Board of Directors (In Public)

Schedule	Friday 30 April 2021, 9:15 AM — 12:00 PM BST
Venue	Via video conferencing
Description	A meeting of the Board of Directors will take place on Friday, 30 April 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 04 30 Apr.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

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

---

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

---

6. Minutes of the previous meeting
   To APPROVE the minutes of the meeting held on 26 March 2021
   For Approval - Presented by Sheila Childerhouse

   Item 6 - Open Board Minutes 2021 03 26 March Draft.docx

---

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

---

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

---

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

   Item 9 - Chief Exec Report Apr 21.pdf

10:00 DELIVER FOR TODAY

---

10. Integration report - Q4
    To APPROVE the report
    For Approval - Presented by Helen Beck and Kate Vaughton

    Item 10 - WSFT Board_Integration Paper April 21_FINAL.docx

---

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

Item 11 - Operational Board update April 2021.doc

---

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

Item 12 - Board report Cover sheet - M12.docx

Item 12 - Finance Report- March 2021 FINAL.docx

Comfort Break - 10 minutes

11:10 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

---

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

Item 13 - People OD highlight report April 2021.doc

Item 13A - WSFT FTSUG report Apr 2021 FV.doc

Item 13B - West Suffolk Wellbeing Plan 2019 - 21 March 2021.doc

---

13.1. To discussion development of One Clinical Community for West Suffolk (verbal) (9.30 am)
Presented by Andrew Dunn, Amanda Takavarasha and Kate Vaughton

---

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

14.1. Maternity services quality & performance report
For Approval

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

---

14.2. Infection prevention and control assurance framework
For Approval

Item 14.2 - 21-04-30 COVID IPC assurance framework.docx

14.3. Nursing staffing report
For Approval

Item 14.3 - Nurse Staffing Report March 21.docx

14.4. Improvement programme board report
For Approval

Item 14.4 - 210412 IPB Board Report.docx

Item 14.4 - 210412 Status Summary Action Plans OUT.xlsx

---

15. Car parking tariffs and concessions 2020/21 (attached)
To approve the recommendations
For Approval - Presented by Craig Black

Item 15 - Car Parking 20-21 Tariff Paper Update Trust Board 30 April 2021 (002).doc

---

11:25 BUILD A JOINED-UP FUTURE

---

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

Item 16 - FSP Public Board overview April 2021.doc

11:30 GOVERNANCE

---

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

Item 17 - Governance report.doc

11:45 ITEMS FOR INFORMATION

18. 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

19. Date of next meeting
    To NOTE that the next meeting will be held on Friday, 28 May 2021 at 9:15am in West Suffolk Hospital
    For Reference - Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

20. 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, 30 April 2021 at 9:15**. The meeting will be held virtually via video conferencing.

Sheila Childerhouse
Chair

Agenda (in Public)

9:15 GENERAL BUSINESS		
1.	**Resolution** The Trust Board is invited to adopt the following resolution: "That representatives of the press, and other members of the public, be excluded from the meeting having regard to the guidance from the Government regarding public gatherings."	Sheila Childerhouse
2.	**Apologies for absence** To note any apologies for the meeting and request that mobile phones are set to silent.	Sheila Childerhouse
3.	**Declaration of interests for items on the agenda** To note any declarations of interest for items on the agenda	Sheila Childerhouse
4.	**Questions from the public relating to matters on the agenda** (verbal) To receive questions from members of the public of information or clarification relating only to matters on the agenda	Sheila Childerhouse
5.	**Review of agenda** To agree any alterations to the timing of the agenda.	Sheila Childerhouse
6.	**Minutes of the previous meeting (attached)** To approve the minutes of the meeting held on 26 March 2021	Sheila Childerhouse
7.	**Matters arising action sheet (attached)** To accept updates on actions not covered elsewhere on the agenda	Sheila Childerhouse
8.	**Patient or staff story (verbal)** To reflect on the experience shared with the Trust	Sue Wilkinson
9.	**CEO report (attached)** To receive an introduction on current issues	Steve Dunn
10:00 DELIVER FOR TODAY		
10.	**Integration report - Q4 (attached)** To approve the report	Kate Vaughton / Helen Beck
11.	**Operational report (attached)** To approve the report	Helen Beck
12.	**Finance and workforce report (attached)** To approve report	Craig Black
	Comfort break – 10 minutes	

11:10 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP		
13.	**People and OD highlight report (attached)** To approve report 13.1 To discussion development of **One Clinical Community** for West Suffolk **(verbal) (9.30 am)**	Jeremy Over Andrew Dunn/ Kate Vaughton/ Amanda Takavarasha/Shelley Lee
14.	**Quality, safety and improvement report** To approve reports: 14.1 Maternity services quality and performance report, including Ockenden report (attached) 14.2 Infection prevention and control assurance framework (attached) 14.3 Nurse staffing report (attached) 14.4 Improvement programme board report (attached)	Sue Wilkinson / Nick Jenkins
15.	**Car parking tariffs and concessions 2020/21 (attached)** To approve the recommendations	Craig Black
11:25 BUILD A JOINED-UP FUTURE		
16.	**Future system board report (attached)** To approve report	Craig Black
11:30 GOVERNANCE		
17.	**Governance report (attached)** To approve report, including subcommittee activities	Richard Jones
11:45 ITEMS FOR INFORMATION		
18.	**Any other business** To consider any matters which, in the opinion of the Chair, should be considered as a matter of urgency	Sheila Childerhouse
19.	**Date of next meeting** To note that the next meeting will be held on Friday, 28 May 2021 at 9:15 am in West Suffolk Hospital	Sheila Childerhouse
RESOLUTION TO MOVE TO CLOSED SESSION		
20.	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	Sheila Childerhouse

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

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

5. Review of agenda

To AGREE any alterations to the timing of the agenda.

For Reference

Presented by Sheila Childerhouse

6. Minutes of the previous meeting

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

For Approval

Presented by Sheila Childerhouse

DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 26 MARCH 2021 AT WEST SUFFOLK HOSPITAL
Via Microsoft Teams

COMMITTEE MEMBERS			
		Attendance	**Apologies**
Sheila Childerhouse	Chair	•	
Helen Beck	Chief Operating Officer	•	
Craig Black	Executive Director of Resources	•	
Richard Davies	Non Executive Director	•	
Steve Dunn	Chief Executive	•	
Angus Eaton	Non Executive Director	•	
Nick Jenkins	Executive Medical Director	•	
Rosemary Mason	Associate Non Executive Director	•	
Jeremy Over	Executive Director of Workforce and Communications	•	
Louisa Pepper	Non Executive Director	•	
Alan Rose	Non Executive Director	•	
David Wilkes	Non Executive Director	•	
Sue Wilkinson	Interim Executive Chief Nurse	•	
In attendance			
Helen Davies	Head of Communications		
Georgina Holmes	Trust Office Manager *(minutes)*		
Richard Jones	Trust Secretary		
Governors in attendance (observation only): Florence Bevan, Derek Blackman, Carol Bull, Jayne Neal, Joe Pajak, Margaret Rutter, Liz Steele, Clive Wilson,			

Action

GENERAL BUSINESS

21/043 RESOLUTION

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

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

The Chair welcomed everyone to the meeting, including governors who were now able to observe the meeting via MS Teams, and members of the public who had joined the meeting via YouTube.

21/044 APOLOGIES FOR ABSENCE

There were no apologies for absence.

21/045 DECLARATION OF INTERESTS FOR ITEMS ON THE AGENDA

No declarations of interest were received.

21/046 QUESTIONS FROM THE PUBLIC RELATING TO MATTERS ON THE AGENDA

Q What assurance does the Board have that the level of 75% of CQC 'must dos' being Blue/Black/Green' as stated in the Improvement Programme Report Summary (Item 13.4) is an acceptable level of progress?; and is the focus for action on the correct areas?

A This would be answered under agenda item 13.4, improvement programme board report.

Q The latest update from the government indicates that we may go into wave 3 later in the year. Can we be assured that with all the ward movement etc and building repair the Trust would be ready, if needed, to deal with such an increase.

A This would be answered under agenda item 9, operational report, and item 11, finance and workforce report.

21/047 REVIEW OF AGENDA

The agenda was reviewed and there were no issues.

21/048 MINUTES OF MEETING HELD ON 26 FEBRUARY 2021

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

Item 21/031 (page 3); third bullet, second sentence to read; "The clinical helpline also enabled staff to continue to contribute when they were required to self-isolate and work from home."

Item 21/035 (page 9); second paragraph in answer to second question to read; "One of the implications of the white paper was that there would be reserved power over Foundation Trust's capital planning limits, however this was not likely to affect WSFT due to its current financial position".

21/049 MATTERS ARISING ACTION SHEET

The ongoing actions were reviewed and the following noted:

Ref: 1915; Community services leaders to recommend appropriate community effectiveness metrics for future reporting. It was proposed that this action should remain open as community metrics had not yet been fully resolved. It was noted that this was work in progress and updates would be provided to the board.

Ref 1927; Consider future provision of keeping in touch service for acute and community services. It was proposed to extend the target date as this was likely to be a long-term project. The board would be updated on progress.

Ref 1928; Schedule briefing on the Trust's newly-created role of head of mental health. This had been arranged therefore this action could be closed.

The completed actions were reviewed and there were no issues.

21/050

- The Chief Executive thanked all health and care staff for their dedication and work throughout the year since the first lockdown during what had been a very difficult time. Everyone had been affected by the pandemic in some way and many had had to deal with loss and adversity.

- The vaccination programme was going well; over 60% of the adult local population had received their first vaccination.

- The results of the staff survey had shown that there was more to do around making sure that staff felt safe to speak up and there was also a need to improve listening and learning.

- The e Care go-live last weekend had been very successful and included acute and community maternity, scanning for safety in medicine management and a new and updated drug dictionary, which would improve quality and safety of services. The Chief Executive thanked all the teams involved in this.

- The organisation was now starting to think about recovery. However, it also needed to balance the fact that staff were exhausted alongside the need to improve access and start to address backlogs.

- Radiology had recently achieved ten years of accreditation and the orthopaedics team had delivered the best hip fracture repair performance in the country which had been particularly challenging during the pandemic.

Q Currently nearly 76% of staff had been vaccinated, although some had not been able to for various reasons. What was the final number likely to be and was there anymore that could be done to support staff who had not been vaccinated?

A Some staff who had not been able to be vaccinated had now received the vaccine. The bigger group were those who chose not to be vaccinated and a lot of work had been undertaken to address this. There was also a data issue which meant that staff who were recorded as not having been vaccinated included staff who were currently registered as bank staff but had not worked for the Trust for a long time. Work was being done to validate this.

The debate was likely to continue about whether this should be mandatory for health and care staff and the Trust was strongly encouraging all staff to be vaccinated.

DELIVER FOR TODAY

21/051

- Yesterday Simon Stevens reduced the level of management in the NHS for the Covid pandemic from level four to level three. This was very good news as this meant that the level of command and control was now at regional level.

- The Trust was seeing lower levels of Covid admissions but these continued and there was a need to remain vigilant, as of today there were four Covid patients in the hospital. The picture that was reflected across the region was that non-Covid activity had increased sharply and WSFT was seeing over 200 emergency department (ED) attendances on a daily basis.

- In response to the governor's question about the predicted third wave of Covid, there was no modelling to give any indication of numbers or when to expect this so the Trust would continue to be vigilant and watch what was happening elsewhere to try to understand this.

- Progress was now being made on the RAAC plank failsafe programme, which had been possible due to the lower level of admissions. However, managing the failsafe programme and operational programme was a constant balancing act and the risks were being managed on an ongoing basis. Currently there was capacity in the

organisation to empty areas and start the failsafe programme and this would need to be managed as the organisation moved through the next few months.

- National elective restoration planning guidance had been received yesterday afternoon. This was in line with the plans that the Trust had been making and in accordance with what was detailed in this report.

- The first priority for endoscopy recovery was the two week backlog where significant progress had been made but there was still room for improvement. It was hoped that this would be back on track next month.

Q The elective restoration plan was critical as the Trust moved forward; what was the governance around this? Also, looking at the assumptions in the plan, there appeared to be a step up between March and April. What were the core assumptions in the plan and if these were not correct what was at risk?

A At a local level every specialty had a recovery plan that was being monitored on a regular basis. These were in the process of being refreshed and would continue to be focussed on. There were also a number of system and regional meetings with an ICS wide recovery action group and an elective recovery board. Therefore, this was being managed internally and across the ICS.

In terms of activity levels there was a good level of confidence around these; however, issues that may cause a problem were the decant programme and the theatre programme taking longer than expected. Bed assumptions had been modelled on best- and worst-case scenarios. The worst-case scenario assumed an 8% level of Covid and 100% level of non-elective, but the Trust had been advised to model assuming 90% non-elective and 3% Covid; however, this was to some extent guesswork and if the reality was significantly different it would impact on bed capacity. If the Trust was to maintain progress on the failsafe programme there was nowhere to gain additional capacity, therefore it was working with colleagues to look at additional out of hospital capacity.

Q The executive team had provided a good level of assurance on the governance around this, but would it be helpful to have a different view, eg critical friend to provide additional assurance?

A An 'outsiders' view could be helpful.

Action: Consider an appropriate NED to provide additional assurance around governance of the elective restoration plan. **S Childerhouse /H Beck**

Another challenge was the limited options for independent sector capacity therefore conversations were being had with the ICS as to whether there was any way that WSFT could access independent capacity in the East. However, patients were reluctant to travel; only 50 out of 200 patients had been prepared to travel to Ipswich for ophthalmic appointments/treatment.

Following receipt of the national planning guidance a more detailed paper would be taken to the scrutiny committee.

Q The modelling was very helpful; during the summer when there would be a challenge around theatre capacity, would it be possible to get more third party support?

A The Trust would continue to try and secure more support/capacity in the independent sector, however what it had secured so far was nearing the limit of local capacity that

was available, including some insourcing, which was why it was trying to secure independent capacity in the East.

Q What assumptions were being made in the modelling around the need for staff to have time to recover?

A Some of the mitigations around extra sessions and work practices had been developed by the teams from the bottom up so that they owned this and they were very keen to address the problems.

Q How was the Trust engaging with the medical teams in terms of putting together the recovery plans so that they bought into these as a process they had been part of?

A These plans had been developed from the bottom up and were therefore plans that they felt they could deliver. Discussions would be taken place with the clinical directors and clinical leads around the national planning guidance. However, on the whole, the plans that had been developed met the requirements of this guidance apart from outpatients where there was a gap. The teams all wanted to engage in this process and were very keen to treat patients and address the backlog.

Q After Christmas the Trust saw a number of 'did not attends' (DNAs) which started to become a theme across all specialties. Did the Trust have a communications strategy to say that it was open for business and people should attend their appointments? Was the same level of DNAs being seen and what was being done to address this?

A The Trust had not been undertaking face to face outpatient appointments apart from clinically urgent patients. However, there were still a number of DNAs and this was an issue. Consultants were undertaking virtual clinical assessments to encourage patients to come into the hospital but this was a challenge. Hopefully as the Covid situation improved and people were vaccinated this would also improve. Communication will continue to be issued on access to services.

- The anaesthetics team had been under considerable pressure along with the medical division as a whole, who had been greatly affected by the Covid surge. Clinicians were very keen to address the backlogs but certain staff groups and staff members were struggling and a lot of support had been put in place to assist them.

- Re community structure changes detailed in the report, the position for director of integrated community health and adult social care had not been recruited to on Monday. Therefore, this was being progressed through an external advertisement and interim cover arrangements were being discussed.

Q When this person was appointed would they be completely accountable for the whole of community services and would this stray into the area of social care?

A This was a joint appointment with the county council and would give an insight into their board and provide a greater opportunity for learning around social care commissioning. This post would give a real opportunity to progress the integration agenda and it was very important to appoint the right person to this position.

21/052 INTEGRATED QUALITY AND PERFORMANCE REPORT

- One of the consequences of lowering the command level and the reduction in Covid patients meant that the team was in a better place to look at the return to SPC charts. The information team had continued to maintain these therefore it should not be an issue to reinstate them.

- A new set of metrics would need to be developed that would be more helpful in the current circumstances.
- The board commended Jo Rayner and her team for all their work during Covid.

Q The SPC charts were being produced for the board but were not being used for organisational insight. Could the executive team advise the best way forward for these?

A The challenge had been capacity in the team to create dashboards at division and speciality level. This was something that the organisation wanted to do and would be progressed as this moved forward.

ACTION: set timeline for development of SPC charts at Trust, division and specialty level. **C Black**

- Although the actual number of falls had reduced in February this was due to reduced capacity in the organisation.

- Pressure ulcers were still increasing and this was the national picture. The Trust continued to focus on this and work through the patient safety incident response framework (PSIRF) process to look at where it could improve; it was also working with the national team.

- Complaints remained reasonably low but these were likely to increase as patients and visitors started to come back into the hospital.

21/053 FINANCE AND WORKFORCE REPORT

- The Trust continued to forecast that it would breakeven for the financial year.

- A lot of work was going on around the end of year position, as the way that funding was working for this year was that far more income was coming from a greater distance than previously, ie rather than being managed locally it was coming directly from the department of the health (DH). This created a greater degree of uncertainty as there was some significant funding around non-NHS income, ie car parking and catering, both of which had reduced significantly and there was central funding to compensate for this.

- One of the key issues was around annual leave as there had been a significant reduction this year in the amount of annual leave that people in the organisation had taken. This was partly due to the pressure that the organisation had been under and also the fact that there was nowhere for people to go if they took annual leave. As a result, staff would be carrying over more annual leave than usual into next year which would create an accounting entry, ie costs associated with backfilling. This needed to be accrued for as it would cost the organisation several million pounds. This was being managed at DH level.

- Staff being tired and needing to recover was reflected in the budget.

- The organisation had a significant capital programme for the year, however the ability to spend this had been constrained by the situation that it had been facing. Therefore, it was trying to spend as much of its capital allocation for the year as possible as it would lose any that was not spent by the end of the financial year.

- In answer to the governor's question around the remedial programme and managing capacity, this featured in the capital programme for both this year and next year.

- Progress had been made towards the decant ward which would be completed in the first few months of the next financial year. However, there was a bigger uncertainty around the remedial programme and the Trust continued to get more information about the structure on a weekly basis, both in terms of its own building and also within other organisations which meant that the need to respond to these changes was particularly difficult for the operational teams.

- Plans for next year were contingent on the remedial programme and would be affected if this changed. This was a focus of discussions of the scrutiny committee.

- The board had agreed to the financial plans for next year with contingencies to cover additional financial assumptions that were uncertain.

- Confirmation had recently been received that the way in which funding was agreed for this financial year would continue for the first half of the next financial year, but a decision had not been made about the second half of the year which would depend on the way the pandemic progressed.

- Work around the cost improvement plan (CIP) for next year was ongoing within all of the divisions.

Q When the new director for health and social care was in post would budget authority be delegated to them and how flexible would this be, ie a pooled budget with social care, and how would this be moved forward?

A This highlighted the increasing recognition of the inter relationship between expenditure in health and social care. This person would have responsibility for managing the community budget. Hopefully there would be more visibility around financial flows in both health and social care. There were currently no plans to formally pool budgets but this may start to be discussed.

Q As the ICS moved to a statutory footing and a combined budget across the ICS area, what would the implications be for WSFT?

A WSFT already had good relationships across the ICS within the financial sector. Moving away from the focus on individual organisations was likely to increase with the statutory footing of the ICS. However, there would always be a tension as organisations would still be accountable for their own financial performance whilst being mindful of the position across the ICS.

Q Re the planning guidance and provision for capital for the RAAC plank issue, could the board be assured that this work would not have an impact on the Trust's revenue?

A This was one of the areas of uncertainty and if anything changed around the remedial programme this would have an effect on activity and the Trust's ability to recover. Although the assumptions that had been made were subject to change.

The impact that the RAAC plank remedial work could have on activity was raised on a regular basis in conversations with the regional team. The regional team were escalating this issue for all the organisations in a similar situation to the national team. The new planning guidance included an assurance that under performance in the first half of the year would not result in a reduction in income, but it was not yet known if this would be the case for the second half of the year.

Q As the Trust moved into the next financial year was it likely to be on target to achieve its CIP in the first half of the year or would it be building up a deficit that would need to be compensated for?

A The CIP assumption in the plan was 1% for the financial year, which was significantly less than previously. If the Trust was not able to achieve any CIP for the first half of the year this would result in a 2% requirement for the second half the year.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

21/054 PEOPLE AND ORGANISATIONAL DEVELOPMENT (OD) HIGHLIGHT REPORT

- The board congratulated the staff members who had been nominated for Putting You First awards in March. This highlighted the many examples of unsung ways in which people were going the extra mile to support colleagues, patients and their families and to develop the Trust's services.

- The data for the staff vaccination programme showed a proportional take up by BAME staff compared to white staff which was reassuring; this would continue to be monitored.

- The next BAME staff network meeting would be taking place next week and the Trust was continuing to the support the needs of these colleagues in a number of different ways.

- An update was provided on the results of the latest staff survey which highlighted the need to further develop the Trust's people plan in response to this. Historically the results of the staff survey had been very good and improved year on year, however there had been a reduction in scores in the latest survey which had taken place during October/November 2020. The ways in which these scores had reduced were detailed in this report.

- The Trust was very clear about where its priorities lay and where the focus needed to be, ie the extent to which staff felt confident to raise a concern and were reassured that the organisation was acting on this. However, there were areas where the Trust had already taken action which may help to address some of the concerns that the survey raised.

- An explanation was given on the wellbeing guardian role which all NHS organisations had been asked to establish and appoint someone to, preferably a NED. It was noted that Richard Davies had agreed to take on this role.

- Details of the annual gender pay gap report were provided. One of the features of this was bonus pay, which for WSFT related to the national clinical excellence awards scheme; during 2020 all eligible consultants benefitted from this scheme as a result of a national agreement reached with the BMA.

- The board received and noted the reports on education and training, library services and new consultant appointments.

- One of the positive things that had emerged as a result of Covid was the improvement on how the Trust supported the psychological needs of staff. This was already being planned before Covid but the plans had been accelerated and enhanced as a result of the pandemic.

- Emily Baker gave an example of a typical week for the staff psychology support team. They had supported 580 members of staff and 146 different teams, including individuals during particular personal crisis.

  She gave three examples of people who had been supported by the team and the difference it had made to them with were given; one due to Covid, one with an issue that was unrelated to Covid and one with a number of issues.

Q The team were doing an excellent job but the support they provided depended on people coming forward and asking for help. How was the team trying to ensure that it reached people who were reluctant to come forward when they needed help?

A A lot of people brought colleagues with them which had worked well. React training had also been given to managers so that they were able to have conversations with staff and make sure that everyone felt confident and empowered to do this. The team was also running virtual wellbeing sessions on Wednesday afternoons that all staff were invited to join.

Q How had the team been coping in terms of capacity and support provided to them? Would this service continue after Covid what were the plans moving forward?

A All psychiatrists and other team members had to have regular supervisory support and there was also a team huddle everyone morning and afternoon. The team met once a week to provide support to one another and discuss any difficult cases. Individuals also took part in regular reflective practice sessions (care space) and a peer support network was being developed to discuss the challenges that they were facing. There was also a professional network which had excellent resources that it shared.

The plan for the future was to embed this within each of the divisions, ie psychology support for each division for both staff and patients.

Q How did the team engage with occupational health to ensure a consistent approach and that overlaps did not occur? When the team was fully recruited to would it be adapting its approach to provide support to the community health team?

A Sue Pollett (Occupational Health Nurse Advisor) attended the workforce meeting every Thursday and met with the psychology team through this forum. People had also been signposted between the two teams and they supported each other so that work wasn't duplicated.

The team had tried a variety of different ways to support and engage with different groups of community staff but this had been very challenging. Therefore, they had joined community team meetings and provided team sessions rather than individual sessions, although in some cases these had been followed by individual sessions. Members of the psychology support team had also visited some of the community team bases and provided face to face sessions where appropriate. Once the team was fully staffed it was hoped that they could undertake more pro-active work in this area.

Q The work being undertaken by this team was excellent and fundamental to the future of the organisation; how could this become embedded moving forward?

A The Trust was committed to this service and the need to support staff in terms of health and wellbeing. The pandemic had resulted in increased support for staff and the need for this had been highlighted.

Q Once there was less need to provide support as a result of Covid what could the team do to support the wider organisation and also encourage people to speak up? There was also an issue with people who were part of a confidential investigation and were not able to talk about it, which was a source of anxiety for staff; could the team provide support to these individuals?

A This report presented a very strong business case and emphasised the need for this service. WMTY had highlighted the importance of good line managers and the team had not only supported individuals but also supported managers in providing support in situations that they had not had to deal with before and also enabled them to direct people to this team.

One of the aims of the team in the future was to embed support for an individual at the start of any investigation. There was also a lot to do around empowering managers and supporting staff so that they could respond to the needs of patients, eg in ITU.

- The board thanked Emily Baker and her team for everything they were doing to support individual members of staff and also in helping managers to become better managers.
- Assurance was given to the board that plans around the future of this service would be progressed.

Q Was there an internal Trust survey so that progress could be monitored against the outcome of the staff survey and WMTY?

A There was a need to balance the need for a survey and information against survey fatigue. There was a national plan to undertake the staff survey on a more regular basis.

Q The education and training report was a very good report, but it was very hard to measure the quality of training. What data did the Trust have about the quality of what it was delivering and was there any scope for including this in future reports?

A The quality of training delivered was overseen by Health Education England (HEE) who undertook regular visits and engaged with trainees and trainers. An update could be provided to the board following an HEE visit.

ACTION: consider how to develop information on the quality of training provided for future reports. **J Over**

21/055 QUALITY SAFETY AND IMPROVEMENT REPORT

55.1 Maternity services quality and performance report, including Ockenden report

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

- All Trusts had been required to submit actions and information on compliance with the recommendations in the Ockendon report. These were looked at from a regional perspective and feedback given on areas where more evidence was required. The only surprise was that WSFT had been told that it should have a consultant midwife. This had not been mentioned before and the Trust would be working with the region on the funding for this.

- In line with the Ockendon report there was also a requirement to ensure the use of the perinatal clinical quality survey model. Therefore, safety champion feedback and service user feedback would be included in this report.

- The draft report had been received from the assurance visit that took place in February and was very positive overall. There were five ongoing actions from the previous visit which were very close to being finalised. There had been very positive feedback from women about the care they received.

- There continued to be ongoing staffing pressures within maternity due to some of the complex challenges and issues, ie move towards 100% continuity of care, and it was important that the board did not lose sight of this.

ACTION: ensure ongoing visibility to the board of staffing challenges in maternity due to complex issues. **S Wilkinson**

55.2 Infection prevention and control assurance framework

- This report detailed the further requirements that had been received for inclusion in the NHSE ICT COVID-19 board assurance framework.

- A review of visual advice for visitors in other organisations had been undertaken. This would continue to be reviewed as to whether there was any learning from other organisations.

- Although the number Covid patients had reduced in the organisation the team were still working through the serious incidents on outbreaks. Learning from this was being shared through a number of sources and would continue to be use in day to day conversations with staff.

55.3 Nurse staffing report

- Overall fill rates had improved in all staff groups, day and night, and sickness and absence rates had improved compared to previous months. Nursing quality indicators had also slightly improved.

- The final audit report had been received on safe staffing and was appended to this report.

- The Trust was now trying to work with staff and refocussing to ensure that they felt resilient and able to continue to provide quality care for patients.

- The number of nurse vacancies would increase next month due to the inclusion of the vacancies that had been agreed as a result of the nurse staffing review. However, this would be mitigated with the closure of a ward as a result of the RAAC plank remedial work

- It was anticipated that the Trust would be able to recruit a large number of the 20 students who would be qualifying in September.

55.4 Improvement programme board report

- Improvement board meetings took place every month where actions were reviewed as to what was required to move to the next stage in the status report, eg from black (complete) to blue (business as usual).

- There was robust oversight of this and the meetings were attended by external colleagues. Therefore, in response to the governor's question, this provided assurance that 75% of CQC 'musts' being Blue/Black/Green was an acceptable level of progress.

- This programme was now at the point where a number of the CQC must do's had been completed and the team was looking at moving this plan to a Trust improvement plan rather than a CQC improvement plan. This would include actions coming out of PSIRF to demonstrate learning. How this would be managed would be discussed at the next improvement board meeting.

Q A lot had changed in relation to quality improvement in the Trust since it was highlighted and a number of initiatives had been put in place to address this but it was not clear how all these linked together. Were there any plans to update this strategy and how it would be developed throughout the Trust?

A James McFarlane had recently joined the Trust as associate director for quality improvement and had been asked to set out for the whole organisation what quality improvement was and what it did, as there was still a misunderstanding about the difference between improving quality and quality improvement. This would be a key focus of the quality improvement team including how to communicate this to the organisation and the board and how this should be developed moving forward.

Q Why had the action been closed that related to culture and engagement with medical staff?

A This action had not been closed; it was shown as black which meant that it had been completed but now needed to be embedded as business as usual and move to blue. A lot of discussion took place at every meeting about where each plan should sit in the status report.

BUILD A JOINED-UP FUTURE

21/056 DIGITAL PROGRAMME BOARD REPORT

- One of the most significant go-lives in e-care in the last few years had recently been undertaken. This had involved nine hours of downtime of e-care which had to be managed in the organisation in order to implement the changeover.
- The enhancements related to maternity and medicines management. Details of these were provided in the report.
- The board thanked the team involved and commended them in the way this had been undertaken.

Q As an organisation WSFT had adopted and developed the use of e-care. As it moved more toward integrated care it would need to link up with other systems; how would the Trust manage a more global approach around its digital programme?

A There was an ICS digital board which was chaired by the Chief Executive. Work was being undertaken around health information exchange (HIE) and linking up disparate systems across the NHS. Organisations had already been linked up so that consultants could view records across different systems and this would continue to be expanded.

ESNEFT was looking at replacing its digital system and was considering Cerner. It was possible that sometime in the future there would be a move towards an ICS digital system

Q One of the concerns raised by the CQC was the inconsistency of the Trust's medicines management. With the introduction of the new system how would the Trust ensure that this would be effective and give the results required to improve the control of this?

A The electronic medicines management system would provide the Trust with access to more and more data to compare practices and there was the ability to prompt within the system so that decision making was more consistent, eg warfarin prescribing.

There were two aspects to medicines management, ie prescribing by consultants and administration by nurses. Scanning for safety (scanning wristbands) which was now included and was undertaken by nurses was a very important step forward for patient safety.

21/057 FUTURE SYSTEM BOARD REPORT

- The Trust continued to work towards gaining formal acceptance of the strategic outline case (SOC) and had sent an email to the department of health to encourage then to formally assess the SOC.

- The appendix to this report illustrated the work that was going on in the future system programme and highlighted the relationship capabilities that were being developed within the organisation. This reflected the CQC report, WMTY etc and the importance of relationships.

GOVERNANCE

21/058 GOVERNANCE REPORT

- The membership area as set out in the Trust's constitution was being reviewed to take into account the wider geography of services provided by the organisation.
- The board were requested to delegate authority for the amendment of this document to the scrutiny committee. Governors would also be asked to ratify any changes.
- The board agreed to delegate authority for changes to the constitution to the scrutiny committee; approved the quality report for 2019/20 and approved the proposed approach to a well led development review.

ITEMS FOR INFORMATION

21/059 ANY OTHER BUSINESS

There was no further business.

21/060 DATE OF NEXT MEETING

Friday 30 April 2021, 9.15am

RESOLUTION TO MOVE TO CLOSED SESSION

21/061 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 – 30 April 2021

Agenda item:	7			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	23 April 2021			
Subject:	Matters arising action sheet			
Purpose:		For information	X	For approval

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

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

Actions are RAG rating as follows:

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

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**			**Invest in quality, staff and clinical leadership**		**Build a joined-up future**	
	X			X		X	
Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X	X	X	X	X	X	X
Previously considered by:	The Board received a monthly report of new, ongoing and closed actions.						
Risk and assurance:	Failure effectively implement action agreed by the Board						
Legislation, regulatory, equality, diversity and dignity implications	None						

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

Ongoing actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1915	Open	29/1/21	Item 12	Community services leaders to recommend appropriate community effectiveness metrics for future reporting	At April meeting it was proposed that this action should remain open as community metrics had not yet been fully resolved. It was noted that this was work in progress and updates would be provided to the board - update scheduled for May (or timing for completion). **Working group of community team members established and work is progressing.**	HB	28/5/21 ~~26/3/21~~	Green
1927	Open	26/2/21	Item 8	Consider future provision of keeping in touch service for acute and community services	At April meeting it was proposed to extend the target date as this was likely to be a long-term project. The board would be updated on progress. **We have the keeping in touch (KIT) service in our community inpatient areas.**	SW	25/6/21 ~~30/4/21~~	Green
1929	Open	26/2/21	Item 11	When clearer on national reset expectations (standards/targets) develop local metrics for IQPR to support local innovation and drive improvement	IQPR pack being developed but the revision (taking out) and update (adding in) will take more time. This is also impacted changes in roles and options being considered. **Unfortunately we have again needed to second a key member of the team to support CRT for the RAAC works. We are actively looking for external support to backfill this gap.**	HB	30/04/21	Green

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1931	Open	26/2/21	Item 11	Consider use of SPC charts within maternity (prior to reintroduction within wider IQPR)	Review by information team and head of performance and agreed target for inclusion in IQPR by end of May. This will be reviewed through Insight and reported to the Board	CB	~~30/04/2021~~ 31/05/21	Red
1933	Open	26/2/21	Item 14.1	Consider how neonatal staffing is reviewed in the context of wider maternity services	This will be reviewed with the commencement of the Deputy Head of Midwifery and will be re-assessed using the latest staffing assessment tool.	SW	28/06/21	Green
1943	Open	26/3/21	Item 10	Set timeline for develop SPC charts at Trust, division and specialty level	Reviewed date proposed following review with information team and head of performance. Potential for some earlier iterations as the Insight work progresses as we as some different/additional metrics to be reported to the Board.	CB	~~30/04/2021~~ 31/07/21	Red
1944	Open	26/3/21	Item 12	Consider how to develop information on the quality of training provided in the 6-monthly education report		JMO	01/10/21	Green

Closed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1934	Open	26/2/21	Item 14.5	Consider how we take lessons from infection prevention and the learning report into the organisation	This is being incorporated into the strengthened Quality & Safety Teams and will be overseen by the newly appointed Associate Director of Quality & Safety. IPC learning will be aligned to this organisational approach to sharing learning.	SW	30/04/21	Complete
1935	Open	26/2/21	Item 14.5	Next speaking-up report to include focus on “listening-up” (learning and action to improve)	Included in People & OD highlight report, including proposals from our Freedom to Speak Up Guardians	JMO	30/04/21	Complete
1942	Open	26/3/21	Item 9	Consider an appropriate NED to provide additional assurance around governance of the elective restoration plan	Agreed that this will be covered by NED involvement in the Insight committee going forward	HB / SC	30/04/21	Complete
1945	Open	26/3/21	Item 13.1	Ensure ongoing visibility to the board of staffing challenges in maternity due to complex issues	Included in maternity report	SW	30/04/21	Complete

8. Patient or staff story (verbal)

To reflect on the experience shared with the Trust

For Report

Presented by Susan Wilkinson

9. Chief Executive’s report

To RECEIVE an introduction on current issues

For Report

Presented by Stephen Dunn

Board of Directors – 30 April 2021

Agenda item:	9			
Presented by:	Steve Dunn, Chief Executive Officer			
Prepared by:	Steve Dunn, Chief Executive Officer			
Date prepared:	23 April 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 you will know, the end of March marked the **one-year anniversary of the first lockdown** due to Covid-19. As we took time to reflect, I wanted to write to thank all our staff for their hard work, dedication and compassion, during what have been incredibly difficult and challenging circumstances. All our staff, as well as health and care partners, have been absolutely remarkable and inspirational in their dedication and flexibility in responding to the pandemic. They have all risen to the challenge and gone above and beyond to serve our community.

This pandemic has left **no part of our normal lives untouched**. Personally, we have all been dealing with loss and adversity - whether it is losing loved ones, not seeing our nearest and dearest or finding ways to balance our working lives alongside other responsibilities. Professionally, we have worked in a challenging and unpredictable environment. The way you have all dealt with these losses and adversities is truly humbling and I am proud to be part of the West Suffolk team. Of course it is right to pause to reflect on the many losses and sacrifices we have experienced over the course of this pandemic. However, in amongst the darkness, what shines out to me is the team work across the Trust – the bond of West Suffolk colleagues – helping to keep each other going. The true test of a team is how it deals with adversity and there has never been a greater test for us and the rest of the NHS. Our staff should feel tremendously proud of themselves, of the work they have done and continue to do, and how they have all pulled together as a team.

With the second phase of the **Trust's vaccination programme** completed (see annex A for full report) and the clocks having gone forward, we hope we can look forward to brighter times. Life may not return to how it was before the pandemic for some time, but I remain hopeful that, in time we can regain some normality, and that soon we will be reunited with those we love the most.

Although in recent weeks we have seen an improved situation in terms of the impact of the pandemic on our Trust, our community and our lives, **we must not be complacent**. As we hear from new reports from around the world, however, many places are facing very different circumstances and the pandemic is far from over. As an international organisation, with staff from across the globe, the news from many countries – particularly India, Brazil and Nigeria - while upsetting to us all, will be of immense concern to our colleagues with close links to those directly affected.

Our thoughts are with you, your loved ones, friends and families during these difficult times. The UK Government and NHS nationally has already stepped in to help, for example with more than 600 pieces of medical equipment including ventilators and oxygen concentrators already on their way to India. We standby to assist wherever we can. Most immediately we can all do that by redoubling the **kindness and consideration we already show to those around us**, and showing thoughtfulness and compassion for those particularly affected by these horrendous events. As an organisation, we are committed to being as flexible and supportive as possible for those of you who need time and space to attend to family matters. We have achieved so much by working together. I am so proud of how much we support each other, and now more than ever we must do so locally, nationally, and internationally.

This month we announced some forthcoming changes to the **executive leadership team**. Dr Nick Jenkins has confirmed he will be stepping down from his role as our medical director at the end of May in order to spend time supporting his family and providing care, as they deal with a period of illness. However, I am happy to tell you that Nick will continue his work with us as a part-time emergency medicine consultant. Deputy medical director Dr Paul Molyneux will take over in the interim while the recruitment process for our next medical director takes place. In addition Helen Beck, our chief operating officer, has confirmed she will be retiring at the end of November. The process to recruit for her replacement will start in the next month or so and we hope to appoint a successful candidate to commence in post by December. On behalf of the WSFT Board, I would

like to thank both Nick and Helen for their dedication and leadership over the years. Their commitment to the Trust has been unwavering and they have achieved so much. In particular, over the last year, they have both played pivotal roles in helping to steer the West Suffolk through our response to the Covid-19 pandemic. We will be very sad to see Helen go later in the year, but wish her all the very best in her retirement.

The construction site which has appeared outside occupational health is part of the preparation works for the **new decant ward** which will be known as G10. The new decant ward will help to minimise disruption to patients while we carry out maintenance work in the current building. It is designed as a modular structure which means it has the potential to both be put in place quickly – due to complete by the summer - and also to be moved and re-used in the future. As well as delivering the maintenance work described above our focus is on preparing, supporting and delivering the operational reset for our patients waiting for planned care and treatment. We are acutely aware of the impact for patients that long waits have and the operational report on the board agenda sets out how we are responding to this challenge.

At the end of 2020 the Trust was confirmed as one of 40 across the country to receive funding for new build projects from the Government's **New Hospital Programme** (formally the Health Infrastructure Plan). A significant number of public and staff took part in the first phase of engagement at the end of last year which looked at what future clinical services could look like. The next stage will focus on how to plan hospital wards, how to improve patient experience and the use of technology in patient care. We are gathering both staff and patient views through a survey and bespoke discussion workshops. The survey is now live and can be accessed on the website at https://www.wsh.nhs.uk/New-healthcare-facility/Please-tell-us-what-you-think.aspx. A more detailed update will be received by the Board as part of the regular agenda item on this work.

A partnership of health and care providers, including our Trust, has now taken over responsibility for an **early supported discharge service (ESD) for stroke patients** across Suffolk. The specialist service provides up to six weeks of intensive stroke rehabilitation in patients' own homes following their discharge from hospital, in turn helping them to optimise their mobility and independence. The contract has been awarded to the Suffolk Alliance, which is a partnership of West Suffolk, East Suffolk and North Essex Foundation Trust (ESNEFT), and Suffolk County Council, and will run for the next five years. It will give alliance partners the opportunity to work more closely together to provide better joined up care for patients. The service will also link up with charity and voluntary partners, including Livability Icanho, who can offer additional support to patients. The alliance has taken responsibility for delivering the service from Norfolk Community Health and Care NHS Trust. Staff who currently provide the service have transferred to either ESNEFT or WSFT, which means that patients will continue to be cared for by the same team. A fuller report on collaborative and community services is included in the integration report on the main Board agenda.

The new **venous access team** is a nurse-led service that can assist colleagues in providing safe, quality care to patients who present challenges in accessing vessels. The four-strong team is provides a service that allows them to respond to referrals or see patients on the same day or the next. The team will has had specialist training, supervision and assessment, and can provide care for adult patients of all ages.

Catering manager Vanessa Theobald got in touch recently to remind me of all the wonderful work the **Trust's catering team is doing**. She was prompted to do this after watching an episode of BBC1's Countryfile, which ran a feature on hospital food, including concerns about its quality. Watching the show, Vanessa realised that all of the 'solutions' that were being suggested have already been implemented at WSFT. For instance, affiliating ourselves to the Soil Association to make sure that ingredients are sourced locally and using Red Tractor meats to guarantee quality. Here at the Trust we also carry out extensive testing of our recipes to ensure they deliver a good nutritional balance for our patients, and these recipes are also served to our own staff. Recently we

were proud to receive the Hospital Catering Award by the Health Business Awards, who recognise excellence in the NHS and, as a result of the Government-led food review, we have been named as an exemplar site for delivering food to both staff and patients. This is all down to the hard work done by the catering team. Vanessa would like to assure you that the team is constantly working to provide the best possible in-house meals for everyone.

The CQC visited the hospital earlier this month to carry out an **unannounced inspection of our maternity services**. The inspection went well and the team recognised the progress we are making. Overall the initial feedback is positive, particularly on areas such as: risk and governance; leadership; engagement with consultant body; embedding use of Modified Early Obstetric Warning Score (MEOWS); active engagement with women at risk of domestic violence; and referrals to smoking cessation for mothers-to-be. However, they did raise some concerns about: triage tools and staff in maternity day assessment unit (MDAU); specific baby abduction policy; live skills drills (baby abduction and removing woman from birthing pool in an emergency); Staffing levels in F11 and MDAU; and programme of leadership/succession planning.

Overall, we are pleased with how the inspection went and the number of positive improvements they picked up on. We have passed on the CQC inspectors' thanks to our staff for welcoming them and taking the time to speak with them. A draft inspection report will be sent to us in due course, which may raise further issues. As you would expect, the team are already beginning to look at the concerns raised and how best to address them. An update will also be included as part of the maternity services quality and performance report on the main Board agenda.

In addition to the items already highlighted, key areas of focus for the Trust's senior leadership team are reflected on the Board meeting agenda. Key items include the **operational reset** in the next phase of the pandemic recognising the impact over the last year on waiting times, our updated and evolving **integrated and operational report** 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. The **people report** also includes updates from our freedom to speak up guardians - Amanda Bennett and James Barrett.

The Board is making some changes to the way that it manages and receives **assurance on quality, safety and performance**. Informed by the national patient safety strategy, we have worked closely with senior leaders to develop a structure based around Insight, Involvement and Improvement. Recent key appointments to support this structure include James Macfarlane, Associate Director of Quality Improvement and Aderemi Aderibigbe, Associate Director of Clinical Quality and Patient Safety. More detail is provided in the governance report on the main Board agenda.

The Islamic calendar follows the phases of the moon, commonly known as the lunar cycle. As a result, the **holy month of Ramadan** falls approximately 10 days earlier each year in the Gregorian calendar. The Ramadan began on Monday, 12 April following the sighting of the moon over Mecca and lasts for 30 days. The multi-faith room is open 24/7 for prayer. Please follow social distancing rules and bring your own prayer mat. Ramadan Mubarak to all our Muslim colleagues and friends from the chaplaincy team and myself.

NHS West Suffolk NHS Foundation Trust

Trust Board – 30 April 2021

Agenda item:	9 (Annex A)			
Presented by:	Nick Jenkins			
Prepared by:	Jo Rayner			
Date prepared:	23 April 2021			
Subject:	Staff Vaccination at West Suffolk Foundation Trust			
Purpose:	x	For information		For approval

Executive summary:

A multi-disciplinary project team was formed to deliver a hospital hub vaccination programme. The programme started on 4th January through to 5th February 2021 and vaccinated 16,000 people – mainly health and social care workers but also around 1,000 patients. The second dose programme started on 15th March and concluded on 16 April 2021. Whilst catch up vaccination clinics continue to be available on the hospital site the major part of the programme has now concluded and can be considered as a huge success.

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.

Putting you first

The Vaccination Programme at West Suffolk Foundation Trust (WSFT)

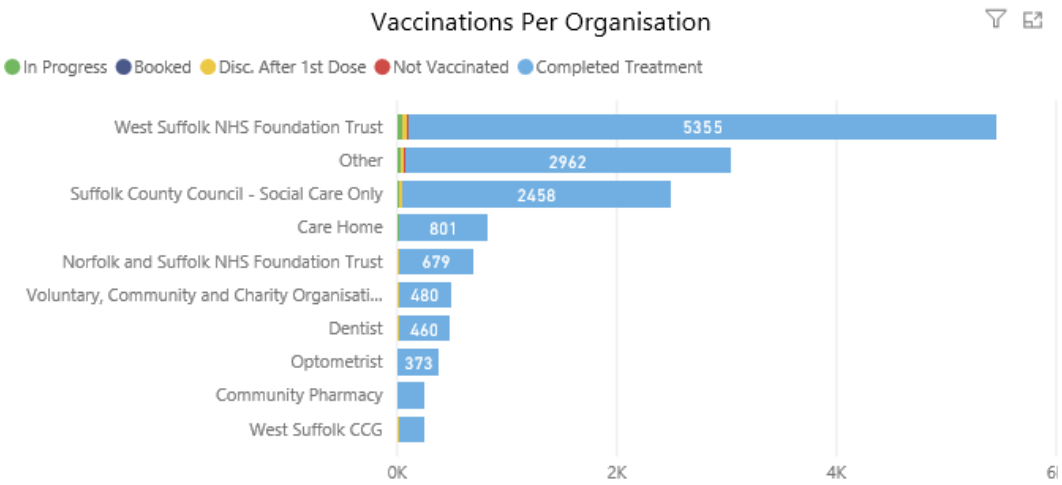
Background

In November 2020 a multi-disciplinary project team was formed to deliver a hospital hub vaccination programme. The first dose programme started on 4th January through to 5th February 2021 and vaccinated 16,000 people – mainly health and social care workers but also around 1,000 patients. The second dose programme started on 15th March and concluded on 16 April 2021. Whilst catch up vaccination clinics continue to be available on the hospital site the major part of the programme has now concluded and been a huge success.

Vaccination Programme

Phase one of the programme which operated in Quince House concluded on 16th April after delivering an amazing 32,000 doses of Pfizer to health and social care staff. This was all made possible by the hundreds of people involved including over 80 vaccinators and 60 staff members, some behind the scenes, ensuring everything ran smoothly. Over the course of the programme 35 volunteers supported the visitors to Quince House, equating to 1912 hours.

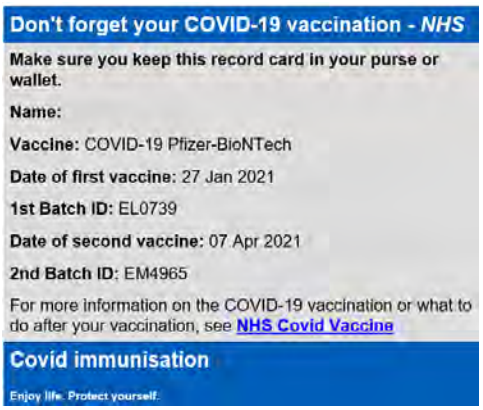
A bespoke booking system was developed internally which enabled us to get through the volumes of staff and provided access to the data to help inform the progress of the programme. Below is a snapshot of the information available to the team which identifies the vaccines delivered by organisation.



Upon reviewing this data there are many different ways to report the information. The table below shows the data broken down by patient facing staff and all our staff, and counts whether they have been vaccinated, whether it was at the hospital hub or elsewhere. Next month this data will include all the second vaccinations as well.

DATA UP TO 31/03/2021	Number of Staff	One dose received at any location, as recorded on NIVS	% Staff with at least one dose
Total Number of WSH Staff involved with Direct Patient Care	4221	3495	82.80%
Total Number of WSH Staff	6285	5207	82.85%

The booking system allowed reminder messages to be issued and provided a self-serve option to change appointments. As well as the paper card provided at the vaccine appointment, an electronic vaccine card was emailed to staff with their vaccine details.


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

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

Name:

Vaccine: COVID-19 Pfizer-BioNTech

Date of first vaccine: 27 Jan 2021

1st Batch ID: EL0739

Date of second vaccine: 07 Apr 2021

2nd Batch ID: EM4965

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

Covid immunisation

Enjoy life. Protect yourself.

Feedback

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

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

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

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

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

The Vaccination team were also honoured to receive a Lord Lieutenant of Suffolk Award for outstanding service to the community.


The Lord Lieutenant of Suffolk Award

West Suffolk Hospital

Covid-19 Vaccination Team

In Recognition of Outstanding Service to the Community in Suffolk during the Covid-19 Pandemic

With Gratitude,

Clare Euston — Clare Countess of Euston, HM Lord Lieutenant of Suffolk

Bridget McIntyre — Bridget McIntyre MBE, High Sheriff of Suffolk

Conclusion

All of those involved in the programme expressed how pleased they were to have had the opportunity to be involved and there were mixed emotions in the final week as many people worked their last shift and said goodbye to the team.

I am very proud of the team leading the process who delivered a safe and successful programme ensuring our staff and those of our partners were able to access a vaccination programme to keep them, their families and their patients safe. I am also very grateful for all the time, effort and hours people gave up to support the programme and make it so successful – it really did showcase the NHS and WSFT and highlight what we can deliver.

A small team continue to oversee vaccinations, to ensure any outstanding matters are managed and an ongoing programme is delivered on site for new staff and new clinically vulnerable patients. The team also continue to work with system partners to provide support and surge capacity as and when required to ensure the West Suffolk community has access to vaccinations to secure our way out of the pandemic. Finally, can I thank everyone for their patience and support throughout the programme; some staff were inconvenienced, others covered team members while they supported the programme and this is recognised and appreciated.

10:00 DELIVER FOR TODAY

10. Integration report - Q4

To APPROVE the report

For Approval

Presented by Helen Beck and Kate Vaughton

West Suffolk NHS Foundation Trust Board Meeting
Friday 30th April 2021

Agenda item:	10			
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:	12/04/2021			
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 based around our four system ambitions:

1. Strengthening the support for people to stay well and manage their wellbeing and health in their communities
2. Focusing with individuals on their needs and goals
3. Changing both the way we work together and how services are configured
4. Making effective use of resources

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 Governing 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

30th April 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 footprint. Several different teams contribute to the report, from across the CCG, the hospital and Alliance partners.

1.2. Information is loosely grouped under each of our four Alliance ambitions although of course most of the initiatives support the delivery of more than one area.

2.0 Alliance Ambition - Strengthening the support for people to stay well and manage their wellbeing and health in their communities.

2.1. This section highlights three initiatives that have each brought additional capacity into the community, improved the way in which we can offer support to our population and deepened our overall understanding of their needs.

2.2. **Integrated health and activity – partnership between WSFT and Abbeycroft Leisure**: An innovative partnership between the West Suffolk Foundation Trust, West Suffolk Council, and Abbeycroft Leisure has been created that focusses on the use of community assets, shared workforce, and skills to deliver activity programmes and support into patient pathways to improve health and wellbeing for those with long term health conditions. This is a key preventative project for our system and will help people to manage their health condition both in the short and longer term. It is also another example of how vertically integrating our provider services allows us to pursue new models that would not have been possible without working together.

2.3. The objectives for this project are:

- *To provide a pathway for the individual from acute and medicalised intervention to embed a sustainable level of continued activity*
- *To create and deliver appropriate and free activity programmes into orthopaedic and pulmonary discharge packages*
- *To build capacity in the system, transforming ways of working in an integrated workforce*
- *To build prevention and rehabilitation into health pathways*
- *To provide effective activity and support opportunities to those on the Community/Integrated Neighbourhood Team (INT) patient lists*
- *To mainstream effective and sustainable interventions and activities that are fun, sociable, effective, and available*

2.4. Working with the Clinicians within the Trust, the Abbeycroft team have been able to develop a programme that allows people to be supported through free exercise and rehabilitation programmes, either one to one, or in classes, up to a period of 24 weeks. Classes will take place within our six Alliance localities and be run by qualified coaches. Activities will focus on strength, balance, breathing better and will encourage participants to build social networks of support and a longer-term active lifestyle. This is linked to the broader work around health coaching, social prescribing and utilising the assets within people's local communities to improve outcomes.

2.5. Evaluation of these outcomes will demonstrate the impact for the people involved and the broader system. The Quality Improvement Team based within the Trust are supporting this work.

2.6. **Additional Roles in Primary Care:** In order to develop the service offer of the Integrated Care Team within each locality and support the further development of the workforce in general practice the Primary Care Networks (PCNs) have been able to access funding for additional roles. Each network has been given the flexibility to determine which roles form a core list they require, based on their patient population requirements. On average, each PCN will have the opportunity to recruit approximately seven Full Time Equivalent (FTE) staff in 2020/21 rising to 20 FTE by 2023/24.

2.7. As primary care are core to our integrated community model this additional capacity will be of benefit to the whole system. Critical to making progress with this is the One Team approach (discussed later in this paper) with its focus on collaboration and co-ordination around the needs of people getting our support.

2.8. The table below shows which Primary Care Networks have signed up for which role:

	Physio	Pharmacist	Pharmacy technician	Care Coordinator	Physician Associate	Occupational Therapist	Mental Health Practitioner	Social Prescriber
Blackbourne Rural	✓						✓	✓
Bury St Edmunds		✓		✓	✓		✓	✓
Forest Heath/Newmarket	✓	✓			✓		✓	✓
Haverhill	✓	✓		✓			✓	✓
Sudbury		✓	✓	✓			✓	✓
WGGL	✓		✓	✓		✓	✓	✓

2.9. *Clinical Pharmacists* work as part of the multidisciplinary team in a patient-facing role to clinically assess and treat patients using their expert knowledge of medicines for specific disease areas. The Clinical Pharmacist can be a prescriber or undertake training to become one.

2.10. *Physician Associates* are healthcare professionals with a general medical education who work alongside and under the supervision of GPs providing clinical care as part of a wider multidisciplinary team.

2.11. *First Contact Physiotherapists* can assess, diagnose, treat, and manage musculoskeletal (MSK) problems and discharge a person without a medical referral. Those working in these roles within a network can be accessed through direct referral by staff in GP Practices. Allied Health Professionals Suffolk has worked with the PCNs to provide hands on staff to the PCNs while still being employed by AHPS.

2.12. *Care Co-ordinator* works closely with GPs and other primary care professionals within the network to identify and manage a caseload of identified patients, making sure that appropriate support is made available to them and their careers. This role has been popular as there is flexibility in the scope of the role.

2.13. *Pharmacy Technician* will complement the work of the Clinical Pharmacist by using their pharmaceutical knowledge to undertake activities such as audits, discharge management and prescription issuing. This role will be under the supervision of the Clinical Pharmacist and will be part of a wider PCN pharmacy team.

2.14. *Occupational Therapist* supports people of all ages with problems arising from physical, mental, social or development difficulties. OTs can help GPs across the network with frail patients, those with complex needs, those who live with chronic physical or mental health conditions and who need help with managing anxiety or depression.

2.15. *Mental Health Practitioner* roles will be directly employed by the Norfolk and Suffolk Foundation Trust and will be working together with CCG funded mental health nurses, providing a link between Primary Care Networks and the mental health service offer, as part of the transformation of local mental health services which is underway.

2.16. Other roles that can be recruited to include: Social Prescribing Link Workers, Community Paramedics, Dietitian, Health and Wellbeing Coach, Nursing Associate, Podiatrists.

2.17. **Supporting our communities to get vaccinated -** The vaccination programme continues with the SNEE ICS having the one of the highest vaccination rates in England. In West Suffolk delivery has been led by GPs and Primary Care Networks, along with WSFT, local pharmacies and Vaccination Centres provided by Essex Partnership Trust. The mix of organisations providing vaccinations has ensured that as a system we have been able to innovate to meet local need.

2.18. At the beginning of the programme an Inequalities Impact Assessment was carried out to identify those most at risk from Covid to ensure they can get vaccinated as soon as possible. This assessment process was carried out in partnership between primary care, colleagues in the district councils, voluntary and community sector, public health, and the communities themselves.

2.19. One output from this was that an additional Health Outreach Service was commissioned to provide bespoke vaccination clinics for marginalised and vulnerable people, for example gypsies and travellers or people who are undocumented or not registered with local GP services.

2.20. In addition to this in West Suffolk a small Alliance team worked with our local populations, including community and faith leaders to develop several innovative approaches locally to improve equity of access for our population and ensure that our most vulnerable communities were protected.

2.21. Below are some examples of this work:

- In Woolpit the surgery set up a drive through clinic to test the concept of a mobile vaccination clinic that could then be used flexibly to target other areas and populations when needed. They were able to vaccinate 2,300 people in one day, and this model is now being explored more widely.
- A collaboration was established between Gatehouse, who work with homeless people, and the Bury Primary Care Network. Together they established special vaccination clinics, with Gatehouse providing the support for people as they went through the vaccination process, including transport to and from the site. In total 77 homeless people received their first vaccination through this route.
- Newmarket and Forest PCN held a clinic in a factory in Newmarket to improve access for the Black, Asian and Minority Ethnic workforce and give a supportive conversation for those who had concerns and required additional conversations before accepting their vaccinations.
- Working with the Bury Islamic Cultural Organisation and a mixed community of factory workers in Newmarket, plans are being developed to take the vaccination bus to the Mosque in Newmarket, and then to run clinics for staff working in the racing industry, many of whom live in houses of multiple occupation, and are in other at-risk groups

2.22. As part of this work stronger relationships have been established with our communities, along with a more detailed understanding of the health inequalities within West Suffolk. The #WhatAreWeMissing group are continuing to build on this work as part of how we support our population to recover from Covid and recognising the impact that the pandemic has had on people and families within West Suffolk.

2.23. An Integrated Care System (ICS) wide social media campaign has included people from West Suffolk explaining what getting the vaccination means to them. The "tiles" created are used as part of the ICS publicity but also can be used by the person themselves as part of their social media. Here are examples of tiles featuring our local population:

2.24. Finally, as a system we have reprioritised our workforce to ensure that all the necessary resources were available to support the vaccination campaign. This has involved additional teams being mobilised to work with primary care to reach the priority groups by contacting people that to date they have not been able to get hold of. It also meant that staff have been supporting the day to day running of the vaccination clinics themselves.

3.0. Alliance Ambition - Focusing with individuals on their needs and goals

3.1. Homelessness is a complex issue which has been compounded by the recent crisis and providing accommodation for people is only a small part of the answer. This project recognises that to make progress agencies must work together, and just as importantly take an asset-based approach with people throughout.

3.2. **Reducing homelessness for rough sleepers in West Suffolk** – In November 2020 the System Executive Group (SEG) sponsored a project to reduce the population of rough sleepers who were on a revolving door in and out of rough sleeping in West Suffolk. In recognition that for many people being homeless is not just about availability of the right and appropriate accommodation, but involves many factors, such as drugs, alcohol, mental illness, finances, employment, and violence. Therefore, any solution needed to include multiple agencies within the alliance and the wider stakeholders within West Suffolk and designed in a system space.

3.3. In February, the Alliance Quality Improvement (QI) partners, and the Institute of Health Improvement (IHI) – ran a series of workshops with 14 key stakeholders to identify the drivers for rough sleeping and the areas for improvement to take forward. They agreed the aim of the projects would be "to end rough sleeping for 15 people by 28th February 2022". The key drivers for this work were established as the following five areas:

1) Build will and a shared vision for change
2) Improve retention in housing (Reduce potential for eviction)
3) Match the spectrum of housing stock to the needs people have
4) Improve mental well-being (build on personal resilience & assets)
5) Prevent rough sleeping (upstream work prior to falling into rough sleep)

3.4. In March 2021, James MacFarlane the new Associate Director for Quality Improvement joined the WSFT team and has been supporting the development of this work with the wider Alliance QI Team. Further workshops have been carried in March and April where the multi-agency teams have further developed the driver themes and plans on testing change ideas and measuring their impact in the coming months.

3.5. The core membership of the steering group for this piece of work includes colleagues from the Department of Work and Pensions along with the Justice Services. Both organisations have a key role to play in ensure that we can build a joined-up support offer for these individuals in the longer term.

3.6. Involvement of co-production representatives is also central to this piece of work and Turning Point has agree to support two previously been homeless individuals to become part of the Core Group.

3.7. West Suffolk Council and the Justice Service are also working together to look at new accommodation pathways for ex-offenders to be underpinned by a newly established support model.

4.0. Alliance Ambition - Changing both the way we work together and how services are configured

4.1. Developing integrated services is a key aim for the Alliance, and there are two areas of work to highlight within this section. The first describes the development an enhanced community offer which has been put in place to support people to manage complex health needs at home, rather than needing hospital care. The second initiative is called One Team and continues a programme that brings together leaders in our localities, supporting collaborative working and ideas of local transformation.

4.2. **Integrated Neighbourhood Team (INT) – the enhanced offer** – The enhanced offer by the Integrated Neighbourhood Teams extends the 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.

4.3. The principles are like 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 and avoid having to go into hospital.
- Personalised health and care support plans.
- 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.

4.4. It is proposed, 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 but will require ongoing system investment subject to the evaluation end of June. Patients in the Covid virtual ward may step down to this enhanced INT approach.

Typical example of the benefits of greater use of telehealth monitoring:

- Telehealth devices can detect atrial fibrillation a significant cause of stroke
- Reduces home monitoring visits by clinicians
- A reduction in the number of hospitals stays for some individuals
- The ability to monitor people at home can reduce length of hospital stays
- Data from digital monitoring devices help clinicians to understand how condition is progressing
- People are reporting that they are less anxious, as they know that they are being monitored and that any deterioration in their condition will be picked up
- This leads to fewer phone calls to professionals
- Reduced levels of deconditioning cause by inpatient hospital stays

4.5. **One Team Development Programme for members of the West Suffolk Integrated Neighbourhood Team** – The aim of this programme is to build on the One Clinical Community programme from 2019/20 and strengthen the sense of team and leadership amongst core Integrated Neighbourhood Team members.

4.6. The programme has been expanded this time round and will bring acute and community clinicians, team managers, district council, voluntary and community sector partners together though a virtual programme, with teaching sessions, partnerships skills development and action learning sets.

4.7. The programme is a mix of core partnership skills, shared understanding of the health, care and wider system, along with a practical emphasis on building the local team. Each cohort will undertake some practical work together, which will be linked through to Alliance priorities and key transformation programmes.

5.0. Alliance Ambition - Making effective use of resources

5.1. In this section we outline the work the Alliance is doing to respond to the current three key drivers for change: learning from Covid, the Future Systems Programme and the NHS White Paper.

5.2. **Alliance Reset –** Alliance partners at the recent System Executive Group (SEG) meeting acknowledge the significant catalysts for change that we have with the experiences we have shared in the last years and the learning that this has generated, opportunity presented to us by the Future Systems Programme and the NHS White Paper's timetable for change.

5.3. All partners emphasised their commitment to alliance working and agreed to reset the work of the Alliance, review the impact of Covid on population health in West Suffolk and re-align our approach to integration and investment around a number of key priorities.

5.4. SEG acknowledged that there is an opportunity to:

- Build on and cultivate established relationships
- Reaffirm commitment to work together as a partnership
- Accelerate and prioritise joint activity, balancing quick wins with medium-longer term
- ambitions
- Capture the benefits working as an Alliance to people and sovereign organisations
- Develop a data culture at a strategic and operational level
- Organise collective leaderships around key issues and connected interdependent programmes
- Foster collaboration across the workforce and diversify input

- Create a shared resource to support our ambitions around the prevention, health and wellbeing agendas

5.5. As a result of these conversations several actions are underway which taken together will support an effective use of resources across the Alliance.

5.6. *Delivery Plan* – the Alliance Delivery Plan is under development, working with a range of partners and making sure that we have a clear idea why we have a plan, what added value it can bring and what we want to use it for.

5.7. *Shared evidence base, insight, and engagement* – this will build on our population health management approach and is looking to create one shared version of the truth.

5.8. *Governance* – reviewing the Alliance governance to ensure we have the right structures to make progress and decisions, as well as the forums to enhance collaboration. The revised Governance model will be included as part of the next Integration update to the Board.

5.9. Sarah Howard the Chair of the Alliance has also introduced two new Lay members to the SEG, Lynda Tuck and Rosemary Mason who will be supporting Sarah to look how the wider lay and elected member representation within the Alliance Governance model.

6.0 Recommendation

6.1. The Trust is asked to note the progress being made through the West Suffolk Alliance and the Trust's wider partnerships.

11. Operational report

To APPROVE a report

For Approval

Presented by Helen Beck

Trust Board – 30 April 2021

Agenda item:	11			
Presented by:	Helen Beck, Executive Chief Operating Officer			
Prepared by:	Helen Beck, Executive Chief Operating Officer Alex Baldwin, Deputy Chief Operating Officer			
Date prepared:	20 April 2021			
Subject:	Operational Update			
Purpose:	x	For information		For approval

Executive summary:

This paper provides an update on the key operational areas of work during the month. This includes; an update on current operational pressures, the impact of RAAC remedial work and updates on reset and recovery planning.

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

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

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

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

Operational update

Covid activity

At the time of writing the trust is in a very positive place in respect to general and acute capacity. We are caring for zero Covid positive patients and have isolation capacity for NIV and Covid cohorts should it be required. Likewise, we generally have sufficient capacity for acute medical and surgical patients and have limited the use of surge capacity. Critical care capacity is more pressured but we continue to manage within our commissioned baseline.

This positive picture reflects the efforts of a large number of staff across the organisation. It is difficult to pinpoint one action which has improved flow but it is certain in this case that a number of factors are at play; restoration of the short stay medical ward on F7, continued focus on medically optimised cohorts, robust and supportive multi-disciplinary and multi-agency discharge planning, and a specific focus on facilitating Pathway 1 discharges have equally contributed to the current position.

This is against a backdrop of reduced general and acute capacity (c.60 beds) and should be noted as a significant achievement.

As always, however, there are challenges ahead. The impending bearing extension programme requires a further reduction of 33 beds. As it stands this is achievable but it will require delivery of additional efficiency savings which will be focused on surgical pathways (this will include further length of stay reductions, enhanced ambulatory care services and further work on short stay surgical pathways).

We also note, with caution, that ESNEFT (specifically the Ipswich site) are experiencing a local Covid surge (53 patients at the time of writing). We do not expect to see a similar local surge imminently but we must remain vigilant and all staff are being reminded of the importance of adherence to IPC, PPE and social distancing standards.

In the medium term a fourth Covid wave is expected sometime between mid-June and September – whilst we have had sight of national forecasts which have been received by SAGE we have not, yet, seen and localised assumptions, however it is anticipated that the impact on our acute bed base will be significantly less than in previous waves due to the impact of the vaccination programme. We are in the process of developing operational plans to respond to a fourth wave which will most likely utilise, in some form, the additional capacity that is provided on G10.

RAAC bearing extension and operational impact

As previously reported bearing extension work commenced on F9 and has now been completed in that area. F10 work will commence shortly and we are planning to relocated F11 to F9 no later than 10 May.

Further to discussion at the most recent scrutiny committee we are working to deliver additional decant capacity in support of the rapid bearing extension work.

The additional capacity will be created via the decant of F3 to F4 and maintenance of elective bed capacity across the surgical footprint. It should be noted that this plan was originally in place to deliver capacity for the permanent critical care move but this has now been suspended. Reduction in volumes of elective activity during the theatre shutdown will support this plan.

Critical care is now scheduled to have full failsafe installation which is estimated to take 4 weeks to complete. During this period the critical care unit will be based on F2. This will reduce the overall

critical care capacity for the duration of the work and we will be seeking mutual aid via the critical care network. During this period we will also loose access to F2 for elective orthopaedic activity.

In order to manage this complex operational plan a core resilience team (CRT) has been commissioned and will take tactical oversight of operational planning and delivery of this programme. The group will be formed by members of the operational and estates teams and supported by emergency planning, communications and business support experts. It is expected that this group will be in situ for the duration of the work.

Elective restoration

The board has previously been appraised of the elective restoration plan and the delivery thresholds set out in the operational guidance (activity at 70% of 19/20 baseline in April rising by 5% per month to 85% from July). March performance was largely positive with follow ups (74%), day cases (72%), MRI (73%), CT (97%) and Endoscopy (72%) above threshold. First outpatients were marginally below (69%) reflecting a later Easter than 19/20. Elective inpatients were below at 65% but this is accounted for due to two closed theatres in the month (theatre 3 due to failsafe propping and theatre 9 due to a faulty theatre light).

Early last week Suffolk and North Easy Essex ICS was invited to bid to become an “Accelerator System”. In short this is a commitment to reaching 100% of baseline activity by 31 July increasing to 120% from September onwards. This ask is supported by funding of up to £10m.

This additional ask is significant and poses particularly challenges to the trust given the unusual operational and clinical challenges we face. However, there are some opportunities to support capacity expansion and future transformation workstreams in addition to funding additional short-term activity. Operationally we are exploring options to procure and run an additional vanguard theatre (likely to be sited at Ipswich), we are exploring use of independent sector capacity with Nuffield Health (likely to be in support of T&O pathways) and will seek to fund renovation work in DSU which will mitigate Covid capacity reductions. This is in addition to acute transformation workstreams focused on outpatients and diagnostics and cancer services which have previously commenced.

Whilst the commitment is at system level there is significant risk of non-delivery at trust level, due to the range of mitigating activities and dual priorities. Our operational bandwidth is already stretched and unable to flex much more. If successful in the bid we would need to recruit additional operational and project support.

As previously noted we have planned for an extensive theatre shutdown programme commencing in May. This will reduce overall capacity by up to 60%. Nevertheless, this will deliver additional capacity from September (subject to recruitment) which should support overall delivery.

Recommendation

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

Appendix1: EOE activity report 20 04 21.

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

				Daycases						Ordinary electives					
				4 Week Average (Final data)			Latest week (Provisional)			4 Week Average (Final data)			Latest week (Provisional)		
Prov code	Provider Name	Region	STP	Same weeks in 2019	4 weeks ending: 04 Apr 2021	as a % of same weeks in 2019	Same week in 2019	w/e 11 Apr 2021	as a % of same week in 2019	Same weeks in 2019	4 weeks ending: 04 Apr 2021	as a % of same weeks in 2019	Same week in 2019	w/e 11 Apr 2021	as a % of same week in 2019
RC9	Bedfordshire Hospitals NHS Foundation	East of England	Bedfordshire, Luton and Milton Keynes	1,334	928	70%	0	0	n/a	184	113	61%	0	0	n/a
RGT	Cambridge University Hospitals NHS Fou	East of England	Cambridgeshire and Peterborough ST	1,478	1,323	90%	1,505	1,464	97%	314	233	74%	303	285	94%
RWH	East and North Hertfordshire NHS Trust	East of England	Hertfordshire and West Essex STP	1,270	1,032	81%	1,325	1,053	79%	139	91	65%	129	150	116%
RDE	East Suffolk and North Essex NHS Found	East of England	Suffolk and North East Essex STP	1,804	1,564	87%	1,846	1,764	96%	254	163	64%	227	206	91%
RGP	James Paget University Hospitals NHS F	East of England	Norfolk and Waveney Health & Care P	621	400	64%	692	523	76%	78	42	54%	72	51	71%
RAJ	Mid and South Essex NHS Foundation Tr	East of England	Mid and South Essex STP	2,274	1,925	85%	2,056	2,148	104%	395	207	52%	369	271	74%
RD8	Milton Keynes University Hospital NHS Fo	East of England	Bedfordshire, Luton and Milton Keynes	551	548	100%	563	594	105%	75	58	77%	58	78	134%
RM1	Norfolk and Norwich University Hospitals	East of England	Norfolk and Waveney Health & Care P	1,911	1,334	70%	1,825	1,540	84%	272	119	44%	270	126	47%
RGN	North West Anglia NHS Foundation Trust	East of England	Cambridgeshire and Peterborough ST	1,139	789	69%	1,155	966	84%	229	40	17%	205	69	34%
RGM	Royal Papworth Hospital NHS Foundatio	East of England	Cambridgeshire and Peterborough ST	197	185	94%	186	203	109%	174	96	55%	162	105	65%
RQW	The Princess Alexandra Hospital NHS Tru	East of England	Hertfordshire and West Essex STP	477	338	71%	447	378	84%	83	61	73%	84	73	86%
RCX	The Queen Elizabeth Hospital, King's Lyn	East of England	Norfolk and Waveney Health & Care P	828	358	43%	849	349	41%	121	10	8%	105	13	12%
RWG	West Hertfordshire Hospitals NHS Trust	East of England	Hertfordshire and West Essex STP	891	583	65%	859	608	71%	126	94	75%	153	103	67%
RGR	West Suffolk NHS Foundation Trust	East of England	Suffolk and North East Essex STP	536	427	80%	573	436	76%	63	39	61%	58	68	116%

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

				First Outpatients						Follow-up Outpatients					
				4 Week Average (Final data)			Latest week (Provisional)			4 Week Average (Final data)			Latest week (Provisional)		
Prov code	Provider Name	Region	STP	Same weeks in 2019	4 weeks ending: 04 Apr 2021	as a % of same weeks in 2019	Same week in 2019	w/e 11 Apr 2021	as a % of same week in 2019	Same weeks in 2019	4 weeks ending: 04 Apr 2021	as a % of same weeks in 2019	Same week in 2019	w/e 11 Apr 2021	as a % of same week in 2019
RC9	Bedfordshire Hospitals NHS Foundation	East of England	Bedfordshire, Luton and Milton Keynes	3,658	3,192	87%	0	0	n/a	7,464	6,442	86%	0	0	n/a
RGT	Cambridge University Hospitals NHS Fou	East of England	Cambridgeshire and Peterborough ST	6,464	4,191	65%	5,631	4,756	84%	7,083	6,623	94%	6,637	7,593	114%
RWH	East and North Hertfordshire NHS Trust	East of England	Hertfordshire and West Essex STP	3,542	2,897	82%	3,401	2,846	84%	7,309	7,199	98%	7,016	7,155	102%
RDE	East Suffolk and North Essex NHS Found	East of England	Suffolk and North East Essex STP	4,908	4,477	91%	4,529	4,814	106%	9,025	7,710	85%	8,940	7,380	83%
RGP	James Paget University Hospitals NHS F	East of England	Norfolk and Waveney Health & Care P	1,342	1,288	96%	1,485	1,164	78%	2,508	2,249	90%	2,626	2,458	94%
RAJ	Mid and South Essex NHS Foundation Tr	East of England	Mid and South Essex STP	6,627	6,169	93%	6,137	6,561	107%	12,814	13,497	105%	11,848	14,638	124%
RD8	Milton Keynes University Hospital NHS Fo	East of England	Bedfordshire, Luton and Milton Keynes	3,409	1,496	44%	3,353	1,608	48%	2,326	2,298	99%	2,272	2,231	98%
RM1	Norfolk and Norwich University Hospitals	East of England	Norfolk and Waveney Health & Care P	4,370	3,213	74%	3,937	3,419	87%	9,219	9,000	98%	8,275	8,601	104%
RGN	North West Anglia NHS Foundation Trust	East of England	Cambridgeshire and Peterborough ST	3,641	1,735	48%	3,584	1,886	53%	5,317	2,908	55%	5,248	3,463	66%
RGM	Royal Papworth Hospital NHS Foundatio	East of England	Cambridgeshire and Peterborough ST	178	154	87%	183	175	96%	544	451	83%	546	473	87%
RQW	The Princess Alexandra Hospital NHS Tru	East of England	Hertfordshire and West Essex STP	2,176	1,633	75%	1,934	1,701	88%	2,960	3,518	119%	2,960	3,536	119%
RCX	The Queen Elizabeth Hospital, King's Lyn	East of England	Norfolk and Waveney Health & Care P	1,579	1,203	76%	1,426	1,101	77%	3,450	2,856	83%	3,575	2,750	77%
RWG	West Hertfordshire Hospitals NHS Trust	East of England	Hertfordshire and West Essex STP	3,139	2,505	80%	3,085	2,569	83%	4,478	3,556	79%	4,362	3,274	75%
RGR	West Suffolk NHS Foundation Trust	East of England	Suffolk and North East Essex STP	1,954	1,417	73%	1,902	1,446	76%	4,437	3,025	68%	4,602	2,839	62%

Source: SUS, Monthly Diagnostics (DM01) and Weekly Activity Return (WAR) *Data in this table has not been adjusted.*				CT Scans						MRI Scans					
				4 Week Average (Final data)			Latest week (Provisional)			4 Week Average (Final data)			Latest week (Provisional)		
Prov code	Provider Name	Region	STP	Same weeks in 2019	4 weeks ending: 04 Apr 2021	as a % of same weeks in 2019	Same week in 2019	w/e 11 Apr 2021	as a % of same week in 2019	Same weeks in 2019	4 weeks ending: 04 Apr 2021	as a % of same weeks in 2019	Same week in 2019	w/e 11 Apr 2021	as a % of same week in 2019
RC9	Bedfordshire Hospitals NHS Foundation	East of England	Bedfordshire, Luton and Milton Keynes	1,516	1,398	92%	0	0	n/a	875	616	70%	0	0	n/a
RGT	Cambridge University Hospitals NHS Fou	East of England	Cambridgeshire and Peterborough ST	956	1,223	128%	914	1,483	162%	674	611	91%	648	666	103%
RWH	East and North Hertfordshire NHS Trust	East of England	Hertfordshire and West Essex STP	1,069	859	80%	1,114	989	89%	575	432	75%	588	506	86%
RDE	East Suffolk and North Essex NHS Found	East of England	Suffolk and North East Essex STP	1,589	1,200	75%	1,640	1,618	99%	750	567	76%	820	705	86%
RGP	James Paget University Hospitals NHS F	East of England	Norfolk and Waveney Health & Care P	562	687	122%	588	743	126%	329	328	100%	366	429	117%
RAJ	Mid and South Essex NHS Foundation Tr	East of England	Mid and South Essex STP	2,882	2,946	102%	2,991	3,276	110%	1,220	1,157	95%	1,268	1,424	112%
RD8	Milton Keynes University Hospital NHS Fo	East of England	Bedfordshire, Luton and Milton Keynes	198	207	105%	210	223	106%	170	104	61%	165	111	67%
RM1	Norfolk and Norwich University Hospitals	East of England	Norfolk and Waveney Health & Care P	1,679	1,720	102%	1,720	2,083	121%	781	601	77%	736	775	105%
RGN	North West Anglia NHS Foundation Trust	East of England	Cambridgeshire and Peterborough ST	1,411	1,656	117%	1,400	1,938	138%	562	571	102%	579	625	108%
RGM	Royal Papworth Hospital NHS Foundatio	East of England	Cambridgeshire and Peterborough ST	86	153	179%	87	176	203%	53	62	116%	44	68	153%
RQW	The Princess Alexandra Hospital NHS Tr	East of England	Hertfordshire and West Essex STP	979	677	69%	940	793	84%	365	285	78%	366	328	89%
RCX	The Queen Elizabeth Hospital, King's Lyn	East of England	Norfolk and Waveney Health & Care P	476	465	98%	480	521	109%	213	116	55%	226	160	71%
RWG	West Hertfordshire Hospitals NHS Trust	East of England	Hertfordshire and West Essex STP	652	864	133%	615	941	153%	269	320	119%	270	323	119%
RGR	West Suffolk NHS Foundation Trust	East of England	Suffolk and North East Essex STP	534	494	92%	534	659	123%	301	252	84%	285	284	100%

Source: SUS, Monthly Diagnostics (DM01) and Weekly Activity Return (WAR) *Data in this table has not been adjusted.*				Colonoscopies						Flexible-sigmoidoscopies					
				4 Week Average (Final data)			Latest week (Provisional)			4 Week Average (Final data)			Latest week (Provisional)		
Prov code	Provider Name	Region	STP	Same weeks in 2019	4 weeks ending: 04 Apr 2021	as a % of same weeks in 2019	Same week in 2019	w/e 11 Apr 2021	as a % of same week in 2019	Same weeks in 2019	4 weeks ending: 04 Apr 2021	as a % of same weeks in 2019	Same week in 2019	w/e 11 Apr 2021	as a % of same week in 2019
RC9	Bedfordshire Hospitals NHS Foundation	East of England	Bedfordshire, Luton and Milton Keynes	84	100	119%	0	0	n/a	105	41	39%	0	0	n/a
RGT	Cambridge University Hospitals NHS Fou	East of England	Cambridgeshire and Peterborough ST	127	45	35%	145	81	56%	30	11	35%	27	6	23%
RWH	East and North Hertfordshire NHS Trust	East of England	Hertfordshire and West Essex STP	78	69	89%	72	176	245%	31	16	51%	36	39	108%
RDE	East Suffolk and North Essex NHS Found	East of England	Suffolk and North East Essex STP	173	42	24%	161	191	119%	54	12	21%	52	55	106%
RGP	James Paget University Hospitals NHS F	East of England	Norfolk and Waveney Health & Care P	32	32	99%	36	41	115%	68	24	35%	65	20	31%
RAJ	Mid and South Essex NHS Foundation Tr	East of England	Mid and South Essex STP	135	226	168%	136	241	177%	73	64	89%	74	73	98%
RD8	Milton Keynes University Hospital NHS Fo	East of England	Bedfordshire, Luton and Milton Keynes	32	75	234%	42	94	223%	16	27	163%	20	38	188%
RM1	Norfolk and Norwich University Hospitals	East of England	Norfolk and Waveney Health & Care P	177	138	78%	153	135	88%	178	44	25%	183	54	29%
RGN	North West Anglia NHS Foundation Trust	East of England	Cambridgeshire and Peterborough ST	128	35	27%	137	15	11%	53	21	39%	50	4	8%
RGM	Royal Papworth Hospital NHS Foundatio	East of England	Cambridgeshire and Peterborough ST	0	0	n/a	0	0	n/a	0	0	n/a	0	0	n/a
RQW	The Princess Alexandra Hospital NHS Tr	East of England	Hertfordshire and West Essex STP	18	44	253%	1	4	375%	5	8	160%	0	0	n/a
RCX	The Queen Elizabeth Hospital, King's Lyn	East of England	Norfolk and Waveney Health & Care P	47	31	67%	49	19	38%	23	12	51%	22	6	28%
RWG	West Hertfordshire Hospitals NHS Trust	East of England	Hertfordshire and West Essex STP	2	99	6567%	3	95	3167%	4	32	762%	5	55	1100%
RGR	West Suffolk NHS Foundation Trust	East of England	Suffolk and North East Essex STP	65	51	79%	65	15	23%	40	26	65%	38	14	36%

Source: SUS, Monthly Diagnostics (DM01) and Weekly Activity Return (WAR) *Data in this table has not been adjusted.*				Gastroscopies					
				4 Week Average (Final data)			Latest week (Provisional)		
Prov code	Provider Name	Region	STP	Same weeks in 2019	4 weeks ending: 04 Apr 2021	as a % of same weeks in 2019	Same week in 2019	w/e 11 Apr 2021	as a % of same week in 2019
RC9	Bedfordshire Hospitals NHS Foundation	East of England	Bedfordshire, Luton and Milton Keynes	158	133	84%	0	0	n/a
RGT	Cambridge University Hospitals NHS Fou	East of England	Cambridgeshire and Peterborough ST	171	96	56%	177	88	49%
RWH	East and North Hertfordshire NHS Trust	East of England	Hertfordshire and West Essex STP	59	54	91%	62	88	141%
RDE	East Suffolk and North Essex NHS Found	East of England	Suffolk and North East Essex STP	128	36	28%	132	113	85%
RGP	James Paget University Hospitals NHS F	East of England	Norfolk and Waveney Health & Care P	24	33	137%	22	53	239%
RAJ	Mid and South Essex NHS Foundation Tr	East of England	Mid and South Essex STP	149	191	128%	153	211	138%
RD8	Milton Keynes University Hospital NHS Fo	East of England	Bedfordshire, Luton and Milton Keynes	40	77	193%	54	74	137%
RM1	Norfolk and Norwich University Hospitals	East of England	Norfolk and Waveney Health & Care P	209	139	67%	198	166	84%
RGN	North West Anglia NHS Foundation Trust	East of England	Cambridgeshire and Peterborough ST	121	45	37%	125	14	11%
RGM	Royal Papworth Hospital NHS Foundatio	East of England	Cambridgeshire and Peterborough ST	0	0	n/a	0	0	n/a
RQW	The Princess Alexandra Hospital NHS Tru	East of England	Hertfordshire and West Essex STP	20	40	204%	1	0	0%
RCX	The Queen Elizabeth Hospital, King's Lyn	East of England	Norfolk and Waveney Health & Care P	62	39	63%	67	35	52%
RWG	West Hertfordshire Hospitals NHS Trust	East of England	Hertfordshire and West Essex STP	7	111	1709%	8	110	1375%
RGR	West Suffolk NHS Foundation Trust	East of England	Suffolk and North East Essex STP	96	74	77%	94	25	27%

12. Finance and workforce report

To ACCEPT the report

For Report

Presented by Craig Black

Board of Directors – 30 April 2021

Agenda item:	12			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	23rd April 2021			
Subject:	Finance and Workforce Board Report – March 2021			
Purpose:		For information	x	For approval

Executive summary:

The reported I&E for March is a small surplus of £145k (YTD £145k surplus), which is slightly better than our forecast to break even.

This position includes receiving all FRF and MRET funding associated with meeting the Financial Improvement Trajectory (FIT), reimbursement of COVID related expenditure (including vaccination costs), shortfalls against non-clinical income receipts as a result of COVID and costs relating to annual leave carried forward.

We have agreed a budget for 2021-22 to deliver a deficit of £10.5m, with a Cost Improvement Programme (CIP) of 1%. However, there is significant uncertainty over income and the funding of COVID related costs and so this budget is heavily contingent on a number of assumptions. As a result, the budget may be updated as this becomes clear.

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

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

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

Recommendation:
The Board is asked to review this report.

FINANCE AND WORKFORCE REPORT
March 2021 (Month 12)

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

Financial Summary

I&E Position YTD	£0.1m	surplus
Variance against Plan YTD	£0.1m	favourable
Movement in month against plan	£0.1m	favourable
EBITDA position YTD	£33.5m	adverse
EBITDA margin YTD	13%	adverse
Total PSF Received	£47m	
Cash at bank	£23.8m	

Executive Summary

- The Trust met its financial forecast to break even for 2020-21.

Key Risks in 2021-22

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

SUMMARY INCOME AND EXPENDITURE ACCOUNT - March 2021	March 2021 Budget £m	March 2021 Actual £m	March 2021 Variance F/(A) £m	Year to date Budget £m	Year to date Actual £m	Year to date Variance F/(A) £m
NHS Contract Income	18.6	20.3	1.6	220.4	222.7	2.3
Other Income	3.0	9.8	6.9	35.4	39.5	4.1
Total Income	**21.6**	**30.1**	**8.5**	**255.8**	**262.3**	**6.5**
Pay Costs	16.3	18.0	(1.7)	193.4	204.6	(11.2)
Non-pay Costs	8.1	12.2	(4.1)	93.5	91.1	2.3
Operating Expenditure	**24.3**	**30.2**	**(5.9)**	**286.9**	**295.7**	**(8.8)**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA excl STF	**(2.8)**	**(0.1)**	**2.7**	**(31.1)**	**(33.5)**	**(2.4)**
Depreciation	0.7	2.6	(1.9)	8.0	9.1	(1.0)
Finance costs	0.3	0.4	(0.0)	3.9	5.2	(1.3)
SURPLUS/(DEFICIT)	**(3.7)**	**(3.0)**	**0.7**	**(43.1)**	**(47.8)**	**(4.7)**
Provider Sustainability Funding (PSF)						
PSF / FRF/ MRET/ Top Up	3.7	2.3	(1.4)	43.1	47.0	4.0
SURPLUS/(DEFICIT) incl PSF	**(0.0)**	**(0.7)**	**(0.7)**	**(0.0)**	**(0.7)**	**(0.7)**
Adjustments for final accounts reporting						
Impairments and donated assets	0.0	0.8	0.8	0.0	0.8	0.8
SURPLUS/(DEFICIT) incl PSF	**(0.0)**	**0.1**	**0.1**	**(0.0)**	**0.1**	**0.1**

FINANCE AND WORKFORCE REPORT – March 2021

Contents:

Key:

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

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

FINANCE AND WORKFORCE REPORT – March 2021

Income and Expenditure Summary as at March 2021

The reported I&E for March is a small surplus of £145k (YTD £145k surplus). 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.

This position includes reimbursement of all COVID related expenditure (including vaccination costs), shortfalls against non-clinical income receipts as a result of COVID and costs relating to annual leave carried forward.

2021-22 Budgets

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

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

Summary of I&E indicators

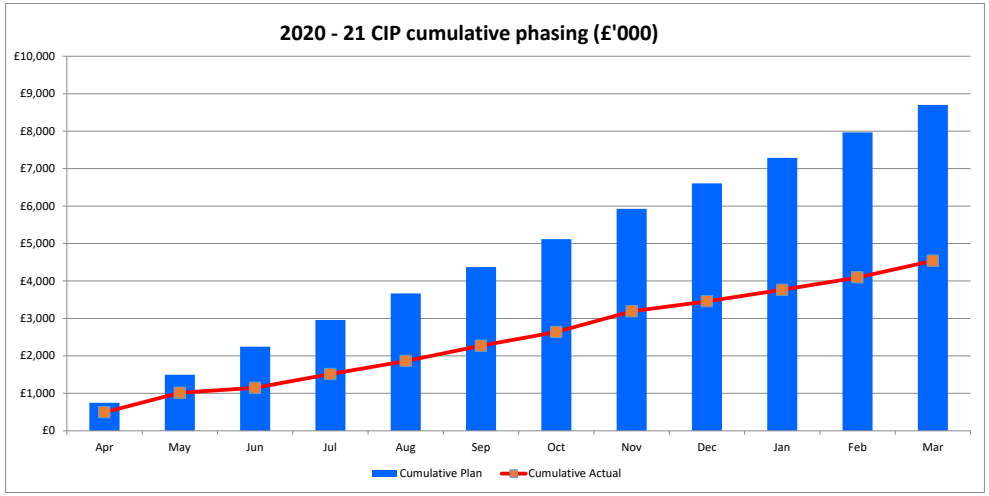
Income and Expenditure	Plan/ Target £000'	Actual/ Forecast £000'	Variance to plan (adv)/ fav £000'	Direction of travel (variance)	RAG (report on red)
In month surplus/ (deficit)	0	(0)	(1)	⟺	Green
YTD surplus/ (deficit)	(0)	0	0	⟺	Green
EBITDA (excl top-up) YTD	(3,746)	(3,048)	698	↑	Green
EBITDA %	(17.4%)	(10.1%)	7.2%	↑	Green
Clinical Income YTD	(232,544)	(233,498)	954	↑	Green
Non-Clinical Income YTD	(66,312)	(75,783)	9,471	↑	Green
Pay YTD	193,423	204,589	(11,166)	↑	Red
Non-Pay YTD	105,446	103,884	1,561	↓	Green
CIP Target YTD	8,700	4,539	(4,161)	↑	Red

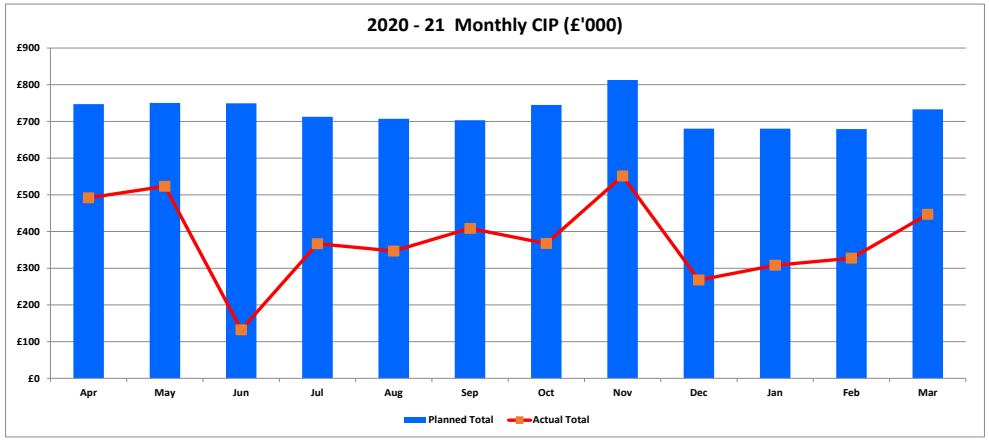
Cost Improvement Programme (CIP) 2020-21

In order to deliver the Trust's control target in 2020-21 we need to deliver a CIP of £8.7m (3.4%). We achieved £4.5m (52.2%). This represents a shortfall of £4.2m which results in a cost pressure for 2021-22.

Recurring/Non Recurring	2020-21 Annual Plan	Plan YTD	Actual YTD
	£'000	£'000	£'000
Recurring			
Outpatients	254	254	55
Procurement	492	492	515
Activity growth	200	200	200
Additional sessions	363	363	100
Community Equipment Service	510	510	338
Drugs	367	367	368
Estates and Facilities	187	187	97
Other	949	949	1,006
Other Income	493	493	223
Pay controls	327	327	195
Service Review	16	16	16
Staffing Review	819	819	722
Theatre Efficiency	302	302	-
Contract Review	50	50	13
Workforce	-	-	-
Consultant staffing	-	-	-
Agency	-	-	-
Unidentified CIP	975	975	-
Recurring Total	**6,304**	**6,304**	**3,847**
Non-Recurring			
Pay controls	580	580	536
Other	1,810	1,810	150
Estates and Facilities	6	6	6
Non-Recurring Total	**2,396**	**2,396**	**692**
Total CIP	**8,700**	**8,700**	**4,539**

Division	Divisional Target £'000	YTD Var £'000	Unidentified plan £ YTD	Unidentified plan £ year
Medicine	2,555	(2,006)	255	255
Surgery	2,029	(862)	203	203
W&C/CSS	1,847	(282)	0	0
Community	1,422	(555)	125	125
E&F	516	(397)	202	202
Corporates	331	(67)	191	191
Stretch	0	0	0	0
Total	**8,700**	**(4,168)**	**975**	**975**





FINANCE AND WORKFORCE REPORT – March 2021

Trends and Analysis

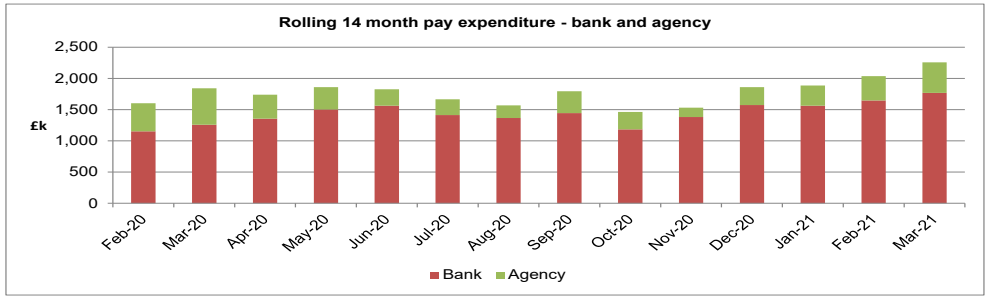
Workforce

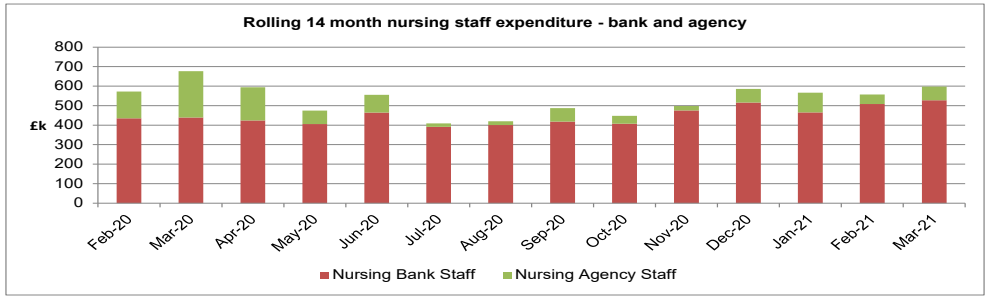
During March the Trust overspent by £1.7m on pay (£11.2m overspent YTD). This includes all COVID related pay costs and accrued leave.

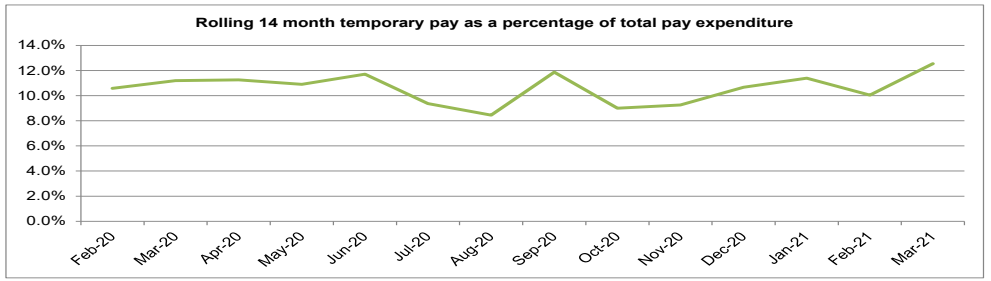
Monthly Expenditure (£)				
As at March 2021	Mar-21	Feb-21	Mar-20	YTD
	£000's	£000's	£000's	£000's
Budgeted Costs in-month	16,252	16,733	14,491	193,423
Substantive Staff	15,737	18,246	14,593	183,111
Medical Agency Staff	171	170	242	1,998
Medical Locum Staff	380	396	283	3,971
Additional Medical Sessions	361	114	234	3,089
Nursing Agency Staff	69	49	237	789
Nursing Bank Staff	528	509	439	5,403
Other Agency Staff	247	170	105	939
Other Bank Staff	272	294	173	2,706
Overtime	135	215	55	1,512
On Call	93	118	71	1,071
Total Temporary Expenditure	2,256	2,035	1,840	21,478
Total Expenditure on Pay	17,992	20,282	16,433	204,589
Variance (F/(A))	(1,741)	(3,549)	(1,942)	(11,166)
Temp. Staff Costs as % of Total Pay	12.5%	10.0%	11.2%	10.5%
memo: Total Agency Spend in-month	488	389	584	3,725

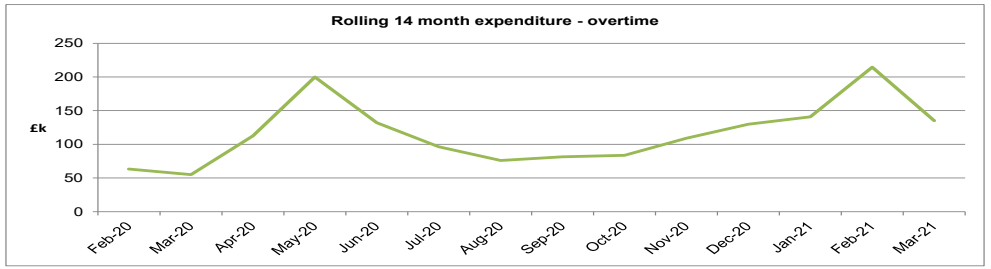
Monthly WTE				
As at March 2021	Mar-21	Feb-21	Mar-20	YTD
	£000's	£000's	£000's	£000's
Budgeted WTE in-month	4,205.7	4,229.4	3,888.5	51,171.2
Substantive Staff	4,041.1	4,004.4	3,706.5	46,143.4
Medical Agency Staff	14.7	11.2	9.8	180.5
Medical Locum Staff	29.1	34.9	28.5	343.3
Additional Medical Sessions	5.3	2.7	10.4	55.0
Nursing Agency Staff	14.9	10.1	32.0	160.6
Nursing Bank Staff	147.1	147.4	132.0	1,600.2
Other Agency Staff	41.0	29.8	23.0	180.4
Other Bank Staff	107.1	108.0	69.8	1,059.1
Overtime	35.1	56.9	14.6	396.6
On Call	7.0	9.8	6.4	84.1
Total Temporary WTE	401.2	410.7	326.6	4,059.7
Total WTE	4,442.3	4,415.1	4,033.1	50,203.1
Variance (F/(A))	(236.6)	(185.7)	(144.6)	968.1
Temp. Staff WTE as % of Total WTE	9.0%	9.3%	8.1%	8.1%
memo: Total Agency WTE in-month	70.5	51.1	64.9	521.5

Pay Costs









FINANCE AND WORKFORCE REPORT – March 2021

Income and Expenditure Summary by Division

	Current Month			Year to date		
	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)
MEDICINE	£k	£k	£k	£k	£k	£k
Total Income	(7,944)	(7,322)	(621)	(89,972)	(75,039)	(14,933)
Pay Costs	4,349	5,517	(1,168)	51,545	58,836	(7,290)
Non-pay Costs	1,604	2,157	(553)	18,841	19,937	(1,097)
Operating Expenditure	**5,953**	**7,674**	**(1,721)**	**70,386**	**78,773**	**(8,387)**
SURPLUS / (DEFICIT)	**1,991**	**(352)**	**(2,342)**	**19,586**	**(3,734)**	**(23,320)**
SURGERY						
Total Income	(5,823)	(4,156)	(1,667)	(65,650)	(43,761)	(21,889)
Pay Costs	3,410	3,609	(198)	40,887	43,168	(2,281)
Non-pay Costs	1,204	1,798	(594)	13,755	11,487	2,268
Operating Expenditure	**4,614**	**5,406**	**(792)**	**54,642**	**54,655**	**(13)**
SURPLUS / (DEFICIT)	**1,209**	**(1,250)**	**(2,459)**	**11,008**	**(10,894)**	**(21,902)**
WOMENS AND CHILDRENS						
Total Income	(2,188)	(2,332)	143	(23,764)	(20,607)	(3,158)
Pay Costs	1,495	1,767	(272)	17,402	17,674	(272)
Non-pay Costs	180	230	(50)	2,058	2,290	(232)
Operating Expenditure	**1,675**	**1,997**	**(322)**	**19,460**	**19,964**	**(504)**
SURPLUS / (DEFICIT)	**513**	**334**	**(179)**	**4,304**	**643**	**(3,661)**
CLINICAL SUPPORT						
Total Income	(786)	(776)	(11)	(9,632)	(7,622)	(2,010)
Pay Costs	2,008	2,694	(686)	21,625	22,005	(380)
Non-pay Costs	1,023	2,478	(1,455)	13,014	15,733	(2,719)
Operating Expenditure	**3,031**	**5,172**	**(2,141)**	**34,640**	**37,738**	**(3,099)**
SURPLUS / (DEFICIT)	**(2,245)**	**(4,396)**	**(2,151)**	**(25,007)**	**(30,116)**	**(5,109)**
COMMUNITY SERVICES						
Total Income	(3,513)	(2,682)	(831)	(42,155)	(41,400)	(755)
Pay Costs	2,548	3,040	(492)	30,495	32,044	(1,549)
Non-pay Costs	1,191	1,152	40	13,205	14,572	(1,367)
Operating Expenditure	**3,740**	**4,192**	**(452)**	**43,700**	**46,616**	**(2,916)**
SURPLUS / (DEFICIT)	**(227)**	**(1,510)**	**(1,283)**	**(1,545)**	**(5,216)**	**(3,671)**
ESTATES AND FACILITIES						
Total Income	(434)	(313)	(121)	(5,207)	(2,543)	(2,663)
Pay Costs	923	1,098	(176)	10,971	11,547	(576)
Non-pay Costs	626	1,572	(946)	7,514	8,694	(1,180)
Operating Expenditure	**1,548**	**2,671**	**(1,122)**	**18,485**	**20,241**	**(1,756)**
SURPLUS / (DEFICIT)	**(1,114)**	**(2,357)**	**(1,243)**	**(13,278)**	**(17,698)**	**(4,419)**
CORPORATE						
Total Income	(4,617)	(14,440)	9,823	(62,379)	(117,755)	55,376
Pay Costs	1,518	266	1,252	20,497	19,315	1,182
Non-pay Costs	2,242	2,591	(349)	25,038	18,195	6,842
Capital Charges and Financing Costs	993	1,907	(914)	11,912	13,085	(1,173)
Operating Expenditure	**4,753**	**2,857**	**1,895**	**57,447**	**37,510**	**19,937**
SURPLUS / (DEFICIT)	**(136)**	**11,583**	**11,719**	**4,932**	**80,245**	**75,312**
TOTAL						
Total Income	(25,305)	(32,021)	6,716	(298,760)	(308,727)	9,967
Pay Costs	16,252	17,992	(1,741)	193,423	204,589	(11,166)
Non-pay Costs	8,070	11,977	(3,907)	93,425	90,909	2,516
Capital Charges and Financing Costs	993	1,907	(914)	11,912	13,085	(1,173)
Operating Expenditure	**25,314**	**31,876**	**(6,562)**	**298,760**	**308,583**	**(9,823)**
SURPLUS / (DEFICIT)	**(10)**	**145**	**155**	**(0)**	**145**	**144**

Page 6

Medicine (Sarah Watson)

The division is behind plan in month by £2.3m and £23.2m YTD.

Clinical income is behind plan in month by £744k and £14.7m YTD. This is driven by the reduction in activity across the Trust as a result of COVID and is witnessed in medicine across all types of activity (elective, non-elective & outpatient). From April to November 2020, this reduction narrowed, only to increase again as the impact of wave 2 hit in December. It is noted that this loss of divisional income is offset within the Corporate division due to the guarantees over the block contract.

With the pressures from COVID easing in March, activity levels improved. Elective activity is now 26% behind plan (February 33%) and Non-Elective activity reduced to 11% (February 24%) behind plan in month whilst Outpatient activity remained 8% behind plan. It should be noted that all 3 types of activity are now above their mean levels over the last 24 months. We anticipate that activity levels will continue to increase as the recovery to 85% pre-COVID activity is targeted in Q1 21/22.

With the effect of Clinical Income removed, the division would record an adverse variance of £1.5m in month and £8.5m YTD. Ongoing drivers of this variance that have continued in March are *identified* additional costs of COVID (£653k) and unmet CIP schemes (£187k). Non-recurring costs in March include:

- Recognition of under-accruals in Cardiology (£229k).
- Overspends on drugs in Haematology and Rheumatology (£76k)
- Additional sessions (£171k overspend in month) due to covering wards at short notice during wave 2 (including delayed claims).

To date, the division has recorded £12.7m of expenditure towards COVID. £4.7m is a result of additional costs being incurred due to COVID and £5.7m is using existing resources (e.g. medical wards) solely towards COVID. The remaining £2.3m is recognising the CIP schemes that are unable to be met due to COVID.

Surgery (Simon Taylor)

The position for the division was £2.3m behind plan in month (£21.8m YTD).

Clinical income is behind plan in month by £1.8m (£21.6m YTD). Throughout the year, the clinical income position has been driven by the activity levels being below plan as a result of COVID and this is evident across all areas of activity. In the month of March with COVID pressures easing, activity levels have improved across Surgery. Outpatient activity is 30.1% behind plan in month (February 36.22%), Elective activity is 17.5% behind plan in month (37.63%), and Non-Elective activity is 13.7% behind plan in month (35.61%).

The division continue to work on mitigating the loss of theatre capacity such as planning additional weekend sessions as theatre refurb and roof failsafe works have now commenced. DSU returned to a green area at the beginning of the month so green pathways are now up and running.

Pay reported an overspend of £121k in month, (£2.2m YTD). The overspend continues to be driven by the additional COVID provision required to support wards and critical care.

The non-pay budget is £2.2m underspent YTD, predominantly within Prothesis (£1.2m) and MSE (£519k). This is as a result of the reduced activity levels.

Women and Children's (Michelle O'Donnell)
In March, the Division reported an adverse variance of £179k (£3.7m YTD).

COVID has depressed activity with low levels of elective activity in Gynaecology and low levels of non-elective activity in Paediatrics. However, in recent months neonatal, antenatal and post-natal activity has been higher. Consequently, income is ahead of plan by £143k in-month and behind plan by £3,158k YTD.

Pay reported a £235k overspend in-month (£234k YTD). In-month and year to date, both paediatrics and the maternity service have struggled to fill vacancies which has created underspends. However, these underspends have been offset by spending on COVID initiatives such as consultant cover, running additional clinics, shielding cover and increased ward staff levels.

Non-pay reported a £50k overspend in-month (£232k YTD). Non-pay costs were high in-month due to settling a historic invoice, whilst YTD the overspend us due to COVID related expenditure on low value equipment.

Clinical Support (Michelle O'Donnell)
In March, the Division reported an adverse variance of £2.15m (£5.1m YTD).

Income for Clinical Support reported £11k behind plan in-month (£2,010k YTD). 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 £675k overspend in-month (£369k YTD). In-month, the costs of backfilling carried forward annual leave has been accrued. Year to date, it has been difficult to fill vacancies in Radiology, Outpatients and Pharmacy. This underspend was offset by the in-month annual leave accrual.

Non-pay reported a £1,455k overspend in-month (£2,719k YTD). In-month, outstanding balances with ESNEFT and CUH were agreed. The vast majority of the year to date overspend relates to COVID recovery expenditure with private sector suppliers and dissolution costs from the pathology partnership.

Community Services (Michelle Glass)
In March the division reports an adverse variance of £1.3m (£3.7m YTD)

Income reported a £755k under recovery at year end, where elements of the division's income plan that are allocated on a cost and volume basis, were impacted by COVID. In addition, some staff normally deployed to external organisations, either through rotation or secondment, were redeployed within WSFT during COVID, reducing income receipts. The delay in delivery of some CIP schemes due to COVID impacted the division's income position too.

This year there was an over spend on pay of £1,526k. Whilst this was incurred to support the division's response to COVID, the division has a favourable underlying pay position without COVID costs. The division utilised agency staff to cover some vacant Therapy roles, as well as to provide a peripatetic team of nurses operating across the Community Health Teams and additional staffing to support winter beds in the community. Resource continued to be required through winter to ensure capacity was in place to meet increasing demand for community services.

In 20/21 there was an over spend on non-pay of £1,367k. This position primarily reflects delays in the delivery of some CIP schemes due to the impact of COVID and additional costs incurred to support the Division's COVID response. Additional community equipment costs were incurred to provide the equipment needed to enable timely hospital discharges, including an increase in same day and out of hours and to support more than a doubling of discharges through Pathway 1 this year. Additional community equipment costs were also incurred to support end of life patients to remain at home in line with the revised end of life patient strategy and to provide community equipment for additional external bed capacity secured.

Additional costs continued to support the division's COVID response as well as winter planning. The division is using the learning from some new ways of working, including our improved online offer, to create opportunities for the cost improvement programme for 21/22.

FINANCE AND WORKFORCE REPORT – March 2021

Statement of Financial Position at 31 March 2021

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2020	Plan 31 March 2021	Plan YTD 31 March 2021	Actual at 31 March 2021	Variance YTD 31 March 2021
	£000	£000	£000	£000	£000
Intangible assets	40,972	48,986	48,986	59,987	11,001
Property, plant and equipment	110,593	142,614	142,614	129,314	(13,300)
Trade and other receivables	5,707	6,366	6,366	6,341	(25)
Total non-current assets	**157,272**	**197,966**	**197,966**	**195,642**	**(2,324)**
Inventories	2,872	3,000	3,000	3,481	481
Trade and other receivables	32,342	18,000	18,000	20,438	2,438
Cash and cash equivalents	2,441	2,005	2,005	23,788	21,783
Total current assets	**37,655**	**23,005**	**23,005**	**47,707**	**24,702**
Trade and other payables	(33,692)	(30,838)	(30,838)	(53,598)	(22,760)
Borrowing repayable within 1 year	(58,529)	(3,200)	(3,200)	(6,439)	(3,239)
Current Provisions	(67)	(70)	(70)	(46)	24
Other liabilities	(1,933)	(2,000)	(2,000)	(1,357)	643
Total current liabilities	**(94,221)**	**(36,108)**	**(36,108)**	**(61,440)**	**(25,332)**
Total assets less current liabilities	**100,706**	**184,863**	**184,863**	**181,909**	**(2,954)**
Borrowings	(52,538)	(51,358)	(51,358)	(47,719)	3,639
Provisions	(744)	(750)	(750)	(852)	(102)
Total non-current liabilities	**(53,282)**	**(52,108)**	**(52,108)**	**(48,571)**	**3,537**
Total assets employed	**47,424**	**132,755**	**132,755**	**133,338**	**583**
Financed by					
Public dividend capital	74,065	164,063	164,063	158,650	(5,413)
Revaluation reserve	6,942	6,900	6,900	8,743	1,843
Income and expenditure reserve	(33,583)	(38,208)	(38,208)	(34,055)	4,153
Total taxpayers' and others' equity	**47,424**	**132,755**	**132,755**	**133,338**	**583**

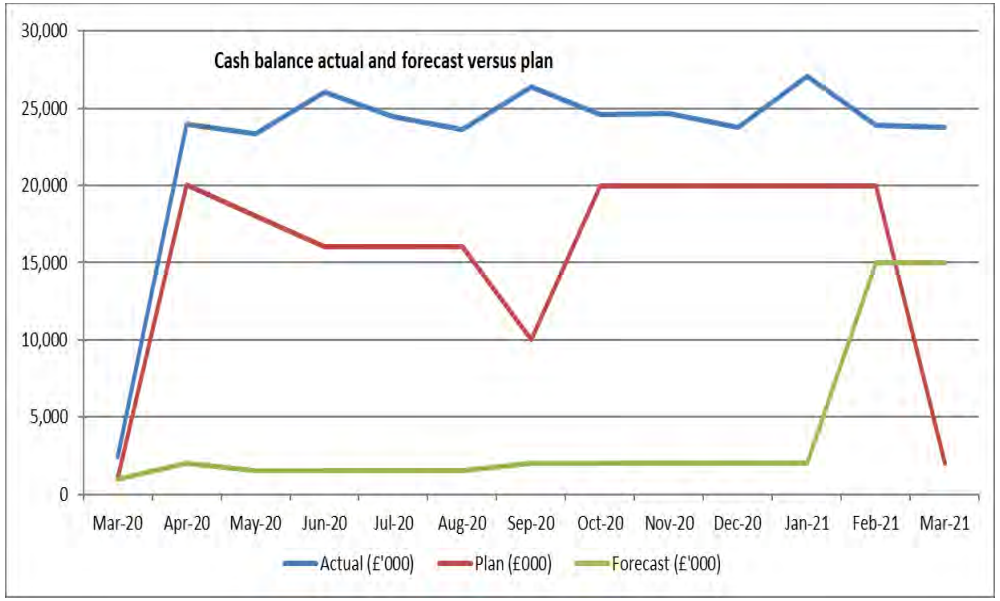
There has been little movement in the balance sheet against plan, other than cash and payables being higher than planned.

There has been a large rise in payables and this is due mainly to the increase in the annual leave accrual, which is as a result of staff being unable to take their annual leave during the pandemic. There was also a large amount of capital and other payables at the year end, which links to the increase in cash.

Public dividend capital (PDC) is in line with expectations and is lower than plan due to the fact that the plan included expected PDC for the ED project that has been put on hold. The significant increase in PDC at the year end compared to last year is due to the conversion of borrowing to PDC during the year, plus the funding required to support the capital programme for 2020/21.

Cash Balance Forecast for the year

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



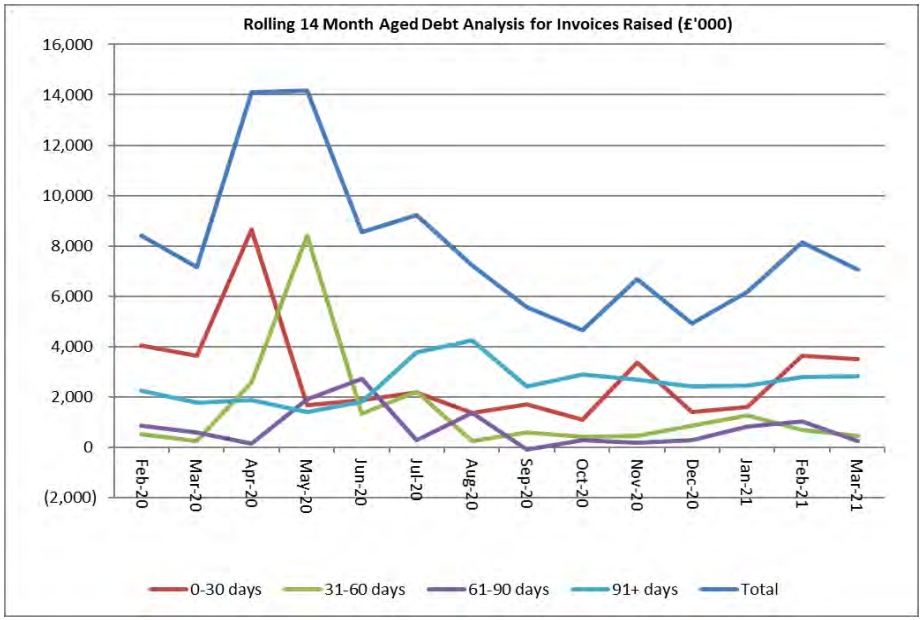
The cash balance has increased significantly during the year and this is due to the current cash regime within the NHS. The large cash balance at the year end is mainly due to number of payables outstanding at the year end.

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

FINANCE AND WORKFORCE REPORT – March 2021

Debt Management

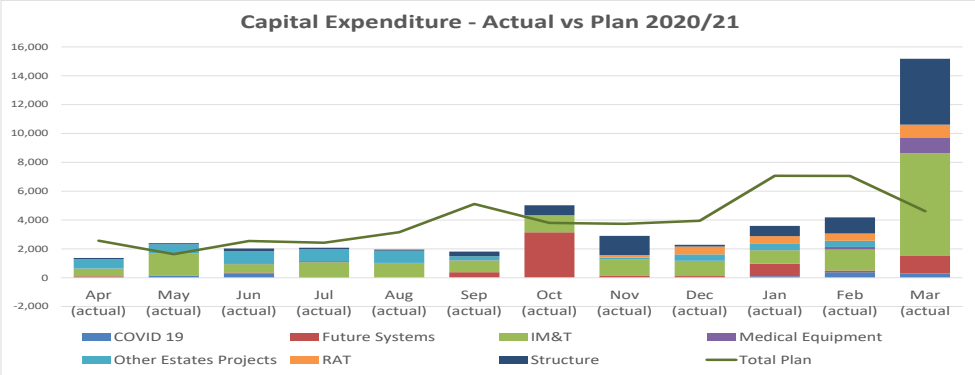
The graph below shows the level of invoiced debt based on age of debt.



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

The overall level of sales invoices raised but not paid has remained stable, with a slight decrease at the year end. The large majority of the debts outstanding are historic debts, although these are reducing. Over 60% of these outstanding debts relate to NHS Organisations, with 43% of these NHS debts being greater than 90 days old. We are actively trying to agree a position with the remaining corresponding NHS Organisations for these historic debtor balances and a significant amount of work has been completed in this area to help reduce these historic balances.

Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Actual £'000	Aug Actual £'000	Sep Actual £'000	Oct Actual £'000	Nov Actual £'000	Dec Actual £'000	Jan Actual £'000	Feb Actual £'000	Mar Actual £'000	Total 2020-21 £'000
COVID 19	58	153	305	32	10	17	16	46	26	103	379	300	1,445
Future Systems	51	2	62	3	0	364	3,138	78	90	865	127	1,204	5,984
IM&T	520	1,541	568	1,037	988	813	1,156	1,118	1,048	934	1,447	7,129	18,299
Medical Equipment	16	16	16	75	27	16	27	16	16	16	182	1,090	1,513
Other Estates Projects	639	610	895	838	852	285	0	139	436	433	428	-15	5,540
RAT	0	0	0	0	0	4	1	177	550	529	507	887	2,655
Structure	83	69	178	95	74	315	686	1,328	113	715	1,109	4,567	9,332
Total / Forecast	1,367	2,391	2,024	2,080	1,951	1,814	5,024	2,902	2,279	3,595	4,179	15,162	44,768
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 outturn for the year was £44.8m. The Trust was able to take advantage of some surplus capital funds available regionally to accelerate parts of the 2021/22 capital programme. This was mainly in relation to IM&T hardware and software. The funds allocated via Public Dividend Capital were fully spent during the year.

Comfort Break - 10 minutes

11:10 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

13. People and organisational development (OD) highlight report

To APPROVE a report

For Approval

Presented by Jeremy Over and Amanda Bennett

Board of Directors – Friday 30 April 2021

Agenda item:	13			
Presented by:	Jeremy Over, Executive Director of Workforce and Communications			
Prepared by:	Members of the Workforce & Communications directorate and our WSFT Freedom to Speak Up Guardians			
Date prepared:	22 April 2021			
Subject:	People & OD Highlight Report			
Purpose:	✓	For information		For approval

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

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

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

- Putting You First Awards
- Strengthening our WSFT People Plan in response to the national staff survey
- Quarterly Freedom to Speak Up Report from our FTSU Guardians
- Our WSFT staff well-being plan
- Quarterly mandatory training and appraisal update
- East of England Medical Bank and Agency initiative – our progress at WSFT
- National contract reform for Specialty and Associate Specialist Doctors 2021
- Consultant appointments

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

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

Previously considered by:	N/A
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 – April awards

Olly Best
Olly joined the patient experience team in March 2020, just as the team was preparing to work from home due to the first lockdown.

It was such a difficult time for a new member of staff to join the team, without having his colleagues physically around him to answer his questions and support him, but Olly quickly adapted. At this time he was even part of a team running the newly created webchat, responding to queries on a range of topics.

Olly has been so flexible and is a real support to everyone on the team. He gives his all to any task he is given and always does so with a smile on his face. He will happily help out his colleagues when needed, whether it's answering calls for the PALS team or organising video calls in the Keeping in Touch team, all alongside his usual day to day role.

Olly has also managed to set up some successful video interpreting sessions for our community colleagues which has never been done before, he is a real star and such an asset to our team.

Thank you Olly!

My WiSH Charity fundraising team
Natasha and Amy (quality improvement) met with Sue Smith last week to discuss how QI could support them and left the meeting completely in awe of what Sue and the team have achieved in the 12 months during the Covid pandemic for staff. The list includes….

- Setting up calm rooms
- Creating welfare packs
- Creating shielding packs
- Creating packs for patients (such as toothpaste, deodorant etc).
- Setting up the marquees for additional staff rest areas
- Sending out support gestures for staff, e.g. coffee cups & chocolate
- As well as their day jobs i.e. procuring equipment for dementia ward with Julie Fountain; funding a play coordinator for ED etc.

Two members of the team also volunteered to be redeployed to other roles in the Trust as part of our pandemic response, so they been working with a smaller team than usual.

They have done so much behind the scenes to put staff first and provide support, so I just wanted to see if we could do something nice for them, as they have done so much for us.

Lucy Webb
I am nominating Lucy Webb for her brilliant work on the fit testing programme.

She has worked tirelessly, most often leaving the office very late, so that the Trust has a robust fit testing programme. Her work has helped our colleagues to ensure that they are protected when dealing with Covid patients.

It is vital, before using a respirator/FFP3 for the first time, that the wearer passes a fit test for the model and size of the mask that they are going to use.

I have no doubt that Lucy's leadership in ensuring the Trust has a robust fit testing programme has helped our staff to reduce the risk of contracting Covid whilst caring for our patients.

Strengthening our WSFT People Plan in response to the national staff survey

Since providing the Board with an overview of the 2020 staff survey results last month, work has been ongoing to share the feedback at a wider level, and to develop our response. This has included presenting the themes at various forums with staff and staff representatives. Further analysis has also been undertaken to understand the range of results within our organisation, to ensure that actions are targeted at the areas that need specific support, and we celebrate and learn from the staff groups / teams that are reporting a positive experience.

Our new team of HR business partners is working with their respective divisions and corporate directorates to ensure each area works through their own results and develops a plan to respond to their specific priorities.

In addition to this, at an organisational level, we are using the results to strengthen and expand our West Suffolk People Plan. Two workshops are taking place in early May and will engage staff representatives, ambassadors and supporters in developing the plan.

It is expected that an updated West Suffolk People Plan will be shared at the May meeting of the Board.

Quarterly Freedom to Speak Up Report from our FTSU Guardians

The second of the regular reports from Amanda Bennett and James Barrett is attached to this report as Appendix A, which reflects their learning, influence and experience over the past quarter. They will be in attendance to present and discuss the report at our meeting on 30 April, which helpfully details proposed areas of development which we will want to hear and reflect on as a Board, and agree actions and timeframes to take forward.

Our WSFT Staff Well-being plan

Work has continued to implement our West Suffolk Wellbeing Plan 2019 to 2021 (an updated version is attached as appendix B).

In addition to supporting the emotional and mental wellbeing of staff during and beyond the pandemic we are focussing on help for staff to maintain their physical wellbeing.

All staff have free access to the virtual and physical resources of Abbeycroft Leisure and by mid-April 1000 trust staff had registered for membership. We are also working with One Life Suffolk to reinstate the health checks, help to stop smoking and weight

management support. Our in-house staff physiotherapy and moving and handling teams continue to provide vital services for staff. Staff physiotherapy saw 387 new staff patients in the 12 months from April 2020. The moving and handling team work with individuals and teams to support safe practise and reported a reduction in moving and handling incidents in the last quarter of 2020/21 with 14 incidents reported (a reduction of 23 on the previous quarter).

The trust 'flu team has been working on our plans for the 2021 flu vaccination programme since February and will be taking the opportunity to learn from the success of our COVID-19 vaccination programme.

Our occupational health service continues to play an important role in supporting all staff in the risks they face from occupational exposure to COVID-19. The risk assessment tool developed by the team in March 2021 has been updated regularly as our understanding of the virus and risk factors has developed. We are currently out to tender for a new provider of occupational health services since our contract with our current partner, Cambridge Universities Hospitals NHS Trust, comes to an end on 30th September 2021. We will also be reviewing our externally provided employee assistance programme with our new occupational health and wellbeing partner.

The work to support great line management that forms part of our WSFT people plan includes providing training and support to line managers in having effective and supportive conversations with their teams about wellbeing. Plans for this are being developed by Rebecca Rutterford, our new wellbeing and inclusion manager and the Staff Support Psychology team. Rebecca is also working with our communications team to provide easier access to all information about the very wide range of health and wellbeing support available to staff.

Quarterly Mandatory Training and Appraisal update

Our **mandatory training** compliance target is set at a minimum of 90% in all subjects (95% in information governance). Overall compliance in April 2021 was 88%. This is an increase of 2% since January, despite all face-to-face refresher mandatory training being paused from January to the end of March due to the second wave of the pandemic. Twelve of twenty-five mandatory training subject areas are at 90% or higher and for the first time since June 2020 no topic is below 70%. The action plan to achieve compliance across all subject areas continues to be implemented and this also includes divisions agreeing trajectories for achieving the target level.

The Trust **appraisal** compliance target is set at 90%; the March 2021 compliance figure is 79.7%; this is an increase of 0.9% since December 2020, which was reported to the Board in January 2021. Implementation of the action plan to support increased compliance continues to be implemented and this includes divisions agreeing trajectories for achieving the compliance target.

Supportive, productive appraisal conversations between managers and their staff members provide an opportunity to build relationships and improve the focus on well-being, at a time when many colleagues will be feeling the impact of working during the pandemic.

NB: appraisal has restarted for all consultants, SAS doctors and trust doctors following the pause from the end of March 2020 to the start of 2021 for all consultants.

East of England Medical Bank and Agency initiative – our progress at WSFT

This initiative is designed to monitor agency rates within the region and is reported on a monthly basis. Over the last 18 months the drive of the initiative has been to reduce agency costs by encouraging Trusts within the region to 'stand firm' against escalated rates with an agreed upper bar being set for each grade of doctor.

The agencies fall under an Alliance Framework created and led by the East of England Collaborative Procurement Hub which monitors strict governance checks to ensure we receive high quality doctors for our patients' safety and care.

Our Medical Staffing team, and a specific mention to Danielle Bourdiec, have consistently achieved an 80% compliance on the rates, second only to ESNEFT, who have a managed service in place. By meeting the compliance rates, the Trust ensures that the cost of agency doctors is kept to a minimum and continues to control agencies expectations on rates.

National contract reform for Specialty and Associate Specialist Doctors 2021

NHS Employers has been working with the British Medical Association (BMA) and the Department of Health and Social Care (DHSC) since February 2020 to formally negotiate a revised Speciality Doctor grade and introduce a new Specialist grade.

In January 2021, an agreement was reached which covers a three-year agreement from 1 April 2021 to 31 March 2024 for a reformed Specialty Doctor contract and a new Specialist contract. In March, the BMA members voted in favour of the new contracts and it has now been approved by Government.

The new contracts will apply to new staff to the SAS grades from 1 April 2021 and to SAS doctors being employed on new contracts from that date forwards. Current SAS doctors employed on national terms and conditions of service have been given the option to transfer to the equivalent revised terms and conditions or remain on current terms and conditions. They have a six-month window, April to September 2021, to make this decision.

Key elements of the reform include:

- the introduction of a new grade named the Specialist grade which will provide an opportunity for progression for highly experienced specialty doctors. The introduction of the role will help to recruit, motivate and retain senior doctors and contribute to SAS grades being a positive and fulfilling career choice.

- a reformed Speciality Doctor pay structure to move from an 11 point pay scale to a 5 point pay scale. This will enable SAS doctors to access the top of the pay scale more quickly than the current system, increasing the career average earnings.

- A new pay progression system that is not automatic and will link progression to the development of skills, competencies and experience through the processes of job planning, appraisal and mandatory training.

- A number of key terms and conditions changes in relation to out of hours definitions, on-call availability supplements and safeguards that allow work patterns to balance flexibility and support the health and wellbeing of SAS doctors.

Our eligible SAS doctors, of which there are 42 at West Suffolk, have received an offer to transfer, following local discussions and partnership work with medical staff representatives at our TNC.

Recent Consultant Appointments

Post:	Consultant in Acute Paediatrics
Interview:	23 March 2021
Appointee:	Dr Halima Nakato
Start date:	3 May 2021 (TBC)

Current post: Fixed-term Consultant Paediatrician: West Suffolk NHS Foundation Trust
June 2020 to present

Previous Position:
March 2018 - March 2019
ST8 Senior Paediatric Registrar – Colchester University Hospital

Jeremy Over
Executive Director of Workforce & Communications
April 2021

Freedom to Speak Up: Guardian's Report April 2021

Introduction

Since November 2020, two Guardians, James Barrett and Amanda Bennett have been employed at WSFT. A significant increase in the number of concerns raised with the Guardians has been seen compared to data in previous quarters although barriers to speaking up still exist. More work is needed to improve the culture of speaking up and the Guardians will continue to work with others throughout the organisation to promote this agenda.

Data

Data Submitted to NGO for Q3 2020/2021

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
Registered Nurses and Midwives	2
Nursing Assistants or Healthcare Assistants	2
Administration, Clerical & Maintenance/Ancillary	7
Not Known	3
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	6
The number of these that responded 'Yes'	5
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'	0

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 promoting 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

Data Submitted to NGO for Q4 2020/2021

Number of cases brought to FTSUGs / Champions per quarter	10

Numbers of cases brought by professional level

Worker	3
Manager	3
Senior leader	1
Not disclosed	3

Numbers of cases brought by professional group

Registered Nurses and Midwives	1
Nursing Assistants or Healthcare Assistants	1
Administration, Clerical & Maintenance/Ancillary	1
Not Known	5
Other	0

Of which there is an element of

Number of cases raised anonymously	2
Number of cases with an element of patient safety/quality	2
Number of cases with an element of bullying or harassment	4
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	2
The number of these that responded 'Yes'	2
The number of these that responded 'No'	0
The number of these that responded 'Maybe'	0
The number of these that responded 'I don't know'	0

Common themes from feedback

Covid: communications over timing of second vaccination, importance of maintaining social distancing at work (even in staff areas) and managers supporting isolating staff

Difficulties in relationships between staff members and between staff and their managers

Staffing levels

Summary of learning points

Importance in communicating issues over Covid rules and enforcing these so staff feel safe.

Importance of managers supporting staff and colleagues - listening (to understand concerns and able to show that these have been understood), appropriately escalating concerns and supporting those self-isolating or working from home due to Covid rules.

Continue to raise profile of FTSU and Guardians and to combat perception that detriment will occur.

The Guardians are working to improve the culture of speaking up throughout the WSFT. Our actions are categorised under 8 key workstreams:

Workers throughout the organisation have the capability, knowledge, and skills they need to speak up themselves and to support others to speak up.

What's going well:

- Rolling programme of training given to overseas nurses, HCA's and Foundation year doctors
- NGO e-learning programme ("Speak Up" and "Listen Up") promoted via Green sheet, core brief and at meetings
- Promoting Speaking Up, Listening Up and Following Up at team meetings, Nursing and Midwifery Clinical Council and Medical Staff Committee meetings
- Offering drop in sessions to teams
- Training presentation and resources made available to teams
- Posters starting to be distributed around Hospital and community sites

Even better if:

- Introduction of regular training / awareness programme for FTSU for all employees
- Mandatory FTSU training for all staff and listening training for all managers at induction (in discussions with Executive Director of Workforce ongoing)

Speaking up policies and processes are effective and constantly improved

What's going well:

- Raising concern process established and shared with staff Governors and CEO to ensure continuity in response.
- Guardians both members of the policy working group ensuring FTSU represented on policy updates.
- Currently reviewing WSFT FTSU policy to update in line with NGO guidance

Even better if:

- Disseminate and promote information to ensure all staff have clarity around the process of speaking up
- Assist Board in production of clear FTSU strategy

Senior leaders are role models of effective speaking up

What's going well:

- Megan Reitz discussion with board members and invited to 5 O'clock club
- Quarterly meetings in place with CEO, Chair of Board and Senior independent director
- Excellent support from Chief and Deputy Chief Nurses

Even better if:

- National Guardian's Office e-learning recommended to all senior leaders when available (to be published later this year.)
- FTSU pledge to be established for Board and wards

All workers are encouraged to speak up

What's going well:

- Significant increase in number of concerns raised compared to previous year
- Contact with the Trusted Partners to explore new ways / role development to support staff in speaking up

Even better if:

- Concerns around perceived negative consequences of speaking up (detriment) must be challenged
- Network of FTSU ambassadors to be established to encourage and facilitate speaking up
- "Learning Bulletin" developed to complete feedback loop and show that speaking up leads to change and improvement

Individuals are supported when they speak up

What's going well:

- Individuals report feeling supported by the Guardians when raising concerns

Even better if:

- FTSU ambassadors to be representatives from all groups traditionally less likely to speak up

Barriers to speaking up are identified and tackled

What's going well:

- Good relationships with HR Business Partners and working together to analyse staff survey results
- Links with Union representatives and their views gathered to identify barriers to speaking up

Even better if:

- Listening up training undertaken by all managers
- Mindset of "being a trouble maker" for speaking up to be challenged and perceptions changed to a positive message of improvement
- Speaking up rewarded and embraced within teams
- Integration of FTSU within the Just and Learning culture, so that speaking up is "business as usual"

Information provided by speaking up is used to learn and improve

What's going well:

- Working with Patient Safety colleagues
- Individual improvements have been witnessed by the FTSU Guardians following raising concerns

Even better if:

- Development of methods of dissemination of learning to the wider West Suffolk FT community
- Developing "stories" to encourage Speaking Up

Freedom to speak up is consistent throughout the health and care system, and ever improving

What's going well:

- Both Guardians attended NGO on-line training for Guardians

- Members of East of England FTSU Guardian Network and have attended quarterly meetings

Even better if:

- National data from NGO FTSU Guardian Survey 2020:
    - Only 50% of FTSU Guardians nationally believed managers supported staff to speak Up
    - Pandemic had negative effect on training
    - Only 50% said that significant barriers to speaking up did not exist (better in higher CQC rated organisations)
    - Detriment: Leaders must communicate that detriment will not be tolerated, act to prevent detriment and look into cases of detriment when it is reported

Appendix B

West Suffolk Wellbeing 2019 – 2021

Leadership

Trust Ambition 7 *Support all our staff*

Our Health Work and Wellbeing Strategy ensures we have a consistent and positive approach to employee wellbeing throughout the Trust

Current services and support

- Health and Wellbeing Steering Group meets quarterly to provide oversight and strategic direction
- Better Working Lives Group (sub group of H&WB Steering Group) focussing on the wellbeing of medical staff
- Updates to the Trust Board twice a year
- Talent Management Strategy provides career management for all to enable all staff to achieve their potential
- Leadership and management development for line managers to provide them with the skills they need to support their staff
- Shining Light Awards held annually to celebrate the achievements of staff
- Wellbeing co-ordinator role and Assistant Communications Manager support wellbeing activities

Action 2019 to 21

- Promote personal stories of self-improvement to encourage staff engagement through Better for me, better for you campaign to be developed by the Communications team. Initially 5 staff stories to be publicised in West Suffolk and Newmarket Hospitals. *Paused due to COVID-19. Launched in Greensheet October 2020.*
- Identify and address particular issues facing community staff in accessing wellbeing support. *Health and wellbeing offer promoted at Community staff inductions*
- *Identify a Wellbeing Guardian for the Trust to look at the Trust's activities from a health and wellbeing perspective and act as a critical friend (**NHS People Plan**) Dr Richard Davies has taken on the role.*
- *Ensure all staff have a health and wellbeing conversation and a personalised plan (**NHS People Plan**)*
- *Provide all new starters with a health and wellbeing induction (**NHS People Plan**)*
- *Wellbeing and Inclusion Manager in post from February 2021*

Mental Health

Trust Ambition 5 *Support a healthy life* **Trust Ambition 7** *Support* all our staff

It is important for all staff to be aware of the importance of supporting mental health and mental wellbeing and that they have access to support and information as required

Appendix B

Current services and support

- Care First Employee Assistance Programme provides access to information, advice and counselling
- Trust library provide resources for mental wellbeing, including mood boosting books for their uplifting qualities, Books on P rescription providing self-help techniques, colouring materials for mindfulness.
- Mental Health for Managers training (103 participants in 2019) and mental health awareness and emotional first aid workshops for staff (108 participants in 2019)
- Wellbeing Workshop for medical staff (25 participants - 9 and 10 September 2019)
- Mindfulness training at Grand Round 50 medical staff attended April/May 2019
- Freedom to Speak up Guardian in place since 2017 and range of other options via 'staff supporters'
- Tea and Empathy – giving staff on-the-day access to 1:1 support from a colleague if they have had a bad day and want to talk
- Trusted partners – provide a listening ear and independent advice to staff with concerns including bullying and harassment and inclusion
- Chaplaincy provides pastoral and spiritual support in times of need

Action 2019 to 21

- Action plan to tackle bullying and harassment built on learning from 2019 Summer Leadership Summit and internal survey to be implemented, including anonymous reporting, mediation support and unconscious bias training. *Action plan implementation started: accredited mediation available, progress reviewed with divisions Sept.19 through PRM meetings. Progress of action plans to be reviewed by HR Business partners and in light of just culture plans.*
- Trust inclusion strategy objectives 2019 – 21 and supporting action plan include taking action to support the mental health wellbeing of staff. *Inclusion action plan being implemented. Mental health awareness training sessions delayed due to COVID-19. Sessions ran November 20 to March 21.*
- Doctors 'burnout' surveys – action to be taken by Better Working Lives Group. *Wellbeing session arranged for medical staff January 2021 – postponed to May 2021 due to second wave COVID-19*
- Survey of medical staff to explore the impact of IT systems on working lives and opportunities to improve experiences – action to be taken by Better Working Lives Group. *COVID-19 survey carried out and results fed back.*
- Development of a business case for in-house clinical psychology to support staff mental health, including debriefing of individuals and teams – led by Better Working Lives Group. *Complete Business case implemented and expanded Staff Support Psychology Service in place to support staff during COVID-19 pandemic and beyond.*
- *Evaluation of staff psychology support service two-year pilot programme.*
- *Provide support for staff facing challenging and stressful times, including SUI, coroner's cases and trauma.*
- *Love Yourself Week – events held during February 2021*

- *Wellbeing Wednesday sessions from February 2021*
- *Virtual coffee lounge hosted by Staff Support Psychology Service Team Mondays and Fridays from February 2021*
- *Calm room provided in Quince House*
- *Additional break areas created in marquees in Rainbow and Gnome courtyards from January to April 2021*

Life Style

Trust Ambition 5 *Support a healthy life* **Trust Ambition 7** *Support all our staff*

We aim to support people through all individual lifestyle choices, habits and behaviour which in turn impact on their wellbeing

Current services and support

- Engagement with Suffolk County Council Health Promotion Campaign Planning
- WSFT Smoke Free Environment
- One Life run Stop Smoking Clinics on site weekly
- NHS Health Checks. One Life Suffolk on site monthly to provide free health checks for staff aged between 40-74
- Health Walks One Life Suffolk
- One Life Suffolk weight management course for staff who meet BMI criteria
- Physical activity- WSFT Staff currently run Circuit Exercise and Tae Kwando classes on site aiming for ease of access to staff members and encourage physical activity.
- Active travel. One element is the national Cycle-to-Work scheme, purchasing cycling goods tax-free.
- Healthy Eating. Time Out staff restaurant provides healthy choices and has won Eat Out, Eat Well award.
- Preceptorship Days and other Training/workshops include the Wellbeing Market Place which provides information regarding WSH staff benefits and available support services also road showing I.T systems and programmes.

Action 2019 to 21

- Physical activity - Explore opportunities to provide further exercise options on site for staff e.g. Tai Chi. *Paused during COVID-19 pandemic*
- Supporting staff to stop smoking – WSFT will be actively promoting Stoptober in October 2019. *Complete*
- Seek agreement for One Life presence on site once a fortnight to help promote services and provide support and information to staff and patients as required. *Paused during COVID-19 pandemic – programmes to re-start following discussion with One Life April 2021*
- Healthy eating – catering team exploring vegan options in Time Out. *Promotions paused due to COVID-19*
- *Free membership at Abbey Croft Leisure for WSFT staff from March 2021*

Appendix B

Focus on: MSK Musculoskeletal **Trust Ambition 5** *Support a healthy life* **Trust Ambition 7** *Support all our staff*

We aim to support all members of the workforce in preventing MSK injury through various methods including education, providing equipment and moving and handling techniques. We support staff return to work and encourage self-care is encouraged

Current services and support

- Specialist Physiotherapy self-referral service for staff
- Moving and Handling Team provide assessment, training and specialist advice for staff
- Monthly information/advice to be provided by Physio and published in staff Greensheet

Action 2019 to 21

- Wellbeing Coordinator and Moving and Handling Advisor are looking into Desk exercises (stretching) to support staff, predominantly those sitting at a work station.

Appendix B

Focus on: Preventing Flu and COVID-19

Trust Ambition 5 *Support a healthy life*

Throughout the flu season we offer and provide our staff with the Flu vaccination and we provide vaccination for staff against COVID-19

Current services and support

- Flu Strategy
- Follow NHS checklist for beat practice management checklist for public assurance via trust Boards.

Action 2019 to 21

- 2019, 2020 flu seasons – target of 80% vaccination of frontline/patient facing staff. *80% achieved. 2020 flu season target of 90% of frontline/patient facing staff vaccinated. Campaign launched with additional flu vaccination stations and strategies to give all staff easy access to vaccination. Sufficient vaccine purchased for all staff. 67% take up by frontline staff.*
- *2021/22 flu season – planning underway starting with learning from 2020 experience*
- *Provide COVID-19 vaccination for WSFT staff*

Life Experiences and Ill Health

Trust Ambition 5 *Support a healthy life* **Trust Ambition 7** *Support* all *our staff*

Life experiences and ill health will have a completely different meaning to each individual employee. We aim to holistically support staff through generalised life events (e.g. menopause, caring responsibilities) as well as specific health conditions

Current services and support

- The Trust has a range of policies and guidance to support staff and enhance a healthy workplace culture
- Health and Wellbeing Focus Group quarterly.

Action 2019 to 21

- Improving the working lives of disabled staff – Workforce Disability Equality Standard action plan developed, including establishing a disabled staff network, reviewing policies and supporting reasonable adjustments. *Open forum/network meeting held Sept.19 to discuss WDES. Disability leave policy approved by Trust Council January 2021. Reasonable adjustments in recruitment and selection approved by Trust Council January 2021.*

- Menopause workshop – additional workshop in 31 October 2019, explore setting up a menopause support network. *Further workshop arranged for November 2020 with on-going promotion of resources and support.*
- Family Carer Workshops for those caring for elderly friends or relatives. *Paused for COVID-19*
- Handling stress and anxiety workshop 20 September 2019. *Workshop held. Further events paused for COVID-19*
- Mental health awareness and emotional first aid workshops for staff and managers – build on 2019 activities. *Mental health awareness training sessions delayed due to COVID-19. Sessions run November 2020 to March 2021.*
- Supporting parents of children facing mental health difficulties in support of the Director of Public Health for Suffolk's Annual Report 2019 "Suffolk through a child's eyes" *Registrar in public health to initiate action from Autumn 2020*
- *Provide practical support to staff during the COVID-19 pandemic. Following provided for staff: food packages, free tea/coffee at WSH, tea/coffee packages sent to community teams, free car parking on trust sites, free accommodation on and off side for staff with vulnerable people in their households and those with long distances to travel, access to information about childcare via Suffolk County Council Family Information Centre, extended staff meal times for hot food and free hot food at night, temporary change to carers leave policy providing up to 3 days paid carers leave, calm rooms to provide space for staff to relax and reflect, information about support available, including external support e.g. wellbeing apps, discounts etc. via staff extranet available on any device.*

Financial Wellbeing

Trust Ambition 7 *Support all our staff*

We are aware of the impact and implications that negative financial situations can have on people and seek to offer access to practical support

Current services and support

- 'Neyber' financial wellbeing service. Details are available to staff via the intranets and Neyber staff attend special events on site as required.

Action 2019 to 21

- Preceptorship marketplace 18th December 2019. Event held
- *National NHS Finance Health and Wellbeing offer launch promoted to all staff via Greensheet October 2020 and via wellbeing section of the intranet – free and impartial advice for NHS staff from Money Advice Support*

Absence Management

Trust Ambition 7 *Support all our staff*

We will support the physical and mental wellbeing of all our staff to help minimise absence from work

Current services and support

- Absence Management Training is held x4 yearly, is also available ad-hoc on request.
- Bradford Factor scores used for absences.
- Return to work interviews conducted, appropriate support provided alongside specific risk assessments taking into an individual's health status. Reasonable adjustments are available to employees in line with recommendations for relevant professionals.

Action 2019 to 21

- OH contract review – ensure staff have timely access to occupational health services to support remaining at and returning to work. *OH contract to be retendered with new provider in place from Autumn 2021*
- Promotion of occupational health services – self referral by staff and raising line manager awareness of the support available to them *active promotion paused due to COVID-19 will be included as part of process to communicate new provider arrangements*
- Workforce Disability Equality Standard action plan – supporting staff with disabilities, explore potential for a disability leave policy. *Approved by Trust Council January 2021*
- The Improving Employee Health, Wellbeing and Attendance Policy is currently being reviewed, with phased returns being an element of focus. *Process for arrangements for staff to agree a phased return without automatic involvement of Occupational Health agreed and communicated to managers in January 2020. Initial plan for a six month trial extended to one year due to COVID-19. Review due January 2021*

Safe Environments

Trust Ambition 5 *Support a healthy life* **Trust Ambition 7** *Support all our staff*

We aim to provide all staff with a safe working environment

- Health and Safety training provided to all staff relevant to their role at induction and on -going mandatory training
- Restrictive Physical Intervention (RPI) Team. A specialist team undertakes Restrictive Physical Intervention (RPI) to provide

support to staff when they are nursing clinically confused patients who become violent and aggressive.

- Management of Violence and Aggression Policy covers a wide range of issues around the creation of a safe working environment for staff through the prevention and management of physical and non-physical violence and aggression.
- All areas/departments of the hospital are required to have a Health & Safety Link person.

Action 2019 to 21

- *AccessAble to develop guide to courtyard gardens at West Suffolk Hospital with recommendations matrix to ensure gardens are available to as many staff as possible. Initial implementation planned for July 2020 delayed due to COVID-19. Planned for summer 2021.*

- *Develop individual staff risk assessment tools to facilitate joint understanding and decision making in relation to the individual risk of occupational exposure to COVID-19 and measures needed to reduce it to as low as is reasonably practicable. Risk assessment tool developed in March 2020 and updated in the light of evidence. All staff required to undertake risk assessment. Process has been supported by occupational health advice where needed. Additional tool and resources developed to support the return to work of shielding staff.*

13.1. To discussion development of One Clinical Community for West Suffolk (verbal) (9.30 am)

Presented by Andrew Dunn, Amanda Takavarasha and Kate Vaughton

14. Quality, safety and improvement reports

To APPROVE the reports

Presented by Susan Wilkinson and Nick Jenkins

14.1. Maternity services quality & performance report

For Approval

Trust Open Board – 30th April 2021

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

Executive summary:

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

This report contains:

- eCare go live
- Changes in the senior team
- Strategy update
- Maternity improvement plan
- Safety champion feedback from walkabout/virtual session
- National Staff Satisfaction Survey Results
- Service user feedback
- External assurance and oversight
- National best practice publications and local HSIB reports
- Learning from incidents / learning from deaths
- Maternity Clinical and Quality dashboard **(**Annex A**)**
- Continuity of Carer progress (see Quality dashboard Annex A)

eCare go live

On Sunday 21st March Maternity on eCare went live. This had originally been due to happen in spring 2020 but had been delayed by the pandemic. The inclusion of Maternity in the main hospital electronic record will enhance continuity of care (e.g. if a pregnant or post-partum lady is admitted to the acute wards or presents at ED). Other benefits are reduction in duplication of documentation (pre eCare 3 separate places), accessibility of documentation across community and hospital settings, women having digital notes via the patient portal with timely access to notes, results and documentation.

Changes in the senior team

The newly appointed Clinical Quality & Governance Senior Midwifery Matron (Karen Green) takes over from Jane Lovedale who retires at the end of April. This post, previously designated as Senior Risk Midwife, leads the local quality & safety team and will work with the senior management leads in Midwifery and Obstetrics to take forward the Quality and Safety Framework and improvement plan.

A new post of Deputy Head of Midwifery, successfully appointed to in April, due to commence in August/September will support the operational management of the service including the ongoing implementation of 'continuity of carer' and provide cohesive working between maternity and neonatal services.

Quality and Safety Framework / Strategy update

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

It is now in its final pre-approval stage (including providing a copy to the CCG and NHSE for their information following the assurance visit) and plan to present to the new Insight Committee for formal approval in June.

Maternity improvement plan including Ockenden

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

Following Executive sign off and approval at LMS, the Ockenden assessment & assurance tool was submitted to NHSE on the 12th February 2021. Feedback has been received, the next stage is to collate the evidence.

Safety Champion Walkabout feedback

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

To enable accessibility to a Safety Champion our NED Safety Champion held a virtual 'walkabout' on 19th March 2021. Engagement was good from community and inpatient midwifery teams. Themes from the discussion were generally about staffing and welfare of staff. Due to significant staffing shortages in maternity, staff reported they are moved from their allocated place of work to another, concerns raised that Continuity of Carer (CoC) and homebirth provision are threatened by the staff shortages and limited/no time for lunch/coffee breaks or to access the wellbeing service.

Following this staff have been updated at our monthly unit meeting regarding the LMNS recruitment drive, reminders given of new starters and to escalate inability to take full breaks to the Maternity bleep holder. Ensuring everyone has had a break is an item on the maternity safety huddle. The PMA (Professional Midwifery Advocate) service are supporting staff and ensuring all that wish to can access the wellbeing service. Until all the vacancies are filled we will not be able to roll out the next CoC teams and our homebirth service is continuing to run.

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

National Staff Satisfaction Survey Results

The National Staff Satisfaction Survey results were published in March 2021. The survey was conducted between October and November 2020, mid-pandemic and also on the back of a staff consultation in maternity to move towards an increased trajectory of CoC. The staff survey results for maternity staff reflect the issues raised with the safety champion in March. As a division these results have been taken very seriously with the immediate implementation of HR clinics to listen to staff, the new PMA service is engaging actively with staff, management have increased their presence within all clinical areas including the community setting. There is a plan to repeat parts of the survey to capture if there is any change in staff's satisfaction at work.

Service User feedback via F&FT and maternity Facebook page

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

In March, the maternity service received 65 FFT returns. 100% of women would recommend the service in all areas except postnatal community where satisfaction was 97%

External assurance and oversight

In February the CCG and local stakeholders undertook an assurance visit. A draft report has been sent to the Trust to check for factual accuracies, which has been completed. Feedback from the visit has been overall very positive. Whilst we await the final report to be shared areas for development are reflected within the overall Maternity improvement plan.

In addition, the CQC are undertaking a nation-wide regulatory review of Maternity services according to their new framework (which considers restrictions on on-site visiting due to COVID).

In April the CQC visited several local Maternity units including WSH on the 13th April. The visit reflected the ongoing local scrutiny of the Maternity improvement plan and noted the continued efforts to progress this. High level feedback was shared on the day and any outstanding actions will be added to the overall Maternity improvement plan

National best practice publications and local HSIB reports

MBRRACE-UK provides a national reporting framework for the surveillance and investigating the causes of maternal deaths, stillbirths and infant deaths. Since the last Maternity Board report, no new reports have been issued (reports can be found at https://www.npeu.ox.ac.uk/mbrrace-uk/reports)

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

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

Learning from incidents / learning from deaths (LfD)

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

Maternity dashboard (see Annex A)

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

The **Quality Dashboard** is also included. This gives assurance that the maternity service has a robust monitoring and auditing programme relating to quality and safety. The indicators include, appraisal completion, mandatory training overview, equipment safety checks, and audit results. The RAG rating has been determined by the department and purposely to reflect a small window of non-

compliance. This will be reviewed once compliance is improved and embedding of changes is reflected. Longer term the plan is to move from RAG rating to a more SPC / 'plot the dots' style of reporting in line with the national NHSI model.

Indicators	Narrative
Grade 2 section decision to delivery time	7 delays and therefore a thematic review has taken place. No one theme identified all individual reasons. All babies born in good condition.
Appraisal completion Mandatory training	In March the focus was on staff training and support with new IT system, compliance reduced this month in some areas.
Smoking cessation / CO checks	Change in national recommendation to reintroduce CO monitoring but only where safe to do so reflected in compliance
MLBU 'fresh ears' (documentation)	Quality assurance midwife lead working with the Birthing unit lead midwife on strategies to improve performance

LMNS Perinatal Quality Oversight Highlight Report

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

Local audit / monitoring

Currently a report is submitted monthly to the CQC for the indicators highlighted within the Section 29A letter. Compliance has been high and any areas of non-compliance have been addressed and documented within the report. Results from March 2021 report are represented in our quality dashboard (see Annex A).

CNST Maternity incentive scheme

Now in its third year, the maternity incentive scheme supports the delivery of safer maternity care through a '10 steps to safety' framework underpinned by an incentive element to the trust's contributions to the CNST (clinical negligence scheme for trusts. It should be noted that the Ockenden review and essential actions include a degree of overlap with the CNST scheme and therefore progress with one will aid the other.

Other Maternity indicators including those incorporated elsewhere in board reporting schedule

- Maternity serious incidents in March - one

These are reported in the closed board 'serious incidents, complaints, claims and inquests' report on a monthly basis. This includes details of the incident, duty of candour status and whether it is reportable to the HSIB or for local investigation. There was one serious incident reported; a Neonatal death (originally reported by WSFT as a baby sent to tertiary unit for cooling but very sadly the baby subsequently died 5 days later.)

As per protocol a local rapid review took place to identify if there were any learning points / issues for immediate action. The Perinatal Mortality Review Tool was also completed. There were no immediate concerns raised but some learning points were identified including reviews of the hypertension in pregnancy guidelines and the process of organising urgent transfusions for neonates in theatres.

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

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

Annex A – Maternity Clinical and Quality Dashboard

West Suffolk NHS Foundation Trust

	Green	Amber	Red	Apr20	May20	Jun20	Jul20	Aug20	Sep20	Oct20	Nov20	Dec20	Jan20	Feb20	Mar20
Total Women Delivered	>208 or <216	>216 or <208	> 224 or <2 00	178	180	187	174	183	202	203	178	159	181	166	
Total Number of Babies born at WSH	>208 or <216	>216 or <208	> 224 or <2 00	179	182	190	175	187	204	206	181	160	183	169	
Twins		No target		1	2	3	1	4	2	3	3	1	2	3	
Homebirths	2.5%	2% or less	Less than 1%	5 2.8%	7 3.9%	5 2.7%	3 1.7%	2 1.1%	6 3%	7 3.4%	4 2.2%	3 1.9%	6 3.3%	6 3.6%	
Midwifery Led Birthing Unit (MLBU) Births	≥20%	19- 15%	14% or less	3 1.7%	12 6.7%	26 13.9%	22 12.6%	20 10.9%	27 13.4%	26 12.8%	17 9.6%	17 10.7%	16 8.8%	13 7.8%	
Labour Suite Births	77.5%	69% - 74%	68% or less	170 95.5%	161 89.5%	154 82.4%	149 85.6%	161 88%	169 83.7%	170 83.8%	157 88.2%	139 87.4%	159 87.8%	147 88.6%	
Total Caesarean Sections	<26.%		> 26%	34 19.1%	36 20%	56 29.9%	46 26.4%	43 23.5%	48 23.8%	47 23.2%	39 21.9%	33 20.8%	47 26%	49 29.5%	
Total Elective Caesarean Sections	11%	>11% -13%	13% or more	14 7.9%	14 7.8%	23 12.3%	14 8%	20 10.9%	20 9.9%	18 8.9%	11 6.2%	10 6.3%	14 7.7%	13 7.8%	
Total Emergency Caesarean Sections	14.3%	14.4%-14.9%	15% or more	20 11.2%	22 12.2%	33 17.6%	32 18.4%	23 12.6%	28 13.9%	29 14.3%	28 15.7%	23 14.5%	33 18.2%	36 21.7%	
Grade 1 Caesarean Section (Decision to Delivery Time met)	100%	96 - 99%	95% or less	100%	100%	100%	100%	100%	91%	100%	n/a	100%	100%	67%	
Total Instrumental deliveries	12% - 14%	>14% - 15%	> 15%	9.6%	10.6%	7.0%	8.6%	11.5%	14.9%	14.3%	10.1%	14.5%	13.3%	15.7%	
Inductions of Labour (ex pre labour & twins)	<31%	>31% -32.9%	>33%	39.9%	35%	32.6%	36.2%	39.3%	38.1%	38.9%	52.8%	36.2%	39.7%	47.6%	
Postpartum Haemorrhage 1500 mls or more	<3.5%	3.5% - 3.8%	> 3.8%	1.7%	1.1%	8%	4.0%	2.7%	2.5%	3.9%	2.8%	2.5%	2.8%	1.8%	
Shoulder Dystocia	2	3-4	5 or more	3	7	4	4	5	2	2	3	5	1	2	
Unit Closures	0		1	0	0	0	0	0	1	0	0	0	0	1	

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

West Suffolk NHSFT		MIDWIFERY SERVICE: QUALITY DASHBOARD											
QUALITY TOPIC		Denominators											
		RAG	GREEN	= Standard or above		AMBER	≥5% below standard		RED	> 5% below standard			
STAFF SUPPORT & DEVELOPMENT													
Appraisal completion	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Midwives Hospital % in date	90%				94.0%	97%	97%	97%	100%	89%	82%	87%	80%
Midwives Community & ANC % in date	90%				83.0%	90%	80%	100%	98.50%	98.50%	95%	98%	98%
Support Staff Hospital % in date	90%				90.0%	90%	88%	84%	72%	76%	81%	83%	81%
Support Staff Community & ANC % in date	90%				100.0%	100%	No data	93%	91.50%	91.50%	91.5%	87%	100%
Medical Staff % in date	90%	Medical Staff appraisal suspended during Covid pandemic											
Mandatory Training Overview	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Midwives: % compliance for all training	90%		70.3%	74.8%	77.6%	78.3%	79.9%	80.1%	81.9%	92.2%	93.4%	92.1%	95.5%
Midwives: % compliance with PROMPT training	90%		52.7%	75.0%	75.9%	77.2%	81.4%	85.5%	93.3%	89.7%	86.4%	87.3%	96.0%
Midwives: % compliance with GAP training	90%			79.0%	91.0%	92.0%	98.0%	96.0%	96.0%	96.0%	96%	89.0%	87.0%
Midwives: % compliance with Safeguarding Children training	90%					99.3%	No data	99.0%	94.0%	94.0%	97%	96.0%	98.0%
Midwives: % compliance with Fetal Monitoring training	90%										68.6%	75.9%	78.1%
ANC Midwives: % compliance with Fetal Monitoring training											40%	71.4%	100%
MCA: % compliance for all training	90%		81.5%	83.2%	84.9%	85.6%	81.2%	85.7%	86.0%	92.8%	92.5%	94.1%	94.9%
MCA: % compliance with PROMPT training	90%		58.8%	72.2%	72.2%	72.2%	57.1%	65.0%	80.0%	83.3%	87.5%	87.5%	94.9%
MCA: % compliance with Safeguarding Children training	90%					99.4%	No data	100.0%	94.0%	91.0%	97%	100.0%	100%
Obstetric Medical Staff: compliance with PROMPT training	90%			70.0%	70.0%	73.3%	57.1%	69.6%	76.0%	79.2%	84%	84.6%	89.7%
Obstetric medical staff: % compliance with GAP training	90%			88.0%	83.0%	58.0%	92.0%	87.0%	83.0%	86.0%	83%	79.0%	80.0%
Obstetric Medical Staff: compliance with Safeguarding Children training	90%						No data	84.0%	50.0%	84.0%	90%	80.0%	85.0%
Obstetric Medical Staff: % compliance with Fetal Monitoring training											89.5%	76.2%	90.9%
Anaesthetic compliance with PROMPT training	90%						No data	50.0%	53.9%	53.9%	60%	64.3%	73.3%
Theatre staff compliance with PROMPT training	90%						No data	34.3%	47.4%	47.4%	50%	50.0%	74.4%
Sonographer: % compliance with GAP training	90%			93.0%	93.0%	79.0%	86.0%	79.0%	86.0%	93.0%	93%	86.0%	86.0%

EQUIPMENT SAFETY													
Checking of Emergency Equipment	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Labour Suite: Adult Trolley	100%			86%	100%	100%	100%	100%	100%	100%	100%	100%	97%
Labour Suite: Resuscitaires				73%	86%	76%	88%	96%	98%	97%	92%	98%	99%
Ward F11: Adult Trolley					97%	100%	97%	100%	100%	100%	100%	100%	97%
Ward F11: Resuscitaire					77%	84%	93%	97%	100%	100%	100%	100%	97%
MLBU: Resuscitaires	100%				95%	100%	93%	94%	97%	97%	96%	93%	97%
Community: Emergency Bags					89%	98%	95%	84%	82%	100%	96%	100%	94%
Checking of Fridge Temperatures	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Labour Suite	100%				97%	100%	100%	100%	93%	97%	97%	96%	97%
Ward F11					100%	100%	93%	100%	100%	97%	100%	100%	100%
MLBU					97%	100%	100%	100%	100%	100%	100%	100%	100%
ANC					100%	100%	100%	100%	100%	100%	100%	100%	100%
Ambient Room Temperature (where medication is stored)	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Labour Suite	100%				97.0%	100.0%	100%	100%	93%	97%	97%	96%	97%
Ward F11					100.0%	100.0%	97%	100%	97%	97%	1005	100%	100%
MLBU					97.0%	100.0%	100%	100%	100%	100%	100%	100%	100%
ANC					100.0%	100.0%	100%	100%	100%	100%	100%	100%	100%
Checking of CD's	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Labour Suite	100%				100.0%	98.0%	100%	100%	100%	100%	100%	100%	100%
Ward F11					100.0%	100.0%	97%	100%	100%	97%	100%	100%	100%
MLBU					97.0%	100.0%	100%	100%	100%	100%	100%	100%	100%
MONTHLY QUALITY & SAFETY AUDITS:													
	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Supernumerary Status of LS Coordinator	100%				84%	74%	No data	83%	70%	91%	90%	92%	97%
1-1 Care in Labour	100%	97.4%	100.0%	100.0%	100.0%	100.0%	99.5%	100.00%	100%	100%	100%	100%	No data
MW: Birth Ratio	1:28	1:26	1:26	1:27	1:30	1:27	1:31	1:31	1:27	1:25	1:29	1:27	No data
No. Red Flags reported				3	4	2	1	14	12	12	4	6	1

DOCUMENTATION & CARE AUDITS	Standard	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Compliance with MEOWS completion	100%			98.0%	99.5%	99.0%	99. 8%	99%	99.3%	99.40%	99.6%	99.50%	99.2%
Compliance with NEWTT completion	100%	97.0%	97.0%	96.0%	95.0%	99.0%	100%	100%	100%	97.50%	98%	99%	98%
Carbon Monoxide Monitoring													
Smoking at booking recorded	95%	Audit suspended due to Covid-19				100.0%	100%	100%	100%	100%	97.5%	100%	100%
Smoking at 36 weeks recorded	95%					45.0%	78%	74%	85%	97.50%	93%	90%	72.5%
Compliance with DV questions													
Antenatal period	100%					95.0%	100%	98%	98%	100%	98%	100%	100%
Postnatal period	100%					97.5%	95%	90%	80%	94%	90%	98%	98%
Swab Count Compliance													
Birth	100%				56.0%	85.0%	87%	93%	100%	73%	85%	80%	88%
Suturing	100%				54.0%	90.0%	87%	96%	92%	66%	78%	70%	95%
Compliance with completing WHO checklist @ CS	95%	No audit		93.0%	96.0%	96.0%	90%	96%	100%	96%	96%	92%	92%
Recording of Pain Score													
Labour Suite	100%					99.0%	100%	100%	98%	100%	100%	100%	99%
Triage						100.0%	100%	100%	100%	100%	100 %	100%	97%
MLBU						100.0%	100%	100%	100%	100%	100%	96%	100%
Ward F11						97.0%	100%	100%	98%	100%	100%	100%	97%
MDAU						100.0%	100%	100%	100%	100%	100%	100%	100%
Completed Drug chart information: weight and allergies	100%						7.00%	73%	76%	60%	48%	76%	100%
Fresh Eyes													
Labour Suite	100%						20%	100%	80%	100%	100%	67%	100%
Fresh Ears													
MLBU	100%					80.0%	50%	80%	88.80%	88%	89%	100%	66%

Epidural response <30 min	90%					92%	98%	87%	98%	Data per 1/4	Data per 1/4	ust awaiting data	No data
Breast Feeding													
Total women delivered who breastfed their babies within the first 48 hrs	80%	76.7%	72.8%	80.7%	71.4%	79.2%	82.2%	81.8%	73.10%	77.8%	80.5%	78.1%	No data
Unicef baby friendly audits	10, 8, 6		0	0	0	0	40	0	0	0	9	0	No data
LSCS decision to delivery time met													
Grade I LSCS	95%		100%	100%	100%	100%	91%	100%	None	100.0%	100%	67.0%	100%
Grade 2 LSCS	80%		81%	67%	95%	78%	83%	82.3%	68%	75%	58%	81%	64.0%
Neonatal Outcomes													
Mag Sulphate for preterm infants												1 of 1	No data
Pre-term infants birth in right place												100%	No data
Continuity of Care Outcomes													
Women Booked onto the continuity pathway	Number									415	473	542	No data
	%									18%	20.6%		
Women who received 70% of care	Number									31	36	26	No data
	%									1.30%	2.9%	15.60%	
Governance													
Outstanding Datix (last day of the month)												4	2
Out of date guidelines										0	0	2	2
Number of serious incidents										1	2	2	1

14.2. Infection prevention and control assurance framework

For Approval

Board of Directors – 26th March 2021

Item no.	14.2			
Presented by:	Sue Wilkinson Exec Chief nurse			
Prepared by:	Rebecca Gibson – Head of Compliance & Effectiveness			
Date prepared:	April 2021			
Subject:	NHSE ICT assurance framework			
Purpose:	x	For information		For approval

Executive summary:

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

This month's report contains

- Dashboard (Appendix 1)
- Integrated 'learning from outbreaks' plan (Appendix 2)

The updated NHSE BAF and response to the HSE national report mentioned in last month's meeting is due to be presented to the Executive Directors meeting and will include a gap analysis and action plan.

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

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

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

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

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

Appendix 1: Dashboard

Measure	Time period reported	Data		
		Previous	Last period	This period
Compliance to Antimicrobial stewardship (AMS) standards	91.7% (Q2)		No Data	
AMS ProTectis compliance	85.8% (Q2)		No Data	
Nosocomial C19 (probable + definite)	Mar21	60	0	0 →
Staff work-related C19 cases reported to RIDDOR	Mar21	0	0	0 →
Incidents relating to C19 management	Mar21	79	27	21 ↓
Admissions swabs within 24 hours of DTA	Mar21	97%	97%	97% →
C19 clusters / outbreaks	Mar21	3	0	0 →
Staff sickness / absence due to C19	Mar21	856	312	226 ↓
Staff uptake of lateral flow test	To date	3354	3408	3726↑

Associated charts / tables / narrative

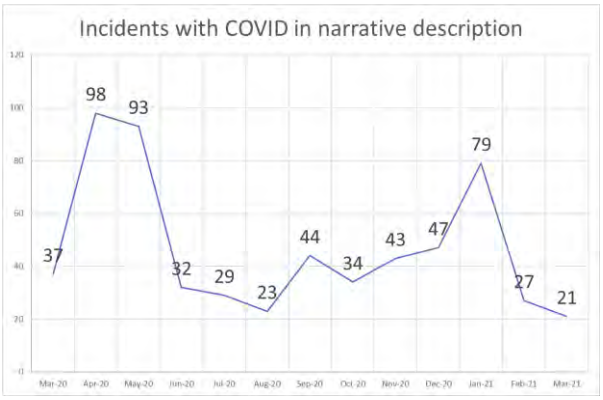
Antimicrobial audits are currently on hold whilst infection prevention resource is focussed on the pandemic. AMT intend to resume antimicrobial stewardship audits as staffing allows (probably April/May). In the interim the AMT has worked with the biochemistry department to allow PCT (procalcitonin) testing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

C-19 admission swabs

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

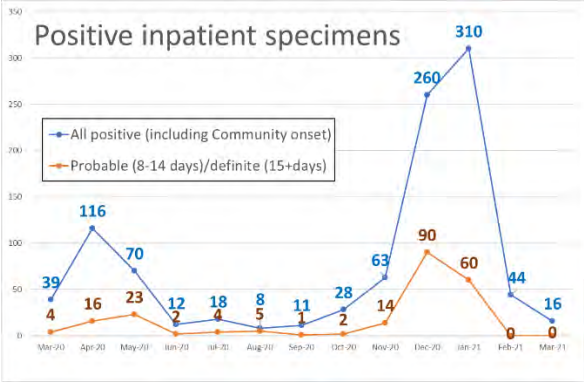
43 patients (3%) do not have a record of having a swab taken in this episode.

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



The number of **incidents relating to C-19** recorded in March fell again and remains at similar levels in Jun-Aug months. 19/21 March reported incidents were green, there was two amber and no reds:

The two ambers were a category 3 pressure ulcer (incident unrelated to Covid) and a retrospectively reported incident relating to wound care highlighted via a claim. The latter noted that patient had not been attending the hospital during the pandemic but they were still under the care of tissue viability and the district nursing team in the community.



Nosocomial (Hospital-Onset) C19

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

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

Overall Stats

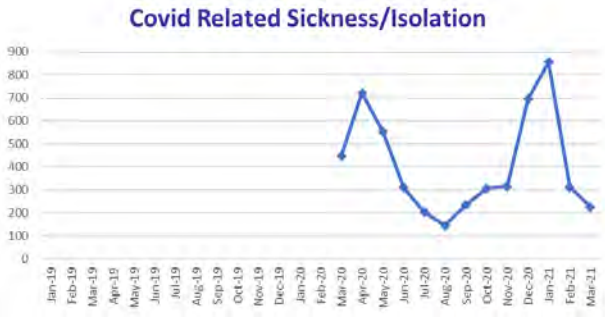
	Batch 1	Batch 2
Number of kits received	3483	3726
Number of staff spoken to	3798	
Accepted	3557	
Declined	241	
% Staff Accepted	**93.7%**	
Number of kits distributed to staff	3338	1600
Number of kits distributed to ED/Maternity		486
% Kits issued	**95.8%**	**56.0%**
Balance of kits in stock	1785	

LFD Results	
Number of Staff/Patients with at least 1 result (note: this contains duplicates)	4237
Total number of Results returned to 6th April	55029
Number of Positive LFD Results Submitted	244
Number of Positive LFD Results Actual (no errors)	222
Number of Positive LFD Results with a PCR result	219
Number of Negative PCR Results following Positive LFD	17
Percentage of positive PCR results following positive LFD result (effectiveness)	92.2%

Staff uptake of lateral flow test

The number of staff accepting and using the lateral flow tests remains high and results are posted weekly. This forms part of the updated BAF.

Weekending:	14/03/2021	21/03/2021	28/03/2021	04/04/2021	11/04/2021	18/04/2021
Results Posted	2128	1993	2063	1828	2060	1884
Number of staff posting	1245	1183	1143	1048	1106	1057



Sickness / isolation

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

In March 2021 there were 226 episodes recorded, a continued decrease from February (312 episodes). This matches the wider community picture in West Suffolk.

Note last month's IQPR incorrectly reported 921 episodes in February.

Appendix 2 - Action and learning from COVID outbreaks / ward clusters

To date the organisation has reported 15 outbreaks requiring ward closure, ward infection clusters or staff infection clusters. There have been none reported since February.

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

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

To date the main points are as follows:

- Data information systems
- Onsite COVID-19 testing capacity
- Test and Trace system
- Use of PPE
- Staff exposure to aerosol generating procedures
- Staff movement between wards
- Trust-wide learning
- Staff wellbeing
- Movement of patients throughout the hospital
- Unknown source of transmission
- Patient movements / interactions around ward environment away from their bed space
- Patient non-concordance (including through lack of mental capacity) leading to increased risk of transmission to patients and staff
- Lack of social distancing and screening.
- Frequently touched surfaces and shared facilities requiring enhanced cleaning regime
- Adequate physical segregation of patient – no sharing/mixing of personal equipment
- Confused and wandering patients may present an increased risk of transmission of COVID-19.
- Time limited housekeeping service (Rosemary ward)
- Adapted process for collecting patient's meal trays after use without IPC guidance
- 2m spacing between patients not possible on G5 increasing likelihood of transmission by droplet spread.
- Patients sharing belongings (e.g. toiletries, magazines)
- Occasions where full PPE was not able to be donned by staff before attending to prevent patients from falling which may have led to possible transmission

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

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

14.3. Nursing staffing report

For Approval

Trust Board – 30 April 2021

NHS West Suffolk NHS Foundation Trust

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

Executive summary:

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

Highlights

- Overall Trust fill rates continue to be above 90%. Some challenges with NA day shifts fill due to sickness
- Sickness rates have improved compared to previous months seen at height of Covid pandemic
- Nurse quality indicators have improved further illustrating the link with fill rates and patient safety
- RN vacancies remains static at 9%
- NA vacancies improved from 7% to 4%
- Supernumery status of labour suite coordinator continues to improve

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 March'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 March 2021.

The following sections identify the processes in place to demonstrate that the Trust proactively manages nurse staffing to support patient safety.

2. Nursing Fill Rate

The Trust's safer staffing submission has been submitted to NHS Digital for March within the data submission deadline. Table 1 shows the summary of overall fill rate percentages for these months and for comparison the previous four months.

	Day		Night	
	Registered	Care Staff	Registered	Care staff
Average fill rate for November 2020	101%	97%	99%	110%
Average fill rate for December 2020	94%	84%	94%	98%
Average fill rate for January 2021	92%	78%	94%	94%
Average fill rate for February 2021	96%	86%	97%	101%
Average Fill rate for March 21	98%	87%	95%	99%

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

Day shift fill rates for registered nurses (RNs) has improved markedly this month with only three wards falling below 90%. Overall Nursing assistant fill rates in the day has also improved with nine wards falling below 90%. A full list of ward by ward fill rates can be found in appendix 1. Of Note, F7 appears consistently understaffed for this month. On review with the ward/operational teams bed occupancy was extremely low as the ward remained a Covid ward as the pressure of the pandemic begun to wane, therefore this shortfall didn't not affect patient safety, and adequate nursing numbers were able to provide appropriate levels of care.

The matron of the day (MOD) mitigates short notice staffing shortfalls and the Trust has mobilised additional staff to support inpatient areas during March.

Overall fill rates for RNs at night have reduced this month, however only four areas are driving this. Most significantly, in G5 is demonstrating an underfill, however this is only representative of a few shifts as the ward closed on the 3.3.21.

3. Care Hours per Patient Day (CHPPD)

CHPPD is a measure of workforce deployment and is reportable to NHS Digital as part of the monthly returns for safe staffing (Appendix 1)

CHPPD is the total number of hours worked on the roster by both Registered Nurses & Midwives and Nursing Support Staff divided by the total number of patients on the ward at 23:59 aggregated for the month (lower CHPPD equates to lower staffing numbers available to provide clinical care).

Benchmarking CHPPD with other organisations is difficult as patient mix, establishments and ward environments all contribute the outcome. Ward by ward CHPPD can be found in appendix 1. By itself, CHPPD does not reflect the total amount of care provided on a ward nor does it directly show whether care is safe, effective or responsive. It should therefore be considered alongside measures of quality and safety (NHSI, 2020).

4. Sickness

In December the Trust began to see an increase in admission of Covid 19 positive patients and also an increase in community prevalence of Covid 19 infections within Suffolk and these pressures continued into January. Sickness rates in January were higher than in the first wave of this pandemic. Sickness within nursing and care staff, in March, has continued to fall for unregistered staff with a slight increase for registered staff and is still much improved compared with previous months.

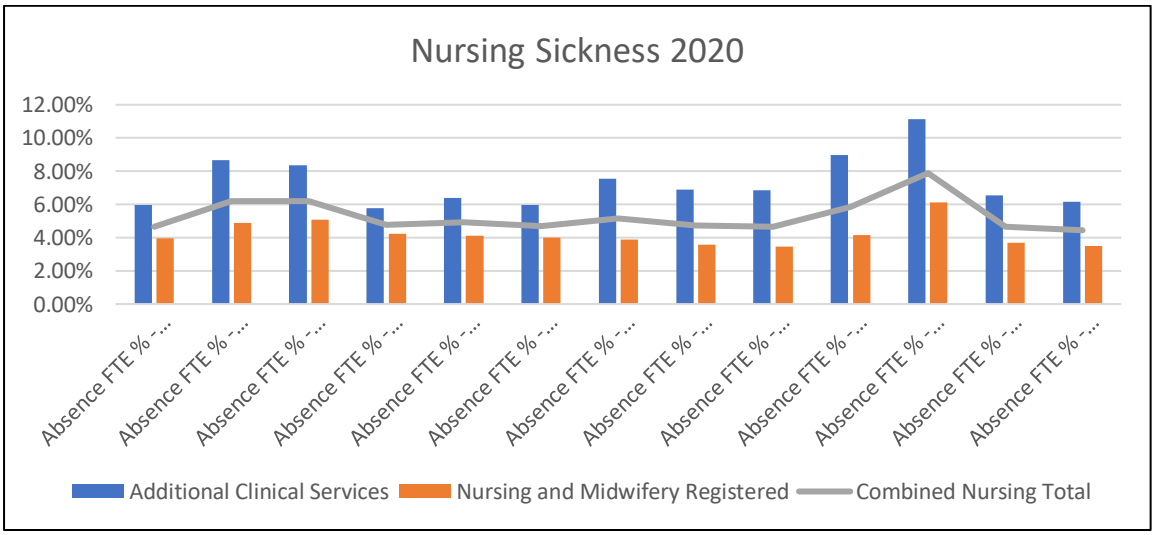


Chart 2.

	Aug	Sept	Oct	Nov	Dec	Jan 21	Feb 21	Mar 21
Unregistered staff (support workers)	5.95%	7.56%	6.90%	6.83%	8.97%	11.30%	6.75%	6.17%
Registered Nurse/Midwives	4.01%	3.89%	3.57%	3.47%	4.16%	5.99%	3.49%	3.51%
Combined Registered/Unregistered	**4.69%**	**5.15%**	**4.72%**	**4.64%**	**5.86%**	**7.86%**	**4.61%**	**4.44%**

Table 2b

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

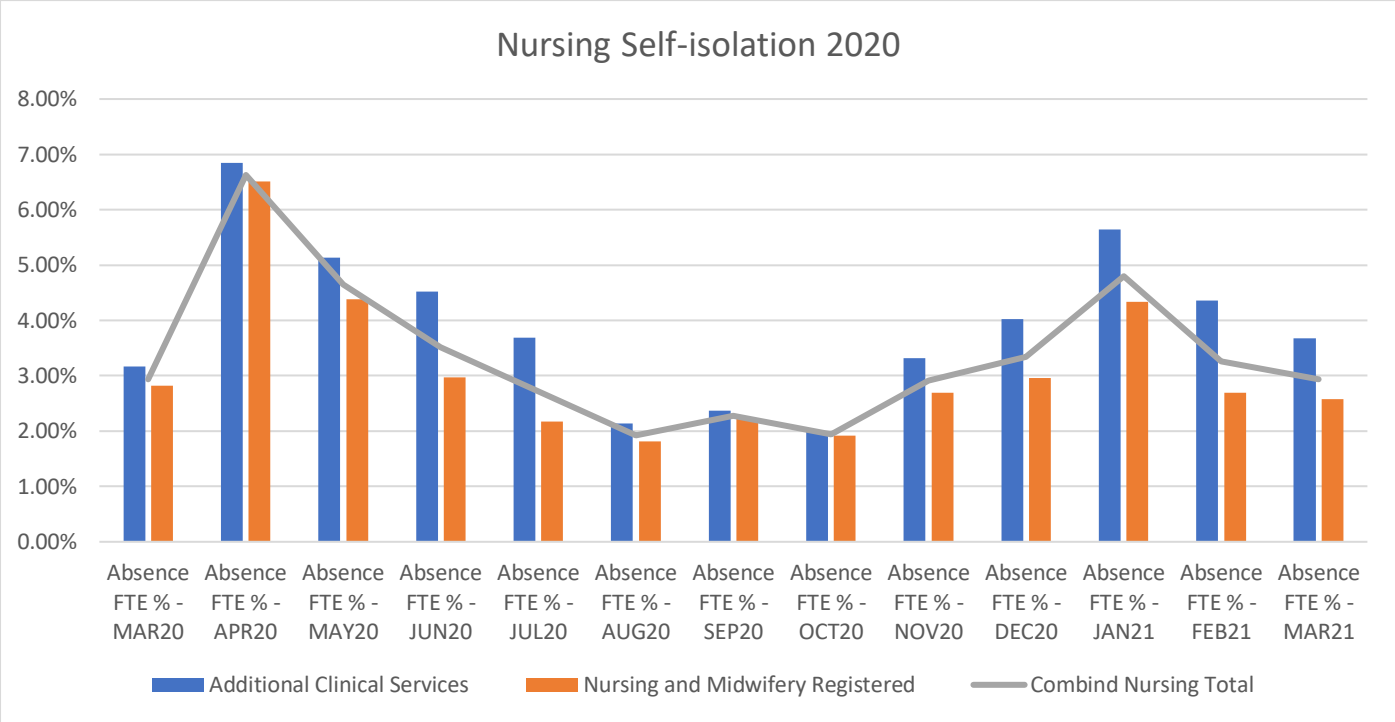


Chart 3

5. Patient Flow and Escalation

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

- 03/03 – F9 relocated to G5
- 04/03/ – F9 closed for structural work
- 24/03 - F10 closed

F9 staff displaced the temporary winter escalation ward and the staff supporting this area have returned to their original wards. Staff from F10 have been redeployed around medicine and AAU to support current vacancies.

In addition, no wards or bays were closed during this period due to any covid19 outbreaks.

- 24/03 – F12 is now our Covid ward
- 23/03 – G9 D bay NIV Covid negative
- 23/03 - G9 A bay NIV Covid positive
- F7 Side rooms Covid negative throughout March

6. Recruitment and retention

Vacancies: Registered nursing (RN):

Vacancies have reduced this month from 66.8 to 46.6. This is driven by the closure of the winter escalation ward. Total RN/RM establishment has increased marginally and the overall vacancy percentage remains static this month at 9%. A breakdown of ward by ward vacancies can be found in Appendix 2. It is expected that this vacancy parentage will increase next month as establishment uplifts appear in the new Financial year budget.

	Ward Nursing	Sum of Actual Period 7 (Oct)	Sum of Actual Period 8 (Nov)	Sum of Actual Period 9 (Dec)	Sum of Actual Period 10 (Jan)	Sum of Actual Period 11 (Feb)	Sum of Actual Period 12 (March	Sum of CURRENT MONTH VARIANCE
RN/RM Substantive	Ward	587.4	609.4	603.9	609.8	610.2	611.7	48.0
	CV19 Costs	6.0	11.4	10.3	2.0	(0.1)	1.4	(1.4)
Total: RN Substantive		**593.4**	**620.8**	**614.2**	**611.8**	**610.2**	**613.1**	**46.6**

Table 4

Vacancies: Unregistered Nursing assistants (NAs): The vacancy rate of unregistered support staff is demonstrating an over establishment of 22.4 WTE. This is driven by additional Covid support costs. Data reviewed on a ward by ward analysis shows this is more likely to be a vacancy rate of 4%. There is a national ambition to reduce NA vacancies to 0% by April. The trust has joined this program and has received funding for additional HR support, to quicken onboarding, and also for pastoral care to support new NA in the clinical environment. This has already proved effective and having a positive effect on recruitment processes. The success of this can be seen in the net increase on the budgeted establishment and the increase in attendances to trust induction (table 6)

	Ward Nursing	Sum of Budget Period 7 (Oct)	Sum of Budget Period 8 (Nov)	Sum of Budget Period 9 (Dec)	Sum of Budget Period 10 (Jan)	Sum of Budget Period 11 (Feb)	Sum of Budget Period 12 (Mar)	Sum of CURRENT MONTH VARIANCE
Nursing Unregistered Substantive	Ward	355.9	363.4	375.1	380.6	386.2	393.8	(3.0)
	CV19 Costs	8.1	8.4	9.0	0.0	16.9	19.5	(19.5)
Total: NA Substantive		**364.0**	**371.9**	**384.0**	**380.6**	**403.0**	**413.2**	**(22.4)**

Table 5

Overseas Nurse (OSN) recruitment:

Five nurses arrived as planned within March and following quarantining will join an April induction. We are currently scoping the option of increasing this monthly cohort in recognition of the establishment review uplifts budgeted for April 2021. This is dependent on a number of variables including accommodation capacity and training capacity.

New starters

	December	January	February	March
Registered Nurses	10	16	17	30
Non-Registered	11	11	17	28

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

In March 2021 thirty RNs completed induction; of these; nine are community nurses, and twenty-one are for the acute trust, four in midwifery. Two inductions were completed in March in recognition of the annual spike of new qualifying nurses within this month. Nine nurse apprentices qualified this month and all are employed within the Trust. Of the traditional Nursing degree program, five of the eight students were employed within WSH.

In March twenty eight NAs completed induction; of these two NAs are in the community and twenty-six for the acute Trust, one in midwifery, two for WSP.

7. Quality Indicators

Falls

Incidence of falls have reduced using the falls per 1000 bed day measure and is below the national average (set in 2015) of 6.63. A full list of falls and locations can be found in appendix 3.

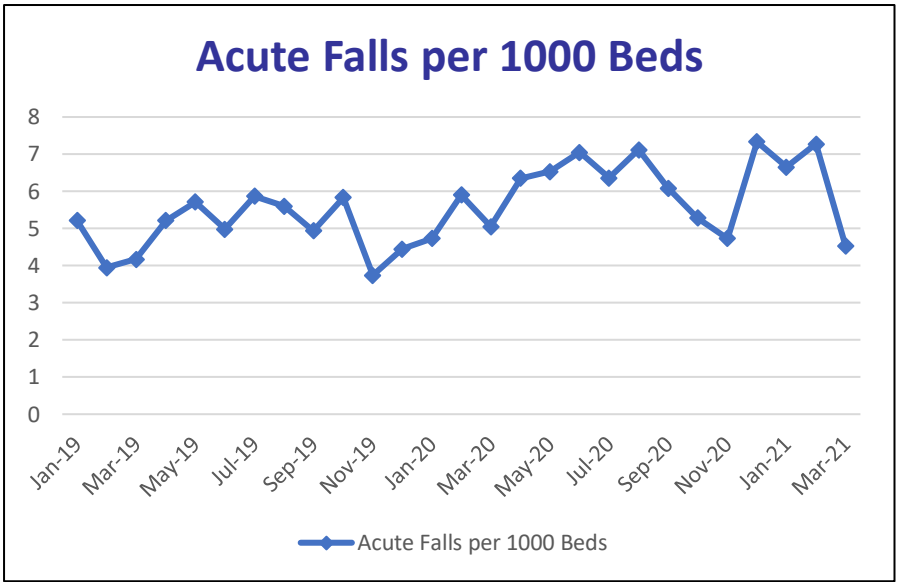


Chart 6

Pressure Ulcers

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

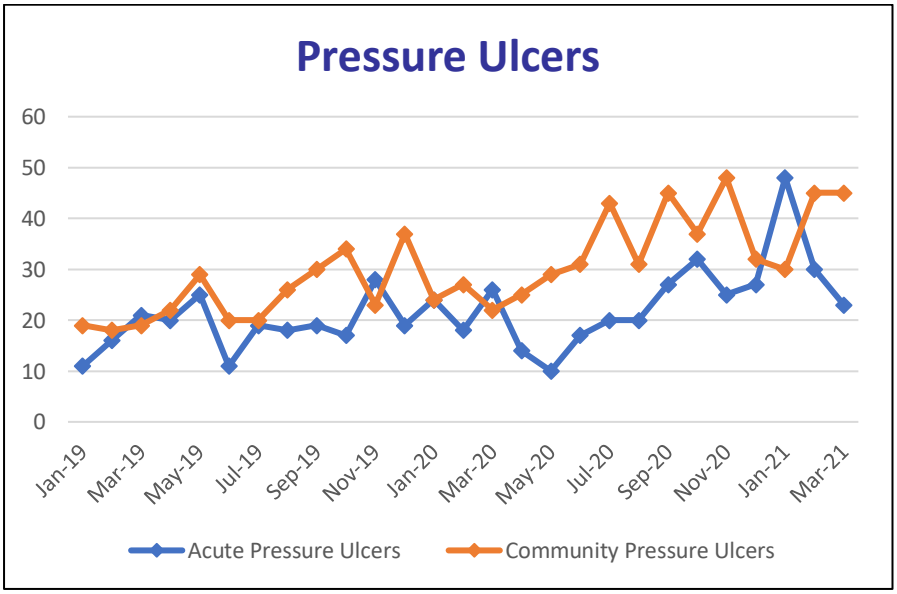


Chart 7a

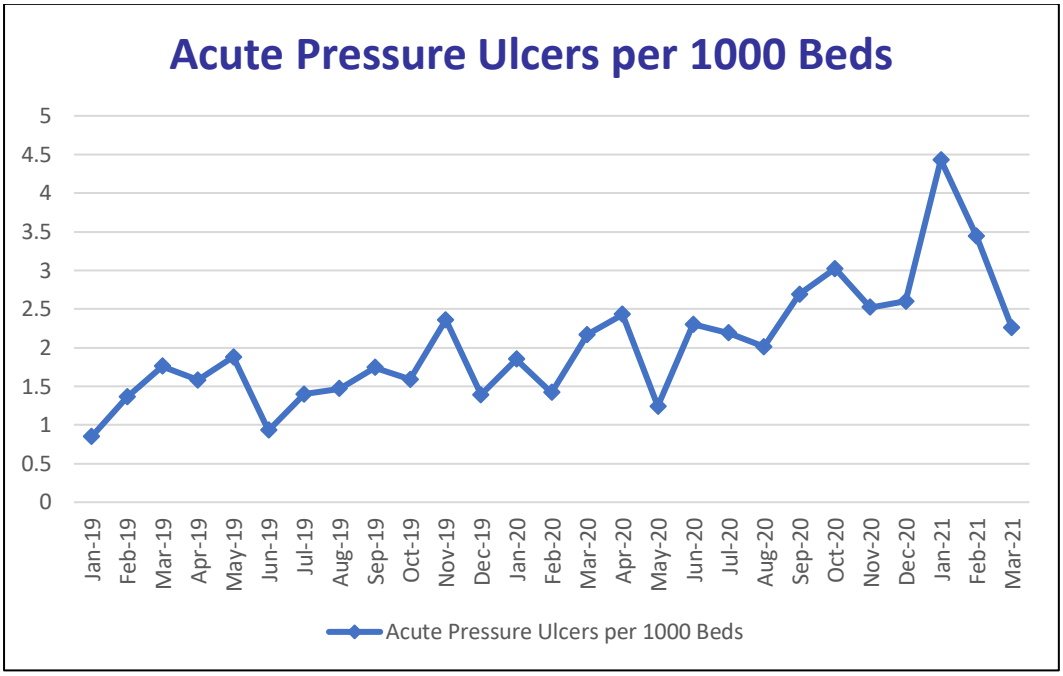


Chart 7b

8. Compliments and Complaints - updated

Table 8 demonstrates the incidence of complaints and compliments for this period. Lockdown measures have continued in March however we have seen more complaints similar to the amount received pre-Covid (March 2020).

The clinical helpline has been maintained and an average of 140 calls a day to assist relatives who are unable to attend the wards to receive updates of the care of our patients.

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

Table 8

9. Adverse Staffing Incidences

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

- In March there were 15 Datixs recorded for nurse staffing that resulted in a Red Flag event (see table 9.)

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

Table 9.

10. Maternity Services

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

Red Flag events

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

- There was one red flag incident reported in March 2021 related to a shortfall in midwives. No patient harm occurred

Midwife to Birth ratio

Data temporarily unavailable due to implementation of eCare.

Supernumerary status of the labour suite co-ordinator

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

In March we achieved 97% compliance. The escalation policy was activated however there is a time delay from on-call staff being called to them physically being present on the unit. To note all women received one to one care in labour. We are currently working with our NHS Improvement officer to find long-term resolution to this problem. Recruitment drive for further labour suite co-ordinators has been completed and start dates have been confirmed for May 2021.

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

As per NQB (2016) recommendations and strengthened by the developing workforce safeguards document (NHSE, 2018), acute providers are expected to formally review nursing establishments biannually. The biannual acuity and dependency audit commenced in September and concluded in October. The recommendations of this review were presented to the Trust public board in January 2021. The review will have an impact on nursing vacancies in April 2021 as funding becomes available. The review will provide a net increase of approx. 19 RNs and a net reduction of 4 NAs.

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

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

12. Resource Management

Following Lord Carters review in 2016 operational productivity is improved when eRostering is used to its fullest potential (NHSE, 2020). WSH has had eRostering in use for many nursing teams for a while, however, formal oversight has been light due to Covid 19 restriction. In order to better identify improvements and best practice, virtual monthly meetings between the Deputy Director of Nursing, eRostering team and nursing leaders have been re-established and commenced in October as planned. These 'check and challenge' meetings will identify areas of good practice in roster management and areas of improvement and will track concordance.

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

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

Weakness in process were judged to include

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

The majority of the improvement actions have already been identified following the Deputy Chief Nurse's and WSP lead process reviews and are in train. Actions will be monitored through audit committee. An updated summary of these action can be found in appendix 5.

13. Recommendations and Further Actions:

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

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

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each day	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	1082.75	1003	1742.75	1366.5	1069.5	989	1083.5	1093	93%	78%	92%	101%	452	4.4	5.4	9.8
Glastonbury Court	716.75	737.5	1051.25	943.5	713	714	542.5	608	103%	90%	100%	112%	384	3.8	4.0	7.8
AAU	2104.5	2138	2495.5	2023.25	1759.5	1734	1426	1345.5	102%	81%	99%	94%	761	5.1	4.4	9.5
Cardiac Centre	2845	2749.517	1265.5	1147.5	1782.5	1706	713	660	97%	91%	96%	93%	632	7.0	2.9	9.9
F10	1109.5	1058.75	1098.917	984.9167	828	833	828	828	95%	90%	101%	100%	707	2.7	2.6	5.2
G9	1420.5	1435	1407	1289	1426	1401.5	1069.5	1097.667	101%	92%	98%	103%	752	3.8	3.2	6.9
F12	557.5	635	348	412	708	682	356.5	355.5	114%	118%	96%	100%	240	5.5	3.2	8.7
F7	1414.5	1236.75	2122.5	1465	1426	1088.5	1763.5	1275	87%	69%	76%	72%	683	3.4	4.0	7.4
F9	1435.5	1360.75	2126	1906.5	1069.5	1052.5	1426	1517	95%	90%	98%	106%	744	3.2	4.6	7.8
G1	2450.4	2396.517	1051.5	840.5	713	711	355	367	98%	80%	100%	103%	361	8.6	3.3	12.0
G3	1422	1362.333	2130.5	1957.5	1069.5	1037	1065	1526	96%	92%	97%	143%	864	2.8	4.0	6.8
G4	1432.75	1421	2108	2231.5	1070.5	1087	1417.5	1707	99%	106%	102%	120%	896	2.8	4.4	7.2
G5	220.5	195	195.5	161	103.5	69	161	133	88%	82%	67%	83%	760	0.3	0.4	0.7
G8	2129.667	1939.833	1848.75	1797.167	1426	1408	1069.5	1124.333	91%	97%	99%	105%	615	5.4	4.8	10.2
F8	1412	1461.917	2118.5	1710.5	1069.5	1023	1426	1448.5	104%	81%	96%	102%	723	3.4	4.4	7.8
Critical Care	2699.25	2704.75	328	512.75	2794.5	2626.5	0	196.5	100%	156%	94%	N/A	388	13.7	1.8	15.6
F3	1786	1612.667	2117	1979.5	1069.5	1070	1426	1471.25	90%	94%	100%	103%	732	3.7	4.7	8.4
F4	897.5	743.5	764.75	626	690	609.5	611	530	83%	82%	88%	87%	633	2.1	1.8	4.0
F5	1778.25	1368	1398.5	1300	1058	1023	719.25	687.25	77%	93%	97%	96%	698	3.4	2.8	6.3
F6	2036.5	1853.25	1670.5	1309.5	1058	997.5	707.5	810.5	91%	78%	94%	115%	939	3.0	2.3	5.3
Neonatal Unit	1116	1130	372	222.5	1116	918	372	276	101%	60%	82%	74%	116	17.7	4.3	22.0
F1	1230.5	1477.5	713	639.25	1069.5	1296.5	0	105.5	120%	90%	121%	100%	115	24.1	6.5	30.6
F14	720	776	156	156	744	744	0	44.5	108%	100%	100%	100%	106	14.3	1.9	16.2
Total	34,017.82	32,796.53	30,629.92	26,981.83	25,833.50	24,820.50	18,538.25	19,207.00	**96%**	**88%**	**96%**	**104%**	**13301**	**4.3**	**3.5**	**7.8**

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

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

Ward/Department	Registered Nursing (RN)				Ward/Department	Non Registered Nursing (HCSW)			
	Budgetted establishment	Actual establishmet	Vacancy rate (WTE)	Vacancy percentage		Budgeted Establishment	Actual Establishment	Vacancy rate (WTE)	Percentage Vacancy rate
AAU	30.1	26.8	3.3	10.9%	AAU	28.3	22.4	5.9	21%
Accident & Emergency	64.0	63.0	1.0	1.6%	Accident & Emergency	26.5	26.3	0.3	1%
Cardiac Centre	40.7	36.9	3.8	9.4%	Cardiac Centre	15.7	17.0	(1.3)	-8%
Community - Glastonbury Court	11.7	11.5	0.2	1.7%	Community - Glastonbu	12.6	11.5	1.1	9%
Critical Care Services	45.0	45.1	(0.1)	-0.2%	Critical Care Services	1.9	5.8	(3.9)	-209%
Day Surgery Wards	11.0	7.2	3.8	34.7%	Day Surgery Wards	3.9	3.9	0.0	0%
Gynae Ward (On F14)	12.8	10.2	2.6	20.1%	Gynae Ward (On F14)	1.0	1.0	0.0	0%
Neonatal Unit	20.8	19.5	1.3	6.3%	Neonatal Unit	4.3	5.0	(0.7)	-16%
Newmarket Hosp-Rosemary ward	12.4	14.8	(2.4)	-19.4%	Newmarket Hosp-Rose	13.5	16.3	(2.8)	-21%
Recovery Unit	21.9	20.2	1.7	7.9%	Recovery Unit	0.9	0.9	0.0	1%
Ward F1 Paediatrics	20.4	21.4	(1.0)	-5.0%	Ward F1 Paediatrics	7.2	7.4	(0.3)	-3%
Ward F12	10.2	8.8	1.4	14.1%	Ward F12	5.9	3.5	2.3	40%
Ward F3	22.2	19.7	2.5	11.2%	Ward F3	25.8	24.4	1.5	6%
Ward F4	14.2	14.0	0.2	1.4%	Ward F4	13.9	8.6	5.3	38%
Ward F5	22.2	19.3	2.9	13.0%	Ward F5	12.9	13.6	(0.7)	-5%
Ward F6	24.0	13.6	10.4	43.3%	Ward F6	14.8	16.1	(1.3)	-9%
Ward F7 Short Stay	22.3	21.1	1.2	5.5%	Ward F7 Short Stay	28.3	23.4	5.0	18%
Ward F9	19.3	16.5	2.8	14.6%	Ward F9	25.8	24.0	1.8	7%
Ward G1 Hardwick Unit	28.7	25.3	3.4	11.8%	Ward G1 Hardwick Uni	10.5	10.0	0.6	5%
Ward G3	19.5	16.7	2.9	14.7%	Ward G3	25.6	26.3	(0.8)	-3%
Ward G4	19.5	19.3	0.3	1.3%	Ward G4	25.4	23.6	1.8	7%
Ward G8	27.5	23.2	4.3	15.6%	Ward G8	20.6	19.0	1.6	8%
Renal Ward - F8	19.4	17.0	2.4	12.2%	Renal Ward - F8	25.8	25.6	0.2	1%
Winter Escalation 20/21 - G5	11.0	9.3	1.7	15.3%	Winter Escalation 20/2	6.2	10.5	(4.3)	-69%
Ward F10*	19.2	17.4	1.8	9.4%	Ward F10*	18.0	18.8	(0.8)	-5%
Respiratory Ward - G9	23.7	19.9	3.8	15.9%	Respiratory Ward - G9	18.0	14.5	3.6	20%
Total	**593.8**	**537.7**	**56.1**	**9.4%**	**Total**	**393.2**	**379.1**	**14.1**	**4%**
Hospital Midwifery	57.7	43.5	14.2	24.6%	Hospital Midwifery	15.6	14.7	0.9	6%
Continuity of Carer Midwifery	27.3	30.4	(3.1)	-11.3%	Continuity of Carer Mid	0	0	0.0	0%
Community Midwifery	11.2	9.5	1.8	15.6%	Community Midwifery	3.8	3.7	0.1	3%
Total	**96.2**	**83.4**	**12.9**	**13.4%**	**Total**	**19.4**	**18.4**	**1.0**	**5%**

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

Appendix 3:

Ward by Ward breakdown of Falls and Pressure ulcers March 2020

HAPU

	Cat 2	Unstageable	Total
Total	23	1	24
Cardiac Centre - Ward	1	0	1
Critical Care Unit	3	0	3
F12 Isolation Ward	2	0	2
F3 - ward	2	0	2
F5 - ward	2	0	2
F6 - ward	0	1	1
G3 - Endocrine and General Medicine	3	0	3
G4 - ward	2	0	2
G8 - ward	5	0	5
Labour Suite (CDS)	1	0	1
Acute Assessment unit (AAU)	1	0	1
Early Intervention Team	1	0	1

Falls

	Moderate	Total
Total	1	68
Cardiac Centre - Ward	0	2
CHT Sudbury	0	1
Community Paediatric OT	0	1
Community Paediatric SLT	0	1
Day Surgery Unit - Ward / Adjacent Area	0	1
F10	0	3
F14 (Gynae - EPAU)	0	1
F3 - ward	0	2
F4 - ward	0	1
F5 - ward	0	4
F6 - ward	0	4
G1 - ward	0	2
G3 - Endocrine and General Medicine	0	4
G4 - ward	1	1
G8 - ward	0	12
Gastroenterology Ward	0	2
Glastonbury Court	0	5
Macmillan Unit	0	1
Renal Ward	0	2
Respiratory Ward	0	7
Rosemary Ward	0	5
Emergency Department	0	1
F7	0	3
Acute Assessment unit (AAU)	0	2

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: Updated summary of RSM audit actions

RSM audit actions (V2 updated 22.4.21)						
Mgnt Action No	Priority	Finding	Action	Progress	completion date	date completed
1	Medium	Ensure that the rostering policy is reviewed, revised and communicated to relevent staff	Roster to be updated as per RSM audit and nursing resource improvement plan	19.3.2021: Roster policy intentionally overdue to ensure that all actions and recommnedtaions in the RSM are captured. On track for completion in April 22.4.21: Policy update and completed. Socialised with matrons. With HR to review Just Culture language before publication	1st April 2021	
2	Low	Ensure that staffing escalation policy is reveiwed and updated and clarify out of hours of temporary	Roster to be updated as per RSM audit and nursing resource improvement plan	19.3.2021: Roster policy intentionally overdue to ensure that all actions and recommnedtaions in the RSM are captured. On track for completion in April 22.4.21: Policy update and completed. Socialised with matrons. With HR to review Just Culture language before publication	1st April 2021	
3	Medium	Ensure that the accuracy and timeliness of bank and agency shifts within healthroster	email sent to all ward mangers and matrons requesting cessation of all local agency bookings	19.3.2021 sent on 3.3.21	1st April 2021	3.3.2021
			Review electronic sign off of agency shifts that will drive and eliminate retrospective bookings	19.3.2021, being scoped by WSP lead 22.4.2021 prinicple agreed with WSP lead.	2nd April 2021	
4	Low	Monitor lead times for bank staff booking in roster review meetings	Bank shift lead time to be added to TOR of 'check and challenge' meetings	19.3.21 Added to TOR first iteration of roster reviews in. 22.4.21. TOR updated to reflect update. Agreed at Check and Challenge meetings on 21.4.21. evidence in action log	1st April 2021	21.4.21
5	Low	ensure bank staff are sought in the first instance before agency	Process to be included in staffing escalation roster	19.3.2021: Roster policy intentionally overdue to ensure that all actions and recommendations in the RSM are captured. On track for completion in April 22.4.21: As per action update in action 1 and 2	1st May 2021	
6	Medium	Ensure bank time sheets are completed and approved electronically	electronic time sheet for bank shifts to be introduced	implemented in 1.12.2020	N/A	1.12.2020
7	Medium	To ensure that out of hours requests are appropriately authorised and supported by electronic audit trails	OOH process to be articulated in staff escalation policy (see action 2)	19.3.2021: Roster policy intentionally overdue to ensure that all actions and recommendations in the RSM are captured. On track for completion in April 22.4.21: As per action update in action 1	1st April 2021	
			deliver training and QRG to 888 team for OOH requests and temporary staffing fill	19.3.2021: being scoped with tactical lead given these staff are all OOH workers 22.4.21. training has commenced with OOH team, but challenges in competion due to staff working consistently OOH	1st April 2021	
8	High	Ensure O/T authorisation is able to be demonstrated and authorised	procedure to authorise O/T to be introduced that is auditable and ensures net hours used	19.3.2021: No functionality within eRoster to complete this. Hard copy request to be considered and implemented	1st July 2021	
9	Low	Check and Challenge TOR are formally circulated and approved	To update and recirculate TOR	19.3.2021: completed and updated as per action 4	1st April 2021	19.3.2021

14.4. Improvement programme board report

For Approval

Trust Open Board – April 2021

Agenda item:	14.4			
Presented by:	Steve Dunn, Chief Executive Sue Wilkinson, Executive Chief Nurse			
Prepared by:	John Connelly, Head of PMO			
Date prepared:	23 April 2021			
Subject:	Improvement programme board report			
Purpose:		For information	X	For approval

The Improvement programme board meeting, held on **12th April 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:

Transition to new framework for engagement and oversight for quality, safety and improvement
A paper outlining transition to a new framework for engagement and oversight for quality, safety and improvement was presented at April IPB based on the National Patient Safety Strategy, structured around Insight, Involvement and Improvement as the three improvement pillars. The paper reflects a co-produced approach following discussions with staff, specialists and senior leaders at the Trust and reflections from the IPB membership. The new committee structure will be in place at the Trust from May 2021 and will empower the divisions in terms of accountability and enhance shared learning.

Improvement Plan Format: Quality Assurance and Reporting
The design of the Improvement Plan will be reviewed over the next month with a new format presented at the Improvement Committee in May reflecting the quality improvement assurance priority at the Trust.

The current plan will be archived with a gap analysis undertaken to ensure that outstanding plan items are brought forward in to the new reporting format.

RAG reporting clarity and consistency
A thorough review was undertaken regarding RAG clarity and consistency as an action taken from March IPB. The proposal at April IPB based on SRO engagement with external partners is as follows:

- Overall RAG and completion date RAG for plans that exceed completion date move to Red except:
    - When there are additional plan actions in a revised plan at which point:
        - Completion date RAG moves to Red until IPB agree revised completion date based on revised plan
        - Overall RAG for plan (does not move to Red) reflects overall plan progress to date taking in to account agreed plan changes

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

1. One Plan moves from Black to BAU
- Plan No 36: Infection prevention and control: bare below the elbows

2. Two plans move from Green to Black:
- Plan No 65: Community Clinical Audit
- Plan No 74: Community (Newmarket): monitoring Individual goals and outcome measures
3. One Plan moves from Amber to Black
- Plan No 73: Community (N/M) Senior leader skills to use outcome data to improve services

4. One plan moves from Red to Black:
- Plan No 2: Freedom to speak up

5. Two plans move from Red to Amber:
- Plan No 31: Community Pain Assessments
- Plan No 12: Mandatory Training (Also covers plans 32, 63, 70)

6. Three plans move from Green to Red:
- Plan No 47: Labour suite coordinator supernumerary (Maternity)
- Plan No 58: Consumable equipment not opened prior to use
- Plan No 75: Perinatal clinical quality surveillance model (Maternity)

7. One Plan moves from Green to Amber
- Plan No 48: PROMPT Training (Maternity)

8. Three plans move from Amber to Red:
- Plan No 6: Patient follow up appointments and surveillance pathways
- Plan No 81: Risk assessment recorded at every contact (Maternity)
- Plan No 88: Implement RAG Triage Tools (Maternity)

9. One plan extended completion date by one month:
- Plan No 5: HR Processes

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

1. One plan moving from Red to Amber:
- Plan No 55 (64, 71): Appraisal. Completion date passed. Trajectories required for plans 12 & 55

Trust priorities	**Deliver for today**		**Invest in quality, staff and clinical leadership**		**Build a joined-up future**		
	X		X		X		
Trust ambitions	*Deliver personal*	*Deliver*	*Deliver joined-up*	*Support a healthy*	*Support a healthy*	*Support ageing*	*Support all our*
	X	X	X	X	X	X	X
Previously considered by:							
Risk and assurance:							
Legislation, regulatory, equality, diversity and dignity implications	See individual references throughout the document						

Recommendation:

1. Note the report and contents
2. Approve the updated Trust improvement plan (Annex A)

Appendix A – Improvement Plan

Find no.	Improvement required	Improvement action / Assurance framework	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale	Origin / Source
WSFT_0002 CQC 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	**Assurance Framework:** The plan will return to IPB with an assurance framework at June IPB for quarterly review until either the 3 'i's committee meetings have evolved with the potential to move to reporting via the insights forum with the People Plan or via an internal HR Strategic Committee	Stephen Dunn	Jeremy Over	**Black**	**28.02.21** ~~**31.03.21**~~ ~~**30.11.20**~~	**IPB Update 12.04.21: Proposal is that plan moves from Red to Black** **- All items within the ACSA action plan complete** **- Priorities to improve support for staff, learning from survey, have been identified.** **- Six theme leads identified and work is in delivery. Plan is housed in people plan for monitoring.**	
WSFT_ 0004.1 CQC 4.1 CQC 41	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.	**Revised Plan Actions** **1.Review access database for effectiveness and accuracy of data** **2.Create and Implement formal Clinical Audit registration and completion process** **3.Ensure participation in the Annual Clinical Audit Awareness week** **4.Implement Clinical Audit training programme** **5.Collate Clinical Audit programme for each division** **6.Facilitate the ongoing capture of progress for the divisional audit programmes, to quarterly include Clinical Audit to the Divisional Clinical Governance meeting agenda** **7.Reinstate KPI indicator as part of the Trust's developing insight committee reporting framework.** **8.The Maternity Clinical Audit and Effectiveness midwife to work with the trust 9.Clinical Audit and Effectiveness lead to standardise HSIB process.** **10.Develop a framework for responding to HSIB publications** **11.Using the HSIB model as a pilot, further develop a framework for the identification and response to other national best practice publications.** **12.Associate Medical Director for Quality and Safety Job Description to have a defined role and allocated responsibilities for Clinical Audit and Effectiveness** **13.Budget planning for 2021/22 needs to consider the requirements of the Clinical Audit and Effectiveness team** **14.Consider the formation of QICE to be chaired by the new Associate Medical Director for Quality and Safety as part of the trust's redevelopment of the quality & safety committee structure.** **15.Trust wide Clinical Audit and Effectiveness roles to have regular scheduled meetings to promote co-working.**	Nick Jenkins	Rebecca Gibson	**Amber**	**31.07.21** ~~**31.03.21**~~ ~~**01.07.20**~~ ~~**31.12.20**~~	**IPB Update 12.04.21: Plan stays Amber. Revised plan prepared.** **March IPB proposal to move plan from Amber to Green rejected due to number of outstanding actions.** **IPB agreement in meeting was plan stays Amber** **- Plan will complete (Black) when Q1 divisional clinical audit programmes progress is reported in July 2021**	
WSFT_0005 CQC 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.	Complete a review of HR policies to ensure a more kind and compassionate approach aligned to a 'Just' culture	Jeremy Over	Claire Sorenson	**Green**	**30.04.21** ~~**31.03.21**~~ ~~**31.10.20**~~	**IPB Update 12.04.21: Proposed plan completion date extends by one month to 30.04.21 as additional action is included in the plan around CEO communication. Work to complete final plan actions includes:** **- New policies submitted for approval at TNC and Trust Council** **- CEO Communications to staff regarding HR policies re-set**	
WSFT_0006 CQC 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.	Identify and deliver training for process changes to relevant staff groups for both follow ups and surveillance.	Helen Beck	Hannah Knights	**Red**	**30.04.21** ~~**31.03.21**~~ ~~**01.08.20**~~	**IPB Update 12.04.21: Trust plan to design and embed robust processes for follow up and surveillance patients are in place.** **However, the proposal is that the overall plan RAG and the end date move from Amber to Red given training delays associated with uploading e-leaning training packages at Trust and training programmes will complete by the end of April rather than the end of March.**	

Find no.	Improvement required	Improvement action / Assurance framework	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale	Origin / Source
WSFT_0012 CQC 12, 32, 63, 70	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. Review mandatory training requirements needs to ensure staff have the correct training assigned to them for their role. 2. Processes to alert managers to areas where compliance is low being piloted by Education and Training team to assess impact. 3. Community paediatrics training data to be reviewed and updated if required 4. Bank mandatory training compliance to be increased through implementation and further development of action plans. Target date to be agreed for 90% compliance. 5. Support Divisions to establish trajectories for compliance with mandatory training available via e-learning	Jeremy Over	Denise Pora	Amber	31.05.21	**Update 12.04.21: Proposal is to move plan from Red to Amber as revised plan items prepared as part of recovery planning process.** **- MT recovery plan will be managed with divisional input at joint PRM.** **- Recovery plans will be gauged with comparative organisations eg. ESNEFT, QUHKL, JPUH** **Key Risk: Delivery subject to divisions managing MT compliance within teams**	
WSFT_0030 CQC 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	30.04.21 ~~31.03.21~~ ~~01.08.20~~	**See plan No. 6**	
WSFT_0031 CQC 31	The trust must ensure staff complete and record patient pain assessments in patient records.	Assurance Framework: 1. Compliance monitored via monthly reporting by senior matrons as part of their monthly performance review. 2. Senior matrons produce a report from the patient care plans and pain assessments - this is a standard BAU monthly report available from SystmOne. 3. The monthly reporting will be supplemented by a quarterly 'deep dive' review process to align with the service line reviews, launch date 31.03.21. 4. WSFT Head of Community Nursing and CCG Chief Nurse Officer will review formerly in regular performance monitoring 1:1's 5. Collect and collate patient experience information 6. Compliance levels will be presented to IPB on a monthly basis as part of the Trust BAU assurance process.	Helen Beck	Michelle Glass	Amber	? ~~31.03.21~~ ~~31.12.20~~ ~~01.03.20~~	**IPB Update 12.04.21: All actions complete. Proposal is that overall plan moves from Red to Amber As the revised plan has been agreed at IPB, the completion timeframe can also be reviewed at April IPB as the timescale for achieving 80% compliance becomes clear.** **- Plan turns Black when 80% compliance levels are achieved for syringe driver patients. The clinical opinion based on experience is that the appropriate pain assessment compliance rate in the community is 80% for syringe driver patients. The rate is based on 6 patient visits over an average 6 days where one of the visits is the bereavement visit.** **Trust BAU assurance framework is presented in the improvement action / assurance framework column.** **- The Trust Improvement plan also accommodates the patient experience information as suggested by Suffolk Healthwatch**	
WSFT_0032 CQC 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**	
WSFT_0033 CQC 33	Current Pathology plan is essentially a Trust Plan as original CQC improvement requirement is outmoded. Trust Pathology plan reports directly to WSFT Scrutiny Committee on a quarterly basis, including all transformation plans	Updated Improvement Plan post Attain Plan review: ESTATES ACTIONS: - Review off site commercial options - Undertake feasibility studies - Consult with staff regarding process to identify preferred location LIMS ACTIONS: LIMS Review plan on track to present recommended option to April Board regarding replacement of LIMS - Plan operationalised by 31.05.21	Nick Jenkins	Fiona Berry	Green	31.05.21 ~~31.03.21~~ ~~31.01.21~~ ~~31.12.20~~ ~~01.03.20~~	**IPB Update: 12.04.21: IPB request new plan be prepared for Plan No 33 Pathology** **- Estates review paper going to April Trust Board with options.** **- Recommendation will be to upgrade Containment Lab (CL3) on current site to address current Red Risk with a view to move to new lab facility at new site in 5 years** **- LIMS Review plan on track to present recommended option to April Board regarding replacement of LIMS Recommendation is to continue shared LIMS with ESNEFT (Partnership contract) with a view to re-procure 2024. This stabilises current service provision whilst allowing suitable time to undergo re-procurement.** **Plan remains in track to complete by 31.05.21**	
WSFT_0036 CQC 36	The trust should ensure all staff follow infection prevention and control procedures and bare below the elbow guidance at all times.	Assurance Framework: 1. Use Infection Control audits to provide BAU assurance.	Susan Wilkinson	Formerly Anne How	Blue	31.10.20 ~~11.02.20~~	**IPB Update 12.04.21: Proposal is that plan moves to Blue (BAU) from Black as BAF and Infection Control audits have demonstrated more than three months of embeddedness. Current status of Assurance Framework items are as follows:** **(1) BAF and regular Infection Control audits are providing assurance**	
WSFT_0041 CQC 41	The trust should ensure that appropriate action plans to address national audit shortfalls are implemented and effectively monitored.	See Plan No 4.1	Nick Jenkins	Rebecca Gibson	Amber	31.07.21 ~~31.03.21~~ ~~01.07.20~~ ~~31.12.20~~	**See Plan No 4.1**	

Find no.	Improvement required	Improvement action / Assurance framework	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale	Origin / Source
WSFT_0047 CQC 47	The trust should ensure that the labour suite coordinator is supernumerary.	Outstanding Improvement Action: 1. All labour suite coordinators moved to supernumerary Assurance Framework: 2. All coordinators made bleep holders	Susan Wilkinson	Karen Newbury	Red	31.05.21 ~~31.03.21~~ ~~08.02.20~~	**IPB Update 12.04.21: Proposal is that the plan moves from Green to Red as supernumerary coordinators appointed but will not in post by planned date. The revised expectation is that all coordinators will be in post by 31.05.21** **Current status of Improvement Action / Assurance Framework items are as follows:** **(1) All supernumerary labour suite coordinators have been appointed, but some will not be in post until May. Once in post, Quality Dashboard can be used to demonstrate 100% of coordinators have supernumerary status** **(2) All night coordinators were bleep holders. Additional bleep holders employed**	
WSFT_0048 CQC 48	The trust should ensure a higher percentage of staff complete mandatory training including PROMPT.	Outstanding Improvement Action: 1. Decide on mandatory status of PROMPT training for medical anaesthetic team	Susan Wilkinson	Karen Newbury	Amber	30.04.21 ~~31.12.20~~	**IPB Update 12.04.21: Proposal is that plan reverts to Amber from Green as several staff groups are not hitting the 90% training compliance target. Current status of Improvement Action / Assurance Framework items are as follows:** **(1) TBC**	
WSFT_0055 CQC 55,64 & 71	The trust should ensure that appraisal rates are met for staff.	Improvement Actions: 1.HR Business partners to work with divisions to set appraisal improvement trajectories 2.Dashboard of appraisal compliance to be published in the Green sheet monthly to raise the profile of appraisals and positive reinforcement for good practice 3.Training is available for all appraisers	Jeremy Over	Denise Pora	Red	31.12.20	**IPB Update: Plan stays Red based on IPB discussion. Trajectories also required for both plans 12 and 55.** **IPB Update 12.04.21: Proposal is to move plan from Red to Amber as revised plan actions prepared as part of recovery planning process** **Key Risk: Delivery subject to divisions managing MT compliance within teams**	
WSFT_0058 CQC 58	The trust should ensure consumable equipment is not opened prior to use to prevent infection prevention and control risks.	Outstanding Improvement Action: 1. Review storage of adult consumables to balance safety and infection control needs	Susan Wilkinson	Karen Newbury	Red	28.02.21	**IPB Update 12.04.21: Proposal is that plan moves from Green to Red as planned completion date has passed. Current status of Improvement Action items are as follows:** **(1) As a short-term solution for this finding, suction consumables are now being changed and labelled every month, although there are concerns about this approach which are on the agenda for discussion at the next Deteriorating Patient Group on 22.04.21**	
WSFT_0061 CQC 61	The trust should consider security enabled doors in the paediatric outpatient department.	WSFT Estates to fit security enabled door	Helen Beck	Michelle O' Donnell	RED	30.04.21 ~~28.02.21~~ ~~31.12.20~~ ~~01.05.20~~	**IPB Update 12.04.21: Eight week extensiom agreed at March IPB to 30.04.21. The plan has been subject to change but there are no additional actions and so the plan remains RED. Current status update as follows:** - Financial approval received for Mag Locked doors solution with automated opening. - 8 week lead in team for maintenance team to fit.	
WSFT_0062 CQC 62	The trust should consider a system to monitor the average waiting times for a follow up appointment.	See No 6	Helen Beck	Helen Beck	Amber	30.04.21 ~~31.03.21~~ ~~01.08.20~~	See No. 6	
WSFT_0063 CQC 63	The trust should continue to improve mandatory training completion rates to meet the trust's target completion rate of 90%.	See No 12	Jeremy Over	Denise Pora / Michelle Glass	Amber	31.05.21	**See No. 12**	
WSFT_0064 CQC 64	The trust should continue to improve appraisal completion rates to meet the trust's target completion rate of 90%.	See No 55	Jeremy Over	Denise Pora / Michelle Glass	Red	31/12/2020	**See No. 55**	
WSFT_0065 CQC 65	The trust should ensure that governance and oversight are strengthened to ensure performance and local audit are monitored and measured to improve practice.	Review of governance and oversight team and function to include within this local audit requirements to inform quality assurance will be formulated	Nick Jenkins	Michelle Glass / Nic Smith-Howell	Black	31.03.21	**IPB Update 12.04.21: Plan moves to complete as the central clinical audit coordinator is in post 08.03.21.** **- BAU evidence base will be the community clinical audit planning schedule and the audit capacity mitigation plan.** **- Community Paediatrics Audit capacity risk being mitigated via the wider community Clinical Governance Steering Group. Also meeting arrenged with central clinical audit w/c 15.03.21 which may provide clear view of audit requirements going forward which is a helpful mitigation. The first step however is to ensure the service has worked up a clear audit formula requirement to engage in meaningful mitigation discussion.**	
WSFT_0070 CQC 70	The trust should continue to improve mandatory training in key skills to all staff to meet trust targets.	See No 12	Jeremy Over	Denise Pora / Michelle Glass	Amber	31.12.20	**See No. 12**	
WSFT_0071 CQC 71	The trust should continue to improve appraisal completion rates to meet the trust's target completion rate of 90%.	See No 55	Jeremy Over	Denise Pora / Michelle Glass	Red	31/12/2020	**See No. 55**	

Find no.	Improvement required	Improvement action / Assurance framework	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale	Origin / Source
WSFT_0073 CQC 73	The trust should ensure that all senior leaders have the skills to access and use patient outcome data to improve services. Specific to Newmarket Hospital	Assurance Framework: 1. Goal setting measures are agreed on the monthly report which identifies the patients which have had goals set 2. This monthly report feeds into the monthly clinical governance meeting 3. Clinical governance meeting reports feed into the service line reviews 4. Quality reports that go from the Senior Matron to the Head of Nursing 5. Assurance from the heads of nursing that the matrons are reviewed on that during their appraisal (refer to appraisal percentage) 6. Contractual reporting requirement with CCG includes reporting Barthel for the Community beds	Helen Beck	Sharon Basson	Black	31.03.21 ~~31.05.21~~ ~~31.12.20~~	**IPB Update 12.04.21: Proposal is to move plan from Amber to Black as all actions complete.** **Completed items were as follows:** **1. Information team engaged regarding data reporting requirement changes** **2. Contractual reporting agreement with CCG**	
WSFT_0074 CQC 74	The trust should ensure that individual goals and outcome measures are routinely monitored and audited to improve care.	Assurance Framework: 1. Monthly reporting on patients' goals 2. Monitoring via Service Line Reviews 3. Monitoring via Heads of Nursing 4. Monitoring via appraisals	Susan Wilkinson	Gylda Nunn	Black	31.03.21 ~~30.08.20~~	**IPB Update 12.04.21: Proposal is to move the plan from Green to Black as all actions are complete.** **Current status of Assurance Framework items are as follows:** **(1) Monthly report feeds into Clinical Governance Meetings** **(2) This is then fed into the Service Line Reviews** **(3) Senior Matrons produce a monthly Quality Report which goes to the HoNs** **(4) The above process is reviewed via matrons' appraisals, giving an achievement percentage for additional assurance**	
WSFT_0075	Perinatal Clinical Quality Surveillance Model	1. Enhanced Safety (Ockenden Report)	Susan Wilkinson	Karen Newbury	Red	31.01.21	**IPB Update 12.04.21: Proposal is that plan moves from Green to Red as planned target date has passed. Completion expected by 31.05.21. LMNS safety pathway has commenced and Regional Safety slide set is finalised.**	Ockenden Report
WSFT_0076	Consultant led ward rounds twice daily on labour suite	3. Staff training and working together (Ockenden Report)	Nick Jenkins	Ravi Ayyamuthu	Amber	30.04.21	**Update 02.02.21: Extra ward rounds on weekend evenings in practice, but job plans not yet reviewed and updated due to Covid**	Ockenden Report
WSFT_0077	MDT Training Scheduled	3. Staff training and working together (Ockenden Report)	Susan Wilkinson	Karen Newbury	Complete	31.03.21	**Trust Response 21.12.20: MDT Training schedule is in place**	Ockenden Report
WSFT_0078	MDT Training Implemented	3. Staff training and working together (Ockenden Report)	Susan Wilkinson	Karen Newbury	Green	31.03.21	**Update 16.03.21: Awaiting March statistics to evidence 90% training compliance, but plan remains on track**	Ockenden Report
WSFT_0079	Named consultant lead/audit	4. Managing Complex Pregnancy (Ockenden Report)	Nick Jenkins	Ravi Ayyamuthu	Amber	31.01.21	**Update 02.02.21: A list of named leads for a range of conditions is in place for new patients, but legacy patients will not yet be able to benefit from this**	Ockenden Report
WSFT_0080	Development of Maternal Medicine Centres	4. Managing Complex Pregnancy (Ockenden Report)	Helen Beck	Michelle O'Donnell	Green	31.01.21	**Update 02.02.21: Trust is ready to link with MMCs once they are set up. Until this is in place, monthly meetings with Norfolk and Norwich for complex cases are in place as mitigation**	Ockenden Report
WSFT_0081	Risk assessment recorded at every contact	5: Risk assessment throughout pregnancy (Ockenden Report)	Susan Wilkinson	Karen Newbury	Red	31.01.21	**IPB Update 12.04.21: Proposal is to move plan to Red as planned completion date has passed. Completion is expected by 30.04.21, as eCare transfer is due late March; process will be re-reviewed once eCare is live**	Ockenden Report
WSFT_0082	Pathways of care clearly described, on website	7: Informed Consent (Ockenden Report)	Susan Wilkinson	Lee White	Amber	31.01.21	**Update 02.02.21: Work is ongoing to get guideliness added to Trust website and to make information leaflets available in top 5 languages**	Ockenden Report

Find no.	Improvement required	Improvement action / Assurance framework	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale	Origin / Source
WSFT_0083	Trustwide Baby Abduction Policy	1. Develop a baby abduction policy 2. Disseminate policy to all staff 3. Audit reporting to ensure policy is being followed by all staff	Helen Beck	Barry Moss	Amber	28.02.21	**Update 02.02.21: Draft Missing Person policy exists and is on track for sign-off by the end of February and to go to Divisional Board in March**	West Suffolk Site Visit Summary Report 06.01.21
WSFT_0084	Maternity Strategy	Development of a maternity strategy remains outstanding (West Suffolk Site Visit Summary Report 06.01.21)	Susan Wilkinson	Michelle O'Donnell	Red	TBC	**Update 02.02.21: Completion date for this will depend on finalisation of the Trust Organisational Strategy**	West Suffolk Site Visit Summary Report 06.01.21
WSFT_0085	Maternity Risk Management Strategy	The maternity risk management strategy to be approved by the triumvirate, chief nurse and trust governance lead which must work in harmony with the new Trust governance strategy (West Suffolk Site Visit Summary Report 06.01.21)	Susan Wilkinson	Michelle O'Donnell	Amber	28.02.21	**IPB Update 12.04.21: The strategy exists and is planned to be submitted to TEG in May. Guidance requested from IPB as to new RAG status and extension to end date**	West Suffolk Site Visit Summary Report 06.01.21
WSFT_0086	Embed dedicated consultant obstetric governance, guidelines, and labour ward / fetal monitoring lead roles	Dedicated consultant obstetric governance, guidelines, and labour ward / fetal monitoring leads: these roles need to be embedded (West Suffolk Site Visit Summary Report 06.01.21)	Nick Jenkins	Ravi Ayyamuthu	Red	28.02.21	**Update 06.01.21: A new CD has recently been appointment for the division. This is individual is now dedicated consultant obstetric governance, guidelines, and labour ward / fetal monitoring leads. These roles need to be embedded to ensure there is medical engagement and oversight of the governance processes and MDT training**	West Suffolk Site Visit Summary Report 06.01.21
WSFT_0087	Embed safety huddles and twice daily obsteric MDT ward rounds in practice	Safety huddles and twice daily obstetric MDT ward rounds have not been embedded in practice (West Suffolk Site Visit Summary Report 06.01.21)	Nick Jenkins	Ravi Ayyamuthu	Amber	28.02.21	**Update 02.02.21: Morning obstetric ward rounds are in place but the weekend rounds have not yet been embedded**	West Suffolk Site Visit Summary Report 06.01.21
WSFT_0088	Implement RAG triage tools	RAG Triage tools have not been implemented (West Suffolk Site Visit Summary Report 06.01.21)	Susan Wilkinson	Karen Newbury	Red	28.02.21	**IPB Update 12.04.21: Proposal is to move plan to Red from Amber as planned completion date extends by two months to 30.04.21. Implementation will be delayed to prioritise transfer to eCare**	West Suffolk Site Visit Summary Report 06.01.21
WSFT_0089	Midwifery-led birth centre criteria pathway	Midwifery led birth centre criteria pathway has not been completed (West Suffolk Site Visit Summary Report 06.01.21)	Susan Wilkinson	Karen Newbury	Amber	28.02.21	**Update 16.02.21: Pathway is out for consultation now and is expected to go through Governance in April**	West Suffolk Site Visit Summary Report 06.01.21
WSFT_0090	Additional Ward Clerks	Bank shifts remain unfilled due to sickness/shielding (West Suffolk Site Visit Summary Report 06.01.21)	Susan Wilkinson	Lee White	Amber		**Update 16.03.21: Temporary roles have been recruited and are in post. Business plan is in progress to enable funding for 24-hour ward clerking on Labour Suite and for 12 hours on F11**	West Suffolk Site Visit Summary Report 06.01.21
WSFT_0091	Divisional Governance Review	Divisional governance review to be completed (West Suffolk Site Visit Summary Report 06.01.21)	Helen Beck	Michelle O'Donnell	Amber	14.01.21	**Update 02.02.21: This has dependcies with the wider Trust governance reviews**	West Suffolk Site Visit Summary Report 06.01.21
WSFT_0092	Senior Staff (Band 7 and above) Development Programme	Develop Labour Ward Band 7/ ward manager's leadership development programme (West Suffolk Site Visit Summary Report 06.01.21)	Susan Wilkinson	Karen Newbury	Amber	1.1.22	**Update 02.02.21: In progress**	West Suffolk Site Visit Summary Report 06.01.21

Find no.	Improvement required	Improvement action / Assurance framework	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale	O
WSFT_0002 CQC 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.	**Assurance Framework:** The plan will return to IPB with an assurance framework at June IPB for quarterly review until either the 3 'i's committee meetings have evolved with the potential to move to reporting via the insights forum with the People Plan or via an internal HR Strategic Committee	Stephen Dunn	Jeremy Over	**Black**	**28.02.21** ~~**31.03.21**~~ ~~**30.11.20**~~	**IPB Update 12.04.21: Proposal is that plan moves from Red to Black** **- All items within the ACSA action plan complete** **- Priorities to improve support for staff, learning from survey, have been identified.** **- Six theme leads identified and work is in delivery. Plan is housed in people plan for monitoring.**	
WSFT_ 0004.1 CQC 4.1 CQC 41	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.	**Revised Plan Actions** **1.Review access database for effectiveness and accuracy of data** **2.Create and Implement formal Clinical Audit registration and completion process** **3.Ensure participation in the Annual Clinical Audit Awareness week** **4.Implement Clinical Audit training programme** **5.Collate Clinical Audit programme for each division** **6.Facilitate the ongoing capture of progress for the divisional audit programmes, to quarterly include Clinical Audit to the Divisional Clinical Governance meeting agenda** **7.Reinstate KPI indicator as part of the Trust's developing insight committee reporting framework.** **8.The Maternity Clinical Audit and Effectiveness midwife to work with the trust 9.Clinical Audit and Effectiveness lead to standardise HSIB process.** **10.Develop a framework for responding to HSIB publications** **11.Using the HSIB model as a pilot, further develop a framework for the identification and response to other national best practice publications.** **12.Associate Medical Director for Quality and Safety Job Description to have a defined role and allocated responsibilities for Clinical Audit and Effectiveness** **13.Budget planning for 2021/22 needs to consider the requirements of the Clinical Audit and Effectiveness team** **14.Consider the formation of QICE to be chaired by the new Associate Medical Director for Quality and Safety as part of the trust's redevelopment of the quality & safety committee structure.** **15.Trust wide Clinical Audit and Effectiveness roles to have regular scheduled meetings to promote co-working.**	Nick Jenkins	Rebecca Gibson	**Amber**	**31.07.21** ~~**31.03.21**~~ ~~**01.07.20**~~ ~~**31.12.20**~~	**IPB Update 12.04.21: Plan stays Amber. Revised plan prepared.** **March IPB proposal to move plan from Amber to Green rejected due to number of outstanding actions.** **IPB agreement in meeting was plan stays Amber** **- Plan will complete (Black) when Q1 divisional clinical audit programmes progress is reported in July 2021**	
WSFT_0005 CQC 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.	Complete a review of HR policies to ensure a more kind and compassionate approach aligned to a 'Just' culture	Jeremy Over	Claire Sorenson	**Green**	**30.04.21** ~~**31.03.21**~~ ~~**31.10.20**~~	**IPB Update 12.04.21: Proposed plan completion date extends by one month to 30.04.21 as additional action is included in the plan around CEO communication. Work to complete final plan actions includes:** **- New policies submitted for approval at TNC and Trust Council** **- CEO Communications to staff regarding HR policies re-set**	
WSFT_0006 CQC 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.	Identify and deliver training for process changes to relevant staff groups for both follow ups and surveillance.	Helen Beck	Hannah Knights	**Red**	**30.04.21** ~~**31.03.21**~~ ~~01.08.20~~	**IPB Update 12.04.21: Trust plan to design and embed robust processes for follow up and surveillance patients are in place.** **However, the proposal is that the overall plan RAG and the end date move from Amber to Red given training delays associated with uploading e-leaning training packages at Trust and training programmes will complete by the end of April rather than the end of March.**	
WSFT_0012 CQC 12, 32, 63, 70	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. Review mandatory training requirements needs to ensure staff have the correct training assigned to them for their role. 2. Processes to alert managers to areas where compliance is low being piloted by Education and Training team to assess impact. 3. Community paediatrics training data to be reviewed and updated if required 4. Bank mandatory training compliance to be increased through implementation and further development of action plans. Target date to be agreed for 90% compliance. 5. Support Divisions to establish trajectories for compliance with mandatory training available via e-learning	Jeremy Over	Denise Pora	**Amber**	**31.05.21**	**Update 12.04.21: Proposal is to move plan from Red to Amber as revised plan items prepared as part of recovery planning process.** **- MT recovery plan will be managed with divisional input at joint PRM.** **- Recovery plans will be gauged with comparative organisations eg. ESNEFT, QUHKL, JPUH** **Key Risk: Delivery subject to divisions managing MT compliance within teams**	

Find no.	Improvement required	Improvement action / Assurance framework	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale	Ot
WSFT_0030 CQC 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	30.04.21 ~~31.03.21~~ ~~01.08.20~~	See plan No. 6	
WSFT_0031 CQC 31	The trust must ensure staff complete and record patient pain assessments in patient records.	Assurance Framework: 1. Compliance monitored via monthly reporting by senior matrons as part of their monthly performance review. 2. Senior matrons produce a report from the patient care plans and pain assessments - this is a standard BAU monthly report available from SystmOne. 3. The monthly reporting will be supplemented by a quarterly 'deep dive' review process to align with the service line reviews, launch date 31.03.21. 4. WSFT Head of Community Nursing and CCG Chief Nurse Officer will review formerly in regular performance monitoring 1:1's 5. Collect and collate patient experience information 6. Compliance levels will be presented to IPB on a monthly basis as part of the Trust BAU assurance process.	Helen Beck	Michelle Glass	Amber	? ~~31.03.21~~ ~~31.12.20~~ ~~01.03.20~~	IPB Update 12.04.21: All actions complete. Proposal is that overall plan moves from Red to Amber As the revised plan has been agreed at IPB, the completion timeframe can also be reviewed at April IPB as the timescale for achieving 80% compliance becomes clear. - Plan turns Black when 80% compliance levels are achieved for syringe driver patients. The clinical opinion based on experience is that the appropriate pain assessment compliance rate in the community is 80% for syringe driver patients. The rate is based on 6 patient visits over an average 6 days where one of the visits is the bereavement visit. Trust BAU assurance framework is presented in the improvement action / assurance framework column. - The Trust Improvement plan also accommodates the patient experience information as suggested by Suffolk Healthwatch	
WSFT_0032 CQC 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	
WSFT_0033 CQC 33	Current Pathology plan is essentially a Trust Plan as original CQC improvement requirement is outmoded. Trust Pathology plan reports directly to WSFT Scrutiny Committee on a quarterly basis, including all transformation plans	Updated Improvement Plan post Attain Plan review: ESTATES ACTIONS: - Review off site commercial options - Undertake feasibility studies - Consult with staff regarding process to identify preferred location LIMS ACTIONS: LIMS Review plan on track to present recommended option to April Board regarding replacement of LIMS - Plan operationalised by 31.05.21	Nick Jenkins	Fiona Berry	Green	31.05.21 ~~31.03.21~~ ~~31.01.21~~ ~~31.12.20~~ ~~01.03.20~~	IPB Update: 12.04.21: IPB request new plan be prepared for Plan No 33 Pathology - Estates review paper going to April Trust Board with options. - Recommendation will be to upgrade Containment Lab (CL3) on current site to address current Red Risk with a view to move to new lab facility at new site in 5 years - LIMS Review plan on track to present recommended option to April Board regarding replacement of LIMS Recommendation is to continue shared LIMS with ESNEFT (Partnership contract) with a view to re-procure 2024. This stabilises current service provision whilst allowing suitable time to undergo re-procurement. Plan remains in track to complete by 31.05.21	
WSFT_0036 CQC 36	The trust should ensure all staff follow infection prevention and control procedures and bare below the elbow guidance at all times.	Assurance Framework: 1. Use Infection Control audits to provide BAU assurance.	Susan Wilkinson	Formerly Anne How	Blue	31.10.20 ~~11.02.20~~	IPB Update 12.04.21: Proposal is that plan moves to Blue (BAU) from Black as BAF and Infection Control audits have demonstrated more than three months of embeddedness. Current status of Assurance Framework items are as follows: (1) BAF and regular Infection Control audits are providing assurance	
WSFT_0041 CQC 41	The trust should ensure that appropriate action plans to address national audit shortfalls are implemented and effectively monitored.	See Plan No 4.1	Nick Jenkins	Rebecca Gibson	Amber	31.07.21 ~~31.03.21~~ ~~01.07.20~~ ~~31.12.20~~	See Plan No 4.1	
WSFT_0047 CQC 47	The trust should ensure that the labour suite coordinator is supernumerary.	Outstanding Improvement Action: 1. All labour suite coordinators moved to supernumerary Assurance Framework: 2. All coordinators made bleep holders	Susan Wilkinson	Karen Newbury	Red	31.05.21 ~~31.03.21~~ ~~08.02.20~~	IPB Update 12.04.21: Proposal is that the plan moves from Green to Red as supernumerary coordinators appointed but will not in post by planned date. The revised expectation is that all coordinators will be in post by 31.05.21 Current status of Improvement Action / Assurance Framework items are as follows: (1) All supernumerary labour suite coordinators have been appointed, but some will not be in post until May. Once in post, Quality Dashboard can be used to demonstrate 100% of coordinators have supernumerary status (2) All night coordinators were bleep holders. Additional bleep holders employed	
WSFT_0048 CQC 48	The trust should ensure a higher percentage of staff complete mandatory training including PROMPT.	Outstanding Improvement Action: 1. Decide on mandatory status of PROMPT training for medical anaesthetic team	Susan Wilkinson	Karen Newbury	Amber	30.04.21 ~~31.12.20~~	IPB Update 12.04.21: Proposal is that plan reverts to Amber from Green as several staff groups are not hitting the 90% training compliance target. Current status of Improvement Action / Assurance Framework items are as follows: (1) TBC	
WSFT_0055 CQC 55,64 & 71	The trust should ensure that appraisal rates are met for staff.	Improvement Actions: 1.HR Business partners to work with divisions to set appraisal improvement trajectories 2.Dashboard of appraisal compliance to be published in the Green sheet monthly to raise the profile of appraisals and positive reinforcement for good practice 3.Training is available for all appraisers	Jeremy Over	Denise Pora	Red	31.12.20	IPB Update: Plan stays Red based on IPB discussion. Trajectories also required for both plans 12 and 55. IPB Update 12.04.21: Proposal is to move plan from Red to Amber as revised plan actions prepared as part of recovery planning process Key Risk: Delivery subject to divisions managing MT compliance within teams	
WSFT_0058 CQC 58	The trust should ensure consumable equipment is not opened prior to use to prevent infection prevention and control risks.	Outstanding Improvement Action: 1. Review storage of adult consumables to balance safety and infection control needs	Susan Wilkinson	Karen Newbury	Red	28.02.21	IPB Update 12.04.21: Proposal is that plan moves from Green to Red as planned completion date has passed. Current status of Improvement Action items are as follows: (1) As a short-term solution for this finding, suction consumables are now being changed and labelled every month, although there are concerns about this approach which are on the agenda for discussion at the next Deteriorating Patient Group on 22.04.21	

Find no.	Improvement required	Improvement action / Assurance framework	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale	O
WSFT_0061 CQC 61	The trust should consider security enabled doors in the paediatric outpatient department.	WSFT Estates to fit security enabled door	Helen Beck	Michelle O' Donnell	RED	30.04.21 ~~28.02.21~~ ~~31.12.20~~ ~~01.05.20~~	**IPB Update 12.04.21: Eight week extensiom agreed at March IPB to 30.04.21. The plan has been subject to change but there are no additional actions and so the plan remains RED. Current status update as follows:** - Financial approval received for Mag Locked doors solution with automated opening. - 8 week lead in team for maintenance team to fit.	
WSFT_0062 CQC 62	The trust should consider a system to monitor the average waiting times for a follow up appointment.	See No 6	Helen Beck	Helen Beck	Amber	**30.04.21** ~~**31.03.21**~~ ~~01.08.20~~	See No. 6	
WSFT_0063 CQC 63	The trust should continue to improve mandatory training completion rates to meet the trust's target completion rate of 90%.	See No 12	Jeremy Over	Denise Pora / Michelle Glass	Amber	**31.05.21**	**See No. 12**	
WSFT_0064 CQC 64	The trust should continue to improve appraisal completion rates to meet the trust's target completion rate of 90%.	See No 55	Jeremy Over	Denise Pora / Michelle Glass	Red	**31/12/2020**	**See No. 55**	
WSFT_0065 CQC 65	The trust should ensure that governance and oversight are strengthened to ensure performance and local audit are monitored and measured to improve practice.	Review of governance and oversight team and function to include within this local audit requirements to inform quality assurance will be formulated	Nick Jenkins	Michelle Glass / Nic Smith-Howell	**Black**	**31.03.21**	**IPB Update 12.04.21: Plan moves to complete as the central clinical audit coordinator is in post 08.03.21.** **- BAU evidence base will be the community clinical audit planning schedule and the audit capacity mitigation plan.** **- Community Paediatrics Audit capacity risk being mitigated via the wider community Clinical Governance Steering Group. Also meeting arrenged with central clinical audit w/c 15.03.21 which may provide clear view of audit requirements going forward which is a helpful mitigation. The first step however is to ensure the service has worked up a clear audit formula requirement to engage in meaningful mitigation discussion.**	
WSFT_0070 CQC 70	The trust should continue to improve mandatory training in key skills to all staff to meet trust targets.	See No 12	Jeremy Over	Denise Pora / Michelle Glass	Amber	**31.12.20**	**See No. 12**	
WSFT_0071 CQC 71	The trust should continue to improve appraisal completion rates to meet the trust's target completion rate of 90%.	See No 55	Jeremy Over	Denise Pora / Michelle Glass	**Red**	**31/12/2020**	**See No. 55**	
WSFT_0073 CQC 73	The trust should ensure that all senior leaders have the skills to access and use patient outcome data to improve services. Specific to Newmarket Hospital	Assurance Framework: 1. Goal setting measures are agreed on the monthly report which identifies the patients which have had goals set 2. This monthly report feeds into the monthly clinical governance meeting 3. Clinical governance meeting reports feed into the service line reviews 4. Quality reports that go from the Senior Matron to the Head of Nursing 5. Assurance from the heads of nursing that the matrons are reviewed on that during their appraisal (refer to appraisal percentage) 6. Contractual reporting requirement with CCG includes reporting Barthel for the Community beds	Helen Beck	Sharon Basson	**Black**	**31.03.21** ~~31.05.21~~ ~~31.12.20~~	**IPB Update 12.04.21: Proposal is to move plan from Amber to Black as all actions complete.** **Completed items were as follows:** **1. Information team engaged regarding data reporting requirement changes** **2. Contractual reporting agreement with CCG**	
WSFT_0074 CQC 74	The trust should ensure that individual goals and outcome measures are routinely monitored and audited to improve care.	Assurance Framework: 1. Monthly reporting on patients' goals 2. Monitoring via Service Line Reviews 3. Monitoring via Heads of Nursing 4. Monitoring via appraisals	Susan Wilkinson	Gylda Nunn	**Black**	**31.03.21** ~~30.08.20~~	**IPB Update 12.04.21: Proposal is to move the plan from Green to Black as all actions are complete.** **Current status of Assurance Framework items are as follows:** **(1) Monthly report feeds into Clinical Governance Meetings** **(2) This is then fed into the Service Line Reviews** **(3) Senior Matrons produce a monthly Quality Report which goes to the HoNs** **(4) The above process is reviewed via matrons' appraisals, giving an achievement percentage for additional assurance**	
WSFT_0075	Perinatal Clinical Quality Surveillance Model	1. Enhanced Safety (Ockenden Report)	Susan Wilkinson	Karen Newbury	**Red**	**31.01.21**	**IPB Update 12.04.21: Proposal is that plan moves from Green to Red as planned target date has passed. Completion expected by 31.05.21. LMNS safety pathway has commenced and Regional Safety slide set is finalised.**	
WSFT_0076	Consultant led ward rounds twice daily on labour suite	3. Staff training and working together (Ockenden Report)	Nick Jenkins	Ravi Ayyamuthu	**Amber**	**30.04.21**	**Update 02.02.21: Extra ward rounds on weekend evenings in practice, but job plans not yet reviewed and updated due to Covid**	
WSFT_0077	MDT Training Scheduled	3. Staff training and working together (Ockenden Report)	Susan Wilkinson	Karen Newbury	**Complete**	**31.03.21**	**Trust Response 21.12.20: MDT Training schedule is in place**	
WSFT_0078	MDT Training Implemented	3. Staff training and working together (Ockenden Report)	Susan Wilkinson	Karen Newbury	**Green**	**31.03.21**	**Update 16.03.21: Awaiting March statistics to evidence 90% training compliance, but plan remains on track**	
WSFT_0079	Named consultant lead/audit	4. Managing Complex Pregnancy (Ockenden Report)	Nick Jenkins	Ravi Ayyamuthu	**Amber**	**31.01.21**	**Update 02.02.21: A list of named leads for a range of conditions is in place for new patients, but legacy patients will not yet be able to benefit from this**	

Find no.	Improvement required	Improvement action / Assurance framework	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale	O
WSFT_0080	Development of Maternal Medicine Centres	4. Managing Complex Pregnancy (Ockenden Report)	Helen Beck	Michelle O'Donnell	Green	31.01.21	**Update 02.02.21: Trust is ready to link with MMCs once they are set up. Until this is in place, monthly meetings with Norfolk and Norwich for complex cases are in place as mitigation**	
WSFT_0081	Risk assessment recorded at every contact	5: Risk assessment throughout pregnancy (Ockenden Report)	Susan Wilkinson	Karen Newbury	Red	31.01.21	**IPB Update 12.04.21: Proposal is to move plan to Red as planned completion date has passed. Completion is expected by 30.04.21, as eCare transfer is due late March; process will be re-reviewed once eCare is live**	
WSFT_0082	Pathways of care clearly described, on website	7: Informed Consent (Ockenden Report)	Susan Wilkinson	Lee White	Amber	31.01.21	**Update 02.02.21: Work is ongoing to get guideliness added to Trust website and to make information leaflets available in top 5 languages**	
WSFT_0083	Trustwide Baby Abduction Policy	1. Develop a baby abduction policy 2. Disseminate policy to all staff 3. Audit reporting to ensure policy is being followed by all staff	Helen Beck	Barry Moss	Amber	28.02.21	**Update 02.02.21: Draft Missing Person policy exists and is on track for sign-off by the end of February and to go to Divisional Board in March**	W : S (
WSFT_0084	Maternity Strategy	Development of a maternity strategy remains outstanding (West Suffolk Site Visit Summary Report 06.01.21)	Susan Wilkinson	Michelle O'Donnell	Red	TBC	**Update 02.02.21: Completion date for this will depend on finalisation of the Trust Organisational Strategy**	W :
WSFT_0085	Maternity Risk Management Strategy	The maternity risk management strategy to be approved by the triumvirate, chief nurse and trust governance lead which must work in harmony with the new Trust governance strategy (West Suffolk Site Visit Summary Report 06.01.21)	Susan Wilkinson	Michelle O'Donnell	Amber	28.02.21	**IPB Update 12.04.21: The strategy exists and is planned to be submitted to TEG in May. Guidance requested from IPB as to new RAG status and extension to end date**	W :
WSFT_0086	Embed dedicated consultant obstetric governance, guidelines, and labour ward / fetal monitoring lead roles	Dedicated consultant obstetric governance, guidelines, and labour ward / fetal monitoring leads: these roles need to be embedded (West Suffolk Site Visit Summary Report 06.01.21)	Nick Jenkins	Ravi Ayyamuthu	Red	28.02.21	**Update 06.01.21: A new CD has recently been appointment for the division. This is individual is now dedicated consultant obstetric governance, guidelines, and labour ward / fetal monitoring leads. These roles need to be embedded to ensure there is medical engagement and oversight of the governance processes and MDT training**	W : S (
WSFT_0087	Embed safety huddles and twice daily obsteric MDT ward rounds in practice	Safety huddles and twice daily obstetric MDT ward rounds have not been embedded in practice (West Suffolk Site Visit Summary Report 06.01.21)	Nick Jenkins	Ravi Ayyamuthu	Amber	28.02.21	**Update 02.02.21: Morning obstetric ward rounds are in place but the weekend rounds have not yet been embedded**	W : S (
WSFT_0088	Implement RAG triage tools	RAG Triage tools have not been implemented (West Suffolk Site Visit Summary Report 06.01.21)	Susan Wilkinson	Karen Newbury	Red	28.02.21	**IPB Update 12.04.21: Proposal is to move plan to Red from Amber as planned completion date extends by two months to 30.04.21. Implementation will be delayed to prioritise transfer to eCare**	W :
WSFT_0089	Midwifery-led birth centre criteria pathway	Midwifery led birth centre criteria pathway has not been completed (West Suffolk Site Visit Summary Report 06.01.21)	Susan Wilkinson	Karen Newbury	Amber	28.02.21	**Update 16.02.21: Pathway is out for consultation now and is expected to go through Governance in April**	W :
WSFT_0090	Additional Ward Clerks	Bank shifts remain unfilled due to sickness/shielding (West Suffolk Site Visit Summary Report 06.01.21)	Susan Wilkinson	Lee White	Amber		**Update 16.03.21: Temporary roles have been recruited and are in post. Business plan is in progress to enable funding for 24-hour ward clerking on Labour Suite and for 12 hours on F11**	W :
WSFT_0091	Divisional Governance Review	Divisional governance review to be completed (West Suffolk Site Visit Summary Report 06.01.21)	Helen Beck	Michelle O'Donnell	Amber	14.01.21	**Update 02.02.21: This has dependcies with the wider Trust governance reviews**	W : S (

Find no.	Improvement required	Improvement action / Assurance framework	Executive lead	Project lead	Overall status RAG	Project end date	Current status / overall RAG rationale	Ou
WSFT_0092	Senior Staff (Band 7 and above) Development Programme	Develop Labour Ward Band 7/ ward manager's leadership development programme (West Suffolk Site Visit Summary Report 06.01.21)	Susan Wilkinson	Karen Newbury	**Amber**	**1.1.22**	**Update 02.02.21: In progress**	W

15. Car parking tariffs and concessions 2020/21 (attached)

To approve the recommendations

For Approval

Presented by Craig Black

Trust Board - 30 April 2021

Agenda item:	15			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Clare Farrant, Travel and Sustainability Manager			
Date prepared:	22 April 2021			
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. The Trust Board was informed of this in the update paper sent January 2021.

On 23 March 2021 the government released the final definitions for the four identified groups to support their commitment to make hospital car parking free for those in greatest need, regardless of any arrangements linked to the pandemic.

In addition, the government confirmed that free parking should continue to be provided 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:	Trust Board 29 January 2021 - recommendation in lieu of final government guidance 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:

- 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.
- Implement the Government commitment to make hospital car parking free for those in greatest need. (4 identified groups: - Blue badge holders, Parents of sick children staying in hospital overnight, frequent outpatient attenders and staff working night shifts)

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.
- 23 March 2021 — Publication reference C1164 confirming that hospital car parking should continue to be free for NHS staff during this pandemic and setting out the contractual requirement to make hospital car parking free for those in greatest need during April 2021.

Proposal

Continue to provide free parking for NHS staff for the duration of the coronavirus outbreak in line with government guidance. (Publication reference C1164)

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.

The Trust implements:

The Government commitment to make hospital car parking free for those in greatest need. This is a requirement in the standard NHS contract and should be implemented. A grace period from the original implementation date of January 2021 was allowed, however it is expected that the contractual requirement is met during April 2021. Funding will be included in H1 system envelopes. The definitions of those covered by that commitment are:

***Guidance - Disabled people**: this is for holders of a valid Blue Badge attending hospital as a patient or visitor, or for a disabled person employed by the hospital trust. Disabled patients and visitors receive free parking for the duration of their attendance at, or visit to, the hospital. Disabled employees receive free parking while at the hospital for purposes relating to their employment.*

- WSH Response - Onsite parking for blue badge holders continues to be **free of charge**. All onsite parking for staff continues to be **free of charge**, when staff charges are reinstated the process for staff blue badge holders to register for free parking will be communicated.

***Guidance - Frequent outpatient attenders:** free parking will be provided to all out-patients who attend hospital for an appointment at least three times within a month and for an overall period of at least three months. A 'month' is defined as a period of 30 days.*

- WSH Response - Free of charge onsite parking was introduced for Macmillan patients, cardiac rehab patients and phototherapy patients with effect from 1 March 2021.
  Widen the scope of this concession to include all frequent patient attenders.
  Note – if appointments are not known in advance patients will be able to claim back parking charges at the end of their course of treatment.

***Guidance - Parents of sick children staying overnight:** this is for a parent or guardian of a child or young person, under 18 years of age, who is admitted as an inpatient at hospital overnight. They receive free parking between the hours of 7.30pm and 8am while visiting the child. This would apply to a maximum of two vehicles.*

- WSH Response - Implement free parking between the times above. Note other concessionary tariff rates, as appropriate, or the full public rate will apply at all other times.

***Guidance - Staff working night shifts**: this is for members of staff with a shift commencing after 7.30pm and ending before 8am. They receive free parking for the duration of their shift.*

- WSH Response - All staff parking charges continue to be free of charge in line with government guidance.
- When staff parking tariffs are reinstated it is proposed to introduce free parking for all staff working a night shift including those whose shifts fall outside the strict criteria shown in the definition. For example, clinical staff working from 7pm – 7.30am and security and portering staff working from 6pm – 6.30 am.

Recommendation

The Trust Board is asked to approve:

1. the proposal to comply with the government guidance for the 4 groups

2. hold the current tariffs and concessions until further details of the government's plans are received.

3. 2021-22 tariff review for patients, visitors & staff when staff charges are reinstated.

11:25 BUILD A JOINED-UP FUTURE

16. Future system board report

To APPROVE report

For Approval

Presented by Craig Black

Public Board Meeting – 30th April 2021

Agenda item:		16		
Presented by:		Craig Black, Executive Director for resources & Deputy CEO		
Prepared by:		Gary Norgate, Programme Director		
Date prepared:		21/04/2021		
Subject:		Update on the Future System Programme		
Purpose:	X	For information		For approval

In the last month the Future System Project has made progress on several fronts and has received positive feedback from NHSI/E on its strategic outline case.

1.0 Executive Summary

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

1. The Rt. Hon. Jo Churchill MP visited our preferred Hardwick Manor site in April and will also visit the 'plan B' site.
2. The Project Team held a Construction Industry Council Design Quality Indicator for Health 2 (DQIfH2) Briefing Stage workshop at which 46 different aspects of the planned new facility were discussed and rated in terms of importance to the project. These ratings allowed decisions to be taken on the extent to which the project would commit to; comply, exceed or lead the way in terms of standards. These ratings will be reviewed throughout our journey and will allow the project to effectively benchmark costs and quality whilst maximising value for money across the investment cycle (full report available on request).
3. The scoping document covering the detailed plans for an environmental impact assessment of the Hardwick Manor site has been formally submitted to our local council planners.
4. The co-production of our clinical design remains on-track with significant discussion on the configuration of office space and the model for community care representing significant areas of focus.
5. The project has agreed to nominate one of our clinical co production leads to join the Board of the regional project exploring the potential of "virtual hospitals".
6. The project has commenced a 'digital fortnight' during which our co-production teams will be translating the Atos digital blueprint and other digital innovations into tangible clinical impacts (effectively taking the generics of the blueprint and making them personal to WSFT, its patients, its staff and its clinical visions).
7. Although the formal consideration of the project's strategic outline case awaits the outcome of the central scheduling exercise, colleagues at NHSI/E conducted an informal assessment of our SOC against the business case fundamental criteria.
8. The project's efforts to ensure that it is the most co-produced and therefore inclusive of the HIP builds has seen it establish a co-production panel of over 100 volunteers representing our community and all of its facets.
9. We continue to train the project team in building better business cases and are actively applying the lessons learned as we progress.
10. We are working with the widest set of stakeholders to establish a strategy for ensuring our project fully respects our status as a leading anchor institution for our locale. Recent sessions with the Chamber of Commerce have highlighted the need to commence work on ensuring Suffolk is prepared to exploit the significant investment being in made in its infrastructure

(Sizewell C, Felixstowe Freeport, Gateway 14 at Stowmarket and, of course, our new hospital).

2.0 Strategic Outline Case (SOC)

As discussed last month, the national New Hospital Programme (NHP) had informed the Future System team that they would not take the SOC into a formal review until they could confirm expectations regarding the programme as a whole. An update regarding the schedule determining when each project can progress is expected in the coming months. The order in which the projects will progress will be based upon the relative 'readiness' of each case and the extent to which plans are seen as "complimentary to the development of the NHP programmatic benefits and approaches.

The Future System project has a compelling case for change;

- we own the land associated with the preferred option
- we have excellent clinical engagement
- we have evidence of true co-production and
- The programme's system-wide approach ensures support from across the widest set of stakeholders.

We understand that details for the funding of the development of plans will be released in June. Securing planning consent for building on the preferred site is the next step in the project. As a minimum, the project would require funding to complete this exercise (the key deliverables leading up to this outcome are outlined below).

In preparation for the formal submission of the SOC, colleagues at NHSI/E conducted an informal review of its content against the Government's business case fundamental criteria. The appraisers concluded that the SOC was in good shape and that, if it had been formally submitted, they would not hesitate to recommend it for national appraisal by the Department of Health and Social Care. There were a couple of suggestions about how to make the case crisper (e.g. revisit the wording of the investment objectives to allow us to demonstrate progress as our case develops), however, it was fundamentally sound. The review specifically highlighted the clear level of support from across the system as a highly positive aspect of the case. The national NHP team are aware of this assessment and its conclusions.

Next steps and budget: Regardless of when the Future System programme is scheduled for delivery, it is essential that we secure a definitive answer on the extent to which we can build a new facility on our preferred site of Hardwick Manor. In the event that a planning application is rejected or restricted, the FS team would need to seek alternative options, hence, a prompt application is critical. That said, in order to submit a planning application, the project first needs to conclude a clinical design and conduct a detailed assessment of the environmental impact of a new building. To this end our next steps are:

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

In addition to providing an answer on planning consent, this work will provide significant input into the development of our ICS strategy and will provide the detailed information required for the completion of our Outline Business Case. The work is expected to cost in the region of £6m and funding will be sought in line with the June time-line described by the New Hospitals Programme.

3.0 Estates

The Estates work stream is currently on track and continues to be focussed in three principle areas.
1. Further site de-risking of Hardwick Manor
2. Environmental Impact Assessment (EIA)
3. Design

3.1 De-risking - Initial feedback from meetings held with statutory consultees including West Suffolk Council, Natural England, Suffolk Wildlife Trust, SCC Highways, WSC Public Health Housing Officer, Place Services and the Lead Local Flood Authority has now been incorporated into a full site de-risking report.
The exercise builds on the work carried out for the initial site appraisal process, and further validates the selection of Hardwick Manor as the preferred site. Whilst significant risks to planning approval remain, and will do until further detailed design and Environmental Impact Assessment work is progressed / concluded, the further studies
undertaken have increased the optimism of achieving a successful planning outcome.

The most significant risks at this stage are:

3.1.1 Ecology – Protected Habitat - Hardwick Manor is designated as wood pasture parkland which is a priority habitat. However, this is considered a coarse designation based on aerial photography, and should not potentially apply to all areas of the site (for instance the main developable area of grassland in the middle of the site). Detailed botanical surveys are scheduled in May and June, and rare fungi surveys are scheduled in the autumn, to progress the protected habitat issue further.

3.1.2 Ecology – Protected Species - Seasonal ecology surveys continue to progress well and bat roosts, foraging and commuting bats, have been located. Further species identified include a number of badger setts, grass snakes and breeding birds. Great Crested Newt and other surveys are scheduled to inform the ecological constraints plan for the site.
The timing of the December planning application is considered optimum to allow a full suite of surveys to be completed.

3.1.3 Veteran Trees - The constraints posed by veteran trees are well understood and an expert in the field, Treework Environmental Practice, has undertaken a further detailed tree survey. Draft constraint plans indicate that the developable area is expected to be slightly larger than that identified at the site appraisal stage, although mitigation will be required for the removal of a small number of Category A trees in the main developable area, and potentially a larger number of Category B trees. This is considered to be viable.

3.1.4 Transport & Highways–

Operational Traffic - Operational traffic resulting from the new development is not considered to be a prohibitive factor, although the cumulative impact if Hardwick Lane were to be sold for residential use is considered problematic, and the Local Highway Authority have raised concerns on future residential development having an unacceptable impact on the local highway network (**it is not the intention of the project to develop this land, however, all options have to be considered for business case purposes**).

Construction Access (into the site) - The current preferred strategy for accessing the site includes leasing third party land, and the access/egress depends on achieving clear visibility splays along Horsecroft Road. Based on the 60mph speed limit, visibility splays will encroach established trees on the opposite field boundaries and could be problematic.

As mitigation, a speed survey is being progressed as the extent of required visibility splays could be reduced if actual traffic speeds are less than the national speed limit. If splays cannot be achieved a permanent traffic signal may be acceptable as alternative mitigation.
Ecology, and in particular, bat roosts and corridors in and through the tree canopy are a further risk which will need to be ascertained via further survey work, to confirm a viable access point through the western tree belt.

3.2 Environmental Impact Assessment (EIA) - The EIA scoping report was approved by the WSFT and NHSEI Communications teams and submitted to the Local Planning Authority (LPA) on 8th April 2021. The LPA have a statutory period of 5 weeks to provide a "scoping opinion" which will then define the full scope of the formal EIA.
To maintain compliance with the overall project plan, the early activities of the EIA continue to progress concurrently with the scoping opinion, with completion and issue of the EIA targeted for October / November 2021 to support an outline planning application in December 2021.

3.3 Design - A Briefing Stage Design Quality Indicator (DQI) Workshop was facilitated by the Construction Industry Council on 24th March with the Project Director, members of Estates and Clinical work streams, and a patient group representative in attendance.

Pre-set criteria relating to Build Quality, Functionality and Impact were scored with ratings of "Required", "Desired" and "Inspired" allocated to each. The workshop output report will allow the concept design to be scored against the agreed ratings later in the OBC design stage.

The design process is continuing to focus on the following work streams so that the whole hospital design can be progressed when the full schedule of accommodation is available in July 2021.

1. Site Constraints Analysis - Planning De-risking

2. Generic Room Consultation and Sign-off

3. Clinical Flows and Adjacencies leading to 1 to 500 departmental plans

4. Best Practice Ward Design

5. MMC and Structural Design Investigations

6. Net Zero Carbon Strategies Analysis

7. Digital Strategies Analysis

8. Exemplar and Typology Analysis based on international precedent

When the Schedules of Accommodation are released in July, the above work streams will allow quick progress to 1 to 200 layouts to develop the OBC design proposal and support the planning application.

3.4 Summary / Next Steps - The Estates Work Stream continues to progress well and is on track with the master programme. The further site de-risking exercise will conclude in November 2021. The Environmental Impact Assessment Scoping Report has been submitted to the LPA, and early EIA activities related to ecology and transport are progressing concurrently with the scoping opinion. Design continues to progress in relation to exemplar typologies and building massing in order to respond to site constraints, best practice clinical adjacencies and future NHP design guidance. The first public planning consultation event is to be held over June and July 2021 and consultation material and platform will be developed in the next period.

4.0 Clinical Workstream

The Clinical Work Stream is currently on track and has been focussed on three principle areas.

1. Community Services
2. Understanding the potential of digital innovation

3. Learning from other new hospitals

4.1 Community Services – The community services group is focussing on three main care pathways, which are felt to be the most impactful in terms of mitigating demand for secondary care:
1. Frailty assessment and management,
2. End of life care, to further reduce the number of people who die in hospital if that is not their preferred place of death
3. Discharge to Optimise and Assess, to ensure that as soon as people's need for hospital medical care is over they are able to return home, or move to a lower acuity setting, in order to recover and rehabilitate in a more conducive and less dangerous environment

Between them, these three initiatives are currently modelled to reduce the demand for inpatient beds in the new acute facility by about 35. In line with the method being used for each of the hospital workstreams, a service vision and a schedule of the accommodation required to house or provide each of them will be co-produced over the next two-three months. More detail will be brought to future board meetings, however, at this stage, the Board are asked to note a few key points which are of crucial importance:

1. The capital and revenue costs for any changes to the way and location in which services are delivered are not currently accounted for in the Future System business case. The only provision included in the SOC was more outpatient clinic accommodation in satellite sites. Everything new that is planned for a community location will have an estate, facilities, staff, training, equipment and consumables requirement which will need to be calculated and appraised for achievability and affordability. It will affect most if not all alliance organisations, including primary care, social care, the voluntary and community sector, council services, and mental health. There is no spare capacity in the vast majority of community settings currently and failing to plan appropriately for the capital and revenue funding will cause the plans to fail.

2. This risk will be significantly mitigated by the CCG commitment to ensure that 'money will follow the service', and by the help we are getting from our GP leads and GP representatives to understand how to meet the practical needs of primary care when it comes to shifting funding.

3. The estates requirements would ideally be met through increased use of existing public estate including in partnership with West Suffolk Council in the new and future community hubs

4. The data required to model the maximum possible capacity that could be created in the community, and therefore to calculate the capital and revenue requirements, is not easily accessible. Datasets are held by a number of different organisations in a number of different formats and are not routinely brought together for planning or business management purposes. With this in mind the "heads of information" from across the system are coming together to start to try to tackle this, however, there may be a need for short term funding from the Future System programme to obtain the data we need at the timescales we need it for the production of our Outline Business Case

5. The schedule of accommodation for the new acute hospital is currently predicated on the fully integrated alliance model being successfully delivered by 2026. If the enhanced community model is not ambitious, achievable or affordable enough, we will fail to mitigate the growth in demand that is forecast and the hospital will be built too small. If, as the community workstream progresses, it becomes clear that any of the transformed services or relocated services are not realistic or cost-effective themselves, we will need to add capacity back into the acute schedule of accommodation and the floor area and build cost will increase as a result.

Each of these risks will be worked upon and understood in more detail as the workstream progresses and any that are found to be material will be added to the programme risk register.

4.2 Understanding the potential of digital innovation – April saw the digital and clinical workstreams combine to launch an immersive "digital fortnight" during which the teams explored current and forthcoming new technologies that could transform the ways in which the Trust and its partners deliver

health and care. The learning from the first intensive week of presentations and discussions was then applied to the existing clinical visions with a view to ensuring that we have been as digitally ambitious as possible.

The key objectives of the digital fortnight were:

• To create a consistent level of knowledge and understanding of future digital opportunities across the digital and future system clinical teams.

• To develop a shared vision of the opportunities from technology within clinical pathways.

• To revise the existing clinical visions to reflect maximum digital opportunity.

• To consolidate the technology from each clinical vision into a shared digital blueprint for the future state programme.

• To agree the deliverables and milestones to deliver each component of the digital blueprint.

In addition, the outputs of the digital fortnight will feed into the refresh of the trusts overall 5-year digital strategy (including identifying the digital transformation priorities).

The digital fortnight was split into two separate sections. Week one focussed on immersing the digital clinical leads into the 'art of the possible'. The team received demonstrations from a range of suppliers across the globe that are leading the way in new technologies and transforming the delivery of health and care services. Suppliers were briefed to showcase new and emerging technologies with particular focus on how they might support:

• Empowering patients to take more responsibility for their own health

• Remotely monitoring patients

• Ability for clinicians to deliver care virtually – from their homes or across other sites

• Delivering care in single inpatient rooms

• Automation of processes

• Improving quality and safety

• Unlocking the power of data

• Supporting much greater integration between health and care partners.

In addition to hearing from suppliers we will also have a number of key note speakers. These include:

• Healthwatch Suffolk who spoke about digital inclusion.

• A Chief Information Officer from a trust that has recently delivered a new build.

• A consultant breast surgeon who stressed the need to 'remember the patient' as we move forward with the digital programme.

Having achieved a common level of understanding of what is becoming possible, the second week of the fortnight focusses on reviewing the existing clinical visions contained within the SOC to ensure that we have maximised the full potential of digital transformation. The final day of week 2 will have a more strategic focus where we will look to take the key learning from across the fortnight and transfer these into the overall trust digital strategy.

4.3 Learning from other new hospitals – Dumfries and Galloway hospital was a new build that opened its doors in 2018. It serves a population of 150,000 people with a similar demographic profile to WSFT currently serves. The new hospital is built on a greenfield site with significant importance given to the quality of the environment as part of the overall staff and patient experience. With these points in mind, the team concluded that the D and G project had several parallels to that of our own and that a session to understand their experiences, particularly from a patient care perspective, would be of significant value. Mark Manning (the project's nursing lead) met with the nursing lead from D and G and

the following slides summarise the key points of the discussion:

Dumfries & Galloway Hospital

The first 'Garden Hospital'

- New NHS hospital opened in 2018
- Serving a population of approx. 150000
- Contains 344 in-patient beds (further beds at previous site)
- All in-patient care provided in single rooms (NHS Scotland standard)

What has worked well?

- Lowest nosocomial infection rates in Scotland
- Enhanced privacy and dignity (difficult conversations / EOLC)
- Improved patient satisfaction and well-being (all rooms en-suite / outside view)
- Ability to mix patient groups (trauma and elective orthopaedics)
- Flexibility of in-patient areas (generic / replicable design
- Staff / patient engagement - 'You cannot over communicate'

What challenges have you faced?

- Inability to get a feel for the area in a few steps (from a senior clinician perspective)
- 'Deafening quiet' (from a staff perspective)
- Initial increase in patient falls (now returned to base line)
- Ability to locate staff / colleagues
- Feeling of not being supported (junior staff)

What mitigation and design aspects were used?

- Large site but logical flow and good signage
- Dual corridors to allow the separation of patient and hospital service activity
- 'An army of volunteers' to support all areas
- Provision of electrical bikes to book to travel between the 2 sites (approximately 3 miles)
- Light system to identify location of staff
- Communal areas within atriums of horse-shoe wards to ensure staff interaction
- Change in staff and patient mind-set to function within the new space
- Multiple staff 'touch-down stations' in in-patient areas / no single historic nurses station
- Building designed to reflect the outside space to enhance patient and staff well-being
- 'Sanctuary space' for staff to be away from clinical area / pressures
- Modification of non-registered staff to reflect 100 single rooms

If you could, what would you change?

- Better socialisation spaces within the wards for patients
- Re-provision of staff rooms within in-patient areas
- Stop individual decisions being made in specialist areas that did not link in with the overall design / flow
- Do not have open plan office spaces – noise / lack of privacy / staff feedback

These findings have been discussed at the programme board and within the clinical workstream and will be reflected in our own designs as they develop.

5.0 Communications and Engagement –Communications have been sent to local residents affected most by our plans (residents of Horsecroft Road, Sharp Road, Hardwick Lane, Baron's Road, Home Farm Lane and their various off-shoots) advising them of the publication of the Environmental Impact Assessment scoping document on the local planning portal. To support this communication, two engagement events have been planned, one virtual and a teleconference for those not digitally abled, allowing residents to raise any concerns or queries regarding the content of the document with the Future System team. It is stressed that they are unable to alter the content however the team will be able to reassure and provide any clarification whilst raising any additional areas of concern.

6.0 Finance and Economic Workstream – A key part of the Future System Project is its potential to generate a wider commercial social benefit. As a major 'anchor institution' (i.e. major employer and consumer of locally provided services) the Trust has a responsibility to ensure the project maximises its social value. To this end:

1) The concept of maximising our social value is already embedded within the strategic principles of the programme
2) We are joining the ICS Finance Group that is leading on the commercial side of the role of the anchor institution
3) We are joining the Health Anchor Learning Network
4) We have already started regular conversations with the Chamber of Commerce and have started to identify potential local partners and suppliers
5) We have a clear aspiration for a carbon neutral facility and, working with our technical team, we are developing our strategy and options for its execution.
6) We have appointed a dedicated workforce lead who will consider the employment challenges and opportunities associated with our programme.

We plan to bring inputs from these and other workstreams together in early summer for an immersive fortnight during which we will bring a representative co-production team together and, a) educate them all to a common level of understanding of social enterprises / anchor institutions and, then, b) spend the second week asking those teams to translate the outline programme design into the tangible plans that will inform the clinical and physical vision for the construction and ongoing operational model of our new facility.

All in all, a month in which the strategic outline case has been endorsed, phase 2 of the clinical design has commenced, tangible progress has been made towards de-risking our planning application and we have continued to demonstrate our commitment to co-producing a new facility with our community, for our community. Next month will hopefully produce some clarity of the extent to which our proposed pace of development will be supported by the central NHP team.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**		**Invest in quality, staff and clinical leadership**		**Build a joined-up future**		
	X		**X**		**X**		
Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	 *Deliver personal care*	 *Deliver safe care*	 *Deliver joined-up care*	 *Support a healthy start*	 *Support a healthy life*	 *Support ageing well*	 *Support all our staff*
	X	X	X	X	X	X	X
Previously considered by:	Future System Programme Board						
Risk and assurance:							
Legislation, regulatory, equality, diversity and dignity implications	None						
Recommendation: The Board are asked to note the progress being made.							

11:30 GOVERNANCE

17. Governance report

To APPROVE the report, including subcommittee activities

For Approval

Presented by Richard Jones

Board of Directors – 30 April 2021

Agenda item:	17			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	26 April 2021			
Subject:	Governance report			
Purpose:	X	For information		For approval

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

1. **New framework for engagement and oversight for quality, safety and improvement** (for approval)

   As part of a planned review of the Trust's governance committee structure during 2020/21 options were co-produced with senior leaders within the Trust to establish a **new framework for engagement and oversight for quality, safety and improvement**. Implementation of the new framework was delayed during the response to the pandemic but with the start of the new year it is right that, despite the ongoing pressure, the new structure is put in place.

   The proposed framework is heavily influenced by the *National patient safety strategy (2019)* which is structured around:

   1. **Insight** – Improve understanding of quality and safety drawing on multiple sources of information - what the data says (internal and external). Key enabler - effective quality and safety measures.
   2. **Involvement** – give people the skills and opportunity to inform and improve services. Key enablers - effective engagement and skill sets to assess service needs and delivery improvement e.g. patient safety syllabus from Academy of Medical RCs and QI methods.
   3. **Improvement** - effective improvement programmes at corporate and service level. Key enablers - structured understanding and support of QI methods.

   The structure has been developed with relevant specialists to address feedback, including: providing **greater staff engagement, supporting divisional accountability and reducing silo working**. The revised framework ensures that divisions are able to 'push-up' issues (successes and challenges) in a way which allows cross-divisional sharing of solutions and learning. The structure will allow the three committees, Insight, Involvement and Improvement (3i committees), to review national requirements, corporate priorities and divisional priorities in the context of the Trust's strategy and objectives. Annex A provides a schematic of the 3i committee structure.

   The proposed framework **replaces the existing board assurance committee structure** and as a result the following committees/groups would no longer be required: quality & risk committee; clinical safety & effectiveness committee (CSEC); patient experience committee; quality group and improvement programme board. Under the structure TEG's responsibilities will be delivered through the 3i committees, as well as the strategic performance review meetings (monthly joint-divisional triumvirate oversight and review meeting with execs). The accountability of **specialist groups** has been reviewed, removing duplication whenever possible, and determining the most appropriate accountability arrangements within the new structure.

   An important change within the new structure is greater empowerment and engagement with divisions as part of the Board's assurance oversight. As such the 3i committees will include

nonexecutive director members, one of whom will chair the committee. **Membership of the committees is designed to be small but inclusive**. It is expected that the majority of reports will be presented by the committee's membership through the executive or their deputy and divisional representatives or specialist. When appropriate other individuals will be invited to join the meeting to present their report, but this will be by exception.

By the Board's delegation of responsibility to the 3i committees to provide oversight and timely escalation for matters relating to quality, safety and improvement, the Board itself will be able to act more in a more strategic manner. This will be reflected in a reporting framework for the **Board which provides greater emphasis on matters escalated by the committees, people engagement and strategy**.

The Board reporting cycle through the changes moves to a six-weekly meeting cycle which is aligned to allow timely reporting from the 3i committees. The reporting framework for the Board is structured to provide capacity on the agenda to focus on quality, safety and performance as well as people and improvement. This focus would not preclude or delay the consideration of matters by exception or escalation. With this change it is proposed that a **monthly summary of the 3i committees' activities is prepared which can be shared** internally with staff, the Board and our Governors as well as with external partners (CCG, NHSE/I and CQC).

Implementation of the new structure will evolve and progress will be reviewed to ensure effectiveness. This will include **independent review** through the well-led review agreed at the Board in March '21. The scope for this review is currently under development prior to an appropriate tendering exercise.

2. **Amendments to the constitution** (for information)

Based on delegated authority at the last meeting the Scrutiny Committee and Council of Governors approved changes to the Trust constitution. The proposed changes satisfy a number of important principles:

- Reflects the wider delivery of care across the whole of Suffolk but also to surrounding areas outside the periphery of the existing membership area
- Expanding our membership area to include the integrated care system (ICS) in which we sit
- Supports future recruitment of non-executive directors from a wider local geography

In order to expand the membership area without invalidating the existing public constituency and therefore the status of our current elected public governors it was agreed to create an additional public constituency which effectively extends our existing membership area boundary to include the rest of Norfolk, Cambridge and Essex. While it is important to reflect in our membership area this wider geography and the services accessed by its residents, it is also material that this should not be disproportionate in terms of the number of Governors that represent it. It was therefore agreed that when the membership of the new area meets the required threshold (100 members) an election will take place for one additional public governor. This additional Governor will sit alongside the current 14 public governors from our existing membership area.

3. **Annual report and accounts** (for information)

Details of the key dates have now been published alongside the Foundation Trust annual reporting manual (ARM). Preparations are underway to allow submission of the annual report and accounts by the June timescale. Similar to last year the requirement to include a Quality Report in the annual report has been removed. However, it is proposed that a quality account (as required by currently legislation) is prepared as a separate document during this process.

4. **2021/22 priorities and operational planning guidance** (for information)

The principles of the implementation guidance are that:

- System Development Plans (SDPs) should be updated and agreed between system partners and with NHSEI regional teams by the end of Q1, to set out how each ICS will develop the

leadership, capabilities and governance required to take on their anticipated statutory responsibilities from April 2022.

- Each system should also have an implementation plan in preparation for managing their organisational and people transition into the future arrangements.

The national set priorities for the year ahead are:

A. Supporting the health and wellbeing of staff and taking action on recruitment and retention
B. Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19
C. Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services
D. Expanding primary care capacity to improve access, local health outcomes and address health inequalities
E. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay
F. Working collaboratively across systems to deliver on these priorities.

We are working within the ICS to meet the required reporting requirements.

5. **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.

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

7. **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 29 March considered:

- Attain report - the structure of this report details the strategies for the Trust, CCG, the alliance and the ICS. It looks for a degree of coherence between them all and also reviews the services onsite, and considers if there is any services which could be aligned in advance of developing the future system programme
- Future systems programme – this focused on the provision of office accommodation in the new facility
- Review and refresh of the Trust's strategy, including engagement with staff and partners
- Operational challenges, including Covid and reset in the context of the papers received by the Board

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

- **Staff engagement and raising concerns** - the CQC identified that staff do not always feel able to raise concerns and it is clear that we need to listen more to our colleagues, be informed by their views, offer specific support to teams and have a greater focus on leadership and continuous learning. We are reviewing our culture and openness to make sure everyone – including our patients, our staff and our commissioners – can contribute to our improvement.
- **Failure to manage elective and emergency capacity and demand in the context of Covid activity and delivery of the RAAC remediation plan** – command and control structure put in place to manage the Trust's response in line with national emergency response.
- **WSH building structure and provision of suitable estate** – risk assessment and remedial work plans agreed and being undertaken. This includes external assessment of the Trust's response through 'ALARP' (as low as is reasonably practical) and legal opinion.

A full summary of the strategic risk is provided below.

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

As a results of the mitigation put in place the following red risks were downgraded:

- The risk of missing results in the process of endorsement (287)
- Severely reduced staffing levels in Blood Sciences, Haematology, Blood Transfusion, Biochemistry, Microbiology & Histology (2987)
- The management of clinical surveillance pathway (4002)
- Communication of the activation of the major haemorrhage protocol (4635)

8. Charitable funds committee report

The Charitable Funds Committee met on 26 February 2021. The key issues and actions discussed were:

- The Committee discussed the NHS Charities Together funding. The Charity is represented on the local funding panel. A number of proposals have been submitted and the outcome is awaited
- The Committee was updated on fundraising activities which had suffered as a result of Covid. However, this was starting to pick up again. A flat received as part of a legacy has been sold after protracted period.
- The receipt of donations was discussed and all were considered to be acceptable.
- The new MyWish website is due to be completed during April. This will make a huge difference in the visibility of the Charity in the community
- The charity showed that income had exceeded expenditure by £156k. This was primarily due to the NHS Charities Together income increasing the overall income levels. Expenditure was behind the previous year but should increase towards the end of the financial year.
- The Committee was advised of the latest position regarding the investment performance. Initially

the value of the investment dropped significantly as a result of concerns over coronavirus. However, since then there has been a gradual recovery of the market and the investment is currently showing a gain of £260k

- The auditors recommended that the Committee consider on a regular basis whether the Charity was a going concern. The Committee discussed the balance sheet and other issues that might impact the going concern and concluded that the MyWish is a going concern.
- The committee received assurance that all matters raised by the auditors in their report had been actioned.

9. Report from previous closed board meeting

The meeting on 26 March received a patient story which considered the care and treatment of a patient with complex physical and mental health needs. Reflecting on the patient's story it was clear that staff had worked across agencies on behalf of this patient with learning difficulties, led by Helen Beard, head of nursing and the G3 ward staff and the Board thanked them for their dedication and continued care. The aim of those involved was to allow the patient to return home and live independently through discussions with the clinical teams, CCG and health & social care. And doing this while keeping the patient safe and therefore able to be discharged with only intermittent support. It was recognised that the patient had subsequent admissions to the hospital but the case highlighted the importance of a broader system conversation on how to support such individuals. A briefing from the Trust's newly-created role of head of mental health is scheduled for the Board in June and this will provide a further opportunity to ensure we maintain a system-based focus on the physical, mental and care needs of our population.

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

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

Previously considered by:	The Board receive a monthly report of planned agenda items.
Risk and assurance:	Failure effectively manage the Board agenda or consider matters pertinent to the Board.
Legislation, regulatory, equality, diversity and dignity implications	Consideration of the planned agenda for the next meeting on a monthly basis. Annual review of the Board's reporting schedule.

Recommendation:

The board is asked to:

1. **Note** the contents of the report
2. **Approve** the new framework for engagement and oversight for quality, safety and improvement (item 1 of report), including establishment of the identified Board committees and changes to the Board meeting cycle

Annex A: Scheduled draft agenda items for next meeting – 28 May 2021

Description	Open	Closed	Type	Source	Director
Declaration of interests	✓	✓	Verbal	Matrix	All
Deliver for today					
Patient/staff story	✓	✓	Verbal	Matrix	Exec.
Chief Executive's report	✓		Written	Matrix	SD
Operational report	✓		Written	Action	HB
Report from Insight Committee, including integrated quality & performance report (IQPR)	✓		Written	Matrix	CB/HB/SW
Finance & workforce performance report	✓		Written	Matrix	CB
Risk and governance report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
Invest in quality, staff and clinical leadership					
Quality, safety and improvement report - Infection prevention and control assurance framework - Maternity services quality and performance report (inc. Ockenden) - Quality and learning report – learning from deaths, quality priorities - Improvement committee report - Nurse staffing report	✓		Written	Matrix	SW / NJ
People and OD – exception report	✓		Verbal	Exception	AR / JMO
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	SW
Build a joined-up future					
Digital board report	✓		Written	Matrix	CB
Future system board report	✓	✓	Written	Matrix	CB
Strategic update, including Alliance, System Executive Group and Integrated Care System (ICS), including: - Operational planning submissions	✓	✓	Written	Matrix	KV / SD
Governance					
Governance report, including - Agenda items for next meeting - Use of Trust's seal - TEG report - Remuneration committee report - Annual report and operational planning guidance - Risk appetite statement - Scope for well led developmental review - NED responsibilities - Foundation Trust Membership Strategy	✓		Written	Matrix	RJ
Scrutiny Committee report		✓	Written	Matrix	LP

Confidential staffing matters		✓	Written	Matrix – by exception	JMO
Reflections on the meetings (open and closed meetings)		✓	Verbal	Matrix	SC

11:45 ITEMS FOR INFORMATION

18. 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

19. Date of next meeting

To NOTE that the next meeting will be held on Friday, 28 May 2021 at 9:15am in West Suffolk Hospital

For Reference

Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

20. 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