irrespective of their position in the organisation.

Where an employee has a complaint relating to the health and safety provisions the matter should, in the first place, be raised with their line manager and safety representative for the area concerned. If the matter remains unresolved, the employee should use the Trust's Grievance Policy (PP035).

6. Disciplinary Procedure

Where an employee contravenes the Health and Safety at Work etc. Act 1974 and other subsequent statutory regulations, or deliberately ignores safety procedures and processes determined by the Trust, he or she will be liable to full disciplinary proceedings in line with the Trust's Disciplinary Policy and Procedure(PP040).

7. Monitoring Arrangements

Having drawn up a policy, stating the organisation structure and key arrangements for health and safety, it is essential to monitor the Trust's compliance to this policy and assess the health and safety performance of the Trust. The main role of the Health and Safety Committee is to monitor the Trust's health and safety performance and escalate issues of concern or interest. To do this, the Health and Safety Committee will require reports from named leads with the day to day responsibility for key arrangements for health and safety. Please see appendix C which details the key health and safety arrangements, the responsible lead and the frequency of reporting required to the Health and Safety Committee.

The following topics will determine key performance indicators which will enable the Trust to measure and monitor performance:

- Accident and occupational ill health data
- Risk Register performance
- Workplace inspections and associated action plans
- Audits of compliance with legal requirements and approved codes of practice relating to health and safety
- Health and Safety Link Person named for each area and actively undertaking the required duties
- Numbers of staff who have received health and safety training

The responsibility for monitoring performance and enabling improvements in the above mentioned areas lies with the Chief Executive, the Executive Lead for Health and Safety, the Corporate Risk Committee and the Health and Safety Committee. Clear lines of communication are in place to enable these responsibilities to be carried out (as detailed in section 3 of this policy).

8.Review

The Head of Health, Safety and Risk will review this policy every three years or sooner if necessary because of changes to legislation or Trust undertakings.

Author(s):	Head of Health, Safety and Risk
Other contributors:	Trust Secretary and Head of Governance, Estates Manager, Nominated Person – Asbestos, Estates Labour Manager, Local Security Management Specialist, Imaging Services Manager, Trust Infection Control Lead, Occupational Health Manager and Compliance Manager.
Approvals and endorsements:	Health and Safety Committee / Trust Executive Group

Consultation:	Health and Safety Committee Members, Trust Executive Group and the Trust Board.
Issue no:	13
File name:	S:\Governance\Risk Office\Policies and Procedures\Health, Safety and Welfare Policy 17
Supercedes:	PP(17)018
Equality Assessed	Yes
Implementation	See section 3
Monitoring: (give brief details how this will be done)	See page 20
Other relevant policies/documents & references:	See above
Additional Information:	

Role Specific and Mandatory Health and Safety Training Requirements:

2, 3, 5, 6, 7, = Role Specific
1, 4 = Mandatory

Course/Training Element	All Staff	Managers	Health and Safety Link Person	COSHH Link Person	Board Members
1) Trust Induction	Upon starting with at the Trust.				
2) Slips, Trips and Falls (Clinical Staff)	2 yearly				
3) Managers face to face Risk Management, Health & Safety and Investigation of Incidents Induction.		Upon starting with the Trust.			
4) E-learning Health and Safety/Risk management, Health & Safety and Investigation of Incidents.	2 yearly	2 yearly			2 yearly
5) RSPH Level 2 award in Health and Safety for Health and Safety Link Persons			Upon becoming a Health & Safety Link Person with refresher training required every 2 years or earlier if policies / procedures change.		
6) COSHH Link Persons Training				Upon becoming a COSHH Link Person with refresher training required every 2 years or earlier if policies and procedures change.	
7) Risk Assessment	For anyone undertaking risk assessment or involved in the risk assessment/management process.				

Health and Safety Arrangements and Key Leads

Please find the table below which categorises the key health and safety arrangements for the Trust of which are regularly reported to and monitored by the Health and Safety Committee. Each key health and safety arrangement has an identified lead person within the Trust who will lead on implementation and will report regularly to the Health and Safety Committee.

Health and Safety Arrangement	Named Lead within the Trust	Frequency of Reporting to Health and Safety Committee
Health and Safety including: health and safety training; workplace inspections Audits; incident information; risk assessments; and COSHH	Head of Health, Safety and Risk	Quarterly
Estates and Facilities health and safety issues including: plant and machinery; electrical safety; asbestos; Audit; management of contractors; water and legionella control; fire; and environment and waste disposal	Estates Manager	Quarterly
Radiation	Imaging Services Manager	Twice Yearly
Infection Control	Trust Infection Control Lead	Quarterly
Moving and Handling	Moving and Handling Advisor	Quarterly
Occupational Health including: health surveillance; workstation assessments; and stress	Occupational Health Manager	Quarterly
Local Security including: lone working; security; and violence and aggression	Local Security Management Specialist	Quarterly
Medical Gases	Estates Manager	Twice Yearly

YOUNG PERSONS RISK ASSESSMENT

The purpose of the Young Person's Risk Assessment is to ensure that any young person under the age of 18 employed by the Trust is protected at work from risks to their health or safety which are a consequence of their lack of experience, absence of awareness of existing or potential risks or the fact the young person may have not yet fully matured. This will also ensure Managers comply with Regulation 19 of the Management of Health & Safety at Work Regulations 1999.

Measures to manage risks may not be beyond those that are already in place. However, there may be instances where additional measures specific to young persons are necessary, e.g. enhanced supervision.

In determining whether the work will involve harm or risks then an individual risk assessment must be completed by the relevant manager and documented using the attached form, before making any offer of employment. The risk assessment is used to determine if any risks remain, taking into account control measures currently in place.

- the fitting-out and layout of the workplace and the particular site where they will work;
- the nature of any physical, biological and chemical agents they will be exposed to, for how long and to what extent;
- what types of work equipment will be used and how this will be handled;
- how the work and processes involved are organised;
- level of health and safety training given to young people
- Risks from the particular agents, processes and work.

When control measures have been taken against these risks and if a significant risk still remains, young people can do this work under very special circumstances, which are:

- The work is necessary for their training;
- The work is properly supervised by a competent person; and
- The risks have been reduced to the lowest level, so far as is reasonably practicable.

As with any risk assessment, this must be revised periodically or where circumstances may mean it is no longer valid (e.g. nature of work changes, incident occurs).

Definition of Type of risks:		
Physical- *You should: Take account of the physique and experience of the young person e.g. manual handling tasks*	**Harmful / biological agents-** *You should: Consider the type of chemicals, biological agents being used and the potential exposure to the young person e.g. cleaning tasks*	**Cold, heat, noise, vibration** *You should: consider the nature of the job and whether exposure to extreme, cold, heat etc is likely, and what your current control measures are e.g. working in a walk-in freezer*
Psychological- *You should: Focus on critical tasks which rely on skill, experience and an understanding of the task requirements. i.e. using machinery designed for adults, care of acutely sick patients*	**Radiation-** *You should: consider if exposure is likely and what your current control measures are to protect young workers e.g. working in Radiology*	

West Suffolk NHS
on Trust

Name	
Date of Birth	
Job Title	
Main Tasks and Duties	**Please attach current job description**

Task		**Type of risks: Physical, Psychological, Harmful agents, Radiation Cold, Heat, noise , vibration**	**Hazards identified**	**Significant Consequences**	**Current Control measures**	**Furth er actio n Y/N**

RECOMMENDED FURTHER CONTROL MEASURES ARE PROVIDED: **Where the risk assessment indicates that this is necessary to remove or significantly reduce the risk of harm to the young person**.	
1.	
2.	
3.	
Signature of Manager	
Name of Manager	
Date	
Signature of employee	

11:25 ITEMS FOR INFORMATION

21. 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

22. Date of next meeting

To NOTE that the next meeting will be held on Friday, 26 February 2021 at 9:15am in West Suffolk Hospital

For Reference

Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

23. 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